



**Mount
Sinai
Beth Israel**

House Staff Policy and Procedure Manual

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Section HS 1

Credentials for House Officers in Residency/Fellowship Training Programs

Goal: To ensure only highly qualified House Staff be trained at Mount Sinai Beth Israel and facilitate excellent, professional patient care.

The Office of Graduate Medical Education is responsible for developing policies and procedures for credentialing of House Officers.

A. Maintenance of Credentials Files

- 1) Clinical Departments are responsibly for ensuring that all required credentialing documents are supplied to the GME Office for approval prior to commencement of the residency/fellowship program. The documentation must be uploaded to the New Innovations Onboarding Checklist.

Each incoming resident/ fellow shall provide the following (see Credential Checklist for further details):

- House Staff Application
 - Curriculum Vitae (CV)
 - Dean's Letter
 - Letters of Reference
 - Verification of 6 Core Competencies
 - Final Medical School Transcript
 - Medical School Diploma
 - Other Training Program(s) Certificate
 - USMLE/COMLEX Scores
 - BLS, ACLS & PALS (if applicable)
 - ECFMG (if applicable)
 - NPI Number
 - License/Limited Permit for all Non-Accredited Fellows (any house staff in an accredited program that possesses a license must submit documentation as well)
- 2) House Officers may be required to supply additional information to maintain credentialing and remain as active House Officers, on an as needed and/or annual basis, as determined by the policies and procedures of individual departments and/or the GMEC.

- 3) On an annual basis, after credentials verification, appointments to residency/fellowship training programs shall be submitted to the Office of Graduate Medical Education.
- 4) The Department is responsible for developing and monitoring policies and procedures for credentials review. These policies and procedures shall be reviewed periodically by the Office of Graduate Medical Education.
- 7) Collection of documents required for credentialing of House Officers on rotation from affiliated hospitals will be the responsibility of the host department. Verification of delineated privileges will be the responsibility of the department chair or his/her designee. The documents must be forwarded to the Office of Graduate Medical Education not less than 2 weeks prior to commencement of the rotation. Identification badges will be issued by Security only after credentialing by the Office of Graduate Medical Education is completed. House Officers will be provided with authorization by the Office of Graduate Medical Education.
- 8) For House Officers participating in electives or rotations at affiliate institutions, it is the responsibility of the respective department to ensure that the receiving institution is provided with any required credentials as may be determined by that Office of Graduate Medical Education.
- 9) It is the responsibility of the Department to ensure that the Office of Graduate Medical Education receives the fully executed out-agreement and rotation form with goals and objectives and receive approval before beginning of any out rotation.

GMEC approved 4/01, Editorial Revision: 4/11/11

Section HS 2
Compensation Policy for House Officers:

Goal: To assure fair, appropriate and consistent compensation of all House Officers in a manner that takes into consideration current and prior training.

❖ **House Officers Participating in an Accredited Training Program:**

House Officers are assigned a postgraduate year compensation level (PGY) based upon the following:

Those House Officers entering the first year of postgraduate training, subsequent to graduation from medical school, are designated PGY-1 House Officers.

Post-graduate training refers to a program sanctioned by the accepted accreditation bodies Accreditation Council on Graduate Medical Education (ACGME), and American Osteopathic Association (AOA).

House Officers successfully completing a year of training in an accredited program receive credit for an additional PG year and move to the next PGY compensation level (e.g. PGY1 moving to PGY2, etc).

House Officers continuing in the same training program will move to the next PGY compensation level, if all program requirements have been satisfactorily fulfilled, until completion of the accredited training program's requirements.

One or more years of training that has been successfully completed in an unrelated accredited program, will be counted, for a maximum of one year, in the calculation of the PGY salary scale at the discretion of the Program Director and Chief of GME.

House Officers will be compensated in accord with their PGY training level and the compensation pay scale as determined by the Office of Graduate Medical Education and the Human Resources Department of Mount Sinai Beth Israel.

❖ **House Officers Participating in Accredited Programs Requiring Special Training Prior to Entering the Accredited Program:**

It is recognized that certain specialties require a “preliminary” period of training in other medical disciplines.

Any years of **required** preliminary training will be utilized to calculate the PG year of the trainee entering an accredited training program. (E.g. ENT, Radiology, Urology etc).

PGY years will be cumulative for all **required** years of training in **accredited** programs. One or more years of training that has been successfully completed in an unrelated accredited program, will be counted as one year, in the calculation of the PGY salary scale at the discretion of the Program Director and Chief of GME.

❖ **House Officers Participating in Non-Accredited Training Programs:**

House Officers entering non accredited programs will receive:

Salary credit for all PG years in an accredited program resulting in board eligibility or certification, if, and only if, the non accredited program requires such training as a requisite for entering the non-accredited program. The Resident will receive salary credit for each successfully completed requisite years.

A maximum of one PG year credit, for one or more years of training that has been successfully completed in another accredited program will be counted, if the prior training was not required for entrance into the non-accredited program.

Approved GMEC 5/03

Section HS 3
House Officer Recruitment and Selection

Goal: To enroll the most qualified candidates into the BIMC training programs and in accordance with ACGME requirements.

1. Resident eligibility:

Applicants with one of the following qualifications are eligible for appointment to ACGME-accredited programs:

- a. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
- b. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
- c. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
 1. Have received and possess a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment or:
 2. Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are in training or a limited permit
 3. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.

2. Resident selection:

- a. ACGME-accredited and non-accredited programs select from among eligible applicants on the basis of their preparedness, ability, aptitude,

academic credentials, communication skills, and personal qualities such as motivation and integrity. ACGME-accredited and non-accredited programs must not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status.

- b. In selecting from among qualified American applicants, ACGME-accredited programs must participate in an organized matching program, such as the National Resident Matching Program (NRMP), where such is available. It is expected that each program will select the highest quality House Officer for training. Programs, however, can only offer positions to candidates contingent upon the candidate meeting all Institutional Requirements.

- c. Each Department must develop a departmental Recruitment and Selection Policy, which conforms to the Institutional Policy and ACGME Requirements and outlines the department's processes.

- d. It is expected that House Staff selected for residency and fellowship training will seek Board certification, where available, upon completion of the training program.

Approved GMEC: 12-8-03; revision 9-10-07; revision -2-11-08

Approved Medical Board 3-10-08

Section HS 4
Policy for Recruiting Replacement House Officers

Goal: To assist departments in identifying appropriate candidates to fill residency positions that become vacant unexpectedly.

Departments should identify potential candidates, review curriculum vitae, applications and letters of recommendations. Applicants should be interviewed and subject to the same selection criteria utilized for resident selection.

When a department identifies a candidate for a vacancy, all supporting information should be forward to the Office of Graduate Medical Education for review and verification. Letter of offer may only be provided to the candidate after GME written approval. This approval will be given within 48 hours of receipt of the complete application materials.

Approved: GMEC 2/03

Section HS 5
Policy on House Officer Evaluation and Promotion

Goal: To ensure appropriate monitoring and review of House Staff knowledge, skills and attitudes to develop a highly competent physician and ensure optimal patient care.

House Officer Evaluation

The Graduate Medical Education Committee assures that each residency program has developed its own House Officer Evaluation Policy. These policies must detail methods to assess House Officer performance throughout the residency program. Programs must delineate how the results of this assessment process are used to improve House Officer performance. The programs are required to provide accurate assessment of House Officers' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice (the ACGME 6 competencies). If required by the department, participation in the web-based Core Curriculum modules should be monitored as part of the evaluation process.

- a. The programs are monitored, during the Annual Program Evaluation process, to assess compliance with the ACGME's Common Program Requirements. Evaluations incorporate regular and timely performance feedback to House Officers, including a written semi-annual evaluation, or as required by the Residency Review Committee and Program policy, that is communicated to each House Officer and signed by both the evaluator and the House Officer. If any deficiencies are noted, a detailed remediation plan must be developed.

- b. All material in the Resident file should be considered in the evaluation process. Such materials may include:
 1. Issues that have been referred through the Medical Center's risk management/quality improvement processes and/or patient representative department.
 2. Completion of Medical Records.
 3. An evaluation of any complaints made by staff or patients involving the resident being evaluated.
 4. Other objective measures such as 360 degree evaluations, structured observed exams, tests, patient simulations, etc., with which to measure the core competencies.

The process of evaluation is designed to enable the House Officer to achieve progressive improvements in competence and performance. Copies of all evaluations shall be maintained in each department's house officer file.

Final Evaluation

1. The Program Director completes a final evaluation for each House Officer who completes the program. The evaluation includes a review of the House Officer's performance during the final period of education and verifies that the House Officer has demonstrated sufficient professional ability to practice competently and independently. The Office of GME has a form specifically designed for this purpose, available on ***New Innovations***.
2. The final evaluation is part of the House Officer's permanent record maintained by the institution. Final evaluations must be provided to the House Officer and the Office of Graduate Medical Education.
3. House Officers completing training are required to provide a final evaluation of the training program.

Compliance with this policy is monitored during the Internal Review process.

Policy on Promotion of House Officers

The Graduate Medical Education Committee of Mount Sinai Beth Israel assures that each program has a written Promotion Policy. This policy is distributed to all House Officers in the residency and fellowship training programs at the beginning of the training program. The promotion of House Officers throughout the program is based upon the House Officers' successfully fulfilling the educational goals of the program with respect to the knowledge, skills, and other attributes for each major assignment and each level of the program. The program must assess the House Officer with respect to attaining pre-determined milestones. Feedback throughout the educational process is designed to assist the House Officer to maintain strengths and remediate deficiencies so that they can achieve promotion through the program and demonstrate competence with the six (6) domains as defined by the ACGME.

The residency programs consider the House Officers' growing competence in the six areas listed below, when developing promotion criteria and determining whether House Officers can be promoted to the next level of training. House Officers are expected to demonstrate growing competence in:

Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

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

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

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

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

House Officers' participation in scholarly activities is expected, is monitored by the departmental evaluation process and considered when making decisions related to promotion.

Each program has a department-specific Promotion Policy that complies with ACGME standards and conforms to the Institutional Promotion Policy.

Adapted from the Graduate Medical Education Directory 2003-2004

Approved GMEC:12-03 Editorial Revision: 05-15

Section HS 6

House Officer Reappointment, Non-Promotion and Termination Policy

Goal: To retain qualified, professional and competent House Staff until completion of their designated training program(s) and provide mechanisms to guide this process. In the event of non-promotion or termination, to provide a fair process in compliance with Institutional ACGME policies.

1. All physicians rendering care at Beth Israel Medical Center must be appropriately credentialed by the Office of Graduate Medical Education.
2. Appointments for Graduate Medical Education have specific terms (duration) of appointment.
3. At the end of the term of appointment, unless renewed at the direction of the host department, training appointments will automatically terminate. In that case, physicians no longer are credentialed or privileged at Mount Sinai Beth Israel, unless they have applied to the Attending Staff, in which case the procedures set forth in the Medical Staff Bylaws will be followed and credentialing will occur through the Medical Staff Office.

After the House Officer's GME appointment has terminated, he/she may not practice at Mount Sinai Beth Israel until he/she has been formally appointed to the Medical Staff, even if an application for appointment to the Medical Staff has been submitted.

4. When House Officers will not be promoted to the next level of training or will not have their contract renewed, they will be provided with a written notice of intent not to renew a House Officer's contract no later than four (4) months prior to the end of the House Officer's contract. However, if the primary reason(s) for the non-renewal occurs within the four months prior to the end of the contract, Mount Sinai Beth Israel will provide the House Officer with as much written notice of intent not to renew as the circumstances will reasonably allow. House Officers may invoke the department's and the institution's grievance procedures when they have received a written notice of intent not to renew their contract.
5. Host departments are required to notify the Graduate Medical Education Office of any extension of training appointments.

6. Host departments are required to immediately notify the Graduate Medical Education Office of any change of an individual's training status.

Approved 3-03,

Revised 2-12-07

Section HS 7
Grievance Procedure for House Officers

Goal: To provide House Staff with a fair and reasonable procedure to address grievances and ensure due process.

A. Disciplinary Matters

1. Request for Hearing

a. Any House Officer who has received notice of dismissal, non-renewal of a contract, suspension, non-credit or non-promotion or other actions that could significantly threaten a House Officer's intended career development is entitled to a hearing before the House Staff Grievance Committee. In instances of proposed suspension, the House Officer will be required to complete the grievance procedure offered by his/her department before recourse to a hearing before the House Staff Grievance Committee. However, when a dismissal or non-renewal of a contract is proposed, the House Officer will have the right to a hearing before the House Staff Grievance Committee without the requirement of completing the departmental grievance procedure.

If a House Officer who has received notice of dismissal requests a hearing, his/her status during the hearing process, including any appeal to the Board of Trustees, will be suspension with pay, benefits and housing. However, a House Officer who is dismissed in the final year of a residency program is not entitled to receive pay, benefits or housing after June 30 of the year in which he or she is dismissed.

b. A House Officer is also entitled to a hearing if he/she is alleged to have committed professional misconduct or another offense which must be reported to the Office of Professional Medical Conduct of the New York State Department of Health. The purpose of the hearing in this case will be to review and make a determination about the underlying facts, not to determine whether the matter must be reported to OPMC, which is a legal determination to be made by Medical Center administration.

A request for a hearing before the House Staff Grievance Committee must be sent in writing to the President of the Medical Center within 10 days of receipt of the notice of termination, non-renewal, reporting to OPMC, or, in the case of a suspension, completion of the departmental

grievance procedure. In the event the House Officer fails to request a hearing within such 10-day period, the action shall become final and effective.

2. Appointment of Committee

The President of the Medical Center shall appoint a House Staff Grievance Committee (the "Committee") consisting of three members as follows: one Department Chair or Program Director, one physician designated by the President of the Medical Board and one House Officer. The President of the Medical Center shall designate one member of the Committee to serve as Chair. Committee members must not be members of the department of the House Officer requesting a hearing.

3. Hearing

a. The Committee shall hold a hearing no sooner than 15 and no later than 45 days from the date the written request for the hearing is received. In the event the House Officer has been suspended, the hearing shall be held as soon as possible. The House Officer shall be entitled to be present at the hearing, to present relevant evidence and witnesses on his or her behalf and to question witnesses appearing in support of the charges made. The House Officer may have legal representation, the cost of which is the responsibility of the House Officer. All testimony at the hearing shall be under oath and a transcript of the hearing shall be made. The rules of evidence shall not apply. The Committee shall have the right to review the House Officer's entire departmental file. A copy of the House Officer's departmental file shall be provided to the House Officer or his/her legal representative prior to the hearing, stamped as "unofficial," provided that the House Officer signs a stipulation that he/she will use the file documents solely in connection with the pending hearing and any related appeal and acknowledging that the file does not represent an official copy of his/her transcript. Such stipulation shall be developed by the Legal Department. The disciplinary action shall be upheld if the Department shows by a preponderance of evidence that its actions were not arbitrary or unreasonable. All members of the Committee shall be in attendance to constitute a quorum. The House Officer must be free of clinical duties during scheduled hearing sessions. The Committee shall make such additional rules as it deems necessary to assure prompt and fair handling of the matter.

b. Within 10 days of the conclusion of the hearing, the Committee shall submit a written report of its findings and recommendations to the President of the Medical Center who will then render a decision which will be reported to the House Officer and the Departmental Chair.

4. Appeal

The decision of the President may be appealed by the House Officer, or the Department Chair, to the Board of Trustees. A request for review by the Board of Trustees shall be sent in writing

to the Chair of the Board of Trustees, via the Medical Center's General Counsel, no later than 10 days after receipt of notice of the decision of the Committee. In the event no appeal is requested, the decision of the Committee shall be final.

5. Board of Trustees Review

- a. The Chair of the Board shall appoint a Review Committee consisting of not less than three (3) members of the Board, one of whom shall be designated as Chair. The Review Committee may at its discretion limit the appeal to review of the record of the proceedings before the House Staff Grievance Policy and Procedure for House Staff Committee or may conduct a new hearing pursuant to the procedures set forth in #3. The House Officer, Department Chair and/or the Program Director and President of the Medical Center shall be given the opportunity to meet with the Review Committee. The House Officer is entitled to be represented by counsel at his/her expense.

- b. The deliberations of the Review Committee shall be concluded no later than 30 days after receipt of the request for appellate review, except when the House Officer is under suspension or termination, in which case the deliberations shall be concluded as soon as possible. A report summarizing the conclusions and recommendations of the Review Committee shall be presented to the Board of Trustees at the next regularly scheduled meeting following the conclusion of the Review Committee's deliberations. The Board of Trustees may accept, reject or otherwise modify the recommendations of the Review Committee or may take such other action as it deems appropriate. The decision of the Board of Trustees shall be final. The decision of the Board of Trustees shall be presented in writing to the House Officer within 10 business days.

6. Exclusive Remedy

The procedures set forth in this policy represent the sole and exclusive remedy for House Officers and shall be in lieu of any due process or grievance mechanisms set forth in any other Medical Center policies and bylaws.

B. Process for Addressing Complaints by House Officers

House Officers with complaints or grievances, not pertaining to disciplinary action or professional sanctions, shall initially bring such grievances to their Program Director or Department Chair. If the House Officer's concern remains unresolved, the House Officer shall seek assistance in addressing the matter from either the House Staff Committee or the Chief of GME/Academic Affairs. If the matter involves duty hours, legal, regulatory or ethical issues, the House Officer may anonymously call the Corporate Compliance hotline at 1-800-692-2353.

Should the House Officer's complaint remain unresolved after taking these measures, the House Officer is entitled to a hearing. The House Officer must request such hearing in a letter to the Chief of GME/Academic Affairs, describing the grievance and the attempts made to resolve it. The Chief of GME/Academic Affairs will inform the Chair and Program Director of the House Officer's Department/Program that a hearing has been requested. The Chief of GME/Academic Affairs will appoint an ad hoc Committee within two weeks, consisting of: 1) a Program Director who will serve as the Committee Chair; 2) a Senior Faculty member; and 3) a House Officer, none of whom shall be from the House Officer's Department/Program, to review the issue. Within two weeks, the Committee shall interview the House Officer, the Program Director, and other persons as deemed necessary, and present a written recommendation to the Chief of GME/Academic Affairs within two (2) weeks of the hearing. The report and recommendations of the Committee will be presented at the next GMEC meeting and a final decision and/or recommendation shall be made by the GMEC. The GMEC will monitor implementation of all such decisions.

Revision Approved GMEC: 2-04, 2-12-07, 5-14-07, 7-9-07, 12-10-07
Approved Medical Board: 1-14-08

Medical Records and Health Information Privacy

Goal: To protect the confidentiality and privacy of medical records and other health information in accordance with all applicable State, Federal, and local laws and regulations.

House Officers are expected to comply with all applicable laws, regulations, and professional duties regarding privacy and confidentiality, and with all privacy policies and procedures adopted by the Medical Center or by other clinical sites where House Officers may have access to health information. The Privacy Officer will be responsible for monitoring compliance with privacy policies and procedures at the Medical Center.

A. Medical Records. All House Officers shall maintain the confidentiality, privacy, security, and availability of all protected health information in records maintained by the Medical Center, or by privacy policies adopted by the Hospital to comply with current Federal, state, or local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Protected health information shall not be requested, accessed, used, shared, removed, released, or disclosed except in accordance with such health information privacy policies of the Medical Center and as permitted by HIPAA.

B. Health Information Privacy Consents and Authorizations. House Officers shall cooperate with Hospital personnel in obtaining and maintaining the medical record and any and all patient consents or authorizations required under any and all health information privacy policies adopted by the Medical Center to comply with current Federal, State, and local laws and regulations, including, but not limited to, HIPAA.

Approved 11/02

Section HS 9 Equal Employment Opportunity Policy

Goal: To assure an institutional environment free from biases.

Mount Sinai Beth Israel has been undergoing significant changes in response to the dynamic environment of today, and in anticipation of the challenges of the future. However, one principle that remains constant is the need to attract and retain the most talented individuals possible. This principle is fully consistent with another fundamental commitment of the Medical Center: to ensure equal employment opportunity (EEO) for all.

Mount Sinai Beth Israel has taken, and will continue to take, all appropriate steps to comply with both the letter and the spirit of Federal, State and City anti-discrimination laws. The Medical Center will not discriminate against any employee or applicant for employment on the basis of his actual or perceived race, creed, color, veteran status, marital status, age, sexual orientation or any other basis prohibited by law. The Medical Center will base all employment decisions, including promotional opportunities, on job-related and business reasons alone, so as to further the principles of equality and opportunity for all.

The Vice President of Human Resources has overall responsibility for overseeing the Medical Center's Affirmative Action Program, which has been developed in furtherance of the Medical Center's EEO commitment. The Human Resources Department will monitor employment and all other related plan activities with the assistance of staff throughout the Medical Center. All managers, at every level of the Medical Center, are responsible for treating their employees in a fair, objective and consistent manner. Additionally, the Medical Center relies on the support of each employee to ensure a work environment free from discrimination or harassment.

Mount Sinai Beth Israel believes that a sound EEO program, fully implemented, will serve the best interests of the Medical Center. Beth Israel recognizes that implementing this EEO Policy and the Affirmative Action Program is critical to ensure the long-term success of our mission. Every member of the Medical Center family is expected to accept and adhere to this commitment.

Section HS 10

House Officer Duty Hour Monitoring

Goal: To implement a structure whereby Medical Center wide monitoring of Resident Work Hours can be reviewed on a regular basis. This is a requirement of the State of New York Public Health Law, in addition to the ACGME (Accreditation Council for Graduate Medical Education) standards. Monitoring efforts will assist in assuring compliance and Resident/Fellow well-being.

Policy:

To facilitate ongoing review of issues associated with Resident Work Hour requirements, an overview of this activity will be provided to the GMEC (Graduate Medical Education Committee) quarterly in the Mount Sinai Health System Wide Resident / Fellow Work Hour Executive Summary.

Procedure:

Clinical departments that are involved in Resident and Fellow education (both accredited and non-accredited) are required to monitor Resident and Fellow work hours. It is expected that New Innovations (NI) will be used to document duty hours. As of January 2011, Residents and Fellows are required to log onto NI and enter daily duty hours. Entries may be recorded weekly for the previous week's work hours. Coordinators may enter hours for house staff, in accordance with each house officer's schedule, or New Innovations may populate hours from the daily schedule entered into NI. With each of these last two methodologies, house officers are expected to approve and/or revise hours to reflect actual duty hours. The Residency/Fellowship Coordinator will coordinate the aggregation of the data for four four-week review periods which must be submitted to the GME Office and GMEC for review. Data collection includes a Program Duty Hour Reporting template as well as the following individual reports: Hours Logged Report, Violations Report, and Analysis Report (days off per week) and a Corrective Action Plan. The Program Director must review and approve all submissions and sign the Duty Hour Report Checklist. Program data reports will be reviewed by the Mount Sinai Beth Israel GME Office and presented to the GMEC quarterly during the resident work hour report. Program with substantial resident work hour noncompliance will be required to submit monthly reports to the GME Office and GMEC.

If a Resident or Fellow feels that there is a lack of compliance with work hour requirements, he/she should bring it to the attention of the Department Chair or Program Director or, if they prefer, to the Chief of Graduate Medical Education, Director of Graduate Medical Education, the anonymous Corporate Compliance Hotline and/or the anonymous house officer complaint form, accessed

through New Innovations. Hospital appointed ombudsmen are also available to hear house officer concerns.

Should areas of non-compliance be identified, the Department will be responsible for implementing plans of corrective action and monitoring its success.

The results of these activities will be reviewed through the GMEC to the Medical Board and onto the Board of Trustees.

Duty Hour Requirements and Reporting Options

Mount Sinai Beth Israel is committed to full compliance with the State and ACGME regulations limiting the working hours of physicians-in-training. We will uphold these regulations, not only because we are legally obligated to do so, but also because they promote quality patient care and enhance the quality of the educational experience for house officers. **WE ASK FOR HOUSE OFFICER ASSISTANCE IN ENSURING THAT THERE ARE NO VIOLATIONS OF THE LEGAL LIMITS ON RESIDENT WORKING HOURS IN YOUR DEPARTMENT OR ELSEWHERE IN THE MEDICAL CENTER.**

The regulations establish the following limits on resident working hours:

Residents with inpatient care responsibilities:

- No more than 80 hours per week over a four-week period, inclusive of all moonlighting;
- A minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days;
- Duty periods of PGY 1 residents must not exceed 16 hours in duration;
- Duty periods of PGY 2 and above may be scheduled to a maximum of 24 hours of continuous duty
- Program must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between 10PM-8AM is strongly suggested;
- Residents may be allowed to remain on site for transition of care, however, this period of time must be no longer than an additional three hours

- Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty
- PGY1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods
- Intermediate and senior -level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
- Maximum in house call for PGY2 and above is every third night (averaged over 4 weeks)
- Residents must not be scheduled for more than 6 consecutive nights of night float.

Residents in the Department of Emergency Medicine: no more than 12 consecutive hours on duty

WE ENCOURAGE REPORTING OF ANY VIOLATION OF THESE REGULATIONS. If there is discomfort in reporting such violations to the Department Chair or Program Director, please report them directly to the Chief of the Graduate Medical Education/Designated Institutional Official or the Director of Graduate Medical Education.

Alternatively, concerns can anonymously be reported to the CORPORATE COMPLIANCE Hotline (1-800-853-9212).

MSBI is committed to promptly investigating all reports and correcting any violations found. Administration will also ensure that there are no reprisals against any person who reports violations.

Please be assured that, in addition to the aforementioned, the institution is taking many other steps to make certain that Resident working hours remain consistent with the limits of these regulations.

Revised GMEC: 9/05, 12/10, 1/11, 4/11, 4/12,
Editorial Update: 1/15

Section HS 11 Duty Hour Exemptions

Goal: To develop and implement a process to review requests for duty hour exemptions from eligible programs.

Both ACGME and NYS have developed policies for work hour regulations. Beth Israel Medical Center states that House Officers must comply with each policy and that the policy with the most restrictive regulations takes precedence. NYS regulations prohibit exemptions from duty hour regulations and the 80 hour work week.

NYS duty hour regulations do not apply to Radiology, Psychiatry and Pathology programs, therefore ACGME exemption is applicable. The process for these programs to request duty hour exemptions shall be as follows:

- Request submitted to the GMEC detailing the sound educational rationale for the up to 10% of the Plan must include mechanisms to monitor duty hours with sufficient frequency to ensure an appropriate balance between education and service.
- Back up support systems must be included when patient care responsibilities are unusually difficult or further prolonged, or if circumstances create Resident fatigue sufficient to jeopardize patient care.
- GMEC renders a decision.
- If GMEC approves the request, a letter written by the Program Director and Chair of the GMEC will be sent to the program's RRC.
- 80 hour limit exemption

Diagnostic Radiology RRC will not consider requests for exemptions to the 80 hour/week, averaged monthly, limit. Thus, the aforementioned process does not apply to this specialty.

GMEC Approved: 2-04

Section HS 12
Employee Benefits/COBRA

Goal: To provide health and hospital insurance for House Officers and their eligible family members as well as provide and offer disability insurance for disabilities resulting from educational program-related activities.

The Medical Center offers a comprehensive benefits program; these are subject to change. Annually, House Officers are provided with a variety of benefit options. It is the responsibility of the House Officer to enroll in benefits plans. **Refer to: <http://chip.chpnet.org/> Human Resources link, for details.**

COBRA Procedure for Outgoing House Staff:

The GME Office will provide Human Resources a spreadsheet of House Staff that have completed training.

The Benefits Office will prepare COBRA notifications to Benefit Concepts Inc (BCI), the COBRA third-party administrator. BCI will send COBRA materials to the house officers' home (address on file with HR). The House Officer has 60 days from the date of the COBRA notice to complete the form and return it with payment to BCI for processing.

The COBRA qualifying event for all exiting House Staff is June 30. Medical and/or dental COBRA continuation is effective July 1. There is no true break from House Officer coverage to COBRA coverage; however, there is an administrative delay. If eligible services are incurred on July 1 or after, these expenses may be submitted to the insurance carriers for processing once the COBRA set-up is complete. In this case, the House Officer would have to pay for their services up front.

The House Officer plan will be terminated effective June 30 (eligible services may be incurred through 11:59pm).

COBRA materials will be received by the House Officer after the actual plan termination. When BCI receives a COBRA continuation request and payment, they need 2-3 weeks to process it with the insurance carriers. The ex-House Officer will then be set up in medical and/or dental under COBRA group numbers.

Due to the volume of exiting House Staff, the Benefits Office requires a minimum of a week after receipt of the spreadsheet to prepare notifications to BCI. BCI mails COBRA materials within days of Benefits Office notification to them.

Revised: 7-25-07, editorial revision-3-27-09, editorial revision 3-7-11

Section HS 13
Sick Time Accrual Policy

Goal: To inform House Staff of institutional policies related to sick time.

House Officers are permitted 12 days per year (calculated at the rate of one (1) day per month); absences of seven (7) or more consecutive days require a Leave of Absence Form to be completed and a "fit for duty" clearance from Employee Health Services. Unused sick days are not to be rolled over to the next year. Each department has its own specific policy related to the mechanisms of using/reporting sick time. Each department must develop a policy delineating whether sick time is to be accrued or available at the beginning of the academic year. Leave beyond that permitted by individual Boards may result in extension of the residency or fellowship program.

Approved 1/02, revision 11/06, 6/07, 1/10/11, 2/14/11

Section HS 14

House Officer Leave of Absence Policy

Goal: To assure that House Officers are aware of the institutional policies regarding leave for vacation, health or personal reasons and to ensure fair implementation of these policies.

Policy

All leave must be within the guidelines of the respective Residency Review Committees and the Specialty Boards. It is the responsibility of the House Officer to be familiar with these requirements.

Leave beyond that permitted by individual Boards may result in extension of the residency or fellowship program.

The Medical Center provides employees with time off with or without pay for various reasons. This policy establishes Medical Center guidelines for granting and administering leaves of absence in accordance with the Family and Medical Leave Act of 1993, the Americans with Disabilities Act of 1990, Military Selective Service Act, Vietnam Era Veterans' Readjustment Allowance Act and the Uniformed Services Employment and Reemployment Rights Act of 1994.

Benefits

Leave under FMLA, like all other leaves, must be within the time guidelines of the respective Residency Review Committee and Specialty Board, or the House Officer may be unable to graduate as originally scheduled.

Confidentiality

Forms that contain medical information are considered confidential and are treated as such.

House Officers should consult Human Resources for further requirements for taking leave under the FMLA, including application forms and documentation requirements. House Officers are subject to the Medical Center's FMLA policy, except to the extent it is inconsistent with anything in this section. For House Officers employed less than one year, see ***HS Section 44 – Compassionate Leave for New House Officers***.

Paid Days for Birth or Adoption of a Child:

- a. three (3) days parental leave (either sex)
- b. disability due to maternity shall be considered sick leave

Condolence:

- a. up to five (5) days for death of house officer's mother, father, spouse, domestic partner, child, grandparent, brother or sister.
- b. House Officers will not be required to make up missed on-call coverage while on bereavement leave.

Conference Days:

are granted at the discretion of the Program Director based upon:

- i. educational objectives
- ii. departmental needs, and
- iii. performance evaluation

Interview Days:

are granted at the discretion of the Program Director based upon:

- i. maximum of five (5) interview days may be granted at the discretion of the Program Director with pay.
- ii. interview days will only be granted in the appropriate year of a categorical program.
- iii. Residents in preliminary programs must use vacation days for interviews or at the discretion of the Program Director.

Confidentiality

Forms that contain medical information are considered confidential and are treated as such.

Special Note: See *BIMC Human Resources Personnel Policy & Procedure Manual: Leaves of Absence*, Revised: February 1, 2009 see http://intranet.chpnet.org/human_resources/loa/loa.html. (direct link only available if you are on the CHP computer network)

Last Approved 4/04, revised 7-25-07, editorial revision 3-27-09

GMEC: revised 1-10-11; revised 2-14-11

Section HS 15
Vacation Policy

Goal: To advise House Officers of the institutional policy related to vacation time.

Twenty (20) days of paid vacation are allotted. Unused vacation days are not to be rolled over to the next year, nor is payment for unused days permitted. Specific Boards may have requirements that preclude such allotment, which would be detailed in the individual department's policies. House staff in accredited programs are required to take the allotted vacation time. Leave beyond that permitted by individual Boards may result in extension of the residency or fellowship program. Holiday schedules will be determined on a departmental basis by need. Paid holidays are not included in house staff benefits.

Approved 1/02, Revision 11/06, 8/9/10, 1/10/11, 2/14/11

Section HS 16
Physician Impairment/Physician Health

Goal: Promotion of Provider Health, Protection of Patients and Assistance to Providers with Impairments.

Goals/Purpose:

The goals of this policy are: (1) to promote health of Providers (defined below); (2) identify and prevent potential risks to patients which may occur when a Provider is impaired by use of drugs (including depressants, stimulants, narcotics or illegal substances), alcohol, or physical or mental disability; (3) to encourage Providers who suffer from impairments to self-report and to assist them in obtaining appropriate treatment; (4) to ensure that if disciplinary action is taken by the Medical Center with respect to Providers' privileges and employment it is consistent with the Americans with Disability Act, other applicable laws and applicable Medical Center policies; (5) to maintain information about Provider impairment as strictly confidential, except insofar as disclosure may be legally or ethically required; (6) to ensure that Providers are reported to applicable federal or state agencies (the National Practitioners Data Bank and the New York State Office of Professional Medical Conduct or Education Department) if and when legally required.

Scope:

This policy applies to all Physicians, Dentists, or Podiatrists, including members of the Attending Staff, House Physicians and House Officers ("**Providers**"). It also applies to House Officers who are rotating to the Medical Center or who are on elective to the Medical Center from another institution; however, any investigation or action undertaken with respect to rotating/elective House Officers must be in consultation with the sponsoring institution and subject to applicable requirements of the agreement between the institution and the Medical Center.

The requirements for reporting Provider impairment apply to all employees of the Medical Center as well as to all Providers as defined above.

Procedure:

1. Definition of Impairment. For the purposes of this policy, being **impaired** is defined as practicing while the ability to practice may be adversely affected by physical or mental disability or while

under the influence of alcohol or drugs, or being habitually drunk or dependent upon or a habitual user of drugs.¹

2. Obtaining Assistance. Providers who are experiencing medical problems or who suspect that they may be impaired are encouraged to seek assistance from their private physicians. In addition, physicians are encouraged to self-report to the Committee for Physicians' Health of the Medical Society of the State of New York ("CPH"). CPH was established by the State Medical Society to assist physicians with drug or alcohol dependence and mental illness. CPH evaluates physicians, makes treatment recommendations and referrals and monitors follow up.

Reporting to CPH does not exempt the Medical Center from the obligation to report to OPMC; consult the Legal Department as provided in Section 9, below. CPH's telephone number is 800-338-1833.

Physicians, Podiatrists, Dentists and other licensed professionals who abuse drugs and alcohol are encouraged to apply to the Professional Assistance Program of the New York State Education Department ("PAP") for a voluntary temporary surrender of their license. PAP operates pursuant to the New York State Education Law, and makes referrals for evaluation and treatment. A voluntary surrender is not considered an admission of disability or professional misconduct, although PAP notifies the State Health Department and hospitals at which the licensee has privileges of the temporary license surrender. After treatment, the person may apply to PAP for the restoration of his/her license. PAP usually requires two years of monitoring as a condition of restoration. PAP is NOT authorized to grant voluntary temporary license surrender if the licensee's impairment has caused patient harm. PAP's telephone number is 518-474-3817.

The Division of Occupational Medicine/Employee Health Service is also available to make referrals for medical treatment. **(Note: the Employee Health Service is part of Hospital administration and does not establish a confidential physician-patient relationship with respect to impairment evaluations. Its policy is to disclose information concerning Provider impairment to Hospital Administration if there is any question of inappropriate medical practice, patient safety or the like.)** Providers are also encouraged to self-report any suspected impairments to their

¹ The New York State Education Law defines "professional misconduct" to include "practicing the profession while impaired by alcohol, drugs, physical disability, or mental disability" and "being a habitual user of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects, except for a licensee who is maintained on an approved therapeutic regimen which does not impair the ability to practice, or having a psychiatric condition which impairs the licensee's ability to practice.

Department Chair, the Chief Medical Officer or the GME Officer, so that necessary steps can be taken to protect patients and to help the Provider to practice safely and competently.

3. Reporting Cases of Provider Impairment. Any Medical Center employee or member of the medical staff who has a reasonable basis for believing that a Provider may be impaired must promptly report such circumstance, and the facts upon which it is based, to his or her supervisor, or to the Department Chair of the Provider in question, the Chief Medical Officer, or, in the case of a House Officer, the Chief of, or the Director of, the Graduate Medical Education Office (“GME Officer”). Any supervisor receiving a report of Provider impairment must **promptly** relay it to the reported Provider’s Department Chair (attending physicians or other licensed professionals) or the Chief Medical Officer or GME Officer (House Officer), if the person making the report has not already done so.
4. Investigation by Ad Hoc Committee. In instances in which there is a possibility that Provider impairment may potentially affect the Provider’s ability to practice or to render safe and competent medical care, an Ad Hoc Committee will be formed, which will include the Department Chair of the Provider in question, the Chief Medical Officer or GME Officer, and the Director, Occupational Medicine/Department of Employee Health (“OM Director”).² A member of the Legal Department will advise the Committee. The Committee will conduct an investigation, which may include interviewing the Provider and any other individuals who have relevant information, reviewing the Provider’s credentials and QI file, and reviewing any relevant patient records. If necessary to protect patients or staff, attending Providers’ clinical privileges may be suspended pending completion of the investigation, while House Officers may be relieved from clinical responsibilities (and, in appropriate cases, given additional didactic responsibilities).
5. As part of its investigation, the Provider’s Chair or the Committee shall require the Provider to report to the OM Director (this term shall include any designee of the OM Director), Department of Employee Health, for an immediate evaluation of fitness for duty, which may, as appropriate, include a drug or alcohol test or psychiatric or medical evaluation. The Provider should be escorted to the Department of Employee Health. The Provider’s Department Chair or the Chief Medical Officer or designee shall provide the OM Director with a written referral, including the reasons for referral and other information relevant to the OM Director’s assessment. The Provider’s refusal to cooperate with all or part of the evaluation may be the basis for disciplinary action, up to and including dismissal from employment or termination of privileges.

² If the Provider in question is a house officer, the Department Chair may delegate all or part of his responsibilities to the Program Director.

The OM Director will evaluate the Provider's fitness for duty and may require the Provider to be evaluated by additional specialists. The OM Director will report the results of the evaluation to the Committee, and may recommend an appropriate course of action, including medical, psychiatric or other treatment, monitoring, or medical leave of absence.

The Committee will then determine what course of action the Medical Center should follow concerning the Provider, taking into account recommendations from the OM Director, if any. In addition to the evaluation by the OM Director, the Provider, at his or her option and expense, may obtain an independent medical evaluation and forward the results to the Committee for its consideration. Any decision by the Committee to grant or extend a medical leave of absence to a House Officer or other employed physician requires consultation with the Department of Human Resources (HR) and the policies and procedures established by HR shall be followed.

6. Disciplinary Action. Any Provider, except for a House Officer, who is found to be impaired while on duty because of use of drugs (except for an approved therapeutic regimen) or alcohol will be automatically terminated from the Medical Staff and, if applicable, from employment by the Medical Center. With respect to (a) House Officers, and (b) Providers who are not found to be impaired while on duty, but who are nevertheless impaired under this policy (i.e., dependent upon or habitual users of drugs or alcohol), the Committee will make a case by case assessment of whether corrective action, including termination, is appropriate. The factors the Committee will take into account should include, but not be limited to, whether the Provider sought assistance for the impairment and reported it to his/her Department Chair or other Supervisor, whether the Provider has cooperated with the investigation and treatment plan, whether there have been prior instances of the behavior in question, and the Provider's prior record as a whole, including whether he/she has previously been subject to discipline of any kind. Disciplinary actions against non-House Officer Providers are subject to hearing rights under the Medical Staff Bylaws. Disciplinary actions against House Officers are subject to hearing rights under the House Staff Grievance Policy.
7. Return to Work. A Provider who has been on medical leave or found to be unfit for duty may not return to work or resume privileges until he or she has been medically cleared by the OM Director. In appropriate cases, the OM Director, in consultation with the Committee, shall develop a protocol for ongoing treatment, evaluation and monitoring of the Provider.
8. Confidentiality. The deliberations, evaluation and actions of the Committee shall be conducted in strict confidence and shall not be disclosed, except insofar as may be required to meet the Medical Center's legal or ethical obligations.

9.Americans with Disabilities Act. The Legal Department shall be consulted to ensure that any action taken with respect to the Provider is consistent with the Federal Americans with Disabilities Act (“ADA”) and state and local discrimination laws. Briefly, if a Provider has a “disability” which is protected by the ADA, the Medical Center must consider whether there are any “reasonable accommodations” that can be made that would allow the Provider to perform the “essential functions” of his or her position without endangering patients or staff. In addition, the Medical Center may not subject a Provider to discrimination in any term or condition of employment based on disability.

10.Reporting to OPMC and NPDB. The Legal Department shall advise whether a report must be made to the Office of Professional Medical Conduct of the New York State Department of Health (“OPMC”) and/or the National Practitioners’ Data Bank.

11.Education. This policy will be periodically reviewed with all Providers. The Medical Center also will sponsor periodic educational programs addressing Provider health issues. Orientation for House Officers and the House Officer core curriculum will include information on this policy and House Officer health issues. Employees will be educated on their responsibility to report Provider impairment.

Revised and approved GMEC 2/04

Section HS 17A

Business Relationship Between Mount Sinai Health System and Medical Vendor Representatives

THE MOUNT SINAI HEALTH SYSTEM, NEW YORK STANDARD: POLICY AND PROCEDURE	SUBJECT NO. ACS- C.14
DEPARTMENT: Corporate Compliance SUBJECT: Business Relationship Between Mount Sinai Health System and Medical Vendor Representatives	
<u>CROSS-REFERENCE:</u>	

Original date of issue: 01/01/2005

Reviewed:		2/12/2015					
Revised:	5/1/2014	2/12/2015					

PURPOSE

This Mount Sinai Health System (MSHS) comprised of Mount Sinai Beth Israel, Mount Sinai Beth Israel Brooklyn, The Mount Sinai Hospital, Mount Sinai Queens, Mount Sinai Roosevelt, Mount Sinai St. Luke’s, New York Eye and Ear Infirmary of Mount Sinai and the Icahn School of Medicine at Mount Sinai establishes this guidance governing the business relationships between MSHS and Medical Vendor Representatives (“MVRs”). The purpose of this policy is to ensure that the best interest of the patient is the principal factor in any decision to use pharmaceuticals, medical equipment and devices or clinical services in patient care or research activities. In addition to assuring this level of professionalism and impartiality, this policy is designed to:

- Ensure patient confidentiality, compliance with regulatory standards, and a collaborative approach to promote safe and effective product use throughout MSHS.
- Facilitate appropriate MVR interaction with MSHS personnel and dissemination of information without causing a disruption in the care of patients, research or education, or interfering in the work performance of MSHS staff.
- Ensure marketing of products that is consistent with policies and guidelines established by MSHS.

- **This policy is a complement to the MSHS policy titled, “Interactions with Vendors and Other Commercial Entities” and other MSHS policies.**

DEFINITIONS

- 1. Medical Vendor Representatives (MVRs)** as defined in this policy are vendors’ representatives who promote medical, pharmaceutical, research or educational supplies, equipment or other products or services and provide information and services to health care providers on behalf of manufacturers and suppliers. This definition includes positions also known as Medical Sales Representatives, Medical Service Representatives, Pharmaceutical Representatives, Drug Representatives, etc.
- 2.** The term “**visit**” as it applies to MVRs, refers to any contact with MSHS staff, including drug fairs, drug displays, and other multi-vendor events.
- 3. Medical Device** is defined as: "An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or intended to affect the structure or any function of the body of man" (adopted from section 201(h) of the Federal Food Drug & Cosmetic (FD&C) Act).

POLICY

Access to MSHS by MVRs is a privilege provided to allow mutually beneficial interactions. As invited guests, MVRs are expected to strictly adhere to this policy as well as guidelines outlined by the Food and Drug Administration (FDA), the American Medical Association (AMA), and the Pharmaceutical Research and Manufacturers of America (PhRMA). It is MSHS policy that MVR’s may only have controlled access to all medical care facilities and staff.

PROCEDURE

1. Registration

- a. Each company desiring to do business with MSHS must register their MVR’s with the Purchasing Department.
- b. At the first visit to the Purchasing Department, each MVR will receive a registration packet with a copy of this policy and be registered with Vendormate.
- c. Mount Sinai Health System uses Vendormate to credential supplier companies and the representatives who visit our facilities. Every MVR must complete registration online at <https://mountsinaihealth.vendormate.com>.
- d. There is a nominal annual fee for each vendor (tax ID/FEIN) that registers with a new health system. If you are the first from your company to register with Mount Sinai Health System, you may be required to pay this fee. This one fee covers all representatives from your company at Mount Sinai Health System.

- i. Once you have completed registration, you will need to input the required documentation (training and immunizations) and acknowledge any required policies. This information can be found under the document and policy tab in your registration.
 - ii. Badges are required to be worn by all representatives when onsite at MSHS facilities. Make sure you obtain a badge and wear it throughout your visit.
 - iii. Badges are available at Vendormate Kiosks at the Following Locations
 - 1. Guggenheim Pavilion Entrance East - 1468 Madison Avenue
 - 2. Guggenheim Pavilion Entrance West – 1190 5th Avenue
 - 3. Faculty Practice Associates offices at 5 east 98th Street)
 - iv. Should you have questions or require technical assistance during your registration, visit vendormate.com/healthsupport or call [888-476-0377](tel:888-476-0377).
- e. It is the responsibility of each company to ensure that the names of their registered representatives are accurate. The Purchasing Department is to be informed, in writing, of any MVRs that no longer represent their company at MSHS. A “Medical Vendor Representative Registry Form” must be completed for each new individual that represents the company.

2. Access to MSHS Buildings and Areas of Visitation

- a. MVRs are permitted to access MSHS buildings only when they have an appointment with a member of the faculty, a management employee in an applicable area, or a member of the purchasing staff. MVRs are prohibited from setting up appointments with students, house staff, nursing staff, pharmacy staff, or laboratory staff. Appointments may be made by either telephone or e-mail, but must be made in advance of visiting the MSHS.
- b. All MVRs must sign-in at a Vendormate kiosk. The name and location of the individual that the MVR is scheduled to visit and the purpose of their visit must be logged in the Vendormate system. If a MVR has a scheduled visit with more than one department, a separate sign-in is required for each department. Visitation by a MVR not indicated at sign-in will be considered a violation of this policy.
- c. It is the responsibility of the MVR to sign-out at a Vendormate kiosk when they leave the MSHS. MVRs may also sign-out using the Vendormate app on their smartphones.
- d. All MVRs must wear their Vendormate Badge at all times when they are on MSHS property. The badge will print after sign-in at a Vendormate kiosk.
- e. The Vendormate badge must be presented to the Security Officer upon entrance to the MSHS.
- f. MVR's visiting the Operating Room and Cath Lab areas are required to check-in in the Department Administrative Offices before visiting Patient Care Areas.
- g. On occasion, MVR's may bring with them members from their company who do not regularly visit MSHS. These individuals MUST be accompanied by a registered MVR at all times and must wear a Photo ID issued by their company. Individuals who may visit the MSHS more than two times a year with a registered MVR are required to register with Vendormate.

- h. MVRs are not allowed to attend MSHS medical care treatment facility conferences where patient-specific material is discussed or presented.
- i. MVRs are not allowed in patient care areas, either inpatient or ambulatory (including nursing units, clinics and waiting areas), or in work areas (Pharmacy distribution areas, Microbiology work areas, Laboratories, FPA etc.) without permission of the Department Director responsible for the area.
- j. MVRs are not permitted to loiter in common hospital areas, such as lobbies, cafeterias, Medical Library, etc. for the purpose of initiating unsolicited contact with hospital staff and detailing products.
- k. MVR's who wish to be present during any patient procedure must have the permission of the department Director responsible for the area and must conform to all patient and patient safety guidelines.

3. Patient Confidentiality and Privacy

- a. Training by MVRs for new equipment or devices that involves exposure to patients is highly discouraged. When training by a MVR is necessary that involves exposure to a patient or information about a patient, approval from the Departmental Chair AND patient consent, documented in the patient's chart, are required. The Operating Room has specific policies related to training provided by MVRs that must be followed in that area.
- b. Unless otherwise authorized by MSHS, MVRs shall not have access to any electronic or paper information that is patient specific, or could be associated with a particular patient. This includes patient charts, laboratory information, patient bills, etc.

4. Marketing/Solicitation Activities MVRs are authorized to promote their products and disseminate information within the following parameters:

- a. MVRs shall confine their promotional activities within the MSHS to attending medical staff, pharmacy management staff, research faculty and staff, management staff in areas where the commercial enterprise's supplies and equipment could be used, and the Purchasing Department.
- b. MVRs are prohibited from marketing to medical, pharmacy, nursing and other trainees without the presence of a faculty professional.
- c. MVRs will respect and abide by the decision of the appropriate MSHS committees. MVRs are not permitted to promote medications, supplies or equipment contrary to MSHS policies. Before visiting members of the medical staff to promote medications, MVRs shall meet with a member of the Director of Pharmacy to inform/provide them with any of the information they will be using to promote their product(s). Any information/materials deemed inappropriate or biased by the Director of Pharmacy may not be used as information provided to individuals in the MSHS.
- d. The following are **acceptable** forms of information for dissemination by MVRs within the MSHS provided that the drug is a Formulary item and the materials are approved for distribution by the Division of Drug Marketing, Advertising, and Communications (DDMAC) of the Food and Drug Administration:

- i. Reprints of primary literature from peer-reviewed journals
 - ii. Promotional materials that are deemed unbiased
- e. The following are **unacceptable** forms of information for dissemination by MVRs at the MSHS:
 - i. Abstracts related to potential benefits of a drug marketed by the commercial enterprise
 - ii. Information related to the unapproved use of medications as determined by the Food and Drug Administration.
 - iii. Any comparative cost analysis related to the product being promoted.
- f. Provision of food and beverages by MVRs or payment for food and beverages by MVRs is prohibited.
- g. Gifts, **including de minimis items** such as pens and notepads, may not be distributed within the MSHS and/or to MSHS employees.
- h. MVRs may not post any notices at the MSHS that promote their products or a program that they are sponsoring. Program notices must be posted by the MSHS representative responsible for that program in concordance with MSHS policies for posting notices. Promotional materials may only be given to an individual during an appointment and may not be left in hospital areas, including public areas.
- i. MVRs may not engage in initiating unsolicited contact with health care professionals and detailing the individuals or their products.

5. Educational programs

The MSHS has a well-defined policy on commercial support for continuing medical education programs. Please refer to the MSHS Interactions with Vendors and Other Commercial Entities Policy for details.

6. Prohibited Contacts

- a. MVRs are not allowed to attend non-CME approved teaching sessions that are attended by students, residents, pharmacy, nursing, or laboratory staff. Meals may **not** be sponsored, **and** all funds must be unrestricted and must be channeled through the Department, which will in turn make all arrangements.
- b. MSHS does not allow MVRs to meet with students, residents, pharmacy, nursing, or laboratory staff on medical center property. Please refer to the MSHS Interactions with Vendors and Other Commercial Entities Policy for details.
- c. MSHS will not provide the names or addresses of students or staff to MVRs. MSHS does not allow house staff or fellows to accept direct gifts, favors, or trips from MVRs. Any donations from MVRs must be made in accordance with the MSHS Interactions with Vendors and Other Commercial Entities policy.
- d. Faculty and MSHS employees who are offered speaking engagements, consultantships, etc., must follow policies as outlined in MSHS Interactions with Vendors and Other Commercial Entities policy.

7. Access to MSHS Information

MVRs are not allowed access to verbal or written information that refers to patient specific information, quality of care issues, or information that would jeopardize the process for product selection or competitive pricing.

- a. Information discussed or distributed at Medical Board Subcommittees (e.g., Formulary and Therapeutics Committee) or their Subcommittees may NOT be provided to or obtained by MVRs.
- b. Institution specific data related to prescribing practices, product consumption, or prices may not be provided to MVR's except by individuals authorized by MSHS to negotiate contracts.

8. Process for Product Review and Selection

Only attending medical staff can request the addition of a medication to the MSHS Formulary.

9. Drug and Medical Device Samples

- a. **Drug Samples:** Please refer to the MSHS Interactions with Vendors and Other Commercial Entities Policy for details regarding pharmaceutical samples.
- b. **Medical Supplies - Field Stock:** MVR's who provide "Field Stock" or "Trunk Stock" products to MSHS must abide by the following policies:
 - i. Existence of any Field Stock must be communicated with Department Manager upon arrival in Department.
 - ii. MVR must inspect the Expiration date of all products, which MUST be at least 12 months from date of Expiration before they may be given to MSHS Staff
 - iii. Department Manager must review Expiration Date before accepting products
 - iv. MVR must give products directly to a MSHS Representative, and may not place products in a designated Supply Storage Area
- c. **Medical Devices:** To protect the integrity and objectivity of transactions between employees of MSHS and its past, present or future vendors, employees (physician or otherwise) are not permitted to directly accept any medical device from any vendor. Please refer to the MSHS Interactions with Vendors and Other Commercial Entities Policy for details.

VIOLATION OF POLICY

Violation of this policy and procedure by MVRs will result in disciplinary action up to and including termination of access privileges of the MVR at Mount Sinai Health System. In the event a violation occurs, the MVRs employer will be notified of the violation.

Section HS 17A

Business Conflicts of Interest



POLICY ON BUSINESS CONFLICTS OF INTEREST

<http://policies.mountsinai.org/web/corporate-compliance/policies/-/policy-management/viewPolicy/277231>

PREAMBLE

Mount Sinai Health System has an obligation to ensure that its trustees, faculty, employees and other staff adhere to the highest standards of ethical conduct free from any improper external influence or any appearance of impropriety.

Situations can occur in which an independent observer might reasonably conclude that the potential for individual or institutional conflict could influence the manner in which individuals carry out their responsibilities or the decisions made by the institution. Even in the absence of an actual conflict of interest, such situations may require actions to minimize the appearance of a conflict.

At the same time, Mount Sinai understands that such individuals and their close family members may have relationships that could raise perceived or actual conflicts of interest, but could benefit Mount Sinai if carefully examined and properly managed.

In order to safeguard the integrity of both Mount Sinai and its constituents, Mount Sinai has adopted a rigorous conflicts policy predicated on full disclosure and appropriate management of any possible conflict of interest. This Policy on Business Conflicts of Interest (the "Policy") identifies those persons or entities covered by this Policy, sets out the requirements for disclosing potential business conflicts of interest, and specifies the procedures for reviewing such disclosures and determining what measures, if any, should be instituted to manage the conflict.

Please note that New York law prohibits Mount Sinai and its Trustees and Institutional Leaders (as defined herein) from engaging in Related Party Transactions (as defined herein) unless the prior review and approval process outlined in this Policy are followed.

This Policy is intended to cover conflicts that arise out of business relationships. Mount Sinai has related policies that cover other types of conflicts, such as Mount Sinai's Policy on Financial Conflicts of Interest in Research and its Policy regarding Financial Relationships with Outside Entities.

I. Definitions

A. Mount Sinai or Health System or Institution shall mean: Mount Sinai Health System, Inc., Mount Sinai Hospitals Group, Inc., The Mount Sinai Medical Center, Inc., Icahn School of Medicine at Mount Sinai, The Mount Sinai Hospital, Beth Israel Medical Center, St. Luke's-Roosevelt Hospital Center, The New York Eye & Ear Infirmary, MSMC Realty Corp., The Mount Sinai Children's Center Foundation, Mount Sinai Proton Holding Corp., MSMC Residential Realty LLC, MSMC Residential Realty Manager, Inc., Mount Sinai Diagnostic & Treatment Center, Mount Sinai Independent Practice Association, Mitral Foundation, Mount Sinai Care, LLC and any subsidiary, corporation or other entity in control of, or owned or controlled by, any of the foregoing.

B. Covered Person shall mean:

1. Trustees;
2. Full-time and part-time faculty or medical staff;
3. Other employees, including Institutional Leaders (as defined below);
4. Non-employees who are members of Institutional committees; and
5. Members of the voluntary faculty or medical staff.

C. Institutional Leader shall mean any individual at Mount Sinai who holds one or more of the following titles/positions:

1. Officer; and/or
2. Key Employee (as defined in Exhibit B).

D. Related Party shall mean:

1. Spouse or same-sex partner of a Covered Person;
2. Dependent children (natural or adopted) of a Covered Person; and
3. Any Entity (as defined below) or account that a Covered Person controls (directly or indirectly through other Entities or otherwise) or of which any of them is a beneficiary.

E. Business Conflict of Interest (sometimes also referred to as a "Conflict of Interest" or "Conflict"), including an Institutional Conflict of Interest, is defined in Section II.

F. Entity shall mean: any for-profit or not-for-profit entity, including, without limitation, any corporation, partnership, sole proprietorship, firm, franchise,

association, organization, institution, holding company, limited liability company, trust or estate, or any governmental or quasi-governmental advisory committee or group, excluding entities, committees or groups whose sole relationship with Mount Sinai is limited to making philanthropic gifts to Mount Sinai.

G. Outside Entity shall mean any person or Entity that:

1. Provides goods or services to, or otherwise does business with, Mount Sinai;
2. Competes with Mount Sinai;
3. Sponsors or supports research, education or clinical services at Mount Sinai; or
4. Has any other business or financial relationship with Mount Sinai.

H. Staff Conflicts of Interest Review Committee (“SCCOM”) is defined in Section V.B.1.a.

I. Trustee Conflicts of Interest Review Committee (“TCCOM”) is defined in Section V.B.2.a.

II. Business Conflict of Interest

A. General Standards

1. All Covered Persons shall discharge their duties and responsibilities to Mount Sinai in the best interests of Mount Sinai and Mount Sinai’s patients, students, employees, and other constituents, and without favor or preference to any Outside Entity or person.
2. No Covered Person shall use his/her positions at Mount Sinai, or confidential information obtained at or in connection with Mount Sinai, for personal advantage.
3. No financial interest, personal activity or relationship shall impair or appear to impair the judgment of Covered Persons in the discharge of their duties and responsibilities to Mount Sinai or the conduct of their activities at or relating to Mount Sinai.

B. Definition of a Business Conflict of Interest

A Business Conflict of Interest arises when (and is defined as):

1. A Covered Person violates the General Standards set forth in Section II.A above.

2. A Covered Person or one or more of his/her Related Parties (individually or in combination with others) has a relationship with or a financial interest in an Outside Entity, where that relationship could be reasonably perceived as influencing that Covered Person's duties and responsibilities to Mount Sinai or the conduct of his/her activities at or relating to Mount Sinai. Accordingly, a Business Conflict of Interest arises when a Covered Person or one or more of his/her Related Parties:
 - a. Owns, controls, or has the right to own or control, any stock, stock options, warrants, convertible notes, or other securities or ownership/equity interests (collectively, "securities") of any Outside Entity, excluding (i) securities in mutual funds or retirement accounts over which neither the Covered Person nor any of his/her Related Parties has control and (ii) stock of publicly traded companies if the Covered Person and his/her Related Parties together do not own, control, or have the right to own or control, 5% or more of any class of stock of such Outside Entity, and do not have any intention to seek to control or influence the board or management of such Outside Entity; or
 - b. Is a trustee, director, officer, employee, agent, partner, scientific advisor, or limited liability company member of, or consultant to, any Outside Entity; or
 - c. Has the right to nominate or elect, or seeks to nominate or elect or influence the nomination or election of, any director or officer of any Outside Entity; or
 - d. Receives any compensation (salary, bonus, fees, options, etc.), loans (other than from established banks or financial institutions on arm's length terms), gifts, royalties, honoraria or other cash or in-kind payments, or anything else of value, from any Outside Entity.
3. A Trustee and/or any one of his/her Related Parties (a) engages in, or proposes to engage in, a business transaction or arrangement with any full-time or part-time Mount Sinai employee, or (b) asks a full-time or part-time Mount Sinai employee to engage in a business transaction or arrangement with a third party, including, without limitation, asking a full-time or part-time Mount Sinai employee to join the board of a company or compensating a full-time or part-time Mount Sinai employee for services rendered (other than paying for healthcare services in the ordinary course).

C. Institutional Business Conflict of Interest

In contrast to an individual Business Conflict of Interest, an Institutional Business Conflict of Interest arises when Mount Sinai itself has a Business Conflict of Interest.

The following are examples of the types of conflicts that may occur involving Mount Sinai :

1. Mount Sinai ownership of a greater-than-5% direct or indirect equity interest in publicly traded companies that are Outside Entities.
2. Charitable donations made to Mount Sinai by Outside Entities.
3. Licensing and technology transfer activities involving Mount Sinai and Outside Entities.

D. Trustee/Institutional Leader Related Party Transactions

Business Conflicts of Interest, as defined in this Policy, are distinct from Trustee/Institutional Leader Related Party Transactions (“RPTs”), which are defined in Exhibit A and are subject to different and specific review and approval processes, which are also described in Exhibit A.

III. Specific Activities Prohibited

The following activities are so inherently inconsistent with the norms of proper and ethical behavior that they almost invariably will be prohibited:

A. Acceptance of Gifts¹, etc:

1. Solicitation or acceptance of gifts, gratuities, payments or consideration of any kind (collectively, “gifts”) or other favors from any person or organization arising because such person or organization does or is seeking to do business with, or establish a relationship with, Mount Sinai. Unsolicited gifts must be returned and the Compliance Department will advise on the best method for returning such gifts.
2. Other than *de minimis* non-cash gifts from patients, the solicitation or acceptance by full-time and part-time faculty and other employees of gifts from patients, former patients, their friends and relatives and Members of the Boards of Trustees. Donors should be directed to the Development Office so that such gifts can be made to the appropriate Mount Sinai entity.

¹ A gift is defined as anything of value that is given by a business or individual that does or seeks to do business with Mount Sinai to either the recipient or his/her close family members, and for which the recipient neither paid nor provided services. Gifts from vendors are strictly prohibited regardless of value. More information regarding gifts is available in the Institutional policy on **INTERACTIONS WITH VENDORS AND OTHER COMMERCIAL ENTITIES**, which may be requested directly from the Mount Sinai Compliance Department via E-mail at compliance.info@mountsinai.org.

B. Use of Confidential Information:

Disclosure or other use of confidential or privileged information gained because of such person's relationship to Mount Sinai for direct or indirect personal advantage or gain, including, without limiting the generality of the foregoing, the use of any such information in connection with the purchase or sale of securities or other investment activities.

IV. Disclosure and Reporting of Business Conflicts of Interest

A. Covered Persons

1. Immediate Reporting Obligation

This Policy requires disclosure of all Business Conflicts of Interest by Covered Persons to the Compliance Department (or, in the case of Trustees, to the General Counsel, and the Chief Compliance Officer). Covered Persons must also disclose any Business Conflict of Interest of Related Parties. Such disclosures must occur at the time that a Business Conflict of Interest arises or when Covered Persons reasonably anticipate that a Business Conflict of Interest is likely to arise. All such reports must be made in writing.

Trustees and Institutional Leaders (and, to the best of their knowledge, other Covered Persons) must also disclose potential Trustee/Institutional Leader Related Party Transactions ("RPTs"), as defined in Exhibit A, to the General Counsel, and the Chief Compliance Officer. All such reports shall be made in writing. **Please note that New York law prohibits Mount Sinai and its Trustees and Institutional Leaders from engaging in RPTs unless the prior review and approval process outlined in Exhibit A of this Policy are followed.**

2. Annual Reporting and Certification by Covered Persons Other Than Trustees and Institutional Leaders

In addition to the immediate reporting obligation, Covered Persons (as selected by the Staff Conflicts of Interest Advisory Committee (defined below)), with the exception of Trustees and Institutional Leaders, are required to complete (and to submit to the Compliance Department) an annual disclosure form and certificate of compliance.

3. Annual Reporting and Certification by Trustees and Institutional Leaders

In addition to the immediate reporting obligation, Trustees and Institutional Leaders are required to complete and to submit to the General Counsel

and the Chief Compliance Officer prior to election and annually thereafter a Business Conflicts of Interest disclosure form and certification of compliance disclosing all Conflicts of Interest.

Trustees and Institutional Leaders must also disclose potential RPTs, as defined in Exhibit A, to the General Counsel, and the Chief Compliance Officer. **Please note that New York law prohibits Mount Sinai and its Trustees and Institutional Leaders from engaging in RPTs unless the prior review and approval process outlined in Exhibit A of this Policy are followed.**

For avoidance of doubt, initial (i.e., upon election) and, thereafter, annual disclosure statements of Trustees shall be submitted to the General Counsel and the Chief Compliance Officer² and must identify, to the best of the Trustee's knowledge: (1) any entity of which such Trustee is an officer, director, trustee, member, owner (either as a sole proprietor or a partner), or employee and with which Mount Sinai has a relationship, and (2) any transaction in which Mount Sinai is a participant and in which the director might have a conflicting interest. Trustees and Institutional Leaders must also disclose potential RPTs, as defined in Exhibit A, as set forth herein. Copies of Trustees' completed statements must be provided to the Chair of the Audit and Compliance Committee.

B. Institutional Business Conflicts of Interest

In addition to the immediate reporting obligation, corporate officers, Covered Persons from Mount Sinai Innovation Partners ("MSIP"), Covered Persons from the Development Office, and other Covered Persons as selected by the Staff Conflicts of Interest Review Committee (defined below) must complete (and submit to the Compliance Department) an annual disclosure form and certification of compliance disclosing all Institutional Business Conflicts of Interest.

V. Review Procedure/Management of Conflicts

The Chief Compliance Officer (and the General Counsel in the case of Trustees) will review all Business Conflicts of Interest (and/or, in the case of Trustees and Institutional Leaders, RPTs) disclosure documents and forward those that report a Business Conflict of Interest (and/or, in the case of Trustees and Institutional Leaders, an RPT) to the appropriate conflicts of interest review committee as follows:

A. Research

² The General Counsel and the Chief Compliance Officer will process these statements internally in the manner directed by the NPRA.

The review procedures for the management of a conflict of interest involving **research** are set forth in the Policy on Financial Conflicts of Interest in Research.

B. Business

All Business Conflicts of Interest, including Institutional Business Conflicts of Interest, will be carefully scrutinized and either prohibited or appropriately managed, depending on the facts and pursuant to the procedures set forth below.

Recusal/No Attempt to Influence: In all cases, anyone with a potential Business Conflict of Interest must not be present at or participate in any Board or committee deliberation of, or vote on, the matter giving rise to the potential Business Conflict of Interest. The Board or relevant committee may, however, request that the person with a potential Business Conflict of Interest present information concerning the matter giving rise to the potential Business Conflict of Interest at a Board or committee meeting prior to the commencement of deliberations or voting related thereto. Further, anyone with a potential Business Conflict of Interest is prohibited from making any attempt to influence the deliberation of, or voting on, the matters giving rise to such potential Business Conflict of Interest.

1. Covered Persons (other than Trustees, Institutional Leaders and their Related Parties)

a. Staff Conflicts of Interest Review Committee (the “SCCOM”)

The SCCOM is a review committee established to review potential Business Conflicts of Interest involving Covered Persons (other than Trustees and Institutional Leaders (and their respective Related Parties)). The SCCOM reports its recommendations to the CEO, whose decisions are final. The SCCOM's membership includes the Executive Vice President and General Counsel, the Executive Vice President and Chief Financial Officer, the Vice President and Chief Compliance Officer, the Vice President Audit Services, a representative from the MSIP, and such other persons as may be chosen by the CEO. The SCCOM will provide a periodic report of its activities to the Audit and Compliance Committee of the Boards of Trustees (“Audit and Compliance Committee”).

b. Review/Procedure

The Chief Compliance Officer will forward all disclosure documents relating to potential Business Conflicts of Interest involving Covered Persons (excluding Trustees and Institutional Leaders (and their

respective Related Parties)) to the members of the SCCOM for review and to recommend the steps needed to manage or eliminate the conflicts. All recommendations of the SCCOM will be forwarded to the CEO whose decisions are final.

2. Trustees and Institutional Leaders

a. Trustee Conflicts of Interest Review Committee (the "TCCOM")

The TCCOM is a subcommittee of the Executive Committee of the Boards of Trustees ("Executive Committee") appointed by the Chairman of the Boards. The TCCOM is a review committee established to review potential Business Conflicts of Interest involving Trustees and Institutional Leaders (and their respective Related Parties and Trustee/Institutional Leader Related Parties as defined in Exhibit A). The Chairman of the Boards shall appoint only independent Trustees (as defined in Exhibit D) to the TCCOM.

b. Review/Procedure

The General Counsel, in conjunction with the Chief Compliance Officer, and with the advice of outside counsel as appropriate, will forward all disclosure documents relating to Business Conflicts of Interest involving Trustees and Institutional Leaders (and their respective Related Parties) to the members of the TCCOM for review and to recommend the steps needed to manage or eliminate the conflicts. The TCCOM may resolve any specific Business Conflict of Interest itself or may refer Business Conflicts of Interest in appropriate circumstances to the full Executive Committee for final resolution.

Where a potential RPT exists (as defined in Exhibit A), the TCCOM shall engage in the review process set forth in Exhibit A. The TCCOM may consult the advice of independent outside counsel as appropriate, and will provide a periodic report of its activities to the Executive Committee and to the Audit and Compliance Committee.

VI. Other Provisions

A. Records

Records of all disclosures and actions taken by the SCCOM, by the TCCOM, by the CEO, the full Executive Committee and/or any other committee authorized to review potential Conflicts of interest, including the minutes thereof, will be kept for a period of six years after the review is complete.

B. Audit Review

All management plans that are adopted are subject to review and audit by the Compliance Office.

C. Report to the Board of Trustees

A report of all Conflicts of Interest shall be made by the Chief Compliance Officer on a periodic basis to the Audit and Compliance Committee.

D. Violations

This Policy will be strictly enforced. Violation of this policy will subject the individual to disciplinary action including possible dismissal and members of the Boards of Trustees will be subject to removal.

E. Other Policies

Covered Persons are responsible for complying with this Policy and with Mount Sinai's Policy on Financial Conflicts of Interest in Research and with Mount Sinai's Policy regarding Financial Relationships with Outside Entities. In the event that a potential Business Conflict of Interest implicates more than one of these policies, then the SCCOM and the Financial Conflict of Interest in Research Committee will coordinate their respective decisions with respect to managing such conflicts.

F. Questions

Any questions regarding this Policy should be directed to Mount Sinai's Compliance Department's Helpline at (800) 853-9212.

G. Examples

A non-exclusive list of hypothetical examples describing potential Business Conflicts of Interest (and how they might be managed or eliminated) is annexed hereto as Exhibit E.

EXHIBIT A

PROCEDURE FOR THE REVIEW AND APPROVAL OF TRUSTEE/INSTITUTIONAL LEADER RELATED PARTY TRANSACTIONS (RPTs)

Definitions:

1. Trustee/Institutional Leader Related Party shall mean:

- a. Any **Relative** (as defined below) of any Trustee or Institutional Leader; or
- b. Any **entity** in which a Trustee, Institutional Leader or any Relative of a Trustee or Institutional Leader has a 35% or greater ownership or beneficial interest, or, in the case of a partnership or professional corporation, a direct or indirect ownership interest in excess of 5%.

Note: The term “**Relative**” shall mean a Trustee’s or Institutional Leader’s (i) spouse, ancestors, brothers and sisters (whether whole or half-blood), children (whether natural or adopted), grandchildren, great-grandchildren, and spouses of brothers, sisters, children, grandchildren, and great-grandchildren; or (ii) domestic partner as defined in Section 2994a of New York’s Public Health Law (see Exhibit C).

2. Trustee/Institutional Leader Related Party Transaction (“RPT”) shall mean: any transaction, agreement or any other arrangement in which a Trustee, Institutional Leader, or Trustee/Institutional Leader Related Party has a **financial interest** and in which Mount Sinai is a participant.

3. Review and Approval Process

Mount Sinai’s procedures for disclosing, addressing, and documenting RPTs are as follows:

a. **Disclosure/Identification:** All Trustees and Institutional Leaders shall disclose in good faith the material facts concerning any proposed RPT pursuant to the methods described in Section IV.A. of the Policy, i.e., under an immediate reporting obligation and no less than on an annual basis. The TCCOM shall then review potential RPTs as follows:

i. **Standard RPT Review and Approval:** The TCCOM must determine that the transaction is fair, reasonable and in Mount Sinai’s best interest at the time of the determination. Such

determination may be based on factors including, but not limited to, price, quality, institutional needs, availability of alternatives, reputation, and past history with Mount Sinai.

ii. Enhanced RPT Review and Approval: With respect to any RPT in which a Trustee/Institutional Leader Related Party has a **substantial financial interest**, the TCCOM shall:

- Alternatives: Prior to entering into the transaction, consider alternative transactions to the extent available; and
- Majority Vote: Approve the transaction by not less than a majority vote; and
- Documentation: Contemporaneously document in writing the basis for the approval (if applicable), including its consideration of any alternative transactions.

C. Recusal: No Trustee, Institutional Leader, or their Trustee/Institutional Leader Related Parties may be present at or participate in any Board or committee deliberations or voting relating to the review and approval of RPTs, provided, however, that the TCCOM may request that such Trustee, Institutional Leader, or Trustee/Institutional Leader Related Party present information concerning an RPT at a Board or committee meeting prior to the commencement of deliberations or voting related thereto. Further, any Trustee or Institutional Leader with a potential RPT is prohibited from making any attempt to influence the deliberation of, or voting on, the matters giving rise to such potential RPT.

EXHIBIT B

A. General Definition of Key Employee

For purposes of this Policy, and consistent (1) with the IRS definition of “Key Employee”; and (2) with the NPRA definition of “Key Employee” (i.e., any person who is in a position to exercise substantial influence over the affairs of the corporation), Mount Sinai considers a Key Employee to be

(1) an officer; or (2) anyone (other than an officer) who meets **all three** of the following tests:

1. \$150,000 Test. Receives reportable compensation from the organization and all related organizations in excess of \$150,000 for the calendar year ending with or within the organization’s tax year.

2. Responsibility Test. The employee:

- a. has responsibilities, powers or influence over the organization as a whole similar to those of officers, directors, or trustees;
- b. manages a discrete segment or activity of the organization that represents 10%

or more of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole;

- c. or has or shares authority to control or determine 10% or more of the organization’s capital expenditures, operating budget, or compensation for employees.

3. Top 20 Test. Is one of the 20 employees (that satisfy the \$150,000 Test and Responsibility Test) with the highest reportable compensation from the organization and related organizations for the calendar year ending with or within the organization’s tax year.

EXHIBIT C

Definition of “Domestic Partner” under Section 2994 of New York’s PHL:

“Domestic partner” means a person who, with respect to another person:

(a) is formally a party in a domestic partnership or similar relationship with the other person, entered into pursuant to the laws of the United States or of any state, local or foreign jurisdiction, or registered as the domestic partner of the other person with any registry maintained by the employer of either party or any state, municipality, or foreign jurisdiction; or

(b) is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance; or

(c) is dependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including but not limited to: common ownership or joint leasing of real or personal property; common householding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners under paragraph (a) or (b) of this subdivision; or the length of the personal relationship of the persons.

***Each party to a domestic partnership shall be considered to be the domestic partner of the other party. “Domestic partner” shall not include a person who is related to the other person by blood in a manner that would bar marriage to the other person in New York state. “Domestic partner” also shall not include any person who is less than eighteen years of age or who is the adopted child of the other person or who is related by blood in a manner that would bar marriage in New York state to a person who is the lawful spouse of the other person.

EXHIBIT D

Definition of Independent Director Under the NPRA:

To be considered an “independent director” a Trustee may not:

1. Be or have been within the last three years an employee of Mount Sinai or any affiliate, or have a relative who is or has been within the last three years a key employee of Mount Sinai or any affiliate;
2. Have received or have a relative who received more than \$10,000 in direct compensation from Mount Sinai or any affiliate within any of the last three fiscal years; or
3. Be an employee of or have a substantial financial interest in any entity that has made payments to or received them from Mount Sinai or an affiliate for property or services which, in any of the last three fiscal years, exceeds the lesser of \$25,000 or 2 percent of such entity's consolidated gross revenues, or have a relative who is an officer of or has a substantial financial interest any such entity.

EXHIBIT E

The following examples are illustrative in nature and do not in any way limit the general principles or the definition of “Business Conflict of Interest” contained in the Policy. In other words, **conduct that does not technically fall within the fact patterns below still might in fact constitute a Business Conflict of Interest.** The term “Mount Sinai” is defined in Section I.A. of the Policy.

- i. A Trustee of the Health System also serves as a member of the Hospital Group’s Patient Care and Quality Assurance Committee. The Trustee’s spouse, Dr. Smith, is the Chairperson of a clinical department within the School and has admitting privileges at Mount Sinai’s hospitals. The Trustee must disclose the potential Business Conflict of Interest to the General Counsel and the Chief Compliance Officer. In addition, he must recuse himself from any assessments regarding the performance of his spouse in her clinical roles at the School and at the hospitals. The Trustee and Dr. Smith must not share information with each other regarding either Dr. Smith’s performance or the Trustee’s Board service that would call upon either of them to reveal information that is confidential or that would otherwise compromise their ability to perform their roles in an objective manner.
- ii. A Trustee of Mount Sinai Hospitals Group holds a majority stake in a real estate development firm that is under consideration by Icahn School of Medicine at Mount Sinai to manage the construction of a new scientific research facility. The Trustee must disclose the potential Business Conflict of Interest to the General Counsel and the Chief Compliance Officer, and must not involve himself in deliberations with respect to the School’s selection of a real estate development firm. This prohibition applies to the Trustee notwithstanding the fact that technically he is on the Board of the Hospitals Group and not on the Board of the School. If, ultimately, the Trustee’s firm is selected to manage the construction of the School’s new building, then the services that the firm provides must be of at least fair market value for the compensation provided. The School (and other Mount Sinai entities, as appropriate) must monitor the firm’s performance in order to ensure that it remains high quality in nature.
- iii. A member of the Pharmaceutical and Therapeutic (“P&T”) Committee has a consulting agreement with a pharmaceutical company that sells drugs to Mount Sinai. This individual will notify the Chair of the P&T Committee of his agreement with the company and must recuse himself from deliberations of the P&T Committee when this company’s product(s) or a competitor’s product(s) are reviewed for inclusion in the Mount Sinai formulary.
- iv. A member of the Device Review Committee (“DRC”) has a consulting agreement with a device company that competes with a company

seeking to put its device in the Mount Sinai formulary. This individual must recuse himself when the competing company's products are reviewed by the DRC.

- V. A department chairman is on the scientific advisory board ("SAB") of a medical instrument company that currently sells products to Mount Sinai and is seeking to increase its business with Mount Sinai. The chairman might be asked to resign from the company's SAB. If he is allowed to remain on the advisory board, both the Materials Management and Purchasing Departments will ensure that all purchases of medical instruments (including from this company) are subjected to a rigorous competitive bidding process and that the chairman remain recused from any selection process.
- vi. A member of Mount Sinai's Finance Committee owns greater than 5% of a publicly traded insurance brokerage company. That company, along with other firms, is under consideration by Mount Sinai in connection with obtaining a particular type of insurance coverage or policy. The Trustee must disclose the potential Business Conflict of Interest to the General Counsel and the Chief Compliance Officer and must recuse himself from the Committee's evaluation of the brokerage firms that are under consideration. If, ultimately, the Trustee's company is selected to provide services to Mount Sinai, then Mount Sinai must receive a quantum of services that is of at least fair market value for the compensation provided, and Mount Sinai must monitor the services provided in order to ensure that they remain high quality in nature.
- vii. A Trustee works at an investment firm that underwrites certain Mount Sinai securities. The Trustee stands to receive compensation upon the sale of those securities. The Trustee must disclose the potential Business Conflict of Interest to the General Counsel and the Chief Compliance Officer and must take steps to ensure that his access to confidential Institutional information does not influence the circumstances surrounding the sale of those securities. In addition, the Trustee must not participate in Mount Sinai's deliberations over whether or not to utilize his investment firm. If, ultimately, the Trustee's investment firm is selected to provide services to Mount Sinai, then Mount Sinai must receive a quantum of services that is of at least fair market value for the compensation provided, and Mount Sinai must monitor the services provided in order to ensure that they remain high quality in nature.
- viii. A Trustee serves on Mount Sinai's Legal Committee. The Trustee's spouse is a partner at a law firm that provides legal services to Mount Sinai in connection with an ongoing real estate transaction. The Trustee must disclose the potential Business Conflict of Interest to the General Counsel and the Chief Compliance Officer and must recuse

himself from any decisions to select his spouse's firm to provide services in the future, from any assessments regarding the performance of his spouse's firm and from decisions about the compensation of the firm. In addition, if the Trustee's spouse's firm is selected to provide services to Mount Sinai in the future, then Mount Sinai must receive a quantum of services that is of at least fair market value for the compensation provided, and Mount Sinai must monitor the services provided in order to ensure that they remain high quality in nature.

- ix. A Trustee sits on the board of an organization that files a lawsuit against Mount Sinai. The Trustee must disclose the potential Business Conflict of Interest to the General Counsel and the Chief Compliance Officer. The Trustee must remain uninvolved in discussions at Mount Sinai regarding the lawsuit. Similarly, the Trustee must recuse himself from discussions at the other organization related to the dispute and to the lawsuit itself, and must not reveal to that organization any confidential information that he learns about Mount Sinai through his service as a Mount Sinai trustee.
- x. A Trustee is the chairman of a biotechnology company that sponsors research at Mount Sinai. The Trustee must disclose the potential Business Conflict of Interest to the General Counsel and the Chief Compliance Officer, and must not involve himself in deliberations with respect to Mount Sinai's selection of companies to fund research of the type that his company typically sponsors. In addition, the Trustee must not participate in Mount Sinai's deliberations over whether or not to permit his specific biotechnology company to sponsor research at Mount Sinai. If, ultimately, the biotechnology company is selected to sponsor research at Mount Sinai in the future, then such sponsorship must be of at least fair market value for the compensation provided, and Mount Sinai must monitor the research that the biotechnology company sponsors in order to ensure that the research and its sponsorship remain high quality in nature.
- xi. A Trustee works in a service organization that provides high quality services to Mount Sinai at a discount from fair market value. The Trustee must disclose the potential Business Conflict of Interest to the General Counsel and the Chief Compliance Officer, and Mount Sinai must monitor the services provided in order to ensure that they remain high quality in nature. In addition, the Trustee must not participate in Mount Sinai's deliberations over whether or not to utilize his service organization.
- xii. A Trustee is an investment advisor at a financial services firm that is under consideration to serve as a broker and/or manager of some portion of Mount Sinai's investment pool. The Trustee must disclose the potential Business Conflict of Interest to the General Counsel and

the Chief Compliance Officer and to the General Counsel and must not participate in any decision with respect to whether or not Mount Sinai utilizes his firm's services. If, ultimately, the Trustee's firm is selected to provide services to Mount Sinai, then Mount Sinai must receive a quantum of services that is of at least fair market value for the compensation provided, and Mount Sinai must monitor the services provided in order to ensure that they remain high quality in nature.

- xiii. A Trustee serves on the board of a pharmaceutical company that does not currently have a business relationship with Mount Sinai. The Trustee proposes to the company that he approach a member of Mount Sinai's faculty about the possibility of serving on the company's scientific advisory board, and the company consents to the Trustee's proposal. This is a Business Conflict of Interest under Section II.B.3. of the Policy because the Trustee plans to engage in the solicitation of a Mount Sinai employee for the scientific advisory directorship, which would constitute a "business transaction or arrangement" with a third party. Therefore, the Trustee must disclose (i) his/her membership on the board of the pharmaceutical company, and (ii) his/her plan to recruit the faculty member to the company's scientific advisory board, to the General Counsel and the Chief Compliance Officer and to the faculty member. In the case of the Trustee, the TCCOM would then review the Business Conflict of Interest and consider how (if at all) the Business Conflict of Interest can be managed. In the case of the faculty member, the faculty member (assuming he/she wishes to serve on the company's scientific advisory board) would disclose the relevant facts to the SCCOM and to the Chairman of his Department and/or the Dean as required by this Policy and other institutional policies governing outside activities. The SCCOM would consider how (if at all) the Business Conflict of Interest can be managed, which would be taken into account by the Department Chair and/or the Dean, as appropriate. Such reviews by the TCCOM and the SCCOM should be coordinated.
- xiv. In the event Mount Sinai and the company described in example "(x)" above later consider a sale of any of the company's products to Mount Sinai, such proposed business relationship is a further Business Conflict of Interest and must be disclosed by both the Trustee and by the faculty member (in the event he/she receives institutional approval to proceed with the proposed arrangement and subsequently is elected to the company's scientific advisory board) in the same manner described in example "(x)" above. The management of such Conflict will include recusal by the Trustee and the faculty member at both the company and at Mount Sinai from any decision with respect to the sale and purchase of such products and a requirement that the products be sold at fair market value, and Mount Sinai must monitor the products that it buys from the company in order to ensure that they remain high quality in nature. In addition, the management of such subsequent

Conflict may include requiring the withdrawal of the faculty member from the company's scientific advisory board depending on all of the facts and circumstances at the time.

- XV. The spouse of an executive vice president (i.e., an Institutional Leader as defined in the Policy) is a principal in a firm that provides consulting services for academic medical centers such as Mount Sinai. All decisions to use the spouse's firm must be made pursuant to a competitive bidding process and the executive vice president must be recused from the review and hiring process.

- XVI. A Mount Sinai Trustee is nominated by the President of the United States to serve on an advisory committee related to federally-funded neurological research initiatives. The Trustee must disclose the potential Business Conflict of Interest to the General Counsel and the Chief Compliance Officer. If selected, the Trustee must not participate in any decision of the advisory committee that relates to, for example, the allocation of funding for neurological research at Mount Sinai. Similarly, the Trustee must recuse himself from any deliberations at Mount Sinai that could reasonably be anticipated to involve the advisory committee, e.g., through participation on Mount Sinai's Research or Government Affairs Committees. In addition, the Trustee must not disclose to the advisory committee any confidential information learned through his role as a Trustee.

Section HS 18
House Staff Health and Well-Being

Goal: To foster House Staff health and well-being by providing mechanisms for House Officers to obtain assistance counseling, support and/or conflict resolution.

Purpose: To provide extra-departmental pathways, alternatives and options for counseling, support and/or conflict resolution.

Multiple pathways for assistance are available to House Staff. House Staff need to recognize the constraints of each choice. **Individuals providing counseling who are employees of Mount Sinai Beth Israel are bound by institutional policies. These policies may require reporting of activities to hospital administration or governmental agencies when such activities are believed to affect an individual's ability to practice medicine or to affect the safety of patients.**

The "Counseling Network" will provide the pathways to counseling. The members of this network are available to:

- meet with House Staff who voluntarily seek assistance and self refer
- be available to aid in addressing House Staff's personal problems
- assist with accessing resources
- assist in addressing concerns that effect the House Officer's training and/or training program that are not resolved through currently established mechanisms
- participate in discussions with House Officers who are having difficulties and be part of the problem-solving team

The "Counseling Network" includes:

- 1) Psychiatrists and family health physicians who have agreed to provide initial consultations free of charge. These individuals will be listed on the website. Their designation as employees or non-employees will be posted and serves to remind House Staff of the counselors' legal obligations. This mechanism provides confidentiality to the extent possible for the House Officer.

- 2) Chaplaincy, comprised mostly of non-BI employees will be available and the contact number will be listed on the website.
- 3) An Ombudsman/woman (hospital employee) will be available to House Staff for counseling, advocacy, and/or consultation referral. (see **Section HS 48 –Ombudman/woman Policy**).
- 4) Employee Health Service.

Contact names and numbers are available in the **House Staff Health and Well-Being** link on the GME web site: www.bethisraelgme.org

Approved GMEC 8/06; editorial revision: 4-24-09, editorial rev: 1-2-2015

Section HS 19
Policy Statement on Harassment

Goal: To provide all House Officers with a bias-free work environment.

General Statement

Consistent with the Medical Center's respect for the rights and dignity of each House Officer, harassment of any kind, whether verbal, physical or environmental, is strictly prohibited and will not be tolerated. The Medical Center relies on the support of each House Officer to ensure a work environment free from discrimination or harassment. Every House Officer is expected to understand and adhere to this policy. Review also the harassment policy and procedure in the Medico-Legal section of the Attending and House Staff Manual.

Policy

Department Chairs and other supervisory employees shall be responsible for ensuring that no House Officer is subjected to conduct which constitutes harassment from colleagues, co-workers or non-employees. Non-employees include, but are not limited to, attending physicians, contractors, vendors and volunteers.

Any complaint regarding harassment may be brought to the attention of the House Officer's immediate Supervisor, Department Supervisor, Department Chair, Program Director, Office of Graduate Medical Education, Corporate Compliance Hotline or the Human Resources Department. All complaints will be promptly and thoroughly investigated. No one who in good faith makes a complaint of harassment or provides evidence of harassment will be subjected to reprisal for doing so. Employees and non-employees found to have engaged in harassment or taking retaliatory action against someone who has participated in an investigation shall be disciplined as appropriate, up to and including discharge.

Section HS 20
Professional Liability Insurance / Tail Coverage

Goal: To provide House Staff with professional liability coverage for the duration of training and to inform the house staff of such coverage.

House Staff employed by the Medical Center are covered by the Medical Center's medical professional liability insurance policy (\$1.3 mil. per occurrence/ \$3.9 mil. in the aggregate) for claims that arise from patient care provided within the scope of employment. A member of the House Staff named as a defendant in a malpractice action will be represented by the Medical Center's attorneys, regardless of when the action commenced, as long as he or she was employed by the Medical Center at the time of his or her care and treatment of the patient/plaintiff. House Staff must immediately notify the Risk Management Department if legal papers (usually called a Summons & Complaint) are received, either through the mail or by direct (in person) service, that names the physician. Failure to promptly inform the Risk Management Department of receipt of such papers could lead to a default judgment being taken by the plaintiff against the House Officer personally and to abrogation of the Medical Center's responsibility to defend and indemnify the House Officer. A risk manager will provide specific instructions to follow in order to protect the physician's interests.

House Staff must not treat anyone (colleagues, nurses, relatives, etc.) other than in the course of their regularly assigned duties in the training program since they have no liability coverage for such treatment and no documentation for such care, resulting in a potentially defenseless situation, whether related to prescription writing or other medical services offered.

House Staff must not write controlled substance prescriptions for themselves or their families.

Professional liability insurance coverage may be extended to professional activities outside the Medical Center only if these activities are deemed to fall within the scope of the training program and prior written approval is obtained from the appropriate Department Chair utilizing the current authorization form and agreement. Care should be taken to ensure that House Officer rotations are officially approved by the appropriate Chair or Residency Program Director, Administration and Office of Graduate Medical Education.

Professional liability insurance coverage does not apply to allegations of a criminal nature or to allegations of professional misconduct brought by the New York State Office of Professional Medical Conduct.

Section HS 21
Call Rooms

Goal: To provide residents with adequate, appropriate and safe sleeping quarters.

House Staff who are assigned to take call in the hospital will have access to on-call rooms which may be shared with several colleagues. The Housekeeping service will clean and provide linen service for these areas, but will not provide personal laundry or be responsible for cleaning areas, which have been subject to disorder and/or abuse by the occupants. Pets are not permitted in the on-call rooms. Snacks will be available in the lounge.

Do not leave any personal possessions in an on-call room. The Medical Center does not accept responsibility for items stolen or damaged in an on-call room. The access and assignment of on-call rooms will be in accordance with the policies of the Graduate Medical Education Committee.

Section HS 22
Meal Reimbursement

Goal: To ensure that residents on duty have access to appropriate food services 24 hours a day.

A meal allowance is incorporated into the house staff salary. In addition, food trays are available (free of charge) for delivery to the house staff in the SICU, ICU and MICU, Labor and Delivery. To request a food tray, it is necessary to call Ext. 20-2810 (Petrie only) before 7:30 pm and provide the name of the doctor requesting, location, time required, etc. If food trays are not available, the Food Service Department will provide a cold meal in lieu of the food tray.

The house staff lounge on 11 Baird also has free coffee and two vending machines where house officers can purchase beverages and snacks. Additionally, individually prepared dinner entrées are sent to the 11 Baird Lounge Monday through Friday. On Friday evenings the refrigerators will be stocked with meals for weekend. Breakfast may be obtained from the food carts on any patient units and will consist of a continental meal including beverages.

Revised and Approved GMEC 2/06; editorial revision: 4-21-11

Revised 3-15-13, 2-2015

Section HS 23
Linen/Laundry Service

Goal: To provide the House Staff with support services to facilitate cleanliness and comfort.

The Medical Center furnishes the House Staff with white jackets and scrubs suits. These items are exchanged, dirty for clean, on a one-to-one replacement basis. Bed linens for the on-call rooms are changed on a daily basis.

Section HS 24
Housing

Goal: To offer safe and convenient housing to House Officers in accredited training programs and who fulfill a critical patient care need.

Policy

The Medical Center attempts, first and foremost, to provide housing to those who fulfill a patient care need and are in an accredited program at the Medical Center. Housing assignments are made in the following priority order, as space permits:

1. House Staff (interns, residents and fellows) in ACGME-accredited programs entirely based at Mount Sinai Beth Israel.
2. House Staff in ACGME-accredited combined Mount Sinai Health Services/MSHS sponsored programs.
3. House Staff who provide a critical care patient care need.

The responsibility for all real estate housing matters or rent offers rests with Real Estate Services. Real Estate Services is responsible for implementing this policy.

Housing is guaranteed to House Staff in ACGME-accredited programs who submit a completed application by the application deadline.

Procedures

Those accepting housing in accordance with the procedures listed herein, will be required to complete a Housing Application, acknowledge a Notice of Housing Priorities and sign an Occupancy Agreement. Pursuant to the terms of the Housing Application and the Occupancy Agreement, any violation of said Housing Application or Occupancy Agreement may result in the termination of the agreement.

All rent determinations will be made by Real Estate Services in consultation with the Office of Graduate Medical Education. Rent for housing will be deducted automatically through payroll deduction.

A. Housing Assignments.

1. Incoming House Officers in ACGME-accredited programs and those in combined Mount Sinai Health Services/MSHS-sponsored programs will receive available housing assignments from Real Estate Services from mid-May to June of each year according to the priority list.
2. During peak season from the March match date to July 31st accommodating the incoming (newly hired) House Staff in housing is the priority.
3. Continuing House Staff who have completed a housing application and have been placed on the wait list will be notified of available apartments by the Office of Real Estate Services.

B. Assignment Guidelines

1. Type of Housing

Assignment guidelines are detailed below in priority order:

Studio

- House Staff with spouse/eligible domestic partner with no children or single House Staff with one child.
- Single House Staff

One Bedroom

- House Staff with spouse/eligible domestic partner and one child or two House Staff who are married/domestic partners.
- House Staff with spouse/eligible domestic partner or single House Staff with one child.

Two Bedroom

- House Staff with spouse/eligible domestic partner and two children
- House Staff with spouse/eligible domestic partner with one child or single House Staff with two children.

The number of occupants in each apartment shall be subject to the Administrative Code of New York City.

2. Location of Housing

Refer to the "Priority Classification for Beth Israel Assignment" document, which will be reviewed periodically and revised, as necessary.

C. Occupancy Guidelines

Only you and your immediate family who live in the apartment full-time are eligible for housing. Eligible family members include your spouse and children. Parents, brothers, sisters, live-in help, etc., will not qualify you for assignment to a larger apartment. To qualify for housing, we must see your original marriage certificate and birth certificates for all children listed. Eligibility of a domestic partner shall be determined solely in accordance with the Real Estate Services department guidelines on domestic partnership, which can be found on the Housing page of the GME website “Affidavit of Domestic Partnership”. Requests for exceptions to these guidelines must be submitted in writing by the House Staff’s Chairman of Service or Administrative Vice President and addressed to the Vice President of Real Estate Services.

D. Length of Occupancy

House Staff (Interns, Residents and Fellows) in ACGME-accredited, as well as, ACGME-accredited combined Mount Sinai Health Services/MSHS-sponsored programs completing residency programs and/or fellowships, must vacate housing by June 30 or by the last day of the training program. Any House Officer terminating employment prior to completion of their residency/fellowship, or prior to June 30 of the year of completion, must vacate Medical Center housing within three weeks of their termination or the last day of the month in which they were terminated, whichever comes first.

E. Wait List

Eligible House Staff who apply for housing or transfer to another apartment when no vacancies exist and, prefer to wait for another apartment, shall have their names entered on a wait list by apartment size, in order of the date of receipt of the application. The Occupancy Guidelines will continue to be a factor in determining a housing assignment. During off-peak season from August 1st to the March Match date, as housing becomes available, House Staff will be contacted with regard to vacancies. If an apartment is offered to a House Staff, the House Staff shall have the opportunity to refuse an apartment one (1) time for any reason. Should House Staff refuse to accept a second offer of an apartment for any reason, e.g., size, location, rent, etc., the House Staff shall lose priority and his/her name will be placed at the bottom of the waiting list.

F. Transfers

House Staff who would like to transfer to the same size apartment may complete a Transfer Application immediately but will be placed on the wait list six months after their move-in date. House Staff who would like an upgrade or a down-grade in apartment size do not have to wait. There is a \$500 transfer fee for transferring to the same size apartment, payable at the time the new lease is signed. All transfers are made from the wait list as apartments become available, except during peak

season, from March Match to July 31st, when there is House Staff Turnover. During House Staff turnover, incoming (newly hired) House Staff have priority for all available apartments.

G. Exceptions

Any request for an exception to this policy or any of the procedures is to be made by the House Staff's Chairman of Service or the Graduate Medical Education Office or Administrative Vice President and addressed to the Vice President of Real Estate Services.

Vacating Housing Procedures

1) Pre-move out inspection

To expedite the preparation of your apartment when you move out of hospital housing and reduce the need to deduct damage fees from your security deposit, Real Estate Services conducts pre-move-out inspections of all apartments that are expected to turnover and schedules any necessary repairs in advance of your move out.

- This pre-move out inspection process takes less than 30 minutes of your time.
- To schedule a pre-move-out inspection of your apartment, please complete the pre-move-out inspection request form and return it to the superintendent or door attendant in the lobby of your building. The deadline to schedule the pre-move-out inspection is mid April for June graduates and mid May for July graduates, after the receipt of the "Vacating Procedures Memo" from Real Estate Services.
- Please be advised that inspections are not performed on the weekends.

The inspection report generated from this pre-move-out inspection will be used together with the report from the final move-out inspection conducted by the superintendent to determine if there are charges to be deducted from your security deposit for damages or cleaning beyond the normal wear and tear of occupancy. The pre-inspection will also give you the opportunity to remedy a situation that would otherwise result in charges. We strongly recommend that you accompany the building superintendent during the inspection. Your signature will be required on the resulting inspection report.

2) Request for Move-out Date and Forwarding Address

Complete and return the request for move-out date and forwarding address form stating your exact move-out date and fax it to the RES Office at (212) 523-5119 or e-mail to reshous@chpnet.org no

later than May 15th for June graduates. Thirty days advance notice must be given to RES when scheduling your move out of hospital housing.

- You will be charged 30-days rent from the date we receive your move-out notice. The last month's rent is not pro-rated to your move-out date.
- Your fully completed request for move-out date and forwarding address form will enable us to stop your payroll deduction of rent and refund your security deposit in a timely manner.
- Please state your exact move-out date on the form and fax it to the RES Office.

3) Early Move-out Incentives

In an effort to encourage early move-out of apartments in June by graduating House Staff and make apartments ready for move-in by incoming House Staff prior to the start of their work schedule, the following rent abatement incentives are offered:

- If you vacate and turn in your keys on or before June 20th, we will charge you only half a month's rent.
- If you vacate hospital housing and turn in your keys any time between June 21 and 25, you will be charged a full month's rent and receive a rent refund of \$30.00 for each day prior to June 30th that you leave early. This refund will be issued via a separate check mailed to your new address.
- If you vacate hospital housing and turn in your keys between June 26 and 30, you will be charged a full month's rent. There will be no refunds or abatements.

4) Preparations for Moving

Please remember that you must vacate your apartment on or before the last day of the month in which your program ends. Your moving out in a timely manner allows us to prepare our housing for the incoming House Staff. Please help us by completing the necessary paperwork and providing the appropriate notices.

- While making arrangements for your move, please remember to turn off your telephone, electricity (if applicable) and cable services.
- You should also complete a change of address form with the United States Postal Service. You can get the form at any post office or at their web site <http://moversguide.usps.com>.

Professional Movers

If you are hiring a professional moving company to move your items, please submit to the Office of Real Estate Services the company's Certificate of Liability Insurance listing the hospital as an

additional insured and yourself as the certificate holder prior to your move-out date. The certificate should also state your building, apartment number, and scheduled date of service.

Medical Sharps

Dispose of medical sharps in a designated sharps container. If you discover any medical sharps while you are packing, the items should be disposed of in a sharps' container located within the Hospital. If you cannot return the medical sharps to the hospital, please dispose of them in the sharps container located on the wall near the superintendent's office at Gilman or in the laundry room at 310 East 24th Street.

Disposing of Bulk Items

Make arrangements with the superintendent for the disposal of bulk garbage items. Bulk items such as old furniture cannot be left in the apartment, hallway or in the basement. If you have bulk items you are not planning to take, please contact the Superintendent in advance so he can arrange for pick up by the Department of Sanitation. You are responsible for putting bulk items at the curb on the scheduled date. Additionally, per New York City Administrative Code section 16-120, any mattress or box spring being set out for the Department of Sanitation must be fully contained within a plastic bag. Suitable plastic bags can be purchased at most home improvement, hardware, or department stores.

If you do not make arrangements in advance for disposal of your bulk items, the cost incurred for removal or improper disposal of items will be deducted from your security deposit.

Final Move-out Inspection

At least two weeks prior to your scheduled move-out date, you may contact the building Superintendent to make an appointment to be present for the final move-out inspection of your apartment. This inspection is done to determine how much of your security deposit will be refunded to you. The Real Estate Office will make a final determination of any monies owed due to damage once you have vacated the apartment. If applicable, your security deposit, minus any charges for rent arrears or damages, will be returned to you within 30 days from the date you turn in your keys and provide us with your forwarding address. Please be advised that Superintendents do not perform inspections on the weekends. If you move out during the weekend, your inspection will take place the following Monday.

Scheduling Elevator Use

One elevator is available for moves. Schedule your move with the Superintendent as soon as possible. The closer your move-out date is to the end of June, the busier the elevator will be. Elevator reservations are made on a first- come, first-serve basis.

Painting

We are required to paint apartments every three years. If your apartment was previously painted within the last three years and needs to be repainted when you vacate, you will be charged as follows:

- A. If the House Staff vacates within six (6) months of occupancy – the full cost.
- B. If the House Staff vacates after six months, but before 18 months of occupancy – 2/3 of the cost.
- C. If the House Staff vacates after 18 months, but before 30 months of occupancy – 1/3 of the cost.

Keys

Return all your keys (including the mailbox key) to the door attendant in the lobby of your building or to the Superintendent.

- Your official move-out date is the date on which you return the keys to the door attendant or superintendent.
- If the door attendant or Superintendent does not receive the keys by your scheduled move-out date, you are still considered the occupant and will be charged rent accordingly.

Security Deposit

Once you return your keys, within approximately 30 days, a separate check for your security deposit minus any charges for rent arrears and/or damages/ excessive cleaning will be refunded and sent to you at your forwarding address.

Complete an official House Staff Release Slip

- You will receive a House Staff Release Slip from your department.
- Please fax the form to RES at (212) 523-5119.
- After you have moved out, returned all of your keys, and arranged for payment of any outstanding charges, RES will sign the Real Estate section of the House Staff Release Slip and return it to your Program Coordinator.
- Vacating charges and/or outstanding rent exceeding your security deposit amount will delay the processing of your House Staff Release slip that authorizes the release of your diploma.

Section HS 25
Guidelines for E-mail Usage

Goal: To enhance effective communication with and amongst all House Officers and Mount Sinai Beth Israel Staff.

BIMC provides all House Officers with access to the GroupWise e-mail system. It is the most direct means for communicating with House Staff. Upon entry into a BIMC training program, each House Officer is provided with a user name and ID Password so that they may have full access to GroupWise. House Officers can connect to GroupWise from any computer with internet access by logging onto www.chpnet.org, clicking on GroupWise, and entering their user name and password. House Officers may not link Group Wise to their personal e-mail address. Such linkages place the individual and the institution in jeopardy of violating the HIPAA compliance regulations. If House Officers forget their passwords, they can call the Help Desk at 212 523-6486, for assistance.

House Officers are requested to check their hospital e-mail frequently to assure reliable and effective communication. Important information from your Program Director, colleagues and other institutional officials will be communicated to you via e-mail. It is the House Officer's responsibility to keep informed of pertinent information.

Section HS 26
House Officer Moonlighting

Goal: To guide moonlighting activities (employment in addition to the House Officer's residency/fellowship program) by Mount Sinai Beth Israel House Officers.

DEFINITION: Moonlighting is defined as any compensated employment performed by a House Officer which is outside the scope of his/her regular training program, rotations, assignments and requirements. Moonlighting activities may not fulfill any part of the clinical experience that is required of the House Officer's training program. Moonlighting may not interfere with the House Officer's training. Residents and Fellows are never *required* to engage in moonlighting.

Moonlighting can occur within Mount Sinai Beth Israel or at an unaffiliated institution. If performed at Mount Sinai Beth Israel, this work can be either within or outside the House Officer's "home department" provided such work is not work which would be regularly performed by the House Officer as part of his/her training program.

PERMISSION TO MOONLIGHT: House Officers can only moonlight after receiving written permission from his/her program director. PGY 1 residents are not permitted to moonlight.

A program director, at his or her discretion, may allow a House Officer to moonlight only if each of the following conditions is met:

1. The place of moonlighting and the responsibilities are delineated in writing by the moonlighter, including the number of hours to be worked,
2. The House Officer wishing to moonlight is in good standing academically and professionally in the "home department",
3. The House Officer's performance will be monitored to assess the effect of the moonlighting activities on performance and stress. Adverse effects will lead to withdrawal of permission to moonlight,
4. Duties and procedures performed during moonlighting cannot be utilized to fulfill any requirements of the residency training program,
5. Failure to comply with this policy may result in disciplinary action.

HIRING DEPARTMENT RESPONSIBILITIES:

A Mount Sinai Beth Israel Clinical Department may hire a House Officer to moonlight if the following conditions are met:

1. The House Officer has a New York State Medical license to perform duties that are required by the hiring department,
2. The hiring department verifies the house officer's competence to fulfill the scope of employment,
3. The moonlighting activity is not the same as the usual activities performed by the House Officer as part of the House Officer's training program.

REQUIREMENTS and LIMITATIONS:

1. Any Mount Sinai Beth Israel House Officer moonlighting in MSBI must complete a Medical Staff Application and be appointed to, and approved by, the medical staff as a "House Physician." It is the responsibility of the Department Chair(s) of the hiring and home departments to assure compliance with this requirement.

A House Physician:

- a. may be a House Officer in a training program at Mount Sinai Beth Israel
 - b. is licensed in NYS with an unrestricted license
 - c. has taken NYS Infection Control Course, as mandated by NYS Dept of Education, at the time of licensure
 - d. has a DEA number, if necessary for scope of practice
 - e. has no admitting privileges
 - f. has an appointment to medical staff which is co-terminus with employment as a House Physician
2. All regulations of the New York State Department of Health 405 regulations and ACGME work hour requirements are fulfilled including but not limited to total hours, periods between duty assignments and one (1) 24 hour period without clinical activities.
 3. Malpractice insurance for moonlighting is provided by Mount Sinai Beth Israel **ONLY** for moonlighting which occurs within the institution. Malpractice insurance for activities occurring outside of Mount Sinai Beth Israel is not provided and must be procured by the House Officer.
 4. House Staff Officers who are not U.S. citizens or permanent residents must discuss and verify eligibility with, and obtain additional written permission from, the International Personnel Office.

PROCEDURE:

1. A House Officer is required to submit a written request, utilizing the GMEC approved Moonlighting Tracking and Attestation form (see attached). The written request *must include detailed description of the moonlighting position*
2. A copy of the House Officer's NYS license and registration must accompany the completed attestation form and forwarded to the Office of GME.
3. Moonlighting authorizations must be renewed at least once per academic year.
4. Moonlighting approvals are specific and not transferable to another activity.
5. Prior to moonlighting, the House Officer must obtain approval from the Office of GME. Approval to start moonlighting outside of Mount Sinai Beth Israel will be conveyed to the House Officer and the Program Director and Coordinator.
6. The signed Moonlighting Attestation form must be kept on file in the House Officer's departmental file.
7. If moonlighting within Mount Sinai Beth Israel, an "Application for Medical Staff Appointment" must be obtained from the Chair of the Department and accompany the Moonlighting Attestation form. The House Officer is responsible for providing the Office of Credentialing Services with all necessary credentialing information (see Office of Credentialing Services' Checklist attached).
8. Approval to start moonlighting at Mount Sinai Beth Israel, based on a complete medical staff application signed by the President of the Medical Center or his designee, will be forwarded to the Office of GME by Office of Credentialing Services. This approval will be shared with the House Officer and the Program Director and Coordinator. The approval is to be added to the House Officer's Department and GME file. Adequate time is to be allotted for this process to occur.
9. Moonlighting hours must be entered into New Innovations and labeled as "moonlighting". A quarterly NI Compliance and Duty Hour Exception report must be submitted to the GME Office quarterly.

Approved GMEC 12/06, rev 12/07
Approved Medical Board, 1/14/08
Revised 10/2007 with attachments (HS Moonlighting Attestation Form & Checklist)
Approved GMEC 3/8/2010: Revised Checklist
Approved Medical Board: 4/12/2010
Revised GMEC: 4/11/11
Revised Medical Board: 5/9/11
Editorial Revision: 12/3/2014, 1/9/2015

**Mount Sinai Health System
Moonlighting Request Form**

Date of Request: _____

Resident/Fellow Name: _____

Residency/Fellowship Program: _____

Training Hospital (circle): Beth Israel Mount Sinai NYEE St. Luke's-Roosevelt

Moonlighting Employer: _____

Name of Supervisor at Moonlighting Location: _____

Contact Phone # of Supervisor at Moonlighting Location: _____

Description of Moonlighting Duties: _____

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

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

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

Professional Liability Carrier: _____

Professional Liability Policy Number: _____

Unlimited Medical License Number (specify state): _____

Resident/Fellow Signature: _____

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

Residency/Fellowship Program Director Name (print)

Date

Residency/Fellowship Program Director Signature

**Mount Sinai Health System
Moonlighting Attestation**

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

1. My moonlighting activities must not interfere with responsibilities related to my residency or fellowship program.
2. I am a United States citizen or green card holder.
3. I must accurately report my moonlighting hours in all work hour surveys.
4. My total work hours must be in accordance with all applicable work hour restrictions, including those in New York State Hospital Code Section 405 and ACGME requirements.
5. I must inform my training director of all moonlighting shifts and schedules.
6. I understand that professional liability insurance (“malpractice insurance”) has been provided for duties within the scope of my residency or fellowship training. This insurance DOES NOT cover moonlighting activities at other facilities. I understand that I will be required to submit proof of separate and appropriate professional liability coverage that covers the requested moonlighting activity.
7. I must possess and maintain a current, unrestricted medical license.
8. I will not report any cases seen during moonlighting activities in procedure logs maintained by my residency or fellowship program.
9. I understand that approval to moonlight is granted through the end of the academic year in which it is approved, and must be renewed each subsequent academic year.
10. My performance in the residency/fellowship program will be monitored for the effects of moonlighting, and permission may be withdrawn if adverse effects are observed.
11. Permission to moonlight may be withdrawn if academic advisement or disciplinary action is issued to me by the residency/fellowship program.
12. Failure to comply with any of the above items may result in withdrawal of permission to moonlight and/or disciplinary action.

Resident/Fellow Name: _____ Date: _____

Resident/Fellow Signature: _____

Chairman Name: _____ Date: _____

Chairman Signature: _____

GME Designee Name: _____ Date: _____

GME Designee Signature: _____

MOUNTSINAI BETH ISRAEL

Name: _____

Checklist of Required Documents for Moonlighting
TO BE PROVIDED BY GME OFFICE

- _____ NYS medical license: Registration and license
- _____ Photo ID – NYS or other state driver license or other Gov't issued ID
- _____ Medical Education: copy of transcript or verification letter and diploma
- _____ Certificates and Evaluations: Internship, Residency, Fellowship
- _____ Updated CV, if current
- _____ Infection Control Course certificate
- _____ ECFMG certificate, if applicable
- _____ Fifth Pathway certificate/letter, if applicable

TO BE PROVIDED BY APPLICANT

- _____ House staff Moonlighting Attestation form with all approvals and signatures
- _____ BIMC Application for Medical Staff Appointment – to be distributed upon authorization by Department Chair
(Reference letters waived, fee waived, malpractice insurance covered by BIMC)
- _____ Updated CV, if not current
- _____ Delineation of Privileges- signed by Chair of training Dept
- _____ Authorization for Release of Information
- _____ Health Evaluation/Assessment- current. Obtained from Employee Health Services
- _____ Board certificate, if applicable
- _____ Name of malpractice insurance carrier from previous training programs, if applicable

Documents submitted by (GME): _____
Credentials Staff: Application complete and required documents rec'd _____
Privileges to Moonlight Approved: _____
Effective Date: _____
Credentials Committee: _____ Medical Board: _____ BOT: _____

Section HS 27
House Officer Rotations Out of MSBI

Goal: To provide a process to facilitate compliance with the required duly executed Institutional Agreement between the participating institutions.

Procedure

Standing rotations (those in which a House Officer in a particular program will participate) should be negotiated by the departments with a certain priority to try to gain needed experiences within the Mount Sinai Health Services/MSHS Partnership, whenever possible. Details of the rotations should be agreed upon by the various Program Directors (and Chairs) and they **MUST** include the six essential areas noted by the ACGME regardless of accreditation status.

The appropriate form for the *proposed* rotation should be submitted to the Office of Graduate Medical Education for review prior to obtaining signatures.

If appropriate the rotation will be scheduled for presentation to the GMEC for approval.

Once approved, the department will acquire the necessary signatures and return the executed Program Letter of Agreement to the Office of Graduate Medical Education.

APPLICATION REQUEST FOR OUTSIDE ELECTIVES

In order for a House Officer to be granted approval for an outside elective, the following conditions must be met:

The House Officer must:

- be in good standing, as determined by the Program Director, in the primary training program
- have completed all medical records at the time of submission. Web-based core competency modules, if a program requirement, must be completed prior to the application being reviewed
- maintain good academic standing until time of departure for the elective

The requested elective must:

- relate to program mission and/or curricula
- provide experience not available at MSBI and /or relate to career goals

- address the 6 ACGME core competencies in the goals and objectives.

Application process:

If the rotation/ elective is within the MSHS, the Delegated Credentialing workflow must be followed and an educational rationale and goals and objectives must be provided to the GME Office for the Program Letter of Agreement. Each department will determine required date of submission; **however**, the deadline for preliminary submission of materials to the Office of GME is 30 days prior to the first day of the proposed elective. The MSBI GME Office will respond in a timely fashion. Final approval must be signed at least two weeks prior to the elective. Verbal approvals will not be issued.

If the rotation/ elective is NOT within the MSHS, the Out Rotation/ Elective Authorization Form must be completed and an educational rationale and goals and objectives must be provided to the GME Office for the Program Letter of Agreement. Each department will determine required date of submission; **however**, the deadline for preliminary submission of application to the Office of GME is 60 days prior to the first day of the proposed elective. The MSBI GME Office will respond in a timely fashion. Final approval must be signed at least two weeks prior to the elective. Verbal approvals will not be issued.

International electives:

The House Officer must apply online through the Mount Sinai Global Health Office (<http://www.gh-training.org/>). The online Global Health Application must include:

1. Name, position, academic rank, training, experience of the Supervisor
2. goals and objectives of the experience
3. description of the facility (resources) in which the elective will take place
4. proposed schedule of the daily activities

The MSBI GME Office will work with Global Health to review the elective and a response will be issued in a timely manner. If the elective is approved a Program Letter of Agreement will be created for the elective.

Approval:

- A response of “Approval” or “Provisional Approval” establishes permission to proceed with plans for the elective. Provisional Approval will be granted if further information is required but the information that is provided appears to meet the above criteria

- A response of “Not Approved” establishes that the House Officer may not proceed with the planned elective. MSBI GME Office recommends that each residency program establish default plans for any House Officer submitting an outside elective application.

Upon completion of the elective:

- **For rotations in accredited programs**, completion of the rotation evaluation will suffice. The Program Director should assess whether this elective should be recommended to other trainees or approved by the program, if again requested.
- **For non accredited and international rotations**, the experience must result in scholarly activity, as determined by the Program Director. This requirement may be satisfied by presentation of Grand Rounds, presentation for Research Day, and/or manuscript for publication.
- **Additionally, for international electives**, the House Officer must demonstrate how the proposed goals and objectives were met in relation to the six core competencies in a written format of sufficiently high quality to satisfy the Program Director.

Costs/Fees

The House Officer is solely responsible for costs/fees incurred during elective rotations. Any costs that are incurred by the House Officer prior to formal GME approval are the responsibility of the House Officer. The House Officer is responsible for all costs if permission is rescinded due to non-compliance with the above requirements.

Approved: GMEC 4/05

Editorial Revision 3/15

Section HS 28

Institutional/Residency/Fellowship Program Closure or Reductions

Goal: To ensure appropriate notification of institutional/residency/fellowship program closure, reductions or any adverse action taken by the ACGME.

Reduction Policy Statement

If the ACGME withdraws accreditation of a program or if a decision is made voluntarily to close a residency/fellowship program or institution, the sponsoring institution must inform the GMEC, DIO and the House Officers as soon as possible. The sponsor will work with participating institution(s) and establish a phase-out plan that allows currently enrolled residents/fellows to complete their training. If that is not possible, the sponsor, in conjunction with the participating institution(s), will assist the displaced House Officers in obtaining positions in other accredited training programs.

In the event that the sponsor and participating institution(s) decide to reduce the number of positions in any residency/fellowship training program, the GMEC, DIO and house officers in that program will be immediately notified. Every effort will be made to accomplish the reduction without adverse effect on House Officers currently in training. If that is not possible, the sponsor, in conjunction with the participating institution(s), will assist the displaced House Officers in obtaining a position in another accredited training program.

ACGME 7/99

Approved GMEC 2/12/07

Approved editorial revision: GMEC 11/14/11

Section HS 29
Dress Code/Personal Appearance

PURPOSE: Medical Center staff are expected to present a professional image which is consistent with their role as health care professionals. They must maintain a neat and clean appearance at all times. The Medical Center reserves the right to set standards of appropriate dress/appearance.

Overall Expectations:

Medical Center staff are required to maintain a high standard of personal appearance, hygiene and grooming at all times. Clothes must be clean and in good condition and appropriate for the individual's job. All staff must wear their identification badges at chest level with the picture facing out at all times while on Medical Center premises. Staff who present for work inappropriately dressed may, at the supervisor's discretion, be sent home without pay.

Staff with tattoos/body art that contains offensive language, nudity and/or culturally insensitive material/language must cover such tattoos/body art. Any visible body piercing or artificial nails that may be perceived as "offensive" by the employees, supervisory staff and patients must not be exposed.

The following are **considered inappropriate for work and may not be worn** by staff while on duty:

- Jeans of any color
- Mini-skirts
- Low back, backless or strapless dresses; tops including midriffs and low-cut tops
- See through or sheer blouses, shirts, pants, skirts or dresses
- Tank tops and T-shirts
- Shorts/capris
- Athletic clothing, sweatshirts (hoodies) or sweatpants
- Head coverings of any type that are not part of a uniform with the exception of those worn for religious reasons
- Slippers, house shoes, flip-flops, sandals
- Spandex, leggings, or any other tight fitting clothing

FOR STAFF WITH DIRECT OR INDIRECT PATIENT CARE CONTACT, THE FOLLOWING ADDITIONAL GUIDELINES APPLY:

- Open toed shoes are not permitted
- Jewelry may be worn. However, it must be minimal, no long, dangling earrings, bracelets or necklaces
- Long hair is to be pulled back
- Nail length should be short enough so as to allow the individual to thoroughly clean underneath them and not cause glove tears. Artificial fingernails or nail wraps may not be worn
- Buttons, badges or other insignia other than those specified as part of the regulation uniform are not permitted. Similarly, identification badges issued by the hospital must not be defaced with buttons, badges or other insignia not issued by the hospital

Staff who come in contact with either clean or soiled patient care items (regardless if the person has actual patient care contact) must comply with the fingernail requirements noted above.

House Staff:

1. Men:
 - Dress shirt
 - Tie (strongly encouraged)
 - White coat (provided)
 - Hospital issued scrub suit may be worn with a white coat
 - Pants
 - Clean white or black sneakers are acceptable unless otherwise prohibited by the department
 - OR booties or hats worn in the sterile environment are not to be worn outside that environment
 - Operating room scrub suits outside of the Operating Room must be covered with a white coat

2. Women:
 - Dresses, skirts, blouses, pants
 - White coat (provided)
 - Hospital issued scrub suit may be worn with a white coat
 - Clean white or black sneakers are acceptable unless otherwise prohibited by the department

- OR booties or hats worn in the sterile environment are not to be worn outside that environment
- Operating room scrub suits outside of the Operating Room must be covered with a white coat.

Staff who fail to adhere to the Medical Center's standards for appropriate dress/appearance may be sent home without pay and disciplined up to and including termination.

This policy and procedure does not supersede more restrictive departmental policies and procedures.

Approved GMEC revisions: 12-10-07, 4-11-11, 3-12-12

Revised Medical Board: 1-14-08, 5-9-11, 4-9-12

Section HS 31

Policy for House Officer Access to Files

Goal: To maintain accessible records of evaluation for House Staff.

House Officers are permitted to review their own summative and rotation-specific evaluations in the presence of the Program Director or his/her designee. When multiple evaluations from individuals (Attending Physicians and/or House Officers) are compiled to generate a summative or rotation-specific evaluation, the summative evaluation may be reviewed by the House Officer. Completed evaluations submitted by individuals may be reviewed at the discretion of the Program Director. House Officers may not photocopy House Officer files. However, programs may give photocopies of summative evaluations to House Officers at the discretion of the Program Director. These photocopies shall be stamped to indicate that they are not original official documents. Evaluations, documents and letters received by the training programs and Office of GME prior to commencement of the residency, cannot be reviewed or copied by the House Officer.

Broader access to House Officer files may be required upon request in connection with a hearing pursuant to the House Officer Grievance Policy. Legal Services shall be consulted in such cases.

Approved GMEC 9/03

Section HS 32
Needle Stick Policy

Goal: To provide expeditious, safe prophylaxis for needle stick injuries and/or exposure to body fluids which occur in the Operating Rooms, while at the same time promoting and ensuring a supportive, responsible environment, **only** under the special circumstances described below.

Under the current institutional policy (Infection Control, Intro, Section F):

- Employees with percutaneous injuries are expected to stop work.
- Immediately go to Employee Health Services (EHS) during the weekday daytime hours or the Emergency Department (ED) during off-hours (evenings, holidays and weekends).
- The employee is required to complete an Incident Report and the Post-Exposure Prophylaxis Consent for Treatment form.
- Appropriate prophylaxis and supportive counseling is provided and follow-up arranged.

Should a percutaneous injury and/or exposure to blood/body fluids occur, the health providers' are **expected** to "scrub out" of the procedure and proceed to Employee Health Services or Emergency Department. **However, IF:**

- The person receiving the injury **cannot** leave the Operating Room due to the inability to locate appropriate replacement personnel which may occur on some nights, weekends, **and**
- The injury is not serious enough to jeopardize self or patient

The following alternative pathway policy will become operative (but only under these circumstances).

Any health professional scrubbed into the OR will have available to them one stat dose of prophylaxis medication in the event of a needlestick injury and/or exposure to blood/body fluids.

The process for obtaining the medication is as follows:

1. Two doses will be stocked in the Pyxis machine (Petrie, Singer) or OR area (Kings Highway Division) at all times along with an in-patient standing order for the medication and the appropriate Consent Form.

2. The Charge Nurse/ Nurse Manager will be informed and summoned to the OR.
3. The injured person and/or Charge Nurse/Nurse Manager will attend to the wound.
4. The Attending Physician or Anesthesiologist will be responsible for signing the standing order form.
5. The injured person will be advised of the risk/benefits and side effects of medical prophylaxis as outlined in the Post-Exposure Prophylaxis Consent Form by the surgeon or anesthesiologist. If there are any questions, he/she may speak to the Infectious Diseases physician on-call. After the Consent Form is signed, only the Charge Nurse/Nurse Manager will be permitted to obtain a stat dose of medication from the Pyxis (Petrie, Singer) or OR area (Kings Highway Division) and medicate the injured medical personnel.
6. The Charge Nurse/Nurse Manager or the injured person will complete an incident report, a copy of which will be forwarded to Infection Control via interoffice mail. The Charge Nurse/Nurse Manager will call the QI Hotline (212) 420-2100 and report the injury, as is done for all incidents occurring in the OR.
7. When the OR case in progress is completed, the injured employee should take the completed paperwork and **immediately** proceed to EHS or the ED for interim medication and the appropriate comprehensive management of the needle stick and/or injury.
8. Quality Improvement staff will inform EHS of the reported incident by calling a designated, confidential phone number. EHS, in concert with Infection Control, will follow up with the injured; however, it is also the responsibility of the injured person to make certain that this follow-up does occur.

This policy does not replace the current policy and procedure for needle stick injuries. The alternate approach described herein is designed to afford timely prophylactic medication under special circumstances that do not permit the injured party to immediately follow the Infection Control Policy and Procedure regarding needlestick injuries. The attending physician is responsible to ensure appropriate and rapid assessment, treatment and support to the injured person.

Approved 12/03

Section HS 33
House Officer Resignation from Training Program

Goal: To facilitate professional communications for House Staff who have resigned from their training program.

1. Should a House Officer resign from a training program, the following steps should be followed:

- The House Officer should send a letter of resignation to the Program Director. The Program Director should forward copies to the Chair and Chief of GME/Academic Affairs
- The program should provide information reviewing the circumstances of the resignation and any counseling/services rendered
- The Chief or Director of GME will meet with the House Officer and conduct a structured exit interview to explore circumstances related to the resignation and attempt to obtain information that would be instructive to the institution.
- House Officer must follow House Staff Release processes including the return of hospital property required for completion of the "House Staff Release Slip".
- The Department will complete the PCF information and Final Check Request
- The Office of GME will notify departments needing to terminate House Officer access e.g. Telecommunications, Housing, Linen, Medical Library, Medical Records, Security, Human Resources, Benefits, Laboratory, Pharmacy, and Employee Health.
- If a Certificate of Training is due the House Officer, the appropriate information should be provided to the Office of GME. The Certificate will be ordered along with the diplomas and other certificates at the end of the training year.
- A final evaluation letter should be placed in the House Officer's file.
- The program shall review with the GMEC plans to fill the vacant position, see Resident Replacement Policy.

2. House Staff Who Accept Another Position after Signing an Employment Agreement with Mount Sinai Beth Israel (MSBI)

The "Resident Agreement" is a legally valid employment contract, which is a binding agreement between both BIMC and the House Officer who signs it. It is a breach of contract for a House Officer to sign an employment agreement and then accept another position elsewhere for the same time period. In addition, it is detrimental to Beth Israel's graduate medical education programs. Failure to fulfill such an agreement is viewed as a breach of professionalism.

If a House Officer breaches an employment agreement with Beth Israel by accepting another position, Beth Israel will:

1. Place the attached memorandum in his/her file.
2. Provide copies of the attached memorandum to prospective employers, along with other credential information customarily provided.

Date: _____

Memorandum to File of _____, M.D.

Dr. _____ entered into an agreement with Mount Sinai Beth Israel to work as a house officer for the academic year July 1, 20__ through June 30, 20__. Dr. _____ breached this agreement with Beth Israel by accepting a position at _____ beginning _____.

Dr. _____ gave the following explanation for his/her actions:

As per Beth Israel policy, this memorandum will be made part of Dr. _____'s permanent record, and a copy will be sent to prospective employers, along with other credential information customarily provided.

Additional Comments:

Signed: _____

Title: _____

GMEC Approved: 5/17/04

Revision: 9/12/05

Section HS 34
H1-B Visa Applications

Goal: To create an efficient process whereby applicable House Staff can obtain required Visas.

House Officers who are accepted into a MSBI training program and require H-1B status will be processed by the Mount Sinai International Personnel office. The Sponsoring Department will be responsible for collecting the required documentation and submitting it along with the required payments to the Mount Sinai International Personnel Office. Residents will be responsible only for the Premium Processing fee of \$1,225.00 (). Premium Processing provides for expedited review of the H-1B petition within fifteen (15) days. If a petition is filed sufficiently in advance of the start date (ideally 6 months in advance) it is possible that use of Premium Processing can be avoided. If a petition is filed without Premium Processing, a Premium Processing request may still be made at any time while the petition is pending, should it become necessary to expedite due to processing delays. The decision as to whether Premium Processing will be necessary will be determined on a case by case basis by International Personnel. Initial H-1B visa holders are permitted to enter the United States no earlier than 10 days.

Process for H1-B Visa Applications

1. All H1-B Visa applications must be processed by the Mount Sinai International Personnel Office.
2. When a prospective House Officer needs to apply for the H1-B Visa, a representative of the applicable department will contact the Mount Sinai International Personnel Office at 212-731-7744. Due to processing times, departments should contact International Personnel at least 6 months in advance of start date.
3. The Mount Sinai International Personnel office will review the applicants Curriculum Vitae along with the position job description to confirm H1-B eligibility.
4. The Sponsoring Department must provide the completed H1-B Application including all supporting documentation (see list) and the required filing fees (see list) to the Mount Sinai International Personnel Office.
5. To qualify for H-1B status, House Officer must have successfully completed USMLE Steps 1, 2, & 3 by match date. If the House Officer has graduated from an accredited US medical school, they will qualify for H-1B status.

Documentation and Fees Required for H1-B Visa Processing

List of Required Documents:

Sponsoring Department:

1. Completed H1B application by department and applicant
2. Detailed job description, job title, salary and minimum education and experience required for the position;
3. Copy of executed letter of offer (must include department name, salary and position)
4. Filing fees:
 - \$325 H-1B immigration fee – standard processing
 - \$500 Anti-fraud fee (**Does not apply to H-1B Extensions**)
 - \$250 Disbursement fee - see Deposit Invoice
 - \$1225 for premium processing – (can be paid by department or employee – this service is optional but recommended to expedite USCIS adjudication and timely start)

Applicant:

1. Copy of current CV;
2. Copy of all educational degrees, transcripts and diplomas, with certified English translations;
3. Proof of USMLE Step 1, 2 and 3; ECFMG certification;
4. Copies of licenses/certifications/permits required for position
5. Complete copy of all passports, including biographical information, all U.S. visa stamp pages, and pages with entry/exit stamps; Passport must be valid beyond 6 months at the time of submission of petition to USCIS
6. Copy of most recent I-94 Arrival/Departure Record (available at <https://i94.cbp.dhs.gov/i94/request>);
7. Copy of all prior Forms I-797 (approval notices), IAP66/DS2019 (front and back), waivers (if applicable) Employment Authorization Document (EAD), I-20 (all pages), visa stamps, etc.; and
8. Copy of latest paystubs from current employer (at least 4)

Dependents:

1. List of family members requiring H4 status with current immigration status (I.E. H-4, J-2, TD, F-2 etc.);
2. Completed I-539 form (attached);
3. Filing fee check in the amount of \$290-payable to U.S. Department of Homeland Security;
4. Disbursement fee check in the amount of \$50 (for each dependent) - payable to The Mount Sinai Medical Center;
5. Copy of unexpired passport and visa stamps (excluding blank pages);
6. Copy of most recent I-94 Arrival/Departure Record (available at <https://i94.cbp.dhs.gov/i94/request>);
7. Copy of Marriage Certificate and/or birth certificate (for children only); and
8. Copy of all prior I-20, DS2019/IAP66, and I-797 (approval notices).

List of Required Fees:

All H-1B petitions are mailed to California Service Center, 24000 Avila Road, Laguna Niguel, CA 92677
 Editorial revision: 6-8-2012, 3-5-15

	<u>Fees payable to U.S. Department of Homeland Security*</u>	<u>Disbursement Fee Payable to Mount Sinai</u>
Form I-129, Immigrant visa petition	\$325 – must be paid by employer	\$250 - must be paid by department Fee applies to initial, extension and transfer applications **
Anti-Fraud fee	\$500 – must be paid by employer Fee applies to initial and transfer applications only	None
Form I-907 Premium processing fee (Optional – if selected, the USCIS will process the case in 15 days)	\$1225 – may be paid by employer or employee	None
Form I-539 (for dependent spouse and children in H-4 status)	\$290 – may be paid by employee or employer	\$50 (for each dependent) – paid by the employee

Section HS 35

Policy: House Officer Transfers

Goal: To determine the appropriate level of education for House Officers who are transferring from another residency program.

The Program Director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring House Officer from the Program Director, at a minimum, and other resources as available including an assessment of competence in the six ACGME competencies, prior to their acceptance into the program. A Program Director is required to provide verification of residency education for House Officers who may leave the program prior to completion of their education.

Approved GMEC 10/05

Section HS 36
Restrictive Covenants

Goal: To ensure there are no restrictive covenants placed upon graduated House Officers.

ACGME accredited programs will not require House Officers to sign a non-competition guarantee.

Approved GMEC: 12-12-05

Section HS 37
DOH Regulation Regarding NYS Issued Prescription Pads

Goal: To minimize Medicaid fraud in prescription drug use.

In an effort to address Medicaid fraud, NYS is phasing in a new personalized prescription pad that is issued by DOH. Effective April 19, 2006 the NYS DOH issued prescription pad **MUST** be used for all prescriptions written in New York State.

The following procedures have been implemented to be in compliance with these regulations:

1. Licensed Prescribers with their own NYS license and DEA number must obtain their own supply of prescription pads from DOH.

Contact: Phone: 1-866-811-7957

2. Unlicensed prescribers currently in BIMC sponsored training programs, NYSDOH prescription pads must be used for all prescriptions. The procedures for accessing these pads are as follows:

1. The Director of your training program will issue you an initial supply of 1 pad (100 prescription blanks per pad).
2. Replacement supply – You will get replacement pads from the BIMC IDS Pharmacy, 1st floor, Silver Building, Monday – Friday from 9:00 a.m. to 12noon and 1:00 p.m. to 4:00p.m. Initially, only a limited amount will be distributed. Once there is a sufficient amount, you will be issued 3 pads at a time.
3. Emergency supply – Pads will be available from the charge nurse at each Nursing station.

It is important that you recognize that these prescription pads will become your personal property and professional responsibility. The sequence numbers given to you will be recorded. If a prescription pad is lost or stolen, you will be obliged to contact DOH at 518-402-0707.

Please anticipate your Rx needs and replenish your supply appropriately since the hours of distribution are limited. Use of emergency supplies will be monitored for appropriateness.

You will continue to use your “plate” to imprint the prescriptions.

Approved GMEC: 12-12-05

Revised: 3-30-06; 4-07

Section HS 38

Professional Activities Outside of the Program

Goal: To provide guidelines for house officer participation/involvement in professional activities, such as institutional committees and community service activities, which are outside of the aegis of the training program.

Policy: House staff must be encouraged and given the opportunity to participate in institutional and non-institutional committees and outside educational programs, to promote professional development, community involvement and enhance knowledge, skills and attitudes essential to the practice of medicine. Wherever possible, program directors should facilitate such participation and accommodate house staff requests.

Any extracurricular non-hospital activities that may impact on the ability of the house officer to meet all responsibilities and obligations of the training program, must be authorized in writing by the training program director. If any activity involves provision of medical care outside of that directed by the training program, the house officer must ensure that he/she has the appropriate licensure and medical malpractice insurance.

Section HS 39
Documentation in Medical Records

Goal: To ensure appropriate maintenance of the medical record for optimal communication, coordination of patient care, and documentation of care rendered.

Medical records are essential to document and assure high quality patient care. Medical records are legal documents and notes in the medical record should be contemporaneous with patient care. Records may not be altered, defaced, or obliterated in any fashion. Alterations must be limited to addenda as stipulated below. Abbreviations should be minimized in the medical record, and banned abbreviations should not be utilized in the medical records. The listing of updated prohibited abbreviations can be found on the GME website, under Special Educational Resources. All entries into the medical records must be legible, dated, timed, and signed. Signatures should be followed by beeper numbers and/or printed or stamped names.

Corrections should be made by drawing a single line through the incorrect entry. Such changes must be dated and initialed.

Addenda should be made infrequently, and only if the information is important to the patient's medical care. If clinically pertinent information needs to be added, it should be labeled as an "addendum" and dated using the date the addendum is written. Addenda should appear in the chart in the chronological order in which they occur.

Medical records must be completed in their entirety in a timely fashion.

Approved GMEC 10-9-06

**Section HS Section 40
Stress, Sleep Deprivation and Fatigue**

Goal: To assure the safety and well-being of patients and house staff

It is important that house staff recognize the effects that stress, sleep deprivation and fatigue may have on cognitive and non-cognitive skills. Sleep deprivation, fatigue and stress can have deleterious consequences for patients, as well as, house staff. It is the responsibility of each program to teach the signs and symptoms of stress, sleep deprivation and fatigue and the measures that can be taken to minimize its effects. It is every house officer's duty to further educate themselves on these topics and be aware of such signs and symptoms in themselves and others.

Each department has developed a policy to identify and respond to evidence of house staff stress, sleep deprivation and or fatigue. When a member of the house staff is experiencing sleep deprivation, fatigue and/or stress, it is his/her responsibility to report it to a supervisor.

Approved GMEC 3/07

Section HS 41

Administrative Support for House Officers in the Event of a Disaster

Goal: To ensure administrative support for GME programs and Residents/Fellows in the event of an extreme emergent situation, disaster or disruption in patient care, and provide assistance for continuation of resident/fellowship assignments.

Institutional Extreme Emergent Situations

1. **Definition:** Extreme emergent situation is a local event, such as a hospital-declared disaster or an epidemic that affects resident education or the work environment, but does not rise to the level of an ACGME-declared disaster.
2. **Institutional Responsibilities:** BIMC maintains a special task force to develop and implement disaster plans in the event of extreme emergent situations. Roles and responsibilities of house staff will be assigned taking into account house officers' degree of competence, specialty training, and the context of the specific situation.
3. **Resident Responsibilities:** Resident performance in extreme emergent situations should not exceed expectations for scope of competence as judged by program directors and other supervisors. Residents are not expected to perform beyond the limits of self-confidence in their own abilities and maturity to act under significant stress or even duress.
4. **ACGME Procedure Requirements:** In the event of an extreme emergent situation, program directors' first point of contact for answers to questions is the GME Office/DIO.
5. **Disruption of Training:** The DIO will contact the Executive Director, Institutional Review Committee only 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 any of its programs' ability to conduct resident education in substantial compliance with ACGME Institutional, Common, and specialty-specific Program Requirements. The DIO will receive electronic confirmation of this communication which will include copies to all Residency Review Committees (RRCs). Upon receipt of this confirmation by the DIO, PDs may contact their

respective RRCs, if necessary, to discuss any specialty-specific concerns regarding interruptions to resident education or effect on educational environment. PDs are expected to follow their institutional disaster policies regarding communication processes to update the DIO on the results of conversations with EDs-RRCs regarding any specialty-specific issues. The DIO is expected to notify the ED-IRC when the institutional extreme emergent situation has been resolved.

Disaster Plans

Icahn School of Medicine at Mount Sinai and its clinical affiliates, including Montefiore Medical Center, Jacobi Medical Center, Bronx Lebanon Hospital Center, North Shore-Long Island Jewish Health System, and Mount Sinai Beth Israel in Manhattan (the Einstein-affiliated institutions) agree as follows:

1. In the event of a disaster or interruption of patient care that results in a disruption of residency training, Icahn School of Medicine at Mount Sinai and its affiliated institutions will collaborate and make best efforts to assist each other in identifying appropriate placements for residents whose programs have been adversely affected.
2. The Associate Dean for GME of Icahn School of Medicine at Mount Sinai will provide a central point for communications with respect to resident placements and relocations among the affiliated institutions.
3. The Icahn School of Medicine at Mount Sinai -affiliated institution that had been the employer of any dislocated residents shall retain financial responsibility for the residents' salary and benefits until such time as an agreement may be reached to transfer this responsibility to another institution to which the resident has been relocated.
4. The Icahn School of Medicine at Mount Sinai -affiliated institutions will cooperate in application to the ACGME, to medical specialty boards, and to state and federal agencies that fund GME, for transfer of authorization for numbers of trainees and funds to support dislocated residents.
5. In the event that house officers are displaced from non - Icahn School of Medicine at Mount Sinai -affiliated institutions, these institutions will give first priority to accepting dislocated residents from within the affiliation network

Approved GMEC: 4-9-07; policy and editorial revision: 1-11-2010; editorial revision 7-14-2011

Section HS 42

Record Maintenance and Retention in GME Programs

Purpose: GME programs collect and generate many documents in the process of administration of the programs and in the training and education of their residents and fellows. The goal of this policy is to provide guidance to the programs and their leadership regarding retention of those records. Record retention times are generally determined by the nature of the particular documents, institutional policy, and by legal and accreditation requirements.

1. Labeling. All house staff files should be labeled “Resident Credential File-Quality Improvement.”
2. Litigation Holds. No house staff file or any record within such file may be destroyed if any litigation, claim, negotiation, audit, open records request, administrative review, or other action involving the record has been initiated. Such files must be retained until notice is given by the Legal Department that their retention is no longer necessary. In this instance, the provisions below DO NOT apply.
3. House Staff Officers Who Were Terminated, Suspended, Formally Disciplined or exhibited significant performance difficulties. The file of any house officer who was terminated or suspended from the program, or received a final recommendation which did not recommend the graduate without reservation, or was reported for professional misconduct, or who had other major disciplinary or quality issues during the residency program, should remain intact in perpetuity.
4. Other House Staff Officers: End of Training Program. At the end of the training program, files of house officers who are certified on the “End of Training Evaluation” as not having committed professional misconduct, and as having demonstrated sufficient competence to practice without direct supervision, may be purged of all information except identifying demographic information, summative evaluations, and the “End of Training Evaluation” form. The summative evaluations and “End of Training Evaluations” must be “retained in perpetuity” pursuant to ACGME guidelines. Other information, including formative evaluations, resident portfolios, exam scores, checklists, and the like, may be discarded.
5. Residents on Rotation from Other Institutions. Rotator files may be discarded six years after the house officer has graduated from his/her primary training program.

6. Applicant Files. Applicant files, delineating the applicant's rating based upon the Program's evaluation/ranking system, should be retained, to the extent possible, for six years. ERAS files should be electronically downloaded and stored until the completion of the period of training for which the applicant had applied.

7. IRIS Report Data. Rotation and assignment schedules, used to configure the IRIS report, should be retained in paper &/or electronic format, for ten years.

Approved GMEC: 3-10-08

Medical Board review: April 14, 2008

Section HS 43
Accommodation Policy

Goal: To comply with Americans with Disabilities Act (ADA) and provide reasonable accommodation to qualified housestaff to the extent possible (*Human Resources Policy & Procedure Manual, Section/Policy# : Administration #1009*)

The Hospital is committed to complying with all applicable provisions of the Americans with Disabilities Act (“ADA”). It is the Hospital’s policy not to discriminate against any qualified house officer in application procedures, hiring, firing, advancement, compensation, training, or in other terms, conditions, and privileges of training, because of such individual’s disability or perceived disability so long as the house officer can perform the essential functions of the position. Consistent with this policy of non-discrimination, the Hospital will engage in an interactive process with the goal of identifying necessary accommodation(s) for a house officer with a disability, as defined by the ADA, who has made the Hospital aware of his or her disability, provided that such accommodation does not constitute an undue hardship on the Hospital. The Hospital encourages house officers with an ADA covered disability to come forward and request a reasonable accommodation if it is necessary to maintain acceptable performance.

Procedure for requesting an accommodation:

1. Employee Health Services (EHS) will evaluate the house officer requesting accommodation, if necessary obtain further information from treating provider, and will determine if the accommodation is medically justified and medically appropriate. EHS will provide notification of decision on the EHS referral slip which should be returned to house officer’s program director and GME Office.
2. If necessary, the GME Office and EHS will meet with the house officer and his/her program director to discuss the precise limitations resulting from the

disability and the potential accommodation that the Hospital might make to help overcome those limitations.

3. The GME Office will determine the feasibility of the requested accommodation considering various factors, including, but not limited to the nature and cost of the accommodation, the accommodation’s impact on the operation of the Hospital, including its impact on the ability of other house officers to perform their duties and on the Hospital’s ability to conduct business.

4. The GME Office will inform the house officer of the decision on the accommodation request and, if there is an accommodation, what the accommodation will be.
5. If the accommodation request is denied, the house officer will be advised of his/her right to appeal the decision by submitting a written statement to the Corp. Vice President for Human Resources explaining the reasons for the requested accommodation. If the request is denied on appeal, that decision is final.
6. The ADA does not require the Hospital to make the best possible accommodation, to accommodate a house officer's inability to perform essential training functions, or to provide personal use items (i.e., eyeglasses, hearing aids, wheelchairs etc.).

House Officers who have questions regarding this policy or believes that he or she has been discriminated against based on a disability should notify the GME Office. All such inquiries or complaints will be treated as confidential to the extent permissible by law.

Approved GMEC: 3-10-08, editorial revision 5-9-11

Medical Board review: 4-14-08, editorial revision 5-9-11

Section HS 44
Compassionate Leaves for New House Officers

Goal: First year and other new House Officers are not covered by the FMLA (Family and Medical Leave Act). The Compassionate Leave Policy is in recognition that new House Officers may need leave in certain instances that would have been available under the FMLA.

The Family and Medical Leave Act allows employees to take up to 12 weeks of leave within a one year period for certain purposes, even if they have exhausted any other leave entitlement they may have. By law, Employees are not covered by the FMLA unless they have worked **at least twelve months** and 1250 hours for their employer. Consequently, first year and other new House Officers are not covered by the FMLA. However, the Medical Center recognizes that new House Officers may need leave in certain instances that would have been available under the FMLA. These are (a) continuous leave (four (4) or more consecutive days) or intermittent leave to care for an immediate family member with a serious medical condition, (b) intermittent leave (part of a work day or part of a work week) to care for oneself with a serious medical condition, or (c) leave to bond with a newborn or newly adopted child. This does not apply to personal medical leave – see regular LOA policy. For purposes of this policy, we will call leave for any of these reasons **after the first month of employment until FMLA eligible**, “Compassionate Leave.” An immediate family member is defined as a child*, spouse (including common law and domestic partner) or parent.

**The term “child” refers to the employee’s own dependent child, adopted child, foster child for whom the employee has legal foster care responsibility, stepchild, legal ward, or a child for whom the employee has overall parental responsibility on an established basis and who is living in the household of the employee.*

While the Medical Center is not, as a matter of law, subject to the FMLA or required to follow its dictates in responding to requests for Compassionate Leave, we will be guided by the FMLA and generally attempt to provide similar benefits. While on approved Compassionate Leave, House Officers remain subject to all changes that may occur in the Hospital’s health care or other benefit programs and are subject to all other employment-related policies. Health insurance is maintained at the level and under the conditions that coverage would have been provided if the employee had continued in employment continuously for the duration of the approved Compassionate Leave.

With respect to a House Officer receiving academic credit and progressing through the program, all leave must be within the guidelines of the respective Residency Review Committees and the specialty Board. It is the responsibility of the House Officer to be familiar with those requirements. **Leave beyond that permitted by the individual Boards may result in extension of the residency or fellowship program.**

A. Compassionate Leave to Care for an Immediate Family Member with a Serious Medical Condition

House Officers who are absent (or will be absent) for four (4) consecutive working days or more or require leave on an intermittent basis to care for an immediate family member with a serious medical condition must follow the procedures outlined below.

- 1) **House Officer** must notify his or her Program Director and complete a Compassionate Leave of Absence Application/Extension Form for House Officers indicating a request for a leave of absence.
 - a) When such leave is foreseeable, the *Compassionate Leave of Absence Application/Extension Form for House Officers* must be submitted to the employee's Program Director not more than thirty (30) days before the leave is to commence.
 - b) In cases of an unforeseeable absence (such as unexpected illness or injury), the employee must submit the application as soon as it is practical and possible to do so.
- 2) **Program Director** must complete the "Program Director Section" of the *Compassionate Leave of Absence Application/Extension Form for House Officers* specific to leave to care for a family member.
 - 1) **House Officer** must fax a copy of the Program Director-signed *Compassionate Leave of Absence Application/Extension Form for House Officers* to the Corporate Human Resources Benefits Office at (212) 523-5610 if the leave is **not** intermittent.
 - 2) **House Officer** must complete a *Medical Substantiation/Proof of Illness Form*. This form must be completed by the employee and the family member's healthcare practitioner and submitted to the Care Liaison Program (CLP) in Employee Health Services (EHS) along with a copy of the Program Director-signed *Compassionate Leave of Absence Application/Extension Form for House Officers*. The forms may be faxed to Employee Health Services at (212) 844-1762.

Extension of Leave of Absence

House Officers who expect to be on leave longer than the originally requested duration must apply for an extension by completing the process outlined above.

Return from Leave

Program Director must prepare a Personnel Change Form (PCF) to return employee from leave of absence and send it to the HR Mailbox.

B. Compassionate Intermittent Leave to Care for Oneself with a Serious Medical Condition

House Officers may take their leave on an intermittent basis (by working fewer days or working reduced hours per week) to care for themselves due to serious medical conditions.

- 1) **House Officer** must notify his or her Program Director and complete a *Compassionate Leave of Absence Application/Extension Form for House Officers* indicating a request for an intermittent leave of absence.
 - a) When such leave is foreseeable, the *Compassionate Leave of Absence Application/Extension Form for House Officers* must be submitted to the employee's Program Director not more than thirty (30) days before the leave is to commence.
 - b) In cases of an unforeseeable absence (such as unexpected illness or injury), the employee must submit the application as soon as it is practical and possible to do so.
- 2) **Program Director** must complete the "Program Director Section" of the *Compassionate Leave of Absence Application/Extension Form for House Officers* specific to intermittent leave requests for the employee's own serious medical condition.
- 3) **House Officer** must complete a *Medical Substantiation/Proof of Illness Form*. This form must be completed by the employee and the employee's healthcare practitioner and submitted to the Care Liaison Program (CLP) in Employee Health Services (EHS) along with a copy of the Program Director-signed *Compassionate Leave of Absence Application/Extension Form for House Officers*. The forms may be faxed to Employee Health Services at (212) 844-1762.
- 2) **Employee Health Services (EHS)** will notify the employee's Program Director of the leave decision (leave is granted or not granted and for what duration) via e-mail or fax.

Extension of Leave of Absence

House Officers who require intermittent leave of longer duration than approved by EHS must apply for an extension by repeating the process outlined above.

C. Compassionate Leave to Bond with Newborn or Newly Adopted Child (Maternity Leave)

House Officers may take leave to bond with their newborn or adopted child immediately following the postpartum disability period or adoption. Leaves to bond with newborns and adopted children are at the sole discretion of the Hospital and based on operational needs. When the leave is for the purpose of giving birth, the employee should follow the procedure outlined under the **Personal Medical LOA** section of the *BI-SLR Leaves of Absence Policy and Procedure Manual*.

- 1) **House Officer** must notify his or her Program Director and complete a *Compassionate Leave of Absence Application/Extension Form for House Officers* indicating a request for a leave of absence not more than thirty (30) days before the leave is to commence.

- 1) **Program Director** must complete the "Program Director Section" of the *Compassionate Leave of Absence Application/Extension Form for House Officers* by checking either "approved" or "denied" and signing and dating the form.

- 2) **House Officer** must fax a copy of the approved Program Director-signed *Compassionate Leave of Absence Application/Extension Form for House Officers* to the Corporate Human Resources Benefits Office at (212) 523-5610.

Extension of Leave of Absence

House Officers who expect to be on leave longer than the originally requested duration must apply for an extension by completing the process outlined above.

Return from Leave

Program Director must prepare a Personnel Change Form (PCF) to return employee from leave of absence and send it to the HR Mailbox.

Approved GMEC: 4-14-08, Editorial Revision HR/Benefits: 4-25-08, Editorial Revision: 10-8-08, HR revision: 3-27-09

Approved for Medical Board Review: 5-14-08

See BI GME website: www.bethisraelgme.org, under **Forms/Requests** for *Compassionate Leave of Absence Application/Extension Form for House Officers*.

Section HS 45
Drug Testing Policy

Purpose:

To outline time requirements for compliance with Institutional policy on Pre-Employment Drug Testing.

Goal: To assure that House Officers comply with the Institutional policy (#7006 *Recruitment & Staffing*) in a timely fashion to enable the House Officer to be hired by the Institution and available for participation in training programs.

1. All House Officers must comply with the Institutional policy for pre-employment drug testing.
2. All potential House Officers must submit specimen, as required by the Institutional policy, within 30 days of receipt of the contract with Mount Sinai Beth Israel.
3. House Officers entering the program off cycle must submit specimen, as indicated in the Institutional policy, within one week of the date of offer for a position in a Mount Sinai Beth Israel training program.
4. If a House Officer has not completed the drug testing within the allotted time frame, Human Resources will notify the GME Office, who will notify the appropriate Program Director. The House Officer will have an additional five days to fulfill the institutional requirements.
5. House Officer applicants that do not fulfill these requirements within the timeframe outlined above will be withdrawn from the Institution. The Institution will notify all appropriate matching agencies of the applicant's failure to comply with employment requirements.

Revised and Approved by the GMEC 4/14/03

Section HS 46
Institutional Support for Pain Medicine and other Specialties

Goal: Because pain medicine is a multi-disciplinary approach to a common problem, to ensure the provision of educational resources committed to pain medicine including all involved disciplines.

Graduate Medical Education of Mount Sinai Beth Israel recognizes that Pain Medicine is a multi-disciplinary approach to a common problem and is committed to ensuring cooperation of all involved disciplines.

Approved GMEC: 4-10-06

Section HS 47
Prescription Writing Policy

Goal: To comply with Federal regulations regarding writing of prescription medication for licensed and unlicensed physicians

The following information is required on all outpatient and discharge prescriptions:

Unlicensed Post-Graduate Physicians with their own NPI number:

- 1) Your own NPI number
- 2) Hospital-issued DEA number and suffix (for controlled substances)

Unlicensed Post-Graduate Physicians without their own NPI number:

- 1) Supervising Physician's Name and NPI number
- 2) Hospital- issued DEA number and suffix (for controlled substances)

Licensed Post-Graduate Physicians:

- 1) Your own NPI number
- 2) Your own DEA number (PLEASE NOTE YOU MAY NOT UTILIZE A HOSPITAL-ISSUED DEA NUMBER)

In addition, licensed or unlicensed post-graduate physicians should NOT indicate the facility's Medicaid provider number (MMIS number) on any prescriptions as this may result in the claim being denied.

Approved GMEC: 10-08, Revised 7-2010

Section HS 48
Ombudsman/woman Policy

Goal: To foster house staff health and well-being and provide a variety of mechanisms by which they can obtain assistance.

Purpose: Although it is expected that most house staff issues will be addressed by the GME's current systems, the GMEC recognizes that there may be times when a house officer may choose to seek assistance outside of their department and the mental health care discipline.

The DIO shall appoint an ombudsman/woman who will be presented to the GMEC for approval.

The Ombudsman/woman will be available as needed to:

- meet with house staff who voluntarily seek assistance and self refer
- be available to address house staff's personal problems
- assist with accessing resources
- assist in addressing concerns that effect the house officer's training and/or training program that are not resolved through currently established mechanisms
- serve as a resource to program directors related to house staff issues
- may participate in discussions about house staff having difficulties and be part of the problem-solving team

The Ombudsman/woman is employed by Mount Sinai Beth Israel and is, therefore, bound by the Medical Center's legal duty to ensure patient safety. Under New York law, the Ombudsman/woman will not be able to keep confidential any information indicating that a house officer has committed professional misconduct, including being impaired while on duty because of use of drugs or alcohol or being a habitual user of drugs or alcohol. Such information must be reported by the Medical Center to the Office of Professional Medical Conduct of the New York Department of Health.

GMEC approved: 1-12-09; editorial revision: 4-24-09

Section HS 49
Policy on Behavior

Goal:

To establish guidelines on acceptable and appropriate staff behavior as well as procedures to manage inappropriate behavior in order to promote an environment that supports high quality and safe patient care.

Policy:

Mount Sinai Beth Israel is committed to the tenets of professionalism with regard to all aspects of patient care.

BI does not condone or tolerate unprofessional actions that are seen as intimidating or disruptive by members of our staff and/or patients or their families. Unprofessional behavior may include, but is not limited to, the following:

- Physical threats
- Verbal abuse/profane language
- Harassment based on sex, race, age, national origin, religion, creed, sexual orientation, disability, or any other basis prohibited by law
- Passive behaviors that are inappropriate or unprofessional, such as not returning pages or using condescending language
- Behaviors that violate the institutional Code of Conduct

Recognizing and reporting these behaviors to a supervisor, as detailed in the procedure section below, is essential. These behaviors/actions undermine the Medical Center's culture of quality and safety, undermine team unity and compromise patient safety and adversely affect patient and employee satisfaction.

Procedure:

1. All staff members are responsible for reporting conduct that is inappropriate, threatening, disruptive, or not in accordance with the Code of Conduct to their supervisor (see Chain of Command policy, 1012, on intranet). This report may be made in person, by telephone, or in writing. Reports may also be made anonymously by using the QI Hotline (212-420-2100) or the

Corporate Compliance Hotline [-800-853-9212]. Retaliation against any staff member who submits a report in good faith will not be tolerated.

2. Once a report is made, the supervisor or Corporate Compliance Officer will investigate the claim/allegation and when necessary develop a plan of action to correct confirmed unacceptable behavior. Such actions, developed in collaboration with the appropriate hospital/medical staff leadership, may include remediation and/or disciplinary actions. If these behaviors are not corrected and further reports are submitted, an individual is at risk for disciplinary action including loss of privileges, suspension, or termination.

Any disciplinary action shall be subject to the Hearing and Appeals Procedure set forth in the Medical Staff Bylaws or to the Grievance Procedure for House Staff, whichever is applicable.

3. Staff education, through new employee orientation and annual core competency training, will include a section on appropriate behavioral expectations.

Approved GMEC: 5-11-09; Revised 7-13-09

Section HS 50

Licensing Examinations Requirements (including USMLE, COMLEX)

Goal: To ensure the highly competent trainees who, upon graduation from their training program, have completed preliminary requirements to obtain a license to practice in the United States.

1. All House Officers **MUST** have passed Step 1 of the USMLE or Level 1 of the COMLEX prior to entering the PGY 1 year.
2. All House Officers are required to successfully complete USMLE Step 2 (CS & CK) or COMLEX Level 2 (CE & PE), prior to beginning the 2nd post-graduate year. Failure to demonstrate passage within the stated timeline will result in termination from the training program at the end of the academic year.
3. PGY 2 or higher applicants must have passed USMLE Step 2 (CS & CK) or COMLEX Level 2 (CE & PE), prior to beginning the program. If these applicants do not pass by the first day of the program, acceptance into the program becomes null and void unless a special exemption is granted by the Mount Sinai Beth Israel GME Office.
4. Mount Sinai Beth Israel does not require House Officers to successfully complete the USMLE Step 3 or COMLEX Level 3.

Approved GMEC 11/08, 12/14 (MSHS); Editorial Revision 6/10, 8/10, 1/14, 3/15
Approved Medical Board: 12/08

Section HS 51
Return Visits During Interview Season

Goal: To facilitate medical student second visits, when necessary or desirable, while respecting patient rights and maintaining institutional policies.

During interview season, medical students may ask for a second visit with the training program. Second visits are observational only. The visiting medical student must be accompanied by an attending physician or current house officer.

Process

1. Second visits must be approved by the program director of the training program in which the prospective applicant is interested.
2. Any program permitting an applicant to return for a second visit must notify security, via memo, before the scheduled visit.
3. On the day of the visit, the visitor must report to the Security desk, produce identification and receive and visibly wear a temporary ID card.
4. All visitors must sign the following statement:

“I understand that I am required under HIPAA and other Federal and state laws to keep all patient information strictly confidential and I agree that I will do so.”

Approved GMEC: 11-9-09

Section HS 52
Evaluation of Faculty and Program

Goal: To ensure a system that enables the program to assess the effectiveness of educational program in achieving resident competence in the six ACGME competencies, as defined in the Institutional, Common and specialty/subspecialty-specific program requirements.

Evaluation of Faculty

1. House staff must confidentially evaluate faculty at least annually.
2. Systems must be in place to ensure confidentiality.
3. Faculty must be evaluated by program at least annually, on their performance related to the educational program, including teaching abilities, commitment to educational program, clinical knowledge, professionalism, and scholarly activity.

Evaluation of Program

1. Faculty and house staff must confidentially evaluate the program at least annually.
2. Systems must be in place to ensure confidentiality.
3. An annual program evaluation, reviewing all evaluation components with faculty and a house officer representative, must occur at least annually using the BI Annual Evaluation form.
4. A completed copy of this form should be forwarded to the GME Office.
5. Follow-up of identified areas in need of improvement should occur as part of the Education/Curriculum committee meetings of the program; attendance and minutes should be documented.

The attached grid summarizes the aforementioned policy requirements. (see attachment).

<u>ACGME EVALUATION REQUIREMENTS</u>					
<u>Evaluation of</u>	<u>Evaluation By</u>	<u>Frequency</u>	<u>Format</u>	<u>Anonymity</u>	<u>Review</u>
(a). House staff					
	Faculty	After every rotation or major assignment	NI	No	sent to house officer for review

Policy and Procedure for House Staff

	Program Director	Semi-annually	NI or checklist	No	Verbally with house staff; Document & house staff indicate review
	Program Director	Completion of program	GME Form or NI	No	House staff sign; send copy to GME Office
(b). Individual Faculty					
	House staff	Yearly	NI	Yes	Annually by PD & Chair
	Medicine House staff	Opportunity after every rotation	NI	Yes	Annually by PD & Chair
	Program Director/Chair	Yearly	Form	No	Annually by PD & Chair w/ faculty
(c). Program					
	House staff	Annually	NI	Yes	Annually; part of program evaluation w/ faculty and house staff rep
	Faculty	Annually	NI	Yes	Annually; part of program evaluation w/ faculty and house staff rep
	Graduates	Every 3 -5 years	NI	Yes or No	Part of Annual Program Review
	Program Director &/or Committee	Yearly	GME Form on Web site	No	Faculty and house staff rep; remediation plans developed, when indicated. Send copy to GME Office

Section HS 54
Appointment of Fellows and Other Learners

Goal: To facilitate optimal learning experiences for MSBI residents and fellows by ensuring that other trainees and learners do not interfere with their education.

MSBI complies with ACGME policy on the appointment of fellows and other learners.

1. The Program Director must consider their patient caseload, learning opportunities and other teaching responsibilities before accepting other learners to participate in the program. The number of learners accepted must be determined by program resources.
2. The presence of other learners (including, but not limited to, residents from other subspecialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents'/fellows' education.
3. The Program Director must obtain authorization from the Designated Institutional Official (DIO)/GME Director and the GME Committee to accept other learners.
4. The Program Director must monitor the effects of other learners on the appointed residents'/fellows' education.
5. All MSBI trainees participating in rotations (including electives), even within MSBI, must complete the *Mount Sinai Health System In-Rotation Form*. Program Directors must complete this paperwork as a means of monitoring learners participating in the program.

Approved GMEC: 2/8/2010

Administrative Revision: 3/5/2015

Section HS 55

Policy for Source Patient Testing after Needlestick or Blood Exposure

Goal: To ensure timely and appropriate requests for source patient testing subsequent to needle stick injury.

Procedure

- 1) All house staff will be trained in the HIV/AIDS testing requirements. Training will include:
 - a) House Staff Orientation
 - b) Web-based training module on the intranet http://apps.chpnet.org/BI_WBT/Default.aspx
 - c) Review of Departmental policy and process
- 2) Samples will be obtained from source patient by the medical provider responsible for the patient's care
- 3) If the patient's medical provider is not available, a member of the health care team caring for the patient should obtain consent and perform the test.
- 4) The exposed health care provider MUST not be involved in this process.
- 5) Exposure evaluation of effected medical provider should include a review of hepatitis B vaccine status, serologic testing or prophylaxis as indicated, and hepatitis C screening.
- 6) Exposure evaluation of source patient includes HIV testing with consent, Hepatitis B serologic surface antigen and Hepatitis C antibody screening.
- 7) Consent forms for HIV testing and of informational packets located in the SICU, MICU, PACU and Patient Care Services Office on 2 Dazian. An additional NYSDOH form (#4054 Authorized release of HIV related information ..) must be completed and signed by the source patient.
- 8) Attending of record must be notified ASAP; if source patient refuses consent for blood work the attending must notified so he/she should attempt to obtain consent.
- 9) The exposed house officer should follow current protocol found on the intranet (Policies and Procedures/Organization: BIMC, Type: BI Infection Control, Policy # 015 Employee Health Services, II Evaluation And Treatment Of Occupational Exposure To Blood And/Or Body Fluids) and BIGME web site (House Staff Policy and Procedure Manual Needle Stick Injuries in the OR):

Employees with percutaneous injuries are expected to:

- a) Stop work.
- b) Immediately go to Employee Health Services (EHS) during the weekday daytime hours or the Emergency Department (ED) during off-hours (evenings, holidays and weekends).
- c) Complete an Incident Report and the Post-Exposure Prophylaxis Consent for Treatment form.
- d) Receive appropriate prophylaxis, supportive counseling and follow-up.

- 10) EHS communicates results of source patient tests directly with house officer, in person or by telephone.

Approved GMEC: 3/8/2010

Scheduled Presentation Medical Board: 4/12/2010

Section HS 56

Evaluations in Programs with Two or Less House Officers

Goal: To ensure the confidentiality of house staff evaluations of program and faculty, as required by ACGME, thus facilitating honest and open feedback.

All programs with two or less house officers should have their house officers complete an End of the Year Evaluation on the Program and Program Faculty which should be sent directly to the GME Office, via New Innovations and/or paper. The Director of GME will collate the information and only report back to the program egregious concerns. Every three years, the Director of GME will submit to the Program Director a complete summary of the evaluations. This report should be reviewed during the program's Annual Program Evaluation meeting and documented on that year's Annual Program Evaluation Form, with action plans identified for any areas of concern.

Programs should also request that House Officers complete individual rotation and Faculty evaluations throughout the year in New Innovations. If any of the house officers are uncomfortable providing feedback on the individual rotation or Faculty evaluations, they can contact the Director of GME or disclose the information on the End of the Year Evaluation. This will enable Programs and Faculty to obtain feedback directly from the House Officer throughout the year.

Approved GMEC: 9/13/2010
Administrative Revision: 3/5/2015

Section HS 57

Issuance of Replacement Diplomas

Goal: To enable previous BI house staff to obtain replacement diplomas in case of loss or damage. Replacement diplomas will not be issued for name or degree changes; the replacement diploma must reflect the status of the house officer during his/her training at BIMC.

Process:

- 1) Replacement diplomas will be issued identical to the original.
- 2) If the original signatories are no longer employed at BIMC, current authorized employees will sign the diploma.
- 3) Replacement diplomas will be stamped "Replacement". The stamp near the program director's name will indicate that the signatory is not the original program director who trained the house officer.
- 4) Replacement diplomas will cost \$100 each to offset administrative and printing costs.

Approved GMEC: 1-10-2011

Section HS 58

Supervision and Delineation of Privileges for House Officers in Residency/Fellowship Training Programs

Goal: To ensure House Staff are appropriately supervised and granted responsibilities according to their education and expertise.

The Program Director, in conjunction with the Chair of each clinical department, is responsible for developing procedures for privilege delineation which comply with institutional purpose and policy objectives, and NYS and ACGME requirements, which include the steps outlined below.

A. Supervision

The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Programs must comply with their RRC definitions of appropriate supervision.

- 1) All Departments must develop a policy outlining supervision procedures. To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:
 - a) Direct Supervision – the supervising physician is physically present with the resident and patient.
 - b) Indirect Supervision:
 1. With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
 2. With Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
 - c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- 2) Part 405.4 of the New York State Health Code states: “Effective July 1, 1989 for postgraduate trainees in the acute care specialties of Anesthesiology, Family Practice, Medicine, Obstetrics-

Gynecology, Pediatrics, Psychiatry, and Surgery, supervision shall be provided by physicians who are board certified or admissible in those respective specialties or who have completed a minimum of four post-graduate years of training in such specialty. There shall be a sufficient number of these physicians present in person in the hospital 24 hours per day seven days per week to supervise the post-graduate trainees in their specific specialties to meet reasonable and expected demand. In hospitals that can document that the patients' attending physicians are immediately available by telephone and readily available in person when needed, the on-site supervision of routine hospital care and procedures may be carried out by post-graduate trainees who are in their final year of post-graduate training, or who have completed three years of post-graduate training". Mount Sinai Beth Israel supports this policy.

B. Delineation of Privileges

- 1) Each clinical department shall have a plan for delineation of privileges for each House Officer. These plans shall be consistent with the special requirements of the program specific Residency Review Committee of the Accreditation Council for Graduate Medical Education, and shall permit increasing privileges, as House Officers demonstrate increased competence with specific examinations, procedures, and/or treatments. Departmental plans shall be reviewed by the Graduate Medical Education Committee (GMEC) of the Medical Board as part of the internal review process and be consistent with TJC standards.

Each department plan should include, but is not limited to, the following:

- a. An explicit statement of the roles of Attendings, Fellows and House Officers in the clinical activities of the department. A specific chain of command for major clinical and non-clinical decisions should be included.
 - b. A general delineation of privileges for House Officers in each post-graduate year of training.
 - c. A list of examinations, procedures and/or treatments which the House Officer is expected to gain proficiency in and the year of training in which this proficiency is expected to be achieved.
 - d. A mechanism to document certification of competence, with the use of ***New Innovations*** software whenever possible.
- 2) The Department Chair or his/her designee shall be responsible for granting privileges based upon documentation of proficiency. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
 - a. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

- b. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
- c. Senior residents or fellows should serve in a supervisory role of 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.
- d. Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
- e. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]
- f. The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. [Optimal clinical workload will be further specified by each Review Committee.]
- g. Delineation of privileges will be reviewed and updated at least annually.

C. Emergency Situations

In situations where immediate emergency medical care is required to preserve life or prevent serious impairment of the health of the patient, all Residents shall be permitted to do everything possible within the scope of their knowledge and skill to save the life of the patient or to save the patient from serious harm.

D. Clinical Circumstances When the Attending Must Be Called:

The Attending Physician responsible for the management of a patient's hospital course must be kept apprised of a patient's condition. The following guidelines may be used to support your decision to call your attending; they do not replace your clinical judgment and are not meant to be exhaustive. Examples of acute, unexpected changes in status, when the attending, supervising physician (or senior resident where appropriate), must be called as soon as possible, include:

<p>CLINICAL CIRCUMSTANCES WHEN THE ATTENDING MUST BE CALLED</p>
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GENERAL REQUESTS

- Any trainee feels a situation is more complicated than he or she can manage
- Nursing physician staff or the patient requests that the attending be contacted

TREATMENT/DISCHARGE ISSUE

- Any significant change in treatment plan
- Patient leaves AMA or elopes
- Unexpected discharge

CRITICAL CLINICAL STATUS

- Transfer to another level of care (i.e. MICU, SICU, CCU, ICU)
- RRT or Code
- Patient Death
- Unplanned intubation or ventilator support
- Hemodynamic instability, including unanticipated arrhythmia
- Development of significant neurological or mental status changes

ADVERSE EVENTS OR UNEXPECTED INTERVENTIONS

- Patient fall or other injury
- Any medication or treatment errors
- Unplanned blood transfusion
- Significant post-procedure complications
- Emergent consult

GMEC approved 4/01, (addition, Clinical Circumstances – When the Attending Must Be Called (Chain of Command) approved: 10/11/2010; Revised GMEC: 4/11/2011

Section HS 59
Transitions of Care

Goal: To ensure patient safety by developing systems and practices that facilitate smooth and well-informed hand-offs between duty assignments.

Programs must design schedules and assignments to minimize the number of transitions in patient care. Programs must demonstrate, teach and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. Programs must train house staff in the skills required to effectively participate in transitions of care and must document this competency. Programs must ensure and document that residents/fellows are competent in communicating with team members in the hand-off process. Faculty oversight of the hand-off process may occur directly or indirectly, depending on trainee level and experience.

All programs should use the applicable tools (written or computerized) to assist them in this structured process.

All programs must develop a policy delineating how they will implement and monitor this process. As part of each program's "Annual Report", presented to the GMEC, programs will provide updates on its methodologies to maintain safe and effective hand-offs and review its policies.

All schedules that inform members of the health care team of attending physicians, nurses, operators and residents/fellows currently responsible for each patient's care must be accessible. New Innovations (NI) will be used throughout the institution to identify house staff and their attending supervisors responsible for patient services. Text paging will be available directly from the schedule in NI. Programs are responsible for keeping the schedules current.

GMEC: approved 11-14-11, revised 11-12-12

Medical Board: approved 12-12-11, scheduled 12-10-12

Section HS 60
Maintenance of Certification

Goal: To ensure the provision of optimal patient care as well as comply with GME and NYS requirements.

In addition to providing evidence of current certification at the time of credentialing, house officers must maintain the following valid certifications:

1. BLS (see guidelines below and attached chart of MSBI Programs)
2. ACLS (see guidelines below and attached chart of MSBI Programs)
3. Infection Control

The New Innovations® software will monitor expiration dates and notify the GME Office, house officer and program coordinator in advance of the actual date. It is the house officer's responsibility to make sure that the certificate is renewed prior to the expiration date.

CPR Guidelines for all Mount Sinai Beth Israel House Staff and Rotators:

Basic Life Support (BLS) is required for all House Staff with patient care responsibilities except Pathology residents and fellows. House Staff must recertify in BLS every two years if they do not maintain current certification in Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS).

Advanced Cardiac Life Support (ACLS) is required every two years for:

- Internal Medicine House Staff (including subspecialties)
- Family Medicine House Staff
- Emergency Medicine House Staff
- Anesthesiology House Staff (including subspecialties)
- All Surgical House Staff (including subspecialties)

- Psychiatry House Staff (including subspecialties)
- Radiology House Staff (including subspecialties)
- Obstetrics and Gynecology House Staff (including subspecialties)
- All House Staff who train in critical care settings (regardless of specialty)
- All House Staff performing sedation or analgesia (regardless of specialty)

Pediatric Advanced Life Support (PALS) is required every two years for:

- Emergency Medicine House Staff
- Pediatrics House Staff

Neonatal Resuscitation Program (NRP) is required every two years for Pediatrics House Staff.

Automated External Defibrillator (AED) Training is required every two years for selected physicians in Psychiatry.

Requirements by MSBI Training Program:

MSBI PROGRAMS	Must be Trained BLS	Must Maintain BLS	Must be Trained ACLS	Must Maintain ACLS	Other Required Training
Accredited Program Name					
Emergency Medicine	X		X	X	PALS
Family Medicine	X		X	X	
Hospice & Palliative Medicine	X		X	X	
Internal Medicine	X		X	X	
Cardiovascular Disease	X		X	X	
Clinical Cardiac Electrophysiology	X		X	X	
Interventional Cardiology	X		X	X	
Endocrinology, Diabetes Metabolism	X		X	X	
Gastroenterology	X		X	X	
Hematology/Medical Oncology	X		X	X	
Infectious Disease	X		X	X	
Nephrology	X		X	X	
Pulmonary Disease/Critical Care Medicine	X		X	X	

Neurology	X		X	X	
Obstetrics & Gynecology	X		X	X	
Orthopaedics: Adult Reconstruction (Shoulder & Elbow)	X		X	X	
Orthopaedics: Hand Surgery	X		X	X	
Pain Medicine Anesthesiology	X		X	X	
Psychiatry	X		X	X	
Addiction Psychiatry	X		X	X	
Geriatric Psychiatry	X		X	X	
Psychosomatic Medicine	X		X	X	
Radiology, Diagnostic	X		X	X	
Vascular/Interventional Radiology	X		X	X	
Surgery	X		X	X	
Urology	X		X	X	
OTHER ACCREDITED PROGRAMS					
Breast Surgery	X		X	X	
Head & Neck Oncologic & Reconstructive Surgery	X		X	X	
Oral Maxillofacial Surgery (Dental)	X		X	X	
Podiatric Medicine & Surgery	X		X	X	
NON- ACCREDITED PROGRAMS					
Advanced Therapeutic Endoscopy	X		X	X	
Brachytherapy	X		X	X	
Breast Imaging Radiology (MRI)	X		X	X	
Congestive Heart Failure	X		X	X	
Neurology (Movement Disorders)	X		X	X	
Orthopaedic Sports & Spine Rehabilitation	X		X	X	

GMEC: approved 1-9-12

Medical Board: Approved

Editorial Update: 3-10-15

Section HS 61

Rapid Response to Resident(s)/Fellow(s) Stress due to a Distressing Event

Goal: To facilitate intervention to assess and support house officers at risk for stress or ill effects from involvement in a distressing event while on-duty.

Such distressing events may include death of a patient, assault, suicide, and violent crime, the results of an untoward medical error or other work or patient-related event. This policy is not directed towards house staff dealing with personal crises.

House staff at risk, or identified by anyone who believes that he or she may have been affected by witnessing or participating in such an event, should be referred to the house officer's program director. The person observing such an event or concerned about a house officer's well-being should first ask the house officer if he/she wishes the report to be made and/or whether he/she would prefer to personally reach out for support.

The program director must be notified and will meet with the house officer(s) involved and offer and encourage additional support, which may include referral to Employee Health Service for evaluation of need for other resources. One of the ombudspersons should also be contacted, who may be able to provide additional support. At a minimum, the program director will notify the Chair of the event and communicate again with the house officer 24 hours later to assess status. Documentation should be limited to the support provided to the house staff.

Program directors and ombudspersons will receive special training on the rapid response management of acute stress disorders. Other interested faculty may also be provided with training.

Approved GMEC: 3-12-2012

Approved Medical Board: 4-9-2012

Section HS 62

Quality Improvement Program Reporting of Errors, Unsafe Conditions and Near Misses

Goal: To provide all residents and fellows the opportunity and mechanism by which to report errors, unsafe conditions and near misses in a protected manner that is free from reprisal.

As part of the hospital's Quality Improvement Program, all house staff are encouraged to report errors, near misses, serious and/or unexpected outcomes and any concerns related to quality and safety. There are many venues through which reporting can occur:

- House staff are encouraged to report any of the above to their Chief Resident, Program Director and/or Chair. If he/she does not feel comfortable reporting intra-departmentally,
- The QI hotline (420-2100) provides anonymity if desired. The caller leaves a message on voicemail, which is checked by QI staff regularly. Email may be sent to dwilson@chpnet.org
- Corporate Compliance hotline may also be used 1-800-692-2353 for anonymous reporting
- Risk Management and/or EHS may be contacted to report unsafe conditions at 420-4672/420-2885, respectively.

Issues described are reviewed with the sole purpose of resolution, remediation, detection of patterns, and future prevention of potential patient safety issues. Blame is not part of the QI culture and all investigations are conducted thoroughly and sensitively. A member of the QI staff receives the message and refers the issue/concern to the appropriate sub-committee. QI sub-committees include: QPIC (Quality Performance and Improvement Committee), Quality Council, Medical Error, Safety, Root Cause Analyses, Infection Control, Blood Management, Pain, QSAG Unit QI (Quality Strategy Advisory Group), and departmental QI committees which report to the institutional committee. Some events/concerns may need to be reported to NYS per NYPORT (New York Patient Occurrence and Tracking System) requirements. Information discussed and documented for the purpose of Quality Improvement activities is confidential and protected pursuant to Section 2805(M) of the Public Health Law (New York State).

House staff are also encouraged to participate on these Quality committees; information may be obtained from the GME and/or the QI offices. Participation will enable house officers to better understand the QI process of maintaining high quality care.

Approved GMEC: 1-14-2013

Approved Medical Board: 2-11-2013

Section HS 63
Online Social Media/Networking

Goal: To provide house staff with guidelines and requirements for participation in social media, which includes all public online communications including blogs, LinkedIn, Facebook, MySpace, Twitter, YouTube, etc., and any other online forum where comments may be posted (“Social Networks”). This Policy does not affect e-mail communications where the recipient is clearly identified by the sender. (Please refer to the Hospital’s Computer and Communication Security Policy for information on e-mail use policies.)

GUIDELINES

1. Persons who have identified themselves as employees of Mount Sinai Health Services/MSHS or for whom the affiliation with Mount Sinai Health Services/MSHS is apparent or who are commenting on Mount Sinai Health Services/MSHS hospitals or staff, should make it clear that they are speaking for themselves and not on behalf of Mount Sinai Health Services/MSHS. The following disclaimer should be included: “The views expressed on this site are my own and do not reflect the views of my employer.” Employees are also prohibited from using the hospital’s logo on their personal Social Networks.
2. Employees should be aware that they are legally responsible for the content of their online postings on Social Networks. Employees should be careful not to commit plagiarism (any referenced sources should be cited), infringe on copyrighted information, and should not compose offensive, defamatory, slanderous, discriminatory, or harassing postings. Employees should use good judgment, and strive for accuracy; information should not be misleading, deceptive or misrepresent oneself. Professional boundaries and privacy concerns must also be taken into consideration. Providing medical advice on Social Networks is prohibited.
3. Confidential or proprietary information about Mount Sinai Health Services/MSHS must not be shared and patient confidentiality must be maintained. Employees are prohibited from posting patient identifying information including photographs or other types of images or provide a sufficiently detailed description from which patient may be identified.

4. Employees are encouraged to understand and use the privacy settings available with various social media accounts. Patients, fellow residents and future employers may look for information about you on the internet; ensure you know how you are represented on the internet and monitor for accuracy and appropriateness.
5. Employees who are contacted by members of the media or by other bloggers or social networkers for information regarding Mount Sinai Health Services/MSHS should refer them to the Department of Public Affairs and Marketing.
6. The following also apply to “employees” use of Mount Sinai Health Services/MSHS’s Social Networks:
 - A. Employees who post on Mount Sinai Health Services/MSHS’s Social Networks must clearly identify themselves as Mount Sinai Health Services/MSHS employees.
 - B. Employees are prohibited from posting comments about the reputation of physicians and other employees. Comments about business associates or competitors are discouraged.
 - C. Comments posted on a Mount Sinai Health Services/MSHS blog must be factual and truthful. Once authors become aware of errors in their posts, they must make appropriate corrections.
 - D. Employees are prohibited from using a Mount Sinai Health Services/MSHS Social Network to provide medical advice.
 - E. Contents of the postings will be reviewed by the relevant Department(s). Any postings that violate the *Online Social Media/Networking Policy* will be deleted.

Violation of the Social Media/Networking Policy

1. Employees who are uncertain whether comments they intend to post on a Social Network website page constitute a violation of the Social Media/Networking Policy, should contact the Department of Public Affairs and Marketing, who can be reached at 212/523-7772.
2. Any violation of Mount Sinai Health Services/MSHS’s Social Media/Networking Policy may result in the imposition of disciplinary sanctions up to and including termination of employment.

Approved GMEC: 3-11-2013

Approved Medical Board: 4-8-2013

HS Policy 64

Fatigue Recognition and Mitigation

Goal: Mount Sinai Beth Israel supports high quality education and safe and effective patient care. The institution is committed to meeting the requirements of patient safety and resident well-being.

Excessive sleep loss, fatigue, and resident stress are serious matters. Appropriate back-up support will be provided when patient care responsibilities are especially difficult and prolonged, and if unexpected needs create resident fatigue sufficient to jeopardize resident health and/or patient care. All attendings and residents are instructed to closely observe other residents for any signs of undue stress or fatigue.

Residents must be able to:

1. Recognize the signs of fatigue and sleep deprivation.
2. Implement alertness management and fatigue mitigation process.
3. Adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

The institution, as well as each program, will annually provide all faculty and residents with information and instruction on recognizing the signs of fatigue, sleep deprivation, alertness management, fatigue mitigation process and how to adopt this process to avoid potential negative effects on patient care and learning.

Safer slides and Sleep deprivation information can be found at: [www.bethisraelgme.org/Special Educational Resources](http://www.bethisraelgme.org/Special/EducationalResources).

Faculty and other residents are to report such concerns of sleepiness, tardiness, resident absences, inattentiveness, or other indicators of possible fatigue or excessive stress to the supervising attending or program director. The resident will be relieved of duties until the effects of fatigue or stress are no longer present.

Sleeping quarters are provided by the Graduate Medical Education Office for overnight call assignments. In addition, these rooms can be used for strategic napping and post-call naps. When a house officer is post-call or at the end of the work day and does not feel safe to drive home, they can request subway or taxi funds to get home.

Stress Management

Stress is a normal part of the work-life of a physician. At times, however, house officers may find a need to reach out for help in managing stressful situations or events. Please refer to *HS Policy 18, Health and Well-being*, for resources available.

Approved GMEC: 3-11-2013

Approved Medical Board: 4-8-2013