RUTGERS
New Jersey Medical School

GRADUATE MEDICAL EDUCATION POLICY

Number:	**003-001**
Section:	**Clinical Learning Environment**
Title:	**Moonlighting/Outside Employment**

Effective Date: 6/15/2017
Previous Review & Approval by GMEC: 5/24/2007, 1/17/2008, 2/16/2012, 2/12/2015
Responsible Office: NJMS Graduate Medical Education
Update: Every five years from effective date or as needed

Background and Purpose: Moonlighting is defined as voluntary, compensated, medically-related employment that is either external or internal to the institution where the resident is in training or at any of its participating sites.[1] The ACGME Task Force on Quality Care and Professionalism concluded that external moonlighting had a similar impact on resident fatigue as the hours that were spent during training.[2] In addition, the Task Force also concluded that since the necessary degree of supervision external to the formal training program cannot be assured, PGY-1 (Post-Graduate Year) residents are not permitted to moonlight.[2,3] The lack of supervision coupled with the added potential for fatigue that may place patients who are in the care of residents, who are moonlighting at increased risk for adversity. Given these factors the ACGME has required that moonlighting hours be included in the clinical and educational work hours limits.[3,4] Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.[4] This policy for moonlighting and outside employment is to establish guidelines as set forth in the University and RBHS Policy in concordance with ACGME requirements.[5]

Scope: This policy will apply to all resident and fellow trainees of the postgraduate training programs at Rutgers NJMS.

Definitions:

1. **Housestaff**/House Officer- refers to all interns, residents and subspecialty residents (fellows) enrolled in a Rutgers New Jersey Medical School (Rutgers NJMS) graduate medical education program. A member of the Housestaff may be referred to as a house officer.
2. **Designated Institutional Official (DIO)** – refers to the individual who has the authority and responsibility for the graduate medical education programs.
3. **Program** – refers to the structured medical education experience in graduate medical education, which conforms to the Program Requirements of a particular specialty, the satisfactory completion of which may result in eligibility for board certification.
4. **Program Director** (PD) – the one physician designated to oversee and organize the activities for an educational program.
5. **Review Committee-** the Accreditation Council for Graduate Medical Education delegates authority to accredit programs/institutions to its Review Committees. The Review Committees are comprised of peer specialists in the field and resident physicians.

Reference(s):

1. Glossary of Terms Related to Resident Duty Hours found at https://www.acgme.org/acgmeweb/Portals/0/PDFs/dh-GlossaryofTerms2011.pdf
2. Riebscgleger M and Nasca TJ. Chapter 5: New Duty Hour Limits: Discussion and Justification in ACGME Institutional Requirements IV.J.1 found at https://www.acgme.org/acgmeweb/Portals/0/InstitutionalRequirements_07012014.pdf
3. ACGME Common Program Requirements, effective July 1, 2017 VI.F.5 found at http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_Section%20VI_2017-07-01_TCC.pdf
4. Rutgers Policy (policies.rutgers.edu)

RUTGERS
New Jersey Medical School

GRADUATE MEDICAL EDUCATION POLICY

Policy:

A. The primary work obligation of a full or part-time Housestaff of the Rutgers NJMS and its affiliate hospitals is to Rutgers NJMS.

B. Housestaff are not required to engage in moonlighting. (IR IV.J.1a)

C. Housestaff must have written permission from the Program Director prior to the start of any moonlighting employment. (IR IV.J.1.b)

D. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety. (CPR VI.F.5.a)

E. Time spent by residents in external moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour maximum weekly hour limit. (CPR VI.F.5.b)

F. Internal moonlighting is only permitted on a case-by-case basis. Program Directors only should contact the DIO for discussion and approval.

G. Rutgers NJMS by means of the Housestaff's program administration, GME, DIO or their designees will monitor the effect of moonlighting activities on a trainee's performance in the program. (IR.J.1.c)

H. Rutgers NJMS by means of the Housestaff's program administration, GME, DIO or their designees will monitor the trainee's clinical and educational work hours.

I. The PD or Chair may withdraw permission to moonlight if there are any observed, documented or perceived adverse effects, which include but are not limited to:

1. Failure to perform usual work-related functions in an acceptable manner
2. Any measurable deficiencies in core competencies (ex: poor performance on the in-training examination, low conference attendance)
3. Adverse patient events
4. Clinical and educational work hour violations

J. PGY-1 residents are not permitted to moonlight (CPR VI.F.5.c)

K. The moonlighting/outside employment activity must be one of general medical duty, not at a specialist level (unless fully trained in that specialty).

L. The resident must hold a full and unrestricted license to practice medicine in the state in which the moonlighting activity takes place.

M. Housestaff may not engage in moonlighting/outside employment if the outside employment:

1. Constitutes a conflict of interest (see University policy, Code of Ethics: General Conduct)
2. Occurs at a time when the Housestaff is expected to perform his/her Rutgers NJMS duty
3. Diminishes the Housestaff's efficiency in performing his/her primary work obligation at Rutgers NJMS
4. Interferes with the resident's ability to achieve the goals and objectives of the educational program

L. **All Housestaff** must annually complete the Outside Activity Questionnaire (accessed, completed and submitted electronically via the Rutgers portal in each member's Office of Ethics, Compliance & Corporate Integrity Dashboard), whether or not he/she plans to engage in outside employment.

Procedure: The following procedure shall be utilized by the PD and the DIO in granting approval for outside employment:

A. The resident must be in good academic standing and performing to the satisfaction of the PD in order to be considered for permission to moonlight.

B. The Housestaff must be able to fulfill his/her educational objectives while engaged in moonlighting/outside employment. Evidence of achievement of educational objectives includes but is not limited to:
   1. Achievement of at least the national average on the In-Training Exam
   2. Ongoing research and scholarly activity demonstrated by first authorship in a peer-reviewed journal, abstract, or poster presentation prior to submitting Outside Activity request.

C. Requests by Housestaff for permission for moonlighting/outside employment activities must be made in writing and submitted to the PD.

D. In those cases where permission is approved:
   1. The DIO or his/her designee shall make a final and binding decision.

   2. The Housestaff must report the moonlighting/outside employment as follows:
      a. Complete the Outside Activity Questionnaire (accessed, completed and submitted electronically via the Rutgers portal in each member's Office of Ethics, Compliance & Corporate Integrity Dashboard)
      b. The resident shall print this questionnaire and provide a copy to the PD and DIO for consideration and approval. The Chair of the department will secure approval of the PD and DIO prior to his/her final approval via the Rutgers Office of Ethics, Compliance & Corporate Integrity Dashboard.

   3. All Housestaff shall be provided with a copy of the Rutgers and NJMS policies regarding Code of Ethics and Outside Employment.

E. Clinical and Educational Work Hour Monitoring. The PD shall monitor the effects of moonlighting to ensure that the quality of patient care and the resident's educational experience are not compromised and hours worked are not excessive.

In the event that the Program Director and/or Chair of the department do not recommend moonlighting, the DIO may convene a committee to consider the Housestaff's application and the reasons for denial by the PD and/or Chair.

RUTGERS
New Jersey Medical School

GRADUATE MEDICAL EDUCATION POLICY

Number:	**003-002**
Section:	**Clinical Learning Environment**
Title:	**Clinical and educational work hours schedules**

Effective Date: 6/15/2017
Previous Review & Approval by GMEC: 5/24/2007, 1/17/2008, 2/16/2012, 2/12/2015
Responsible Office: NJMS Graduate Medical Education
Update: Every five years from effective date or as needed

Background and Purpose: Clinical and educational work hours are defined as all in-house clinical and educational activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, scheduled activities, such as conferences, clinical work done from home and moonlighting.[1] Clinical and educational work hours do not include reading and preparation time spent away from the duty site. The concept behind creating a standard for the residents' clinical and educational work schedule relative to the number of consecutive hours, cumulative weekly and monthly work hours, and rest periods between work hours is to maximize resident education and productivity, maintain high quality of patient care and patient safety. This policy for resident clinical and educational work hours will provide Rutgers NJMS Housestaff with ACGME-established requirements for scheduling.

Scope: This policy applies to all Housestaff.

Definitions:

1. **Housestaff**/House Officer- refers to all interns, residents and subspecialty residents (fellows) enrolled in a Rutgers New Jersey Medical School (Rutgers NJMS) graduate medical education program. A member of the Housestaff may be referred to as a house officer.
2. **Designated Institutional Official (DIO)** – refers to the individual who has the authority and responsibility for the graduate medical education programs.
3. **Program** – refers to the structured medical education experience in graduate medical education, which conforms to the Program Requirements of a particular specialty, the satisfactory completion of which may result in eligibility for board certification.
4. **Program Director** – the one physician designated to oversee and organize the activities for an educational program.
5. **Review Committee-** the Accreditation Council for Graduate Medical Education delegates authority to accredit programs/institutions to its Review Committees. The Review Committees are comprised of peer specialists in the field and resident physicians.

Reference(s):

1. ACGME Common Program Requirements (effective July 1, 2017) VI
2. ACGME Institutional Requirements (effective July 1, 2013)II.D.4.i

Policy:

A. The Program Director is responsible for the clinical and educational work schedules and, if necessary, must make the ultimate decisions regarding on-call scheduling.

B. On-call rooms are provided by the hospital to Housestaff with on-call responsibility.

C. The on-call schedule will be tailored to meet the residency requirements set by the Accreditation Council on Graduate Medical Education for each training program. It is recognized by the sponsoring institution that in-house call is an integral part of the Housestaff education and is to be scheduled so as to maximally enhance that educational pursuit. The GME office receives individual departmental rotation schedules to review for compliance and to formulate monthly Housestaff billings. Additionally, the GMEC as part of the internal review process shall review individual Program hourly work and on-call schedules for compliance.

D. Scheduled call that is not in full compliance with this policy will be returned to the Program Director for revision.

RUTGERS
New Jersey Medical School

GRADUATE MEDICAL EDUCATION POLICY

Number:	**003-003**
Section:	**Clinical Learning Environment**
Title:	**Clinical Experience and Education**

Effective Date: 6/15/2017
Previous Review & Approval by GMEC: 5/24/2007, 1/17/2008, 2/16/2012, 2/12/2015
Responsible Office: NJMS Graduate Medical Education
Update: Every five years from effective date or as needed

Background and Purpose: Clinical and educational work hours are defined as all in-house clinical and educational activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, scheduled activities, such as conferences, clinical work done from home and moonlighting.[1] Clinical and educational work hours do not include reading and preparation time spent away from the duty site. The concept behind creating a standard for the residents' clinical and educational work schedule relative to the number of consecutive hours, cumulative weekly and monthly work hours, and rest periods between work hours is to maximize resident education and productivity, maintain high quality of patient care and patient safety. This policy for resident clinical and educational work hours will provide Rutgers NJMS Housestaff with ACGME-established requirements for scheduling.

Scope: This policy applies to all Housestaff.

Definitions:

1. **Housestaff**/House Officer- refers to all interns, residents and subspecialty residents (fellows) enrolled in a Rutgers New Jersey Medical School (Rutgers NJMS) graduate medical education program. A member of the Housestaff may be referred to as a house officer.
2. **Designated Institutional Official (DIO)** – refers to the individual who has the authority and responsibility for the graduate medical education programs.
3. **Program** – refers to the structured medical education experience in graduate medical education, which conforms to the Program Requirements of a particular specialty, the satisfactory completion of which may result in eligibility for board certification.
4. **Program Director** – the one physician designated to oversee and organize the activities for an educational program.
5. **Review Committee-** the Accreditation Council for Graduate Medical Education delegates authority to accredit programs/institutions to its Review Committees. The Review Committees are comprised of peer specialists in the field and resident physicians.

Reference(s):

1. Glossary of Terms Related to Resident Duty Hours found at https://www.acgme.org/acgmeweb/Portals/0/PDFs/dh-GlossaryofTerms2011.pdf
   https://www.acgme.org/acgmeweb/Portals/0/PDFs/dh-GlossaryofTerms2011.pdf
2. ACGME Common Program Requirements (effective July 1, 2017) VI.F.
3. ACGME Institutional Requirements (effective July 1, 2013) IV.J.

Policy:

A. Guiding Principles

1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the

services required by their patients. Programs must be committed to and be responsible for promoting patient safety and resident well-being in a supportive educational environment. The learning objectives of the program must be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and not be compromised by excessive reliance on residents to fulfill non-physician service obligations. Didactic and clinical education must have priority in the allotment of resident's time and energy. Clinical and educational work assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of all patients.

2. All residency and fellowship programs of Rutgers New Jersey Medical School must conform to the ACGME Clinical and Educational Work Standards.

3. All Housestaff shall abide by the ACGME Common Program Requirement Clinical and Educational Work Standards ACGME Program-Specific Duty Hours Standards, New Jersey State Law, and the Rutgers NJMS Duty Hours Policy.

B. Common Program Requirement Clinical and Educational Work Hour Standards (VI.G)

1. Maximum Hours of Work per Week: Clinical and educational work hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities, clinical work done from home and all moonlighting.
2. Mandatory Time Free of Duty: Residents must be scheduled for a minimum of one day free of clinical work and education every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
3. Maximum Duty Period Length
   a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
      i. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.
      ii. Additional patient care responsibilities must not be assigned to a resident during this time.
      iii. In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; humanistic attention to the needs of a patient or family; or, to attend unique educational events.
      iv. These additional hours of care or education will be counted toward the 80-hour weekly limit.
      v. The Program Director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

4. Minimum Time Off between Scheduled Duty Periods
   a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
   b) Residents should have eight hours off between scheduled clinical work and education periods.
      i. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80- hour and the one-day-off-in-seven requirements.
   c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

5. Maximum Frequency of In-House Night Float: Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. The maximum number of consecutive weeks of night float, and maximum

number of months of night float per year may be further specified by the Review Committee. Each program is responsible for applying its RC specifications.

6. Maximum In-House On-Call Frequency: Residents must be scheduled for in-house call **no more frequently than every third-night** (when averaged over a four-week period).
7. At-Home Call:
   a) Time spent on patient care activities by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of clinical work and education, when averaged over four weeks.
   b) At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each resident.
   c) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients.
   d) These hours of inpatient care must be included in the 80-hour maximum weekly limit.
8. All requests for moonlighting must be approved in advance by the Program Director and DIO (see Policy #003-001, Work Schedules, Moonlighting/Outside Employment).

C. Clinical Responsibilities, Teamwork, and Transitions of Care

a) The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services.
   a. Optimal clinical work load may be further specified by each Review Committee.

b) Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system.

c) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency and structure.

d) Rutgers NJMS and each training program must ensure effective, structured hand-over processes to facilitate both continuity of care and patient safety.

e) Programs must ensure that residents are competent in communicating with team members in the hand-over process.

f) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.

g) Such hand-offs should not detract from the quality of resident educational experience.

h) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in CPR VI.C.2 (Well-Being), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.

D. Clinical and Educational Work Schedules/Scheduling of Residents

a) The Program Director is responsible for the schedules and will make final decisions regarding on-call scheduling.

b) On-call rooms are provided by the hospital for Housestaff with on-call responsibility.

c) The on-call schedule will be tailored to meet the residency requirements set by the ACGME for each training program. It is recognized by the sponsoring institution that in-house call is an integral part of the Housestaff education and is to be scheduled to maximally enhance that educational pursuit. The GME

office receives individual departmental rotation schedules to review for compliance and to formulate monthly Housestaff billings. Additionally, the GMEC as part of the internal review process shall review individual program hourly work and on-call schedules for compliance.

d) Scheduled call that is not in full compliance with this policy will be returned to the Program Director for revision.

E. Responsibility

Responsibility for monitoring compliance with these regulations will rest with the individual Program Director and the GMEC Duty Hours Subcommittee under the direction of the DIO. All programs shall implement policies and procedures consistent with ACGME institutional and program requirements for resident clinical experience and education as well as the working environment.

a) All programs should adopt procedures so that clinical and educational work obligations are shared by trainees in all PGY levels in order to mitigate the possibility for excessive after hours work by junior-level residents and fellows.

b) The DIO will periodically assess compliance by review of on-call schedules and by confidential discussions with individual house staff members.

a) The DIO will report annually on compliance with Clinical and Educational Work Hours Regulations to the Faculty Council of NJMS.

b) The GMEC Duty Hours Subcommittee will meet regularly in order to address institutional and individual program compliance with clinical and educational work hour regulations set forth by the ACGME.

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New Jersey Medical School

GRADUATE MEDICAL EDUCATION POLICY

Number:	**003-004**
Section:	**Clinical Learning Environment**
Title:	**Maggie's Law**

Effective Date: 6/15/2017
Previous Review & Approval by GMEC: 5/24/2007, 1/17/2008, 2/16/2012, 2/12/2015
Responsible Office: NJMS Graduate Medical Education
Update: Every five years from effective date or as needed

Background and Purpose: Maggie's Law (N.J.S.2C:11-5 2C: 11-5; Death by auto or vessel) states that in the event of a motor vehicle accident resulting in the death of a motorist, the driver who is knowingly fatigued or sleep deprived may be convicted of vehicular homicide. The law specifically defines fatigue as "having been without sleep for a period in excess of 24 consecutive hours."[1] This law was enacted in 2003 and was named in honor of Maggie McDonnell, a 20 year-old college student, who was killed when her car was struck head-on by a truck that was operated by a driver who admitted to being awake for 30 hours and using drugs. The Maggie's Law policy is to establish guidelines for Housestaff who are subject to fatigue in order to prevent harm, injury or death of themselves or others.

Scope: This applies to all postgraduate medical education programs.

Definitions:

1. **Housestaff**/House Officer- refers to all interns, residents and subspecialty residents (fellows) enrolled in a Rutgers New Jersey Medical School (Rutgers NJMS) graduate medical education program. A member of the Housestaff may be referred to as a house officer.
2. **Designated Institutional Official (DIO)** – refers to the individual who has the authority and responsibility for the graduate medical education programs.
3. **Program** – refers to the structured medical education experience in graduate medical education, which conforms to the Program Requirements of a particular specialty, the satisfactory completion of which may result in eligibility for board certification.
4. **Program Director** (PD)– the one physician designated to oversee and organize the activities for an educational program.
5. **Review Committee-** the Accreditation Council for Graduate Medical Education delegates authority to accredit programs/institutions to its Review Committees. The Review Committees are comprised of peer specialists in the field and resident physicians.

Reference(s):

1. Maggie's Law N.J.S.2C:11-5 2C: 11-5 found at http://www.njleg.state.nj.us/2002/Bills/A1500/1347_R2.HTM
2. ACGME Common Program Requirements (CPR) VI
3. ACGME Institutional Requirements (IR) II.D.4.i

Policy:

A. Housestaff and residency PD's shall be aware of the potential problems that may result from driving a vehicle after having been without sleep for a period in excess of 24 consecutive hours.

B. Housestaff who have been without sleep for a period in excess of 24 consecutive hours must, before driving, take one or more of the following actions:

1. Sleep for a period of time sufficient to feel rested before driving
2. Arrange to be driven to their home or place of residence, or an alternative site
3. Take public transportation to their home or place of residence, or an alternative site

C. The program in partnership with the sponsoring institution must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (CPR VI.D.3)

D. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in CPR VI.C.2, in the event that a resident may be unable to perform their patient care duties responsibilities due to excessive fatigue (CPR VI.D.2)

E. The program and PD must:

1. Educate all residents and faculty to recognize the signs of fatigue and sleep deprivation (CPR VI.D.1.a)
2. Educate all residents and faculty in alertness management and fatigue mitigation processes (CPR VI.D.1.b)
3. Encourage residents to use fatigue mitigation processes to manage potential negative effects of fatigue on patient care and learning. (CPR VI.D.1.c)
4. The potential impact of sleep deprivation and fatigue on performance
5. Resources available for residents who feel their performance is being negatively affect by fatigue
6. Opportunities in place to assist individuals in complying with Maggie's Law

F. Oversight:

a. Each program must have written policies and procedures consistent with Maggie's Law. These policies must be distributed to the residents and the faculty and kept on file in the GME office. The program, the PD and the faculty must monitor compliance with this policy.

b. The GME Office will oversee that programs comply with this policy.

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New Jersey Medical School

GRADUATE MEDICAL EDUCATION POLICY

Number:	**003-005**
Section:	**Clinical Learning Environment**
Title:	**Working Environment**

Effective Date: 9/21/2017
Previous Review & Approval by GMEC: 5/24/2007, 4/19/2012, 2/12/2015
Responsible Office: NJMS Graduate Medical Education
Update: Every five years from effective date or as needed

Purpose: To establish guidelines to ensure that Housestaff have an adequate clinical learning environment in graduate medical education programs sponsored by Rutgers New Jersey Medical School and core teaching hospitals.

Scope: This applies to all postgraduate medical education programs.

Definitions:

1. **Housestaff**/House Officer- refers to all interns, residents and subspecialty residents (fellows) enrolled in a Rutgers New Jersey Medical School (Rutgers NJMS) graduate medical education program. A member of the Housestaff may be referred to as a house officer.
2. **Designated Institutional Official (DIO)** – refers to the individual who has the authority and responsibility for the graduate medical education programs.
3. **Program** – refers to the structured medical education experience in graduate medical education, which conforms to the Program Requirements of a particular specialty, the satisfactory completion of which may result in eligibility for board certification.
4. **Program Director** – the one physician designated to oversee and organize the activities for an educational program.
5. **Review Committee-** the Accreditation Council for Graduate Medical Education delegates authority to accredit programs/institutions to its Review Committees. The Review Committees are comprised of peer specialists in the field and resident physicians.

Reference(s):

1. ACGME Common Program Requirements
2. ACGME Institutional Requirements (effective July 1, 2103) II.F.1-II.F.3.c
3. Rutgers Policy 00-001-25-60:00

Policy:
The training programs shall provide a working environment that is consistent with proper patient care, patient safety, Housestaff well-being, and the educational needs of Housestaff.

A. Programs, in partnership with their and Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.

B. Housestaff shall be supervised by the teaching staff in accordance with the ACGME's a) Institutional Requirements, b) Common Program Requirements, and c) Individual specialty/subspecialty Program Requirements (found at http://www.acgme.org).

C. Each training program shall establish policies governing clinical and educational work hours and clinical learning

environments that are optimal for Housestaff education and the care of patients. Policies shall meet the special requirements that relate to clinical and educational work schedules based on educational rationale and patient needs, including continuity of care. This is reviewed as part of the GME internal review of programs and more frequently as determined by the GMEC Policies shall include the following items:

1. The goals and objectives of each residency must be accomplished without excessive reliance on Housestaff to fulfill institutional non-physician obligations; and ensure manageable patient care responsibilities.

2. The objectives of the program must be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events.

3. The Program Director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.

4. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the provision of patient- and family-centered care; safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; assurance of their fitness for working, including management of their time before, during, and after clinical assignments; and, recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team; commitment to lifelong learning; monitoring of their patient care performance indicators; and, accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.

5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.

7. Programs must design clinical assignments to minimize the number of transitions in patient care and must monitor effective, structured hand-over processes to facilitate patient safety and continuity of care.

8. Programs should ensure that Housestaff are provided backup support when patient care responsibilities are especially difficult or prolonged.

9. Clinical and educational work hour policies will meet all the specific requirements as specified by the ACGME, as well as meet the general and special requirements pertaining to each program (refer to Rutgers NJMS GME Policy 003-003). If any program's special requirements regarding clinical and educational work hours are more stringent than are those of the general clinical and educational work hour guidelines, then those more stringent guidelines are to be followed.

10. Housestaff on duty will be provided adequate sleeping quarters or safe transportation options for residents who may be too fatigued to safely return home.

11. Housestaff on duty will be provided adequate food services.

12. Training sites will provide effective medical records; patient support services; and laboratory, pathology and radiological services to insure high quality patient care. This will include adequate intravenous access, phlebotomy and transport services to relieve Housestaff of routine performance of these duties.

13. All locations where Housestaff are assigned shall provide security and personal safety measures, including but not limited to parking facilities, on-call quarters, and hospital and institutional grounds, and related facilities.

14. Resident fatigue and sleep deprivation will be monitored and each program shall have a policy to provide support for Housestaff to avoid excessive fatigue and education regarding alertness management and fatigue mitigation.

15. Each Program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.

16. Quality Improvement must be supported through available systems for reporting errors, adverse events, unsafe environments, and near misses in a protected manner as well as access to data to improve systems of care and improve patient outcomes

D. (Alternate to A, B, and C) Each training program shall establish policies governing clinical and educational work hours and working environments that are optimal for Housestaff education and the care of patients. Policies shall meet the special requirements that relate to clinical and educational work hour schedules based on educational rationale and patient needs, including continuity of care. This is reviewed as part of the GME special program review and more frequently as determined by the GMEC. Policies shall conform to the ACGME's Institutional Requirements, Common Program Requirements, and individual specialty/subspecialty Program Requirements (found at http://www.acgme.org). Policies must include the following aspects of the learning and work environment:
   1. Patient Safety
   2. Quality Improvement
   3. Transitions of Care
   4. Supervision of residents/fellows
   5. Duty Hours, fatigue management and mitigation
   6. Professionalism

E. Housestaff are expected to participate in a working environment that is free of objectionable and disrespectful conduct and communication of a sexual nature. The sponsoring institution, the New Jersey Medical School (a unit of Rutgers), will not tolerate conduct of a sexual nature that interferes with an individual's work performance or creates an intimidation, hostile, or offensive working or learning environment (see University Policy on Sexual Harassment # 00-01-35-60:00). The working environment will also be free of objectionable and disrespectful conduct and communication related to religious beliefs and racial or ethnic background.

F. Housestaff are expected to participate in a clinical learning environment that is free of inappropriate and unprofessional conduct towards them by their teachers, instructors and/or supervisors (refer to Rutgers NJMS GME Policy 008-005).

RUTGERS
New Jersey Medical School

GRADUATE MEDICAL EDUCATION POLICY

Number:	**003-006**
Section:	**Clinical Learning Environment**
Title:	**Resident Well-Being**

Effective Date: 9/21/2017
Previous Review & Approval by GMEC: N/A
Responsible Office: NJMS Graduate Medical Education
Update: Every five years from effective date or as needed

Purpose: To establish guidelines to ensure that Housestaff have the resources and skills for self-care in graduate medical education programs sponsored by Rutgers New Jersey Medical School and core teaching hospitals.

Scope: This applies to all postgraduate medical education programs.

Definitions:

6. **Housestaff**/House Officer- refers to all interns, residents and subspecialty residents (fellows) enrolled in a Rutgers New Jersey Medical School (Rutgers NJMS) graduate medical education program. A member of the Housestaff may be referred to as a house officer.
7. **Designated Institutional Official (DIO)** – refers to the individual who has the authority and responsibility for the graduate medical education programs.
8. **Program** – refers to the structured medical education experience in graduate medical education, which conforms to the Program Requirements of a particular specialty, the satisfactory completion of which may result in eligibility for board certification.
9. **Program Director** – the one physician designated to oversee and organize the activities for an educational program.
10. **Review Committee-** the Accreditation Council for Graduate Medical Education delegates authority to accredit programs/institutions to its Review Committees. The Review Committees are comprised of peer specialists in the field and resident physicians.

Reference(s):

4. ACGME Common Program Requirements, effective July 1, 2017 found at http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf
5. ACGME Institutional Requirements (effective July 1, 2015) found at http://www.acgme.org/Portals/0/PDFs/FAQ/InstitutionalRequirements_07012015.pdf
6. Clinical Learning Environment Review (CLER) Pathways to Excellence Version 1.1 found at http://www.acgme.org/Portals/0/PDFs/CLER/CLER_Pathways_V1.1_Digital_Final.pdf
7. Rutgers Policy (policies.rutgers.edu)

Policy:

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. The delivery of safe and high quality patient care on a consistent and sustainable basis can only be rendered when the well-being of clinical care providers is assured. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training.

1. Each program, in partnership with its Sponsoring Institution, must provide education on all aspects related to physician wellbeing. Faculty members and resident's education should include:
    a. the risks, signs, symptoms, and recognition of fatigue

b. the risks, signs, symptoms, and recognition of burnout, depression, and substance abuse,
c. the risks, signs, symptoms, and recognition of those who are at risk of or demonstrating self-harm.
d. to recognize the symptoms of burnout, depression etc. in themselves and how to seek appropriate care.

2. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence. This responsibility must include:
    a. efforts to create a supportive clinical care community that is free of stigma, safe, and embraces, promotes, and supports well-being.
    b. engaging residents, fellows, and faculty members in designing, developing, and continually stewarding priorities and strategies that support well-being.
    c. continuous effort to support programs and activities that enhance the physical and emotional well-being of residents, fellows, and faculty members.
    d. efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships.
    e. attention to scheduling, work intensity, and work compression that impacts resident well-being.
    f. evaluating workplace safety data and addressing the safety of residents and faculty members.
    g. policies and programs that encourage optimal resident and faculty member well-being.
    h. residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.
    i. attention to resident and faculty member fatigue, burnout, depression, and substance abuse.
    j. identifying systems and processes that may impede well-being in the clinical learning environment and works to eliminate these impediments.
    k. active monitoring and assessment of the effectiveness of its efforts to eliminate harm to patients due to clinician fatigue.

3. Programs, in partnership with its Sponsoring Institution, must:
    a. have leadership that demonstrate behaviors that promote well-being, thereby serving as role models for the clinical care team.
    b. ensure confidentiality and actively facilitate early detection of residents, fellows, and faculty members at risk of or demonstrating burnout, depression, substance abuse, suicidal ideation, or potential for violence.
    c. provide access to appropriate tools for self-screening.
    d. provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.
    e. effectively address the emotional needs of its residents, fellows, and faculty members in relation to catastrophic work-related events (in the course of patient care or among the members of the clinical care team.

4. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work.

RUTGERS
New Jersey Medical School

GRADUATE MEDICAL EDUCATION POLICY

Number:	**003-007**
Section:	**Clinical Learning Environment**
Title:	**Patient Safety and Quality Improvement**

Effective Date: 9/21/2017
Previous Review & Approval by GMEC: N/A
Responsible Office: NJMS Graduate Medical Education
Update: Every five years from effective date or as needed

Purpose: To establish guidelines for Housestaff regarding patient safety and quality improvement in graduate medical education programs sponsored by Rutgers New Jersey Medical School and core teaching hospitals.

Scope: This applies to all postgraduate medical education programs.

Definitions:

11. **Housestaff**/House Officer- refers to all interns, residents and subspecialty residents (fellows) enrolled in a Rutgers New Jersey Medical School (Rutgers NJMS) graduate medical education program. A member of the Housestaff may be referred to as a house officer.
12. **Designated Institutional Official (DIO)** – refers to the individual who has the authority and responsibility for the graduate medical education programs.
13. **Program** – refers to the structured medical education experience in graduate medical education, which conforms to the Program Requirements of a particular specialty, the satisfactory completion of which may result in eligibility for board certification.
14. **Program Director** – the one physician designated to oversee and organize the activities for an educational program.
15. **Review Committee-** the Accreditation Council for Graduate Medical Education delegates authority to accredit programs/institutions to its Review Committees. The Review Committees are comprised of peer specialists in the field and resident physicians.

Reference(s):

8. ACGME Common Program Requirements
9. ACGME Institutional Requirements (effective July 1, 2103) II.F.1-II.F.3.c
10. Rutgers Policy 00-001-25-60:00

Policy:

The training programs shall provide a working environment that is committed to patient safety, quality improvement, and accountability.

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

RUTGERS
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GRADUATE MEDICAL EDUCATION POLICY

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

I. Patient Safety:

1. A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

2. The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. The program must have a structure that promotes safe, interprofessional, team-based care.

3. Education on Patient Safety Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques.

4. Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

5. Residents, fellows, faculty members, and other clinical staff members must:
    a. know their responsibilities in reporting patient safety events at the clinical site;
    b. know how to report patient safety events, including near misses, at the clinical site; and
    c. be provided with summary information of their institution's patient safety reports.

6. Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.

7. Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.
    a. All residents must receive training in how to disclose adverse events to patients and families.
    b. Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.

II. **Quality Improvement**:

1. A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

2. Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.

3. Quality Metrics Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts. Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.

4. Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.
    a. Residents must have the opportunity to participate in interprofessional quality improvement activities. This should include activities aimed at reducing health care disparities.