RUTGERS
New Jersey Medical School

GRADUATE MEDICAL EDUCATION POLICY

Number:	**013-001**
Section:	**Resident Participation in Educational & Professional Activities**
Title:	**General Competencies**

Effective Date: 11/19/2015
Previous Review & Approval by GMEC: 5/24/07, 1/17/08, 3/15/12
Responsible Office: NJMS Graduate Medical Education
Update: Every five years from effective date or as needed

Purpose: To establish guidelines for outcomes-based education and training of housestaff in graduate medical education programs sponsored by Rutgers New Jersey Medical School and core teaching hospitals using milestones within the framework of the six ACGME competencies.

Scope: This policy will apply to all of the graduate medical education 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 –** 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 Milestones
   https://www.acgme.org/acgmeweb/tabid/430/ProgramandInstitutionalAccreditation/NextAccreditationSystem/Milestones.aspx

Policy:

A. Introduction

Outcomes-Based Education uses milestones as a framework for determining housestaff performance within the six ACGME Core Competencies. Unlike general goals, competencies are written as real-life abilities that are required for effective professional practice. The ACGME has approved six General Competency domains. The competencies represent areas of skill and knowledge that residents are expected to demonstrate before graduation. Milestones are significant points in development. For accreditation purposes, the Milestones are competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents and fellows from the beginning of their education through graduation to the unsupervised practice of their specialties.

B. General Competencies

The ACGME endorses general competencies for residents in the areas of Medical Knowledge, Patient Care, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice. Identification of general competencies was the first step in a long-term effort designed to emphasize educational outcome assessment in residency programs and in the accreditation process. The general competencies are incorporated into the individual program's Residency Review Committee requirements.

Each residency program must require its residents to develop competence in the six areas below, to the level expected of a new practitioner as defined by the specialty specific milestones. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate achievement of the milestones within each competency. In addition to the required competencies listed below, each program may identify additional specialty-specific competency requirements, as specified by its RRC.

1. PATIENT CARE

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

2. MEDICAL KNOWLEDGE

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

3. PRACTICE-BASED LEARNING AND IMPROVEMENT

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

- identify strengths, deficiencies and limits in one's knowledge and expertise
- set learning and improvement goals
- identify and perform appropriate learning activities
- systematically analyze practice, using quality improvement methods, and implement changes with the goal of practice improvement
- incorporate formative evaluation feedback into daily practice
- locate, appraise, and assimilate evidence form scientific studies related to their patients' health problems
- use information technology to manage information, access on-line medical information; and support one's own education
- participate in the education of patients, their families, students, residents and other health professionals

4. INTERPERSONAL AND COMMUNICATIONS SKILLS

Residents must demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and health professionals. Residents are expected to:

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

5. PROFESSIONALISM

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

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

6. SYSTEMS-BASED PRACTICE

Residents must 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. Residents are expected to:

- work effectively in various health care delivery settings and systems relevant to their clinical specialty
- coordinate patient care within the health care system relevant to their clinical specialty
- incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate
- work in interprofessional teams to enhance patient safety and improve patient care quality
- participate in identifying system errors and implementing potential systems solutions

C. Milestones

The Milestones serve important purposes in program accreditation by:

- Allowing for continuous monitoring of programs and lengthening of site visit cycles
- Providing Public Accountability – report at a national level on aggregate competency outcomes by specialty

- Establishing a community of practice for evaluation and research, with focus on continuous improvement of graduate medical education (GME)

For educational (residency/fellowship) programs, the Milestones:

- Provide a rich, descriptive, developmental framework for Clinical Competency Committees (CCCs)
- Guide curriculum development
- Support better assessment practices
- Enhance opportunities for early identification of struggling residents and fellows

For residents and fellows, the Milestones:

- Provide more explicit and transparent expectations of performance
- Support better self-directed assessment and learning
- Facilitate better feedback for professional development

How are the Milestones used by the ACGME?
Resident/fellow performance on the Milestones provides a source of specialty-specific data for each specialty Review Committees to use in assessing the quality of residency and fellowship programs nationally, and for programs to use in facilitating improvements to curricula and resident performance if and when needed. The Milestones are also used by the ACGME to demonstrate accountability of the effectiveness of GME within ACGME-accredited programs in meeting the needs of the public.

D. Educational Program

The curriculum must contain the following educational components:

a. Overall educational goals for the program, which the program shall distribute to residents and faculty annually;
b. Competency-based goals and objectives for each assignment at each educational level using the ACGME milestones, which must be distributed to residents and faculty annually in written or electronic form and reviewed with the resident at the start of the rotation;
c. Regularly scheduled didactic sessions;
d. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program.

E. Program Responsibilities

a. Curriculum: All traditional components of residency education and training are expected to be continued, such as teaching rounds, bedside teaching, lectures, conferences, and morning report. Increasing emphasis is to be placed on resident learning outcomes, which is achieved by identifying and communicating the exact learning objectives for each learning opportunity and the criteria by which the residents will be assessed, as well as the degree to which additional guided or independent study may be necessary. Programs shall provide multiple identified learning opportunities in each of the six general competency domains.

b. Goals and objectives

i. Programs shall define specific milestone-based objectives for residents to demonstrate learning in the six ACGME competencies. All formats are acceptable provided that the competencies are integrated into the curriculum, and the curriculum is primarily competency based.

ii. Objectives shall be explicit, criteria-driven, and linked to assessment both in theory and in practice.

c. Assessment/Evaluation

i. Programs shall provide evidence that goals and objectives have been accomplished. In addition to assessing residents' attainment of objectives, assessment systems are also intended to facilitate continuous improvement of the educational experience, resident performance, and residency program performance.
ii. Assessments shall be consistent with curriculum/program objectives and based on the specialty-specific milestones.
iii. Multiple approaches and tools shall be used, by multiple observers conducting multiple observations. Assessment shall provide data that is reliable and valid. The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program
i. Program shall document progressive resident performance improvement appropriate to education level.

F. Institutional Responsibility

The Sponsoring Institution must ensure that each program provides effective educational experiences for residents that lead to measurable achievement of educational outcomes in the ACGME competencies as outlined in the Common and specialty/subspecialty-specific Program Requirements.

G. GMEC Responsibilities

a. GMEC must provide assurance that each program provides a curriculum and an evaluation system that enables residents to demonstrate achievement of the ACGME general competencies as defined in the Common and specialty/subspecialty-specific Program Requirements.
b. As part of its internal review of programs, the GMEC shall assess each program's:
    1. Effectiveness of educational outcomes in the ACGME general competencies;
    2. Effectiveness of each program in using evaluation tools and outcome measures to assess a resident's milestone level in each of the general competencies; and
    3. Annual program improvement efforts in:
        a. resident performance using aggregated resident data
        b. faculty development
        c. graduate performance including performance of the program graduates on the certification examination
        d. program quality.

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GRADUATE MEDICAL EDUCATION POLICY

Number:	**13-002**
Section:	**Resident Participation in Educational & Professional Activities**
Title:	**Housestaff Performance Enhancement Program**

Effective Date: 1/17/2019
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 an institution-wide program that assists in elevating the performance of those Housestaff who (1) fail to demonstrate competency in the professionalism and interpersonal communication skills ACGME Milestones or (2) demonstrates repetitive or egregious behaviors in those Milestones in spite of attempts to correct them within the department.

Scope: This program 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 (ACGME) delegates authority to accredit programs/institutions to its Review Committees. The Review Committees are comprised of peer specialists in the field and resident physicians.
6. **Program-based Improvement Plan (PIP)-**the internal process that is implemented by the residency training program when a resident fails to achieve appropriate Milestone levels; this may have been formerly known as “informal remediation.”
7. **Triggers**-behaviors or interactions deemed by the institution, residency training program, and/or departmental leadership as not meeting established standards.

Background: With the implementation of the ACGME’s Milestones, program directors (PD’s) are tasked with ensuring that trainees are progressing at a level that is appropriate to their post-graduate year of training. When Housestaff fail to achieve these levels, it is the responsibility of the residency training program to provide resources and appropriate guidance to improve their performance. However, it is problematic when the internal processes of improvement for a Housestaff are not successful. Housestaff may be left feeling inadequate and stigmatized by the faculty within the department of the training program. It has been documented that professionalism is one of the most difficult competencies to remediate as it is frequently associated with lack of resident insight and buy-in.[1-6] This program combines Rutgers NJMS’ faculty leadership and mentorship with the institutions’ resources in order to provide identified Housestaff with assignments specifically tailored to their individual deficiencies. In this way, the direct onus is taken off of the PD and allows for more objectivity for both the Housestaff and the residency leadership.

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References:

1. Thaxton RE, Woodson SJ, Hafferty FW, et al. Self vs. other focus. Predicting professionalism remediation of emergency medicine residents. *West J Emerg Med*. 2018; 19(1):35-40.
2. Adams KE, Emmons S, Romm J. How resident unprofessional behavior is identified and managed: a program director survey. *Am J Obstet Gynecol*. 2008;198(6):692.e1–4. discussion 692.e4–5.
3. Sullivan C, Murano T, Comes J, et al. Emergency medicine directors' perceptions on professionalism: a Council of Emergency Medicine Residency Directors survey. *Acad Emerg Med*. 2011;18(Suppl 2):S97–103.
4. Silverberg M, Weizberg M, Murano T, et al. What is the prevalence and success of remediation of emergency medicine residents? *West J Emerg Med*. 2015;16(6):839–44.
5. Huddle T. Viewpoint: teaching professionalism: is medical morality a competency? *Acad Emerg Med*. 2005; 80:885-91.
6. Leo T, Eagen K. Professioanlism education: the medical student response. *Perspect Biol Med*. 2008; 51:508-16.

Policy: The Rutgers NJMS Housestaff Performance Enhancement Program (PEP) is a program that addresses those Housestaff who fail to achieve appropriate levels in the Professionalism and Interpersonal & Communication Skills Milestones.

1. Housestaff may only be referred to the PEP by the corresponding program's Clinical Competency Committee (CCC) or the PD.

2. PD's should be able to demonstrate (with appropriate documentation) that sufficient efforts at a program-based improvement plan (PIP) were attempted and were unsuccessful unless the Housestaff displays behaviors that warrant immediate enrollment in the PEP.

3. PD's are required to:
   a. Meet with Housestaff to inform him/her that s/he will be enrolled in this program.
   b. Inform the Department Chair of the Housestaff referral to PEP.
   c. Inform the DIO of the Housestaff referral to PEP.
   d. Consult with the PEP Subcommittee Chair to select a faculty mentor and formulate an appropriate plan.
   e. Collate all previous documentation of the Housestaff's performance and maintain appropriate documentation of the PEP process.
   f. Communicate with the faculty mentor and PEP Chair on a monthly basis to monitor Housestaff progress.

4. Housestaff are required to:
   a. Adhere to all terms and conditions set forth by the PEP contract.
   b. Meet with a representative at the Resident Wellness and Excellence Center within one month of being enrolled in the PEP.
   c. Review and receive a copy of the PEP contract as well as the final PEP evaluation with both the PD and the faculty mentor. Although comments are not required, Housestaff may choose to provide written comments on the final evaluation.

5. Faculty mentors:
   a. Will be identified by the PEP subcommittee members.
   b. Will not be compensated for their participation in this program.
   c. Will be assigned to the Housestaff based on his/her identified strengths, resources, agreement to participate and availability
   d. Will be assigned in conjunction with the PD and the PEP Chair
   e. Will agree to comply to the terms and conditions set forth by the PEP contract which include but are not limited to:
      i. Meeting with the Housestaff on a regular basis as outlined by the PEP contract

ii. Monitoring the progress of the Housestaff PEP objectives
iii. Filling out all necessary paperwork in a timely manner
iv. Communicating progress of Housestaff to the PD

6. The PEP Contract:
   a. Will be completed by the PD, faculty mentor and the PEP Subcommittee Chair.
   b. Will reflect the start and end dates of the PEP cycle
   c. Will document the reasons why the Housestaff has been referred to the PEP
   d. Will document clear objectives for the PEP cycle
   e. Will contain comments by the PD
   f. Will be reviewed and signed by the Housestaff

7. Potential outcomes which may result from the Housestaff's performance in the PEP cycle include but are not limited to:
   a. Successful completion of the objectives outlined in the PEP cycle
   b. Unsuccessful completion of the objectives outlined in the PEP cycle, which may lead to one of the following:
      i. An additional PEP cycle
      ii. Extended residency training/repeat of specific rotations
      iii. Probation
      iv. Non-renewal
      v. Termination

8. Documentation and disclosure to future employers
   a. All PEP documentation is required to be kept in the Housestaff's permanent file.
   b. The PEP contract must be signed by the Housestaff, PD, and the faculty mentor. A copy of this contract will be kept on file and will be sent to and reviewed by the DIO.
   c. The final PEP evaluation must be reviewed and signed by the faculty mentor, Housestaff, PD and the DIO.
   d. Successful PEP cycles are not required to be disclosed to future employers or state medical licensing boards.
   e. Disclosure of unsuccessful terminal PEP cycles to future employers and state medical licensing boards is required

9. Confidentiality
   a. Only the PD, Department Chair, DIO, PEP Chair, and the assigned faculty mentor will be informed of the Housestaff's identity.
   b. The PD, Department Chair, DIO, PEP Chair and the faculty mentor are required to maintain confidentiality and conduct themselves in a manner consistent with the institution's ethical codes and standards.
   c. All Housestaff will be assigned a random number in order to maintain confidentiality.
   d. In the event that discussion involving the Housestaff must take place, s/he will be referred to by this assigned number.

Procedure:

1. Program-based Improvement Plan (PIP)
   a. Implemented when the resident fails to meet appropriate Milestone levels and/or exhibits <3 minor triggers (as identified in Appendix B, *The Professionalism and Interpersonal & Communication Skills PEP Toolkit*) in spite of counseling OR minor trigger(s) in the presence of one moderate trigger (as identified in Appendix B, *The Professionalism and Interpersonal & Communication Skills PEP Toolkit*).

b. A wellness/burnout evaluation should be performed by the PD and/or residency leadership in order to identify any extraneous factors that may be contributing to the Housestaff's performance.

c. The PD must inform the DIO of the Housestaff identified for the PIP.

d. If Housestaff successfully completes the PIP:
   i. The PD must maintain appropriate documentation in his/her file until graduation.
   ii. The PD is not required to disclose the PIP to future employers or state medical licensing boards.
   iii. The PD must inform the DIO for tracking purposes

e. If Housestaff fails to meet minimum expectations set forth by the PIP:
   i. The PD should refer the Housestaff to the PEP.
   ii. The PD must have appropriate documentation in their files maintained.
   iii. The PD must inform the DIO and consider consultation with the PEP Chair.

2. **Performance Enhancement Plan (PEP)**—Refer to Appendix A, *Housestaff Performance Enhancement Program Process*

a. This program is implemented when a Housestaff:
   i. Is unsuccessful in the PIP
   ii. Consistently fails to meet appropriate Milestone levels
   iii. Is greater than one level below expectation for one or more Prof or ICS Milestone
   iv. Exhibits ≥3 minor repetitive behaviors in spite of counseling
   v. Exhibits 1 moderate trigger with ≥3 minor triggers
   vi. Exhibits 2 or more moderate triggers
   vii. Exhibits one or more major triggers

b. Housestaff will receive verbal notification of enrollment in the PEP by the PD and written notification of enrollment by the PEP Chair.

c. Housestaff are referred to the Resident Wellness and Excellence Center for a mandatory wellness and burnout screen.

d. A faculty mentor will be assigned by the PEP Chair, in conjunction with the PD.

e. The PEP contract will be completed, reviewed and signed by the PD, faculty mentor and the PEP Chair as outlined above.

f. A PEP cycle is considered successful if:
   i. All objectives have been met and documented by the faculty mentor

Appendix A: Housestaff Performance Enhancement Program Process

PROGRAM-BASED IMPROVEMENT PLAN (PIP)

Implemented when the Housestaff fails to meet appropriate Milestone levels and/or exhibits <3 minor triggers in spite of counseling OR minor trigger(s) in the presence of 1 moderate trigger

- Also known as "informal remediation"
- Implemented by individual program
- This is a "warning status"
- Conversation should be documented including: infraction(s), counseling, monitoring and re-evaluation.
- Document is placed in file
- Wellness/burnout evaluation performed by residency leadership
- GME office is informed for tracking purposes only

Successful PIP

- Housestaff graduates
- Documentation is expunged
- No disclosure to future employers

Unsuccessful PIP

- Repetitive behaviors
- Document unsuccessful PIP
- Referral for PEP

PERFORMANCE ENHANCEMENT PLAN (PEP)

Institutional Performance Enhancement Plan (PEP)

Implemented when the Housestaff:

- Is unsuccessful in the PIP
- Consistently fails to meet appropriate Milestone levels
- Is greater than one level below expectation for one or more Prof or ICS Milestone
- Exhibits ≥3 minor repetitive behaviors in spite of counseling
- Exhibits 1 moderate trigger with ≥3 minor triggers
- Exhibits 2 or more moderate triggers
- Exhibits one or more major triggers

In the PEP:

- Housestaff are referral to Resident Wellness and Excellence Center for a mandatory wellness/burnout screen
- GME office is immediately notified
- Housestaff receive formal notification of their referral to the PEP
- Faculty guide/mentor is assigned and meeting arranged
- Plan created and reviewed with referring department's CCC
- Documentation (plan, reviewed with and agreed to by referring CCC, monitoring, and re-evaluation)

Successful PEP

- Continued monitoring during and after training
- No disclosure to future employers

Unsuccessful PEP

- Probation, termination, or non-renewal
- Disclosure to future employers, if asked

* Triggers (behaviors or interactions deemed by the institution, residency training program, and/or departmental leadership as not meeting established standards).

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APPENDIX B: HOUSESTAFF PERFORMANCE ENHANCEMENT PROGRAM PROFESSIONALISM AND INTERPERSONAL COMMUNICATION SKILLS TOOLKIT

Milestone Category	Triggers			Tools
Professionalism	**Minor**	**Moderate**	**Major**	
Values and conduct • Honesty, integrity, ethical behavior, respect and trustworthiness	Inappropriate use of sick call Inappropriate elevator talk Inappropriate cell phone communication (texting or using social media)	Inappropriate use of social media Non-HIPPA compliant communication Inappropriate cell phone communication in front of patient/family (texting or using social media)	HIPAA violation Intentional deceit Exhibits unethical behavior with research methods, statistics, data collection, documentation or authorship Misrepresentation of credentials (falsification of test scores, degrees, previous training)	Read HIPAA laws and compliance material and prepare a learning module. Read the "Recommendations for the conduct, editing and publication of scholarly work in medical journals" found on www.icmje.org website.
Accountability • Punctuality, professional appearance and hygiene, pursuit of professional development • Complies with administrative responsibilities and has a sense of duty	Tardiness Poor hygiene Inappropriate attire Doesn't respond to emails, pages in an appropriate time frame	Unresponsive to emails, texts and other correspondence Deficiencies in duty hour, patient case logs, training modules	Untruthfulness Leaves the premises without notifying seniors/faculty/supervisors Patient abandonment	Attire/hygiene: apply link from Rutgers and hospital affiliate policies. Have resident review and discuss with faculty mentor. Time management resources: https://www2.usgs.gov/humancapital/documents/TimeManagementGrid.pdf 7 habits of highly successful people Peak performance Productivity project Deep work Reflective writing

				Personal calendar development Email organization TED talks on accountability
Responsiveness to unique characteristics/needs of patients • Embraces cultural competency, humanism and compassion	Doesn't attempt to get interpreter/translator Lack of compassion for social/economic status Exhibited judgmental behavior in front of peers and staff	Exhibited judgmental behavior in front of patients Receives 1 patient complaint in regards to professionalism	Made a decision based on personal biases which impacts patient care (will not treat someone based on biases/beliefs) Used demeaning language directly to a patient Receives > 1 patient complaint in regards to professionalism	Have resident shadow a social worker for a defined amount of time to help gain patient perspective Self-reflection on difficult cases- can discuss verbally or do written paper
Self-awareness and betterment • Utilizes knowledge of strength and limitations, practices reflection, open to feedback • Recognizes fatigue and stress	Resistant/defensive to feedback	Disappeared/left patient duties unattended without affecting patient care or significant impact on patient outcome Nodded off without impacting patient care	Disappeared/left patient duties unattended resulting in an adverse patient outcome or significantly impacting patient care Fell asleep affecting patient care	The Conscientiousness Index: A Novel Tool to Explore Students' Professionalism
Adaptability • Accepts ambiguity and	Doesn't ask for help when needed Doesn't go through	Deviation from patient care but did not impact patient	Adverse patient outcome because did not call for assistance.	Create patient cases with an emphasis on graduated responsibility and shared decision-making

utilizes resources when dealing with uncertainty	appropriate chain of command/channels Doesn't review literature, refer to text to confirm treatment, procedures, policies	care/outcome		
Interpersonal Communication Skills				
Patient-centered communication	Doesn't introduce himself to patient/family Doesn't address family concerns/questions Poor eye contact Doesn't keep patient abreast of updates	Inappropriate use of humor Use derogatory language or terms	Disrespectful to patient and/or family Used inappropriate language with patients (swearing) Complaints made by patient/family	Martin's Mind Map Simulated exercises with standardized patients (+/- video review)
Health care team communication • Demonstrates respect; effectively transitions care and relays information; exhibits responsiveness; negotiates and resolves conflict	Minor use of inappropriate language (swearing, insensitive jokes). A single complaint from nursing staff.	Recurrent infidelity in reporting prior events, current patient status, or care plan.	Multiple complaints from multiple sources regarding inappropriate communication. Willful failure to provide or receive appropriate transition of patient care. Willful neglect of patient care—includes failure to respond to nursing pages, consults.	Team STEPPS training course
Health care team leadership	Unable to connect or form collegial	Demonstrates bullying behavior	Abusive behavior to team members	Team STEPPS training course

• Understands and respects all members of the team, promotes collaboration; directs teams while promoting safe patient care	relationships with team members Makes unintentional culturally insensitive comments, racial or sexually biased comments	to junior members of the team Insensitive to needs of other team members	Intentionally demeans other members of the healthcare team	Mentored reading program/book club: "Crucial conversations" "How to win friends and influence others"
Documentation in the EMR • Timely, accurate, and concise completion of information, practices within boundaries of record-sharing polices	Inaccurate or incomplete documentation	Failure to complete EMR, dictations in a timely fashion	Willful falsification of health records or other documentation	Review literature on time management: Reese S. 12 smart time management tips for doctors. Medscape. https://www.medscape.com/viewarticle/860328. Published April 27, 2016. Accessed December 6, 2017. Gordon CE, Borkan SC. Recapturing time: a practical approach to time management for physicians. *Postgrad Med J*. 2014;90(1063):267-272. https://doi.org/10.1136/postgradmedj-2013-132012

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GRADUATE MEDICAL EDUCATION POLICY

Number:	**013-003**
Section:	**Resident Participation in Educational & Professional Activities**
Title:	**Housestaff Travel for Presentations at Professional Conferences**

Effective Date: 9/21/2017
Previous Review & Approval by GMEC: 1/17/08, 3/15/12, 11/19/15
Responsible Office: NJMS Graduate Medical Education
Update: Every five years from effective date or as needed

Purpose: To establish guidelines for reimbursable expenses for housestaff in graduate medical education programs sponsored by Rutgers New Jersey Medical School and core teaching hospitals when traveling for presentation at professional conferences.

Scope: This policy will apply to all 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.
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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. Committee of Interns and Residents (CIR) 2012-2018 Agreement
2. University Policy on Travel Related Expense Reimbursements (policies.rutgers.edu)

Policy:

Reimbursement for travel related expenses is available to all Housestaff that meet all of the following criteria (subject to change), at the discretion of the appropriate Dean of GME.

Travel must be within the continental United States.

Resident must be in good academic standing within the department (this includes being up to date on submitting required documentation- case logs, duty hours, evaluations, etc).

Faculty mentor needs to attest that the resident presenting did the substantive amount of work on the project.

a. Work and presentation must take place while the resident is employed by NJMS.

b. Only one resident can submit per project, unless the nature of the presentations is inherently different (eg, residents construct database but have different clinical questions).

There must be IRB approval for the project in question (if human subjects involved) for all presentations.

Additional criteria:

1. Housestaff must receive approval from Program Director or Designee prior to participation in conference
2. Housestaff is presenting a paper, abstract or poster relevant to the specialty in training
3. Housestaff is a first-author in the paper, abstract or poster to be presented
4. Housestaff has not presented the paper, abstract or poster at a previous conference
5. Housestaff has not sought reimbursement for another conference in the same academic year
6. If housestaff has previously received reimbursement for travel from GME he/she is required to provide evidence that previous papers or abstracts presented were submitted for publication in a medical journal (manuscripts or abstracts need not be accepted for publication). If papers or abstracts previously presented at a conference are not submitted for publication, housestaff may submit other work published/submitted for publication to satisfy this requirement. Housestaff must be identified as a first author (exceptions are considered-see procedure below).
7. Resident's attendance at conference cannot create conflict for duty hour requirements (for either the resident or the program). Travel days do not meet the definition of duty hours per ACGME and therefore are days off; the day of presentation is counted as duty hours.
8. Meeting must be accredited for CME.
9. If resident wishes to extend stay for remainder of conference, he/she would be responsible for those additional costs (including any cost due to different flights). Permission to stay is granted at the discretion of the program director.
10. Travel expenses must be incurred for payment.

Commonly Reimbursed Expenses*	Expenses Not Reimbursed*
✓ Expenses for three days (day prior to, day of, and day after presentation) and two nights (day prior to and the day of presentation) ✓ Airfare to and from conference location ✓ Hotel- Two nights (the night before and the night of the presentation) including tax and resort fees ✓ Meals-$50 per diem ✓ Cab fare to and from airport, to and from conference to hotel ✓ Parking at airport (for personal car) ✓ Conference registration fees ✓ Mileage if driving personal car to conference (at Rutgers current rate)	✓ Rental cars ✓ Other hotel expenses (e.g. spa, dry cleaning, computer access fees etc.) ✓ Luggage check-in fees ✓ Alcoholic drinks ✓ Expenses incurred by a traveling companion ✓ Unreasonably expensive meals ✓ Meals included in the cost of conference fees ✓ Expenses related to personal negligence (e.g. parking tickets, fines, towing, traffic violations etc.)

*Not all reimbursable/non-reimbursable expenses are identified. Please contact the Program Director for further information.

It is the Housestaff's responsibility to obtain approval for travel and to submit expense related information after travel within the timeframe outlined below.

Timeline for Reimbursement

At least 1 month prior to travel:

- Housestaff or program designee must submit a Travel Approval (TA) report and other required documents to the Residency/Fellowship Program Office.

1-2 months post travel:

- Housestaff or program designee must submit an Expense Report online with all required documents
- Additional approvals are required if documentation is submitted after 60 days, so housestaff should make every effort to submit within a 2 month window after travel.
- Housestaff should expect reimbursement for travel related expenses approximately 2 pay periods after submitting documentation.

NOTE:

- ✓ Missing documents or submission of incomplete forms will delay reimbursement. It is the housestaff's responsibility to ensure that all required documentation is submitted online. Please follow up with the Program Coordinator for assistance if necessary.
- ✓ Travel advance payments are NOT available.

Procedure:

Prior to Travel:

To be considered for reimbursement the Housestaff must complete and submit the following documentation to the GME office at least one month prior to travel.

1. Complete and submit the Travel Approval Form (TA)
2. A copy of the conference brochure that describes the conference and identifies the housestaff as a presenter
3. A copy of the paper, poster or abstract to be presented (must indicate Housestaff is first author)
4. A signed attestation indicating that the resident has not presented the paper, poster or abstract at another conference
5. Supporting documentation for estimates itemized on the TA including airfare, lodging and registration fees. This documentation can be screen prints, travel agency estimates or hotel/airline estimates. Estimates for meals and transportation (e.g. cab, public transportation, airport parking etc.) are not required.
6. Evidence of publication/submission for publication is required of housestaff who have previously presented at a conference and received reimbursement from the GME office. The Housestaff must be identified as a first author. Exceptions to the first author criteria can be made on a case basis. Please identify and submit a summary of your contribution to the paper or abstract by completing the *Contribution to Abstract/Poster/Paper* (see Appendix E) form and your submission will be considered (does not guarantee approval).

Post Travel:

To complete the request for reimbursement the Housestaff must complete and submit the following documentation to the GME office at least one month after travel.

1. Complete and submit the Expense Report with supporting documentation
2. Upload scanned copies of original receipts for all expenses itemized on the expense report. Expenses identified without supporting receipts will not be reimbursed. All receipts must be itemized (e.g. meal receipts must identify food and drinks)
3. Housestaff will be notified via Rutgers email once the reimbursement is to be issued through payroll check/deposit approximately 2 pay periods after submission.