Denver Health
Residency In Emergency Medicine

Policies and Procedures
Handbook

Last revised: 2/2019

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Document Type: **Policy and Procedure**

Regarding: **Advancement and Graduation**

Last Revised: **2/2019**

POLICY: Residents are typically selected for enrollment in the Denver Health Medical Center Residency in Emergency Medicine ("Residency Program") by the Program Evaluation & Advisory Committee (PEAC) following a formal application and interview process in accordance with the rules of the National Residency Match Program. These Residents are selected for their great potential as emergency physicians. The Denver Health Medical Center Residency in Emergency Medicine is committed to making an effort to help each Resident succeed in the Residency Program. The Residency Program Director is responsible for assuring that the Emergency Medicine Residents progress adequately in the Residency Program. An important aspect of the Residency Program is advancement through the curriculum, with an expanding role and greater responsibility as the Resident progresses through the Program. Milestones to mark this progress are the advancement to upper levels of postgraduate training. Such advancement is not automatic, but depends on the successful completion of the previous level.

PROCEDURE: In order to advance from one postgraduate level to the next within the residency and in order to graduate from the Residency Program, Emergency Medicine Residents must be able to show adequate performance and participation in the Residency Program. If a Resident fails to make the expected progress, it can be grounds for denying advancement or for the disciplinary procedures outlined in the *Procedures for Disciplinary Actions and Termination*. All of the criteria listed below must be met, except in the rare case in which the Residency Program Director waives participation in specified activities for special circumstances.

Criteria for Advancement from the EM1 Year to the EM2 Year:

1. Satisfactory compliance with all aspects of the EM1 job description.
2. No ongoing Academic Probation.
3. Recommendation for Advancement by the Residency Program Director.
4. Completion of all affiliated hospital-wide training, credentialing, and advancement criteria.

Criteria for Advancement from the EM2 Year to the EM3 Year:

1. Satisfactory compliance with all aspects of the EM2 job description.
2. No ongoing Academic Probation.

3. Recommendation for Advancement by the Residency Program Director.
4. Completion of all affiliated hospital-wide training, credentialing, and advancement criteria.

Criteria for Advancement from the EM3 Year to the EM4 Year:

1. Satisfactory compliance with all aspects of the EM3 job description.
2. No ongoing Academic Probation.
3. Recommendation for Advancement by the Residency Program Director.
4. Completion of all affiliated hospital-wide training, credentialing, and advancement criteria.

Criteria for Completion of the EM4 Year and Graduation:

1. Satisfactory compliance with all aspects of the EM4 job description.
2. Completion of the DHREM curriculum.
3. No ongoing Academic Probation.
4. Recommendation for Advancement by the Residency Program Director.
5. Completion of all affiliated hospital medical record and administrative documentation.

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Residency In Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **ACGME Core Competencies**

Last Revised: **2/2019**

Scope: The ACGME and RRC-EM have published enforced requirements on resident performance in the areas of the six-core competencies. This document is designed to reiterate those core competencies and confirm that DHREM is in full support of meeting the spirit and letter of their implementation. Resident evaluations are based on these core competencies and milestones associated with each core competency.

ACGME Core Competencies

The residency program must require that its residents obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the following competency objectives:

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. Among other things, residents are expected to:
    a. Gather accurate, essential information in a timely manner.
    b. Generate an appropriate differential diagnosis
    c. Implement an effective patient management plan.
    d. Competently perform diagnostic and therapeutic procedures and emergency stabilization.
    e. Prioritize and stabilize multiple patients and perform other responsibilities simultaneously.
    f. Provide health care services aimed at preventing health problems or maintaining health.
    g. Work with health care professionals to provide patient-focused care.

2. **Medical Knowledge**: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Among other things, residents are expected to:
    a. Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information

b. Properly sequence critical actions for patient care and generate a differential diagnosis for an undifferentiated patient
c. Complete disposition of patients using available resources

3. **Practice-Based Learning**: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Among other things, residents are expected to:
   a. Analyze and assess their practice experience and perform practice-based improvement
   b. Locate, appraise and utilize scientific evidence related to their patient's health problems
   c. Apply knowledge of study design and statistical methods to critically appraise the medical literature
   d. Utilize information technology to enhance their education and improve patient care
   e. Facilitate the learning of students and other health care professionals

4. **Interpersonal and Communication Skills**: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates. Among other things, residents are expected to:
   a. Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences
   b. Demonstrate effective participation in and leadership of the healthcare team
   c. Develop effective written communication skills
   d. Demonstrate the ability to handle situations unique to the practice of emergency medicine
   e. Effectively communicate with out-of-hospital personnel as well as non-medical personnel

5. **Professionalism**: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to demonstrate a set of model behaviors that include but are not limited to:
   a. Treats patients/family/staff/paraprofessional personnel with respect
   b. Protects staff/family/patient's interests/confidentiality
   c. Demonstrates sensitivity to patient's pain, emotional state, and gender/ethnicity issues,
   d. Able to discuss death honestly, sensitively, patiently, and compassionately
   e. Unconditional positive regard for the patient, family, staff, and consultants
   f. Accepts responsibility/accountability

g. Openness and responsiveness to the comments of other team members, patients, families, and peers

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. Among other things, residents are expected to:
   a. Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care
   b. Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient
   c. Practice cost-effective health care and resource allocation that does not compromise quality of care
   d. Advocate for and facilitates patients' advancement through the healthcare system.

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Document Type: **Policy and Procedure**

Regarding: **Transitions of Care/Patient Hand-off**

Last Revised: **2/2019**

Scope: Per http://www.acgme-2010standards.org/pdf/dh-FAQs2011.pdf, the ACGME requires that "Programs must design clinical assignments to minimize the number of transitions in patient care. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Programs must ensure that residents are competent in communicating with team members in the hand-over process. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

Policy:

1. Transitions of care in the Emergency Department are minimized to three times daily (7am, 3pm, and 11pm). Scheduling shifts that encourage a minimal number of hand-offs is important to the DHREM.
2. Transitions of care on off-service rotations are also important and therefore all rotations (except Orthopedics on Saturday – where the residents work for 24 hours) operate under 12 hour shifts with group sign outs.
3. During faculty staff meetings and faculty development workshops, it has been stressed that effective sign-outs from residents include pertinent elements such as: exam findings, laboratory data, any clinical changes, family contacts, ED treatment, pending studies, expected course of the patient and proposed disposition/plan.
4. Faculty provide mentoring and feedback on sign-out real-time to the residents as they are always present for sign-out rounds.
5. Sign-out and communication of transitions of care is also practiced during Oral Boards.

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Document Type: **Policy and Procedure**

Regarding: **Faculty Involvement in Patient Care**

Last Revised: **2/2019**

Scope: The ACGME/RRC requires faculty involvement in patient care in the Emergency Department, specifically for common circumstances including but not limited to complex patients, ICU transfers and DNRs.

Policy:

1. Faculty are physically present and available 24 hours per day, 7 days a week in all Emergency Departments in the DHREM.
2. Prior to disposition, all patients presenting to the Emergency Department are discussed with the Emergency Medicine Attending Physician on-duty.
3. The EM Attending Physician is integrally involved in all complex patients, including but not limited to critically ill patients, transfers, heart “alert” patients, trauma “alert” and “activation” patients, stroke “alert” patients, cardiac catheterization patients/transfers, care of patients requiring procedures and complex patients.
4. The EM Attending Physician must sign all DNR documents initiated from the Emergency Department.
5. It is expected that the EM Attending Physician is present during the critical parts of any procedure being performed in the Emergency Department.

THE DENVER HEALTH
RESIDENCY IN EMERGENCY MEDICINE

Document Type: **Policies and Procedures**

Regarding: **Policy on creating an environment devoid of fear of intimidation or retaliation**

Last Revised: **2/2019**

Pertinent ACGME Institutional AND Program Requirements for Programs in Emergency Medicine:

Institutional Requirements II.F.1.:
The Sponsoring Institution and its programs must provide an educational and work environment in which residents may raise and resolve issues without fear of intimidation or retaliation. Mechanisms to ensure this environment must include:

- An organization or other forum for residents to communicate and exchange information on their educational and work environment, their programs, and other resident issues.
- A process by which individual residents can address concerns in a confidential and protected manner

Policy: The Denver Health Medical Center Residency in Emergency Medicine is committed to creating an environment of zero tolerance for any intimidation or retaliation toward any resident. The Residency Program Director of the Denver Health Residency in Emergency Medicine with the assistance of the DIO, Vice Chair of Education, and Director of Service, are responsible for remediating any general or individual grievances wherein a resident feels retaliation and intimidation have been used. Furthermore, the Denver Health Residency in Emergency Medicine will provide forums by which residents can anonymously communicate grievances.

Procedure: The following are the mechanisms in place for anonymous reporting of grievances related to intimidation and retaliation and plans for remediation:

A. The resident body meets quarterly for one hour on Wednesday mornings during protected time. The Chief Residents run the meeting and generates minutes. Only residents are present. Residents are expected to discuss any potential issues present within the program. Additionally, each class has a class representative that can also act as the voice for their class. This allows for a venue by which grievances can be brought to the leadership as a group rather than as an individual.

   Any areas requiring action are brought to residency leadership. If there is a report of intimidation or retaliation, it will be immediately reported to the Program Director. The Program Director will meet with faculty creating fear of intimidation and retaliation and create a plan for improvement with the faculty member. The DIO, Vice chair

of education and Director of Service will be closely involved with the process of remediating the faculty to provide an environment free of intimidation and retaliation. Recurrent grievances will be grounds for removing the faculty member from involvement with resident education. The Emergency Medicine Director of Service at Denver Health and the Chair of the Department of Emergency Medicine at University School of Medicine will be integrally involved in this process.

B. The Denver Health Residency in Emergency Medicine has an Ombudsman Program. This is a person outside of our Emergency Medicine Residency who is available to hear resident grievances. A resident can bring an issue to this person anonymously. This person will then help resolve the issue either by involving the Program Director and/or the DIO.

C. Faculty that have been determined to consistently create an environment of intimidation and retaliation will meet with the Program Director and create a plan for improvement. The DIO, Vice Chair of Education and Director of Service will be closely involved with the process of remediating the faculty to provide an environment free of intimidation and retaliation. Recurrent grievances will be grounds for removing the faculty member from involvement with resident education. The Emergency Medicine Director of Service at Denver Health and the Chair of the Department of Emergency Medicine at University School of Medicine will be integrally involved in this process

THE DENVER HEALTH
RESIDENCY IN EMERGENCY MEDICINE

Document Type: **Policies and Procedures**

Regarding: **Plan of action to initiate and evaluate program improvement**

Last Revised: **2/2019**

Pertinent ACGME Institutional AND Program Requirements for Programs in Emergency Medicine:

> **Program Requirement V.C.1 and V.C.2.:**
> If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
> (see emergency medicine program requirements at www.acgme.org)

Procedure: Anonymous evaluations of the Program will be completed by the Residents and Faculty annually. These evaluations will be reviewed by the program leadership. Any deficiencies noted in the program will be discussed at the Education Committee Meeting with resident representation. The Education Committee will create a plan for improvement with input from the Program Director. The action plan will be reviewed and approved by the teaching faculty at all the institutions impacted by the change. The plan for improvement will be implemented immediately or as soon as possible dependent on the requirements of the plan. When a new initiative is implemented residents and faculty will again complete an anonymous evaluation 3 to 6 months after implementation of the plan. These evaluations will again be discussed at the subsequent Education Committee Meeting with evaluations and outcomes documented in the minutes.

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Document Type: **Policy and Procedure**

Regarding: **Disciplinary Action and Termination**

Last Revised: **2/2019**

POLICY: The Denver Health Residency in Emergency Medicine is committed to making an effort to select Resident Candidates with a high potential for success in the Residency Program. Further, the Denver Health Residency in Emergency Medicine is committed to making an effort to help each of those Residents succeed in the Residency Program. The Emergency Medicine Residents, in turn, are committed to applying themselves fully to the Program and to conduct themselves with the highest professional and ethical standards. The Residency Program Director of the Denver Health Residency in Emergency Medicine is responsible for addressing resident discipline issues, including maintaining a process for placing Residents on probation or terminating Residents for disciplinary reasons.

PROCEDURE: Residents are typically selected for enrollment in the Denver Health Residency in Emergency Medicine by the Residency Program Director, with the advice of the Program Evaluation & Advisory Committee (PEAC), following a formal application and interview process in accordance with the rules of the National Residency Match Program. Residents in the program shall sign the House Officer Training Agreement of the Denver Health Medical Center Residency in Emergency Medicine and must fulfill their obligations and responsibilities under that agreement and the PGY specific job description, which are provided to the residents at the beginning of each academic year.

If members of the academic faculty, the resident staff, or the ancillary staff become aware of a Resident who has not met his or her obligations and responsibilities under the House Officer Training Agreement of the Denver Health Residency in Emergency Medicine and/or their PGY specific job description, they should contact the Residency Program Director as soon as possible. This should be followed by a written report of the alleged infraction. This report must be signed; anonymous accusations will not be accepted. However, the Denver Health Residency in Emergency Medicine shall act upon any allegation of sexual or racial harassment (written or not) in accordance with the Denver Health and Hospital Authority policy on sexual or racial harassment.

Upon review of the report of an alleged infraction, the Residency Program Director will consider the seriousness of the allegation. The Residency Program Director or designee may investigate the allegation

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by speaking with the Resident involved as well as any other concerned parties and by gathering and reviewing evidence. The Resident may be relieved of clinical duties (Investigative Leave with pay) pending the outcome of the Residency Program Director's investigation. If evidence of wrongdoing exists, the Residency Program Director will take action, as outlined below.

If the Residency Program Director learns of possible criminal activity on the part of the Resident during the Residency Program Director's investigation, the Residency Program Director shall immediately notify police and cooperate with any criminal official investigation.

In accordance with the Colorado Medical Practice Act, the Board of Medical Examiners will be notified of any Resident who violates the provisions of the Colorado Medical Practice Act or who has not progressed satisfactorily in the program or who has been dismissed from the program for inadequate performance or ethical reasons.

If the Residency Program Director has determined wrongdoing on the part of the Resident, the Residency Program Director has the discretion of imposing multiple layers of discipline. The disciplinary action chosen by the Residency Program Director can include:

1) Verbal Reprimand
2) Written Reprimand
3) Written Reprimand with Academic Probation
4) Residency Honor Council
5) Dismissal

The Residency Program Director may invoke any combination of these procedures. These disciplinary procedures need not be used sequentially; infractions of a more serious nature will incur a greater degree of discipline. The Residency Program reserves the right to dismiss a Resident for any violation of the House Officer Training Agreement. It is expected, however, that in most cases, a progressive approach through these procedures would be used. The procedures for each of these actions are enclosed in this document or referenced from any of the below listed documents:

1) The House Officer Training Agreement
2) Academic Probation and Dismissal Policy and Procedure
3) Resident Honor Council Policy and Procedure
4) Administrative Hearing of the Program Evaluation & Advisory Committee Policy and Procedure

The Residency Program Director, at his or her discretion, may, at any time, relieve a resident of his or her clinical duties as an Emergency Medicine Resident if his or her behavior is considered potentially dangerous to patients, other employees, or the public.

Verbal Reprimand: This procedure is to be used in cases of a relatively minor nature in which compliance with the letter and/or spirit of the House Officer Training Agreement has been less than optimal but in

which there is no proof of serious wrongdoing. The Residency Program Director shall meet with the Resident in question to review the allegations. The Resident will be given the opportunity to explain his or her position. If the Residency Program Director feels that the case warrants, the disciplinary action can be left at the stage of a verbal reprimand. The Resident will be advised about the consequences of any further infractions. A written notation of the verbal reprimand shall be maintained. If the Resident having received a verbal reprimand commits further infractions, the previous reprimand will be taken into consideration in further disciplinary actions.

Written Reprimand: This procedure is to be used in cases of a more serious nature in which compliance with the letter and/or spirit of the House Officer Training Agreement has been less than optimal and has had a negative effect on the Resident's progress in the Residency or on the Residency Program itself. The Residency Program Director shall meet with the Resident in question to review the allegations. The Resident will be given the opportunity to explain his or her position. The Residency Program Director may require the Resident to submit his or her explanation in writing. If the Residency Program Director feels that the case warrants, the disciplinary action can be left at the stage of a written reprimand. The Residency Program Director will provide the Resident with a Letter of Reprimand outlining the infraction. A copy of this Letter of Reprimand shall be placed in the Resident's personnel file. The Resident will be advised in the written reprimand about the consequences of any further infractions. If the Resident so chooses, he or she may write a letter of response outlining his or her position that will be attached to the Written Reprimand in the Resident's personnel file. If further infractions are committed by the Resident having received a written reprimand, the previous reprimand will be taken into consideration in further disciplinary actions.

Academic Probation: This procedure is to be used in cases of a serious nature in which compliance with the letter and/or spirit of the House Officer Training Agreement has been lacking and/or the Resident fails to make adequate progress within the Residency Program due to unsatisfactory clinical skills, medical knowledge, performance of duties, ethical conduct, or other factors. This process is outlined in the *Academic Probation and Dismissal Policy and Procedure* document and involves input and resources from the Residency Program Director, the Denver Health Graduate Medical Education Committee, and the Program Evaluation & Advisory Committee (PEAC).

Honor Council: This procedure is to be used in cases of a serious nature in which compliance with the letter and spirit of the House Officer Training Agreement has been lacking and the Resident's behavior has had a negative effect on the Residency Program itself and the other Emergency Medicine Residents. This process is outlined in the *Honor Council Policy and Procedure* document.

Dismissal: This procedure is to be used in cases of a serious nature in which compliance with both the letter and spirit of the House Officer Training Agreement has been lacking. It is the procedure by which a Resident can be terminated from employment with the Residency

Program. Typically dismissal is preceded by a verbal reprimand, written reprimand and/or academic probation. *In the setting of extreme concerns about compliance with both the letter and spirit of the House Officer Training Agreement, the PGY specific job description, or egregious wrongdoing on the part of the resident, the program director may go directly to dismissal.*

This procedure for dismissal and its appeal is outlined in the *Academic Probation and Dismissal Policy and Procedure* and the *Administrative Hearing of the Program Evaluation & Advisory Committee Policy and Procedure* document and involves input and resources from the Residency Program Director, the Denver Health Graduate Medical Education Committee, and the Program Evaluation & Advisory Committee (PEAC).

Denver Health
Residency In Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Academic Probation and Dismissal**

Last Revised: **2/2019**

POLICY: The Denver Health Residency in Emergency Medicine (DHREM) is committed to making an effort to help each Resident succeed in the Residency Program. The Residency Program Director is responsible for assuring that the Emergency Medicine Residents progress adequately in the residency program. Failure to make such progression or failing to comply with the letter and/or spirit of the House Officer Training Agreement can be grounds for placing a Resident on Academic Probation or Dismissal. The purpose of Academic Probation is to allow a period of time in which substandard performance can be addressed and evaluated. ***The decision to impose Academic Probation or Dismissal is to be made by the Residency Program Director.***

PROCEDURE: If a Resident fails to make adequate progress within the Residency Program due to unsatisfactory clinical skills, medical knowledge, performance in the ACGME six core competencies and achievement of milestones, performance of duties, ethical conduct, or other factors, including the failure to comply with the letter and/or spirit of the House Officer Training Agreement, the Residency Program Director has the option of placing the Resident on Academic Probation. That decision will not be made lightly, but will take into account the circumstances that have led to the failure to progress, the likely positive effect on the Resident of being placed on probation, and the effect of the Resident's difficulties on the entire Residency Program.

The Resident will be notified in person and by written notice of his or her Academic Probation and the terms that will apply. As soon as practical after the Resident has been placed on Academic Probation, the Denver Health Graduate Medical Education Committee (DHGMEC) and the DHMCREM Program Evaluation & Advisory Committee (PEAC) will be notified in writing of the probationary status and terms. Included in the notice to the Resident, DHGMEC and the DHMCREM PEAC will be:

1) The duration of Academic Probation
    a. The period of probation shall be at least one (1) month in duration, but shall not exceed twelve (12) months
2) The areas of unsatisfactory performance and concern;
3) The Terms of Probation
    a. A Resident may not graduate from the Program while on probation
    b. Probation may be extended, as provided for in this procedure

4) The consequences for failing to comply with the Terms of Probation (which may include, but is not limited to, dismissal from the Program).

The Terms of Academic Probation will be tailored to the particular circumstances. These terms may include, but are not limited to:

1) Required extra clinical duties (within the scope of the ACGME-RRC requirements);
1) Required academic work;
2) Required counseling, medical evaluation, or psychiatric evaluation;
3) Repetition of all or part of the curriculum.

While on Academic Probation, the resident may not engage in any outside clinical activity ("moonlighting"), with or without compensation. If the Resident engages in outside clinical activity while on Academic Probation, it shall be viewed as grounds for dismissal from the Program without further due process.

While on Academic Probation, the Resident will be assigned a Faculty Mentor (mutually agreeable to the Resident and the Residency Program Director). The assigned Faculty Mentor will not be the Residency Program Director. The Resident will work with the residency leadership, the Faculty Mentor, and the Porgram Director to develop a plan for improvement. The Resident will be required to meet at specified intervals with the Residency Program Director or designee to discuss the Resident's progress. The meetings should be at least monthly with the Faculty Mentor and at least every three (3) months with the Residency Program Director or designee. It shall be the obligation of the Resident on Academic Probation to schedule the meetings.

APPEALS PROCESS: Upon reading the terms of Academic Probation, the Resident may appeal and request an Administrative Hearing (the procedure for which is outlined in "Administrative Hearing of the Program Evaluation & Advisory Committee"). The request for an Administrative Hearing must be made to the Residency Program Director within fourteen (14) calendar days of the Notice of Probation. The date on the Notice of Probation shall be used when computing the fourteen (14) day request period. The purpose of the Administrative Hearing will be to review the grounds upon which the probation is based and the decision to implement probation by the Residency Program Director. The decision to implement probation may be reversed or the terms of probation may be modified or deleted after the appeals hearing.

At the conclusion of the Hearing, the terms and conditions shall be binding. If an Administrative Hearing is not requested or is not requested within fourteen (14) days of the Notice of Probation, the original terms and conditions as set by the Residency Program Director shall be binding. If other areas of concern become apparent after the initiation of Academic Probation, the Residency Program Director or the assigned Faculty Mentor will speak with the Resident on Academic Probation about those areas of concern. Thereafter, the Residency Program Director may add additional terms to the Terms of Probation.

If additional terms are to be added, the Resident on Academic Probation, the assigned Faculty Mentor, the DHGMEC, and the members of the Program Evaluation & Advisory Committee will be notified in writing as soon as practical by the Residency Program Director. Upon reading the additional terms of Academic Probation, the Resident may again request an Administrative Hearing (the procedure for which is outlined in "Administrative Hearing of the Program Advisory Committee"). The request for an Administrative Hearing must be made to the Residency Program Director within fourteen (14) calendar days of the notice of additional Terms of Probation. The date on the Notice of Additional Terms of Probation shall be used when computing the fourteen (14) day request period. The purpose of the Administrative Hearing will be to review the decision to implement additional Terms of Probation by the Residency Program Director only. The additional Terms of Probation may be modified or deleted.

At the conclusion of the hearing, the additional terms and conditions shall be binding as an amendment or amendments to the original Terms of Probation. If an Administrative Hearing is not requested or is not requested within fourteen (14) days of the notice of additional terms of probation, the additional terms and conditions set by the Residency Program Director shall also be binding.

RESOLUTION: At the end of the duration of probation, the Residency Program Director will meet with the Resident on Academic Probation and the assigned Faculty Mentor. If sufficient progress has been made to warrant the discontinuance of Academic Probation, the Residency Program Director shall remove the probationary status.

If the Resident has not made sufficient progress, Academic Probation may be extended for up to a duration not to exceed an additional six (6) months, or, if so decided, the Residency Program Director may consider dismissal of the Resident from the Residency Program without extension of Academic Probation. If progress has still been insufficient at any time during an extended Academic Probation period, the Residency Program Director may dismiss the Resident from the Residency Program.

If, at any time the Resident on Academic Probation fails to meet the Terms of Probation, the consequences for failing to comply will be imposed by the Residency Program Director. This could include further terms, extending the period of probation, or dismissal from the residency program all of which are subject to appropriate appeals processes. If the Residency Program Director decides to extend the duration of Academic Probation beyond that originally outlined in the Terms of Probation, Academic Probation may be extended for up to a duration not to exceed an additional six (6) months. If the stated consequence of violating the Terms of Probation is dismissal from the Program, the residency Program Director will follow the below stated procedure for dismissal.

During the time between an alleged probation violation and the appeals process, the Resident may be relieved of his or her clinical duties as an Emergency Medicine Resident at the discretion of the Residency Program Director if the behavior of the Resident on Academic Probation

is considered potentially dangerous to patients, other employees, or the public.

In accordance with the Colorado Medical Practice Act, the Board of Medical Examiners will be notified of any Resident who violates the provisions of the Colorado Medical Practice Act or who has not progressed satisfactorily in the program or who has been dismissed from the program for inadequate performance or ethical reasons.

DISMISSAL: ***The ultimate decision for dismissal is made by the Residency Program Director.*** Any decision for dismissal must be made by formal written notification to the Resident, DHREM PEAC and DHGMEC. This written notification must include both a description of the events leading up to the dismissal and the areas of unsatisfactory performance leading to the dismissal. Resident dismissal from the Residency Program, under these circumstances, will be automatically appealed to the Program Evaluation & Advisory Committee as outlined in the *Administrative Hearing Of the Program Advisory Committee Policy and Procedure* and subsequent appeals processes outlined in that said policy. The resident may waive this automatic appeal if he or she so chooses.

Denver Health
Residency In Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Resident Honor Council**

Last Revised: **2/2019**

POLICY: The Denver Health Residency in Emergency Medicine is committed to making an effort to select Resident Candidates with a high potential for success in the Residency Program. Further, the Denver Health Residency in Emergency Medicine is committed to making an effort to help each of those Residents succeed in the Residency Program. The Emergency Medicine Residents, in turn, are committed to applying themselves fully to the Program and to conducting themselves in the highest standards of behavior of the Denver Health Residency in Emergency Medicine Program. This Residency Honor Council Procedure is to be used in cases of a serious nature in which compliance with the letter and spirit of the House Officer Training Agreement has been lacking and the Resident's behavior has had a negative effect on the Residency Program itself and the other Emergency Medicine Residents.

PROCEDURE: The Residency Program Director of the Denver Health Residency in Emergency Medicine has the authority to convene an *ad hoc* Honor Council of the Emergency Medicine Residents whenever he or she believes that a Resident has violated both the letter and spirit of the House Officer Training Agreement in a serious manner and the Resident's behavior has had a negative effect on the Residency Program itself and the other Emergency Medicine Residents.

The Honor Council will be composed of two (2) Residents from each of the four classes selected by the Residency Program Director from volunteers. The Chair of the Council will be a Chief Emergency Medicine Resident, also selected by the Residency Program Director. The Honor Council will meet within thirty (30) days from the date that the members of the Honor Council are selected by the Residency Program Director. The Resident in question must be present at the meeting; it cannot be held *in abstentia*.

The Residency Program Director will inform the Council of the specific accusations and issues involved. The charge to the Council will be to make specific recommendations about disciplinary actions. These recommendations will be made in writing to the Residency Program Director.

In arriving at their recommendations, the Council may hear witnesses, examine evidence, and question the Resident. The Resident may present a defense. The Resident may present evidence and may call witnesses. There will be ample time allowed for questions of the Resident by the members of the Honor Council.

Except for the Resident, the members of the Honor Council, and the witnesses, the Council Meeting will be closed to any other parties, including the Residency Program Director. There shall be no outside representation allowed during the Honor Council Meeting.

Following the presentation of evidence and questions, the Resident and all witnesses will be excused while the Honor Council deliberates. The final decision of the Honor Council will be based on a majority vote. The Honor Council Chair is responsible for keeping the records of the Council. Audio or video tape recording shall not be allowed at the Honor Council Meeting. The Honor Council, through the Chair, shall submit its written recommendations to the Residency Program Director within seven (7) days of the Council Meeting.

Upon receiving the written recommendations of the Honor Council, the Residency Program Director may choose to incorporate some, all, or none of the recommendations into a program of discipline for the Resident in question. The program of discipline need not be limited to the recommendations of the Honor Council, however.

Denver Health
Residency In Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Administrative Hearing of the Program Evaluation & Advisory Committee**

Last Revised: **2/2019**

POLICY: This procedure is to be used in cases of a serious nature in which a Resident's compliance with both the letter and spirit of the House Officer Training Agreement has been lacking. It may also be used in cases in which there is a violation of the Terms of a Verbal or Written Reprimand or Academic Probation. It is the procedure by which a Resident can be dismissed from the Residency Program prior to the ending date of the House Officer Training Agreement.

PROCEDURE: An Administrative Hearing of the Program Evaluation & Advisory Committee will be convened if:

1) A resident placed on academic probation initiates an appeals process as outlined in the *Academic Probation and Dismissal Policy and Procedure.*
2) The Residency Program Director, as outlined in the *Academic Probation and Dismissal Policy and Procedure*, dismisses a resident from the residency program.
3) A resident action of wrongdoing is considered severe enough to warrant dismissal from the program by the residency program director without Academic Probation, as outlined in the *Disciplinary Action and Termination Policy and Procedure*.

If a resident decides to initiate an appeals process involving an Administrative Hearing, it must be made in compliance with the conditions outlined in the *Academic Probation and Dismissal Policy and Procedure*. All members of the Program Evaluation & Advisory Committee, the Associate and Assistant Residency Directors, and the Resident in question will be notified in writing (electronic or paper) of the time and place of the meeting by the Residency Program Director

If the Residency Program Director decides to convene an Administrative Hearing of the Program Evaluation & Advisory Committee due to dismissal of a Resident, all members of the Program Evaluation & Advisory Committee, the Associate and Assistant Residency Directors, and the Resident in question will be notified in writing (electronic or paper) of the time and place of the meeting.

In advance of the meeting, the Resident will be provided with copies of written allegations, a description of the information possessed by the Residency Program Director to be used in the Administrative Hearing, and a list of witnesses who may be called to give testimony against the

Resident. The written notice of the Administrative Hearing of the Program Evaluation & Advisory Committee shall be sent at least (fourteen) 14 calendar days in advance of the actual meeting date. The postmark on the notice shall be used in calculating the time interval. Not less than seven (7) days in advance of the date of the scheduled Administrative Hearing of the Program Evaluation & Advisory Committee, the Resident in question must submit to the Residency Program Director a description of the information that the Resident intends to present in his or her defense, including a complete list of the witnesses that he or she intends to call.

A majority of voting members of the Program Evaluation & Advisory Committee are necessary to hold the Administrative Hearing. The Resident in question must be present at the meeting; it cannot be held *in abstentia.*

The voting members of the Program Evaluation & Advisory Committee present at the Administrative Hearing shall select their Chair. The Chair may not be the Residency Program Director. The Chair shall keep minutes and shall be responsible for the Hearing proceedings. The Residency Program Director will present the case against the Resident. As part of that presentation, the Residency Program Director may present information and call witnesses.

Following the Residency Program Director's presentation, the Resident may present a defense. The Resident may present information and may call witnesses. There will be ample time allowed for questions of the Resident by the members of the Program Evaluation & Advisory Committee.

Except for the Resident, the members of the Program Evaluation & Advisory Committee, the Residency Program Director, the Associate and Assistant Residency Program Directors, the academic faculty, and the witnesses, the Administrative Hearing will be closed to any other parties. There shall be no outside representation by either the Residency Program Director or the Resident. Audio and/or video recording of the Administrative Hearing will not be allowed.

The Administrative Hearing will not apply technical exclusionary rules of evidence followed in judicial proceedings nor entertain technical legal motions. Technical legal rules pertaining to the wording of questions, hearsay and opinion evidence will not be legalistically applied. Reasonable rules of relevancy will guide the committee in listening to the presentation. Postponement, recession, and adjournment of the Administrative Hearing shall be at the discretion of the Chair. Following the presentations of information by the Residency Program Director and the Resident, the Resident, the Residency Program Director, and all witnesses will be excused while the Program Evaluation & Advisory Committee deliberates.

The decision of the Program Evaluation & Advisory Committee will be based on a majority vote of the voting members of the committee present at the Administrative Hearing. The Residency Program Director and the

Resident will be notified in writing of the Committee's decision within ten (10) calendar days of the Administrative Hearing by the Chair.

APPEALS PROCESS: After receiving the decision of the Program Evaluation & Advisory Committee from the Chair of the Administrative Hearing, the Resident or the Residency Program Director may appeal that decision. In order to request an appeal, the Resident or the Residency Program Director must make their request in writing to the Chair of the DHMC Graduate Medical Education Committee (DHGMEC) within ten (10) calendar days of the date that the decision of the Administrative Hearing is issued by the Chair of the Administrative Hearing. If the Resident or the Residency Program Director does not make a request for appeal within the time period allotted, the decision of the Program Evaluation & Advisory Committee Administrative Hearing will become binding.

As soon as practical after receipt of the Resident's request for an appeal, the Residency Program Director will notify the Chair of the Denver Health Medical Center's Graduate Medical Education Committee (DHGMEC). The Chair of the GMEC will convene a meeting of the committee within thirty (30) calendar days to consider the Resident's appeal. The Denver Health Medical Center's General Counsel (or designee) may be invited by the Chair to attend that meeting.

The purpose of the GMEC meeting will be to review the process of the Program Evaluation & Advisory Committee. This will not constitute another Administrative Hearing; new arguments will not be entertained nor will new information be considered. The GMEC will be provided with a summary of the evidence, conclusions, and recommendations of the Program Evaluation & Advisory Committee by the Chair of the Administrative Hearing.

Within ten (10) calendar days of the meeting of the Graduate Medical Education Committee, the Chair of the GMEC will prepare a recommendation to the Chief Education Officer of the Denver Health Medical Center. This recommendation will be to either uphold the decision of the Administrative Hearing or to reverse it. The Chief Education Officer of the Denver Health Medical Center will then issue a final decision in writing to the Resident, the Residency Program Director, the Chair of the Administrative Hearing, and the Chair of the Graduate Medical Education Committee within thirty (30) calendar days of receiving the recommendation from the Graduate Medical Education Committee Chair. The decision of the Chief Education Officer will be binding.

Denver Health Medical Center
Residency in Emergency Medicine

Document Type: **Policies and Procedures**

Regarding: **Program Evaluation & Advisory Committee**

Last Revised: **2/2019**

The Program Evaluation and Advisory Committee will be appointed by the Program Director and will actively help the Program Leadership in the evaluation and development of plans for improvement of the residency curriculum.

Responsibilities Include:

- participate in planning, developing, implementing and evaluating educational activities of the program
- review and make recommendations for revision of competency-based curriculum goals and objectives
- work with the Program Leadership to address areas of non-compliance with ACGME standards
- review the program annually using evaluations of faculty, residents, and others
- document formal, systematic evaluation of the curriculum at least annually
- render a written and annual program evaluation
- prepare a written plan of action to document initiatives to improve performance in one or more areas, delineate how they will be measured and monitored. This plan will be reviewed and approved by the teaching faculty and documented in meeting minutes.

The committee will meet at a minimum 3 times a year. The committee will serve as an advisory body to the Program Director.The Program Director will make final decisions after taking into consideration the recommendations of the committee. If a vote on a recommendation is needed only the members of the committee will be allowed to vote.

Committee Member Plan

Hospital	Total EM1	Total EM2	Total EM3	Total EM4	Total FTE
DH	10.2	6.3	5.6	11.1	33.2
University	6.6	8.4	7.8	2.5	25.3
Children’s	0	1.1	2.4	0.3	3.8
Kaiser	0.2	1.2	1.2	4.1	6.7
Total	17	17	17	18	69

DH - 33.2/69 = .48 = 5
UH - 25.3/69 = .37 = 4
Children’s 3.8/69 = .05 = 1
Kaiser - 6.7/69 = .1 = 1
Residents - 4 chief residents

The Program Leadership will invite faculty and chief residents to serve on the Program Evaluation and Advisory Committee. The Program Director in consultation with the other members of the program leadership team will appoint members to the committee. Members will have to be able to perform the responsibilities listed above and have to be able to attend 3 yearly meetings. Members will serve a minimum of a 2 year term. The Program Director will be the Chair of the Committee and all members of the Program Leadership Team will be on the committee.

Denver Health
Residency in Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Clinical Competency Committee**

Last Revised: **2/2017**

POLICY: Per the ACGME:

The program director must appoint the Clinical Competency Committee. (Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

V.A.1.a).(1) Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. (Detail)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee(Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all resident evaluations semi-annually; (Core)

V.A.1.b).(1).(b) prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)

V.A.1.b).(1).(c) advise the program director regarding resident progress, including promotion, remediation, and dismissal.

PROCEDURE: Given the size of the Denver Health Residency in Emergency Medicine, the program will have 4 clinical competency committees based on class year. Each clinical competency committee will be chaired by the APD in charge of that class year. The Program Director will solicit interest in participation on the clinical competency committee and give final approval on all members of the 4 committees. Possible members of the clinical competency committees will include Emergency Medicine Faculty from

each of the 4 hospitals having resident rotations, off-service faculty, and nurses. The Program Director will participate on all 4 Clinical Competency Committees.

RESPONSIBILITIES: Members of the clinical competency committee will review all evaluations of the class assigned to them. Each member will be assigned to fully review the evaluations of 3 to 4 residents. After individual reviews the clinical competency committee will meet to further discuss the evaluations. The committees will provide a formative summative evaluation for each resident based on milestones. The clinical competency committees are expected to meet at a minimum 2 times a year to create the final report that will be submitted to the Program Director. This report will include both the summative evaluation based on milestones as well as advise on resident promotion, remediation or dismissal. The reports are due to the Program Director semi-annually before the Program Evaluation & Advisory Committee Meeting. Any issues will be discussed during the Program Evaluation & Advisory Committee Meeting.

Denver Health
Residency In Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Duty Hours**

Last Revised: **2/2019**

Scope: The ACGME and RRC-EM have published enforced requirements on resident work hours. This document is designed to reiterate those duty hour regulations and confirm that DHREM is in full support of meeting the spirit and letter of their implementation.

Work Hour Requirements as stated by the ACGME-RRC-EM:

Work hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences.Work hours do not include reading and preparation time spent away from the duty site.

Emergency medicine rotations

a. As a minimum, residents shall be allowed an average of 1 full day in 7 days away from the institution and free of any clinical or academic responsibilities, including planned educational experiences.

b. While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. There must be at least an equivalent period of continuous time off between scheduled work periods.
c. A resident should not work more than 60 scheduled hours per week seeing patients in the emergency department and no more than 72 duty hours per week. Duty hours comprise all clinical duty time and conferences, whether spent within or outside the educational program, including all on-call hours.

Non-Emergency Department Rotations

a. For rotations on other services, duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

b. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

c. Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period

provided between all daily duty periods and after in-house call.

Additional ACGME published Guidelines on Emergency Medicine Duty Hours

Duty Hours on Emergency Medicine Rotations

"There must at least an equivalent period of continuous time off between scheduled work periods. Residents may attend educational activities between work periods, but at some point in the 24 hour period must have an equivalent period of continuous time off between the end of one activity (work or educational) and the start of another activity (work or educational)."

Examples:

Example 1: A resident works the 7:00pm to 7:00am night shift in the Emergency Department (ED) on Tuesday night. Conference is scheduled the next morning (Wednesday) from 8:00am to Noon. The resident is scheduled to work the night shift (7:00pm to 7:00am) again on Wednesday night. The resident would not be able to attend any of the conference because he needs at least an equivalent period (12 hours) of continuous time off. (Ideally, the resident should not work the night shift on Tuesday night, so he can attend conference).

Example 2: A resident works the 11:00pm to 7:00am shift in the ED on Tuesday night. Conference is the next morning (Wednesday) from 8:00am until 1:00pm. The resident is scheduled to work another night shift (11:00pm to 7:00am) the next night (Wednesday). The resident can be required to attend conference, because he has an equivalent period of time off (ie, 8 hours) between the end of conference (ie, 1:00pm) and the start of his next ED work shift (ie, 11:00pm); ie, a total of 10 hours off. (Ideally, the resident should not work the night shift on Tuesday night, so he can get more out of conferences).

Example 3: A resident works the 7:00am to 3:00pm shift in the ED. That evening, Journal Club is scheduled from 6:00pm to 9:00pm. The resident is scheduled to work the day shift (7:00am to 3:00pm) again the next morning. The resident can be required to attend Journal Club, as he will have an equal or greater amount of time off than the scheduled shift (ie, the ED shift was 8 hours and the continuous time off is 10h).

Example 4: A resident works an 11:00pm to 7:00am shift in the ED on Tuesday night. Conference the next day (Wednesday) is scheduled from 10:00am to 3:00pm. The resident is scheduled to work the night shift (11:00pm to 7:00pm) again that night (Wednesday). The resident can be required to attend conference because he will have eight hours off between the end of conference (ie, 3:00pm) and the start of the next ED work shift (ie, 11:00pm). (Ideally, the resident should not work the night

shift on Tuesday, so he will get more out of conference).

Example 5: A resident works the 6:00pm to 2:00am shift in the ED on Tuesday evening. Conference the next day (Wednesday) is scheduled from 10:00am to 3:00pm. The resident is scheduled to work the same 6:00pm to 2:00am shift again on Wednesday evening. The resident can be required to attend conference because he had eight hours of continuous time off between the end of the Tuesday evening shift (ie, 2:00am) and the start of conference (ie, 10:00am).

Procedures for Violations:
The Denver Health Residency Program in Emergency Medicine considers it a critical and important portion of appropriate educational practice to achieve and maintain compliance with the resident work hour regulations for the Emergency Medicine RRC. DHREM affirms we have a zero-tolerance policy when it comes to duty hour violations and abides by all duty hour requirements as stated in the 2011 ACGME Duty Hour document, http://www.acgme.org/acwebsite/home/Common_Program_Requirements_07012011.pdf. Furthermore, DHREM will continue to set a culture of compliance, transparency and honesty when it comes to monitoring and tracking duty hours. Residents are encouraged to accurately report duty hours without fear of retaliation or intimidation. The DHREM Leadership feels strongly about this point and takes steps to ensure compliance exists through a positive, pro-active environment. The Residency leadership, defined as the Program Director and Associate Program Directors will regularly monitor resident duty hours for compliance with the institutional duty hour limitations and RRC regulations by the use of weekly reporting and the review of data. The following policy outlines the procedures that are used in evaluation and response to duty hour issues.

1. The Program will collect and maintain a file containing all of the individual rotation policies concerning resident duty hours.

2. Weekly reporting is the standard at DHREM. Residents report their duty hours weekly on MedHub. All non-compliant responses are followed by an e-mail or a call to the resident to better delineate and understand the reasons for non-compliance. This information will be reviewed by the Residency Leadership for discussion of specific rotation concerns. No resident rotation will be exempted from having to track this information without the explicit consent of the Program.

3. The Program Leadership will review issues of alleged duty hour noncompliance; in each instance, a violation and assessment plan sheet will be filled out (see attachment A). Input from the rotation director will be requested to investigate and remediate the alleged duty hour violation. Action plans from individual rotations concerning individual rotations or residents that are not in compliance with RRC and institution regulations will be documented on the violation and assessment plan sheet.

4. Any individual (resident or faculty) aware of a violation of the policy mandating that interns work no more than 16 hours and PGY 2's work no more than 24 continuous hours with a 4 hour period to transition care (i.e. 28 hours of continuous service) must report the instance to the Program Director immediately. Failure to do so will be considered a breach of professionalism and may result in disciplinary action.

5. Residents may use the department's ombudsman, the chief residents, residency leadership, individual attendings, the RRC resident survey, an additional Annual Program Assessment Survey sent by the DHREM, and MedHub as reporting mechanisms for duty hour

violations. Upon notice of such reporting through a) direct faculty or chief contact, b) a report through an RRC resident survey, or c) a report to the institution from the ombudsman, The Program Leadership will conduct a focus group session with the residents participating in the specific rotation to assess not only compliance with the resident duty hour regulations but also to assess educational aspects, resident fatigue/stress and quality of life issues.

6. Additionally, residents are encouraged to report directly to the Residency Leadership when they are at risk of non-compliance so that the Residency Leadership can pro-actively work on plan to prevent the resident from going over duty hours.

Denver Health
Residency In Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Elective Time**

Last Revised: **2/2019**

Policy: **The Denver Health Residency in Emergency Medicine provides residents with individualized elective time during residency to explore areas of interest within Emergency Medicine. Electives must be linked to the Practice of Emergency Medicine and approved by the Residency Program Director or a Class Specific Associate Program Director.**

Elective Time Allotment:

All residents will be granted 14 weeks total of elective time.

In general, residents with prior specialty training will be granted 2 weeks of extra elective time for each year of prior residency after internship, to a maximum of 6 extra weeks of elective time.

Residents who have completed an obstetrical internship will also be granted two additional weeks of elective if they do not wish to rotate on OB as a senior.

Any prior medical residency training must be relevant to the emergency medicine curriculum as deemed by the program director and approved by ABEM in order to receive additional elective time.

Any additional elective time will ONLY be granted if the schedule allows AND all contractual obligations with off-service rotations are met.

Residents graduating early due to prior training will not be granted additional elective time.

Scheduling / Duty Hours:

Elective time blocks are to be scheduled as seen appropriate by the chief emergency medicine residents with the approval of the residency director.

Elective time is built into the curriculum of the EM2, EM3 and EM4 schedule.

For non-templated electives, residents must provide a written work schedule for their elective time with a minimum of 40 hours per week devoted to the effort, not including travel time for out-of state electives.

Work hours for any elective time may not be in violation of the ACGME duty hour regulations.

Justifications:

Educational justification and how it pertains to residency training must be made (in writing if requested) and approved by the residency director *prior* to the start of all elective time.

Justification for off-site elective time over on-site elective time must be made (in writing if requested) and approved by the residency director prior to the start of any elective time.

Sponsoring Personnel / Evaluations /Elective Summary:

Residents must fill out an elective form with the proposed elective and how it relates to the Practice of Emergency Medicine and e-mail the form to the Program Director or Class Specific Associate Program Director and the Program Coordinator **one month prior to in town electives and 6 months prior to out of state electives**.

Residents must have a sponsoring attending physician willing to accept responsibility for any clinical duties during all clinical electives. The role of the sponsoring attending must be approved by the residency director prior to the start of the elective time.

Residents must have a sponsoring administrator willing to accept responsibility for any administrative duties during all administrative electives. The role of the sponsoring administrator must be approved by the residency director prior to the start of the elective time.

The form needs to be signed by the Program Director or Class Specific Associate Program Director indicating the elective is approved before the resident can be involved in the elective. This will allow the residency program to help the resident with any potential road blocks to setting up the elective.

The resident will receive the signed form and an evaluation form to be filled by the faculty supervising the elective.

The sponsoring attending/administrator must provide an acceptable evaluation of the resident's activities while on the elective attesting to the resident's satisfactory completion of the elective specifically in relation to the ACGME core competencies.

The evaluation form needs to be turned into the Program Coordinator to obtain credit for the elective.

For non-templated electives, the resident must provide a summary of the rotation and experience in writing to the program director or class specific associate program director within 2 weeks of completion of their elective.

If a resident is interested in obtaining credit for conferences attended while on an out of town elective the following components must be turned into the Program Coordinator: conference attendance sheet for the conference attended, an evaluation of the conference attended, an evaluation of the resident and their participation in the conference. The evaluation of the resident and their participation in the conference can also be part of the completed evaluation of the resident on the rotation.

Failure to comply with the above process may lead to an inability to participate in specific electives or failure to receive credit for an elective that a resident may have already participated in.

Malpractice Coverage:

Residents performing any clinical duties on elective time must have adequate malpractice insurance coverage arranged ***PRIOR*** to any elective time.

Often arrangements may be made with the residency director and DHMC's Legal Department for this malpractice insurance coverage, but there is no guaranteed obligation on the part of the residency program or the hospital to grant such coverage.

Concomitant Obligations:

Sick-call obligation (as outlined in the sick call policy) may be required during elective time as seen needed by the scheduling chief emergency medicine residents.

Special clinical coverage for residency-sponsored activities may be required during elective time as seen needed by the scheduling chief residents.

Monetary Support for Electives:

As electives are part of the residency curriculum, residents will receive their usual salary while on elective. If residents are on elective requiring travel or other housing, the residents are responsible to pay their own expenses.

Disclaimer:

This policy supersedes all previous Denver Health Residency in Emergency Medicine policies solely pertaining to elective time. Denver Health and Hospital policies or procedures supersede all

residency program policies if conflicts occur. Conflicts with any other residency program policy are to be resolved and decided upon by the residency director.

Denver Health
Residency In Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Leave of Absence**

Last Revised: **2/2019**

Scope: All residents of DHREM are employees of DHHA. As such any Leave of Absence falls under the most up to date Policies and Procedures document of DHHA. This document is designed to reiterate and confirm that DHREM is in full support of meeting the spirit and letter of this policy. The following document is the most recent DHHA policy:

Supersedes: **1/15/98, 4/26/99, 7/26/99, 2/2000, 1/25/01, 7/8/02**

Effective Date: **11/27/02**

Chapter: **Benefits**

Subject: **Leave of Absence**

<u>Principle</u>:

As approved, part-time and full-time regular employees may absent themselves from duty via a leave of absence; thus, Denver Health hopes to retain the services of an experienced employee. As such, Denver Health recognizes five categories of leave of absence: Personal leave, Educational leave, Family/Medical leave, Colorado Domestic Violence Leave and Military leave. State and federal laws may supersede the content of this Principle. Personal leave and educational leave are granted at the discretion of the organization.

<u>Practice</u>:

PERSONAL LEAVE

1. Personal leaves may be granted in the unusual circumstance where an employee has no PTO available and is not able to resolve his or her particular situation in any other fashion. If Family Medical leave is applicable, it must be used rather than Personal leave or Military leave. Any and all PTO must be used prior to granting a Personal leave of absence.

2. To request a Personal leave of absence, an employee must have been employed by Denver Health for 90 calendar days, the employee must indicate that he or she will return to work at the conclusion of the leave, have no disciplinary actions

at the level of suspension, and must have a "pass" on his or her most recent performance evaluation.

3. All Personal leaves are unpaid. Personal leaves will be granted for a period not to exceed 90 days.

4. All requests for Personal leave will be initiated no later than 14 days prior to the beginning of the leave and must be approved by the employee's supervisor, the Department Manager, and the Chief of Employee Services. When determining whether to approve a Personal leave, the immediate supervisor and Department Manager should consider:
   - whether the employee will, in fact, be able to return to work;
   - how much time off or additional time off is <u>actually</u> needed or has been certified by the physician;
   - the purpose or reason giving rise to the need for time off;
   - the number of other open positions of the same title/function in the department and the ease or difficulty in filling them;
   - the employee's past performance, disciplinary record, attendance/punctuality history;
   - the effect it will have on the department if the employee is granted a personal leave; and
   - past practice in the department.

5. While on Personal leave, the employee will be responsible for assuming the full cost of all of his or her insurance premiums. This cost includes both the employee's cost and the employer's portion. Employees may continue to pay for their health, dental, basic life/AD&D, STD, LTD; and they will not be placed on COBRA while on personal leave. If insurance premiums are not paid while the employee is on a personal leave, coverage will be dropped and the employee may not re-enroll until the earlier of 1) Open Enrollment or 2) a "Qualifying Event".*

6. While an employee is on a Personal leave, Denver Health will attempt to ensure that the employee's position is kept open. However, operational requirements take priority and the employee's position is not guaranteed. If it is found that the position must be filled, the supervisor will attempt to notify the employee by phone or by mail and will give the employee five days to return to work. If the employee is unable to return to work, or does not contact the supervisor, the position will then be filled.

7. Employees who enter into an employment relationship with any other employer or into self-employment while they are on an approved leave of absence will be considered to have voluntarily resigned. Employees who do not return from an approved leave of absence within 3 days of the return date will be considered to have voluntarily resigned.

EDUCATIONAL LEAVE

This leave may be granted only if the education pursued is in a field that would directly benefit Denver Health. Employees studying a curriculum leading to degrees in any licensed health care profession would warrant consideration for this type of leave of absence. The maximum duration of this leave is two years.

1. To request an Educational leave, an employee must have been employed by Denver Health for at least one year, have indicated that he/she will return to work, have no disciplinary actions at the level of suspension, and must have a "pass" on his or her most recent performance evaluation.

2. All Educational leaves are unpaid, except that an employee can request any accrued PTO time be paid while on leave. Any unpaid time off will not accrue additional PTO time.

3. For consideration, all requests for Educational leave must be requested no later than 14 days prior to the beginning of the leave and must be approved by the employee's supervisor, the Department Manager, and the Chief of Employee Services.

4. While on Educational leave, the employee is responsible for assuming the full cost of all of his or her insurance premiums. This cost includes both the employee's cost and the employer's portion. Employees may continue to pay for their health, dental, basic life/AD&D, STD, LTD; and they will not be placed on COBRA while on Educational leave. If insurance premiums are not paid while the employee is on an Educational leave, coverage will be dropped and the employee may not re-enroll until the earlier of:
   1) Open enrollment, each Fall
   2) A Qualifying Event*

5. While an employee is on an Educational leave, Denver Health will attempt to ensure that the employee's position is kept open. However, mission requirements take priority and the employee's position is not guaranteed. If it is found that the position must be filled, the supervisor will attempt to notify the employee by phone or by mail and will give the employee five days to return to work. If the employee is unable to return to work, or does not contact the supervisor, the position will then be filled.

6. Employees who enter into an employment relationship with any other employer or into self employment while they are on an approved leave of absence will be considered to have voluntarily resigned. Employees who do not return from an approved leave of absence within 3 days of their indicated return will be considered to have voluntarily resigned.

MILITARY LEAVE

1. The completion of 90 calendar days of employment and other requirements normally attached to a Leave of Absence are waived for Military leave. This leave is granted automatically only to those employees who leave Denver Health to enter a recognized branch of the military forces for the United States for active military duty.

2. It is requested that as much notice as feasible is given of a Military leave. A copy of orders assigning the individual to Active Duty should be provided prior to the beginning of the leave. If this is not feasible, then the orders must be provided by the end of the leave.

3. The maximum duration for military leave is a five year cumulative leave with certain exceptions. These exceptions include 1) inability, through no fault of the employee, to obtain orders releasing him/her from service; 2) required drills and

annual training and other training certified by the military to be necessary for professional development; 3) service provided during wars or other emergencies, contingencies, or military requirements.

4. To activate their re-employment rights, employees must provide documentation and proof of Active Duty for the entire time that they were on leave. If an employee is activated for a period of less than 91 days, then the employee will be reinstated to the same position held at the time of the Leave of Absence was granted. If the period of activation is 91 days or more, the employee will be reinstated to a position of "like seniority, status and pay", the duties of which the employee is qualified to perform. This pay, status and seniority will be what the employee would have attained had he/she not taken the leave. To be eligible for these re-employment rights, the employee must: 1) not have exceeded the five year cumulative limit on periods of service; 2) have been released from service under "honorable conditions" and 3) report back to his or her civilian job in a timely manner or submit a timely application for re-employment.

5. Absence due to Reserve or National Guard duty should be documented on an approved Leave of Absence request and will always be approved. Failure to report to work because of Reserve/National Guard obligations without notifying the supervisor shall result in termination and loss of re-employment rights.

6. Employees will not be required to use PTO time during a Military leave of absence. If the employee chooses to use PTO time, he or she should document such time on his or her timesheet. PTO does not accrue on any portion of the Leave of Absence which is unpaid by Denver Health.

7. If a Military Leave of Absence is 31 days or less, Denver Health will maintain the employee's benefits. Employees will be responsible for paying the portion of their benefits that they would normally pay. If the Leave of Absence is greater than 31 days, employees will assume payment for both their portion of their benefits and the employer contribution which Denver Health will normally make on their behalf. If employees allow their benefits to lapse while on Military leave, their benefits will be immediately reinstated upon their return.

8. If an employee is in unpaid military training of a temporary nature, then up to fifteen days of pay at 8 hours each day will be paid to the employee. If the training is paid, then the difference between the total amount of pay and the employee's Denver Health pay will be paid by Denver Health provided the military training pay is less than the employee's Denver Health pay.

   Examples of types of pay which would be included in your military pay include, but are not limited to, base pay, allowances for housing and subsistence, flight pay, hazard pay, jump pay, and combat pay. Only travel and per diem are excluded from your total military pay.

9. Employees re-employed by Denver Health following a Military Leave of Absence may not be discharged for a certain period of time except "for cause". If the period of active duty was from 31-180 days, the employee may not be discharged for 180 days following return. If the period of active duty was greater than 180 days, the period of protection is for one year following return.

FAMILY / MEDICAL LEAVE

1. The Family/Medical Leave Act requires certain employers to provide up to 12 weeks of unpaid, job protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible to request "FMLA" if they have worked for Denver Health for at least one year and for at least 1,250 hours over the previous 12 months.

2. Family/Medical Leave may be granted for any of the following reasons:
    - Care of the employee's child after birth, or placement for adoption or foster care;
    - Care for the employee's spouse, same sex domestic partner, son or daughter, or parent, who has a serious health condition;
    - For a serious health condition that makes the employee unable to perform the employee's job.

3. Procedures for taking Family/Medical Leave
    - Any employee requesting Family/Medical Leave should initiate the request for FML at least 14 days prior to the event, if possible, by contacting his or her supervisor.
    - The supervisor will initiate the paperwork by submitting a completed "Family/Medical Leave Request" form to the Benefits Department.
    - The Benefits Department will send the employee a letter outlining his or her rights under the Family Medical Leave Act and will send any supporting documentation required such as a "Health Care Provider Certification". A copy of the letter will be sent to the supervisor.
    - The employee will be given 21 days from the date of postmark of the letter to return required information, such as the "Health Care Provider Certification" to the Benefits Department. Copies of this documentation cannot be requested by and should not be given to the employee's supervisor as it may contain confidential medical information. The employee should notify the Benefits Department immediately if he or she encounters any problems obtaining the necessary information prior to the end of the 21-day period.
    - When the required documentation is received from the employee, the Benefits Department will issue a letter of approval or denial of Family/Medical Leave based on the information received or a letter of request for additional information. A copy of this letter will be given to the employee's supervisor.
    - If there are changes to the circumstances of the leave, the employee should notify the supervisor and the Benefits Department.
    - Once the employee is ready to return to work, he or she must take his or her "Health Care Provider" release to Occupational Health, get a release from Occupational Health, and provide his or her supervisor with that release.
    - It is the employee's responsibility to insure that all required paperwork is submitted to the Benefits Department within the 21-day time frame. No reminders or extensions will be granted unless the employee notifies the Benefits Department of a problem prior to the end of the 21-day period.
    - Failure to submit the required information to the Benefits Department within the 21-day period will result in the denial of employee's request for FML. Once a request for FML is denied, the employee is subject to the terms of the absenteeism policy, PP#4-122, and the employee cannot reapply for Family/Medical Leave for the same time period.

4. Family/Medical Leave is unpaid, however, if the employee has PTO time accrued, any PTO available must be used during the FML. For intermittent leaves, the use of PTO as available will be required. For former CSA employees, accrued sick leave, PTO, combined with Short Term Disability (if applicable) will not exceed 100% of the employee's pre-FML regular earnings.

5. Group benefits will be maintained for employees while they are on Family Medical Leave. However, it is the employee's responsibility to maintain his or her portion of the premium for any leave time that is unpaid. For any time out that is paid, the employee's portion of his or her benefits will be taken by payroll deduction as if the employee is actively at work. For any unpaid leave, the employee will be responsible for ensuring that the payment is sent to the appropriate location.

1. Employees who enter into an employment relationship with any other employer or into self-employment while they are on an approved leave of absence will be considered to have voluntarily resigned. Employees who do not return from an approved leave of absence within 3 days of their indicated return will be considered to have voluntarily resigned.

COLORADO DOMESTIC VIOLENCE LEAVE

1. In compliance with the Colorado Domestic Violence law, Denver Health will grant eligible employees who are victims of domestic violence, and/or stalking and/or sexual assault up to three days of leave to obtain a restraining order, to obtain medical care or counseling, to locate safe housing or to prepare for and/or attend legal proceedings.

2. Specifically, leave will be granted to eligible employees for the following:

   a. To obtain a restraining order to prevent domestic abuse, stalking or sexual assault;
   b. To obtain medical care and/or mental health counseling either for him/herself or his/her children for physical and/or mental injuries resulting from domestic abuse, stalking or sexual assault;
   c. To make his/her home secure from the abuser;
   d. To seek alternate housing to escape from the abuser;
   e. To seek legal assistance in relation to the abuse, stalking or sexual assault; and,
   f. To attend and/or prepare for court related proceedings in relation to the abuse, stalking or sexual assault.

3. Eligible employees must use any and all PTO, and/or other leave available before seeking a Colorado Domestic Violence Leave of Absence.

4. Except in cases where the Denver Health employee is in imminent danger to his/her health and/or safety, employees are required to provide their manager/supervisor with appropriate advance notice, and provide any documentation/information that may support their need for this leave, as required by Denver Health or its management.

5. Managers, supervisors and any other Denver Health employee privy to the information regarding the request for, or grating of, a Colorado Domestic Violence Leave of Absence are mandated to keep all information and documents relative to the request for leave and the actual granting of the leave strictly confidential.

***QUALIFYING EVENT**

a. marriage, divorce, death of a spouse/partner

b. birth or adoption of a child
c. your child ages out of the plan
d. spouse/partner gains or loses benefits
e. increase/decrease in hours worked

If you have a qualifying event, you have 31 days from the date of that event to make changes.

DENVER HEALTH
REQUEST FOR LEAVE OF ABSENCE

I have read and understand Employee Principle and Practice #5-106 and herein request a leave of absence in compliance with the leave of absence policy.

I understand it is my responsibility to contact Employee Services and Resources Department for information relative to benefits.

EMPLOYEE NAME:______________________________DEPARTMENT ________________________

SUPERVISOR'S NAME:___________________________MAIL CODE___________________________

TYPE OF LEAVE REQUESTED ___PERSONAL ___ MILITARY ___EDUCATION

**FOR FAMILY/MEDICAL LEAVE PLEASE USE FMLA REQUEST FORM

DESCRIBE CIRCUMSTANCES

DATE LEAVE BEGINS __/__/__ DATE LEAVE ENDS __/__/__

DATE OF RETURN TO WORK __/__/__

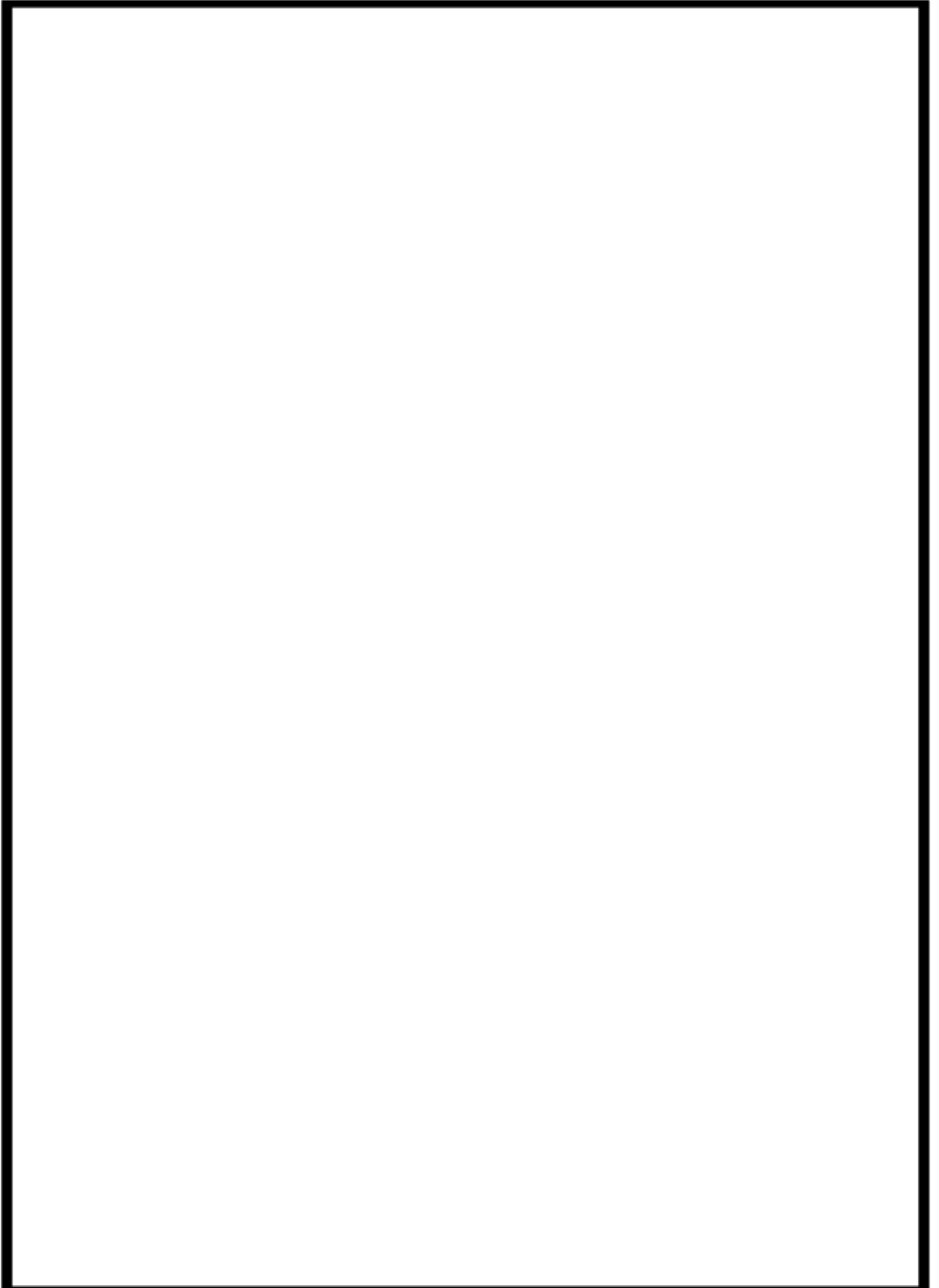
APPROVALS:

____________________________ ___/___/___
Employee's Supervisor Date

____________________________ ___/___/___
Department Manager Date

____________________________ ___/___/___
Chief, Employee Services and Resources Date

***OFFICIAL ORDERS SHOULD ACCOMPANY REQUEST FOR MILITARY LOA**



Family Medical Leave Request Form

Per DHHA Principle & Practice #5-106 and the Family and Medical Leave Act of 1993, eligible employees may take up to 12 weeks of unpaid job-protected leave for certain family and medical reasons. Family/Medical Leave is unpaid, however, if the employee has PTO time accrued, any PTO available must be used during the FML. Family/Medical Leave must be taken concurrently with PTO, if accrued, and may be taken concurrently with short-term disability, worker's compensation, or other applicable paid time off.

Date ___________________

Employee's Name ____________________________ Hire Date ___________

Employee's Social Security Number _____________________

Employee's Street Address ____

City, State, Zip ____

FTE Status (40 hours per week = 1.0, 36 hours per week = .9, etc.) ____________

Does employee work for C☐ or for DHH☐ (Please check one.)

Number of hours worked in last 12 months _______________

FML Begin Date ______________ Anticipated Return Date________________

Reason (or assumed reason) for leave (Please check one):

☐ Employee's own condition. ☐ Adoption or placement of a child

☐ Birth of a child. ☐ Worker's Compensation

☐ To care for a family member. Relationship _____________________

Supervisor's Name ______________________________ Mail Code _________

Supervisor's Signature ___________________________ Phone ____________

Person Completing This Form ______________________ Title _____________

Employee Signature (if possible) ___________________ Date ____________

Return this form to the Benefits Department at MC 1918 or FAX to 303-436-3349.

If you have any questions on how to complete this form, or about Family/Medical Leave, please call the Benefits Department at 303-436-5169.

DENVER HEALTH MEDICAL CENTER
RESIDENCY IN EMERGENCY MEDICINE

MATERNITY LEAVE POLICY

Last Revision: 2/2017

Residents in the Denver Health Medical Center Residency in Emergency Medicine are considered employees of Denver Health Medical Center. As such, they are governed by the same policies and procedures as all other Denver Health employees. Policies and paperwork required for Family Medical Leave can be found on The Pulse. These forms need to be downloaded and completed by residents requesting maternity leave. To access these forms go to Employee Services on The Pulse and then click on FMLA and Leave.

Maternity Leave Pay Diagram:
Short Term Disability:
5 weeks paid for vaginal delivery
7 weeks paid for C-section

Residency Leave and Completion:
From the standpoint of residency completion and extention of training, one year of Residency Training is defined as 46 weeks. For our program, one year is 49 weeks not including vacations. Therefore, if a resident is pregnant we can obsolve 3 weeks in their training and still be in compliance with ACGME rules. These 3 weeks will come out of elective time and reading week.

Examples of Leave time and program extension time:
12 weeks maternity leave = extend training by 9 weeks (12 weeks – 3 weeks)
8 weeks maternity leave = extend training by 5 weeks (8 weeks – 3 weeks)
4 weeks maternity leave = extend training by 1 week (4 weeks – 1 week)

Any deviation from the maternity leave algorithm must be requested in writing prior to the start of any maternity leave. Examples of variations might be stacking all your vacation time together and using vacation time as part of maternity leave, etc.

If you are requesting maternity leave, congratulations. This will be a very exciting time in your life. Please know that we are very excited for you and want to help you in the process of completing the residency and making the transition to parenthood while a resident as smooth as possible.

Denver Health Medical Center
RESIDENCY IN EMERGENCY MEDICINE

Document Type: **Policies and Procedures**

Regarding: **Resident Participation in Clinical Activities outside the Emergency Department**

Last Revised: 2/**2017**

Definition: ***Moonlighting*** is defined as any professional activity which is outside the course and scope of the residency training program, whether or not additional remuneration is offered.

Pertinent ACMGE Institutional AND Program Requirements for Programs in Emergency Medicine:

***Institutional Requirement III.D.1.k.1-2* on moonlighting**

k. Moonlighting:

1. Professional and patient care activities that are external to the educational program are called moonlighting. Moonlighting activities, whether internal or external, may be inconsistent with sufficient time for rest and restoration to promote the residents' educational experience and safe patient care. Therefore, institutions and program directors must closely monitor all moonlighting activities.
2. The Sponsoring Institution must have a written policy that addresses moonlighting. The policy must:
   a. specify that residents must not be required to engage in moonlighting;
   a. require a prospective, written statement of permission from the program director that is made part of the resident's file; and,
   b. state that the residents' performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission.

***Program Requirement VI.B* on duty hours**
(See emergency medicine program requirements at www.acgme.org.)

***Program Requirement VI.C.5* on extracurricular activities**
(See emergency medicine program requirements at www.acgme.org.)

***Program Requirement VI.D.1-3* on moonlighting**

D. Moonlighting

1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements.
3. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80 hour weekly limit on duty hours. (72-hour weekly total limit for emergency medicine.) This refers to the practice of internal moonlighting.

POLICY: **CORD Position Statement on Moonlighting**

CORD believes that ED patient care is best provided by specialists who have successfully completed an accredited residency program in emergency medicine. Residents should not engage in the independent practice of emergency medicine.

In accordance with the CORD Position Statement, and with the acknowledgement that this is a 4 year program, *The Denver Health Medical Center Residency in Emergency Medicine* does not require or encourage moonlighting on the part of the residents. Secondary to its potential impact on education and resident wellness when engaging in moonlighting early in training, moonlighting is not permitted during the EM1, EM2 or EM3 years. We acknowledge that moonlighting can serve some benefits during the EM4 year and for that reason only the EM4s will be allowed to moonlight. However, the Residency Program Director must approve any and all moonlighting activity in advance. Any moonlighting activity must comply with all Denver Health Medical Center institutional policies, this Denver Health Medical Center Residency in Emergency Medicine policy and procedure on moonlighting, and all ACGME Institutional and Program Requirements for Emergency Medicine as a whole and specifically with respect to Moonlighting, Duty Hours, and Extracurricular Activities.

PROCEDURE: Any Emergency Medicine Resident from *The Denver Health Medical Center Residency in Emergency Medicine* interested in moonlighting must apply to the Residency Program Director or EM4 Associate Program Director for approval. This application must be made on a month-by-month basis and shall be for a specific number of hours during the month. The Residency Program Director may approve or deny the application based on the resident's clinical and academic performance, attendance at residency functions, and fulfillment of residency obligations. The Residency Program Director may withdraw the approval at any time if the moonlighting activity interferes with the educational program. No moonlighting activity is allowed while a resident is on probation. The Professional Liability Insurance (malpractice insurance) that the residency provides for the residents does not extend to professional activities outside the course and scope of the residency; any moonlighting activities must be covered by a separate professional liability policy. Failure to comply with all sections of this policy is grounds for academic probation or dismissal from the program.

APPLICATION FOR MOONLIGHTING PRIVILEGES:

The following information will be provided to the Residency Program Director in the form of a written application for moonlighting privileges:

- Name of Resident:
- Effective Dates (month and year):
- Location of Proposed Moonlighting:
- Dates and times of Proposed Moonlighting:
- Name of Organization:
- Address of Organization:
- Phone Number:
- Proposed Number of Hours in the Month:
- Nature of Moonlighting Activity:

DENVER HEALTH MEDICAL CENTER
RESIDENCY IN EMERGENCY MEDICINE

Document Type: **Policies and Procedures**

Regarding: **Research Elective Time**

Last Revised:
2/**2017**

Scope: This document is created to standardize the criteria by which residents may incorporate additional elective time dedicated to performing original research into their curriculum. Historically, this residency has made the offer for up to four (4) weeks of protected research time (in addition to existing built-in elective time) for the resident to conduct an original research project.

Procedure: The following criteria must be met in order to be granted additional protected research elective time:

- The project must be original research. It is not the intent of this elective time to be used to write the manuscript. Instead, this elective time must be used to conduct a significant proportion of the proposed research.
- The length of time for this elective will be up to four (4) weeks, but may be shorter.
- At minimum, the resident must be a co-investigator on the project.
- The project must have already been approved by the Colorado Multiple Institutional Review Board (COMIRB) or Institutional Animal Care Committee.
- The project must be conducted in Denver within the DHMCREM institutions and with DHMCREM faculty. A specific exception is a global health project that must be done out of the country.
- During the protected time, the resident may be assigned to “sick call” duties.
- A written proposal summarizing the project and rationale for the additional elective time, to include a specific schedule for the allotted time, must be submitted and approved by the Director of Emergency Medicine Research and the Program Director prior to April 1 (for July 1 through December 31) or October 1 (for January 1 through June 30) for the time period preceding the requested research elective time.
- This elective time will be contingent upon scheduling availability by the Chief Residents for the upcoming academic year.

Denver Health Medical Center
Residency In Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Resident Presentations**

Last Revised: **2/2017**

Scope: This procedure document is to outline the requirements of the resident presentations.

EM-2 Presentation: EM2 residents will provide a 30 min lecture of a CORE EM topic.

EM-3 Presentations: Each EM-3 will serve as a small group facilitator for specific modules within the didactic curriculum. When possible the topic of discussion will be assigned based on an area of low performance on the previous year's in-service exam. EM-3 M&M case selection and topics must be reviewed and discussed with the assigned EM Chief resident or EM3 Associate Program Director to assure educational benefit.

EM-4 Presentations: Each EM-4 resident must provide one 1-hour Resident Lecture in Emergency Medicine (RLIEM) as part of the didactic curriculum per year. This lecture can be in any area of interest to the resident pertinent to emergency medicine. EM-4 RLIEM must be approved **6 weeks prior to the date of presentation** by the Residency's Didactic Curriculum Director to assure educational benefit.

Handouts: ***Every*** presentation, lecture or M&M will have an appropriate handout and bibliography when indicated for all attendees.

Evaluation: Every lecture should be evaluated by both peer residents and faculty. This evaluation form will cover educational content, lecture quality, lecture delivery /presentation skills, professionalism and the quality of the handout.

DENVER HEALTH MEDICAL CENTER
RESIDENCY IN EMERGENCY MEDICINE

Document Type: **Policies and Procedures**

Regarding: **Scholarly Project Requirements**

Last Revised:

2/**2017**

POLICY: Residents have many demands on their time. Why, then, would we require the completion of a scholarly activity project during the residency?

First, it is required by the EM Residency Review Committee (RRC). The RRC residency requirements state: "The curriculum should include resident experience in scholarly activity prior to completion of the program. Some examples of suitable resident scholarly activities are the preparation of a scholarly paper such as a collective review or case report, active participation in a research project or formulation and implementation of an original research project. Residents must be taught a basic understanding of research methodologies, statistical analysis and critical analysis of current medical literature."

Second, the scholarly activity is one tool through which a resident learns the habit of life-long learning through the practice of evidence-based medicine. You have an opportunity to better understand basic research concepts, and formulate good research questions. These skills are reinforced during clinical work, didactics, journal clubs and by the completion of a Scholarly Activity.

General Instructions

- Completion prior to Graduation. Each resident is responsible for completion of an approved Scholarly Activity (SA). The Program Director will not attest that the resident has completed the residency until the resident has completed a product of “publishable quality” which is “significant” and “related to emergency medicine”. Each resident will present their scholarly activity at conference during the Scholarly Activity Presentation Day in the EM4 year.
- Responsibility: Initiation and completion of the project is the responsibility of the resident and is a requirement for graduation.
- Each Scholarly Activity must:
  - Cover a topic of relevance to emergency medicine
  - Be approved by the Program Director *in writing* (an archived, dated email kept in the resident’s portfolio is sufficient)
  - The initial SA project description and approvals should be in the resident’s folder by the end of the second year.
- Collaboration. Collaboration is encouraged. This helps spreads the workload and promotes continuity. Again, affiliation letters must be on file. Appropriate collaborators include:
  - Other Emergency Medicine Residents at DHREM
  - EM residents at another program (by special permission)
  - Residents in other departments
  - Medical Students

PROCEDURE: OPTIONS FOR SCHOLARLY ACTIVITY

Original research projects: The resident shall serve as principal investigator, co-investigator, or a sub-investigator on a project. If the research has not culminated in a project manuscript by the middle of the resident's senior year, a thoughtful, written essay of not less than 5 single-spaced pages, detailing the process of this research, the role played by the resident, and a careful reflection of the lessons learned by the resident will count as the "publishable project."

- **Evidence-based Medicine, Critically Appraised Topic**: The resident chooses a clinical question, searches the literature for pertinent articles, and writes approximately 10 one-page extensive critiques. If this option is chosen, the relevant articles and reviews are assembled in a notebook and filed for future use by our training program. The articles will be accompanied by a critique of each article's strong and weak points, and a summary recommendation. There will also be a list of debate points at three levels of complexity for future use by the Program.

- **Computer project:** The resident designs a computer program or educational project. A written description, and a completed prototype or product are required. The resident reviews the process for protecting intellectual properties.

- **eBook chapter:** an ongoing chapter in eMedicine that has been newly created or extensively updated by the resident, after the resident has reviewed the current literature.

- **Book chapter:** a new or extensively revised chapter, after the resident has reviewed the current literature, for publication in an appropriate medical textbook.

- **Book revision:** revising an extant book, or translating it into either another language or into another format (such as illustration or video demonstrations of procedures)

- **Book writing:** a book appropriate to emergency medicine wherein the resident served as a major editor or as primary writer is an acceptable project.

- **Practice guidelines:** Using evidence based medicine skills, the resident investigates a clinical question, searches for pertinent articles and/or previously-written guidelines, assesses their validity, and develops a departmental practice guideline. Example: "What are the indications for prescribing antibiotics to patients with acute bronchitis?"

- **Case report:** A publication-ready manuscript is required. Case reports should add to an understanding of pathophysiology in a manner useful to an emergency practitioner. *Case reports for EP-Monthly under Dr. Pryor's "Images in EM" section may be acceptable if the write-up is extensive, evidence-based and adds to the understanding of the topic in the literature. In order to have this count as your Scholarly Activity, you must submit it to Dr. Moreira who will review it with the APDs and decide if the write-up is robust enough to count as your Scholarly Activity.*

- **Collective review:** The resident identifies a topic, performs a literature search, and prepares a manuscript following the style established by the Annals of Emergency Medicine

- Other: if you want to do a Scholarly Activity not on this list, please submit it to Dr. Moreira for review. The Residency Leadership will review your submission to determine if it meets the requirements for Scholarly Activity.

General Pitfalls to a Scholarly Activity

- **Biting off too much**. Keep the project **simple** and **doable**. The first step is formulating an answerable question.
- **Energy Dissipation**. Pick one topic you're interested in and complete it. Most of us are interested in numerous topics and never get any completed.
- **Everyone's responsibility is no one's responsibility**. If you work in a group, an early step should be to write out a division of responsibilities, **time table** and then have regular meetings.
- **Procrastination.** Projects almost invariably take longer than anticipated. Good scholarly activity projects cannot be started and completed by "pulling an all-nighter," and few can be completed during a single research month.

Denver Health Medical Center
Residency In Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Sick Call and Educational Advance Resident Coverage**

Last Revised: **2/2017**

Policy:

Residents who are unexpectedly unable to cover their shifts due to illness or an emergency may implement this policy to achieve last minute coverage for their clinical duties. Indications for sick call are outlined in the **Sick Call Indications** section.

When needing sick call coverage, residents are to activate sick call as outlined in this policy under the **Sick Call Activation** section, including resident and staff notification.

When activating sick call, residents will be responsible for clinical reimbursement of the clinical time covered by sick call as outlined in the **Sick Call Clinical Reimbursement** section.

When covering sick call, residents will be relieved of their assigned clinical duties, such that they are able to cover the shift they are called in for without violating duty hours. This is outlined in the **Sick Call Duties** and **Sick Call and Duty Hours** sections.

Sick Call Indications:

Indications for using sick call include an *unexpected* illness or emergency of a severity such that it is reasonably expected to impair the residents' ability to fulfill their clinical obligations. The on duty attending physician for that service, any of the members of the residency leadership, or the EM Chief Residents are empowered to determine which situations are to be considered reasonable if a question arises. If a resident covering sick call feels that the indication for which they are 'called in' is not reasonable, it is their responsibility to involve one of these parties before covering the clinical shift in order to attempt to achieve resolution.

Examples of appropriate sick call indications include:

- Severe acute unexpected medical illness
- Severe acute unexpected psychiatric illness
- An unexpected immediate family emergency

Examples of inappropriate sick call use includes:

- Inability to be able to rearrange shifts for a prior engagement
- An acute illness that would not otherwise reasonably be expected to impair your ability to fulfill a resident's clinical obligations

- Failure to show for a shift
- Failure to complete obligations for which a resident is being covered to complete (e.g. educational advance obligations, PALS, etc…)
- Being on sick call and failing to respond to a page or cell phone call

Sick Call Activation:

When activating sick call the resident must consider the below points.

- The sick call schedule that is considered most accurate is Amion maintained by the EM Chief Residents.
- The contact information that is to be used for sick call activation is on the Denver EM Google Drive and maintained by each individual resident. **It is the obligation of all residents to maintain accurate contact information on the Denver EM Google Drive or report any changes in contact information to the Residency Coordinator.**

When activating sick call the resident must complete the following list of tasks.

1. ***Call the chief of the month who will activate the sick call resident.***
2. ***Explain the indication*** for sick call to the chief of the month.
3. The Chief Resident will ***call the attending physician for the service being covered*** to notify them the sick call resident will be covering for the sick resident.
4. The Chief Resident will ***send an e-mail*** to the Program Director listing the shift requiring coverage, and indication for the sick call use *within 24 hours*.

If there is any concern raised over the indications for sick call use, contact the on duty attending physician for that service, any of the members of the residency leadership, or an EM Chief Resident to achieve resolution.

In the event of a true *time-dependent* emergency the resident may contact the on duty attending physician for that service, any of the members of the residency leadership, or an EM Chief Resident to arrange for sick call for them.

Sick Call Clinical Reimbursement:

Sick call clinical reimbursement for an **appropriate** sick call indication is as follows:

- For every clinical shift requiring coverage the resident will reimburse the called in resident ONE *like* clinical shift.

Sick call clinical reimbursement for an **inappropriate** sick call use:

- For every clinical shift requiring coverage the resident will reimburse the called in resident TWO *like* clinical shifts.

Sick Call Duties:

It is the obligation of all residents to maintain accurate contact information on the Denver EM Google Drive, as this will be used to activate sick call.

Residents on sick call are expected to respond *immediately* to pages or cell phone calls (<10 minutes). No cellular phone listing on the google drive will indicate the preferred method of contact is paging.

Residents called for sick call are expected to be able to be at the clinical shift being covered within a reasonable amount of time (within 60 minutes *from time of notification*)

There is one resident on sick call at all times. Once sick call is activated, the chief of the month needs to be notified. If another sick call is activated on the same day, the chief of the month will work with the Residency Leadership Administrator on call to determine a plan of action. When there is a second sick call activated on the same day, one of the hospitals will go without a resident on a rotating schedule. Therefore, it is very important that the chiefs keep an updated sick call activation excel sheet delineating person called in and which hospital went without coverage.

Sick Call and Duty Hours:

Residents being called in for sick call are expected not to violate duty hours.

- Since residents on sick call are not on EM rotations, the non-EM duty hours apply. There may be a situation in which a resident fulfills clinical obligations in the AM to be called in to work in the PM or Overnight. This would be similar to an on-call night. In this situation you are allowed adequate time for rest and personal activities (10 hours) before returning to your next shift. At the end of this 10 hour period the resident should return to their clinical duties as scheduled.

Disclaimer:

This policy supersedes all previous Denver Health Medical Center's Residency in Emergency Medicine policies solely pertaining to Sick Call time. Denver Health and Hospital policies or procedures supersede all residency program policies if

conflicts occur. Conflicts with any other residency program policy are to be resolved and decided upon by the residency director.

DENVER HEALTH MEDICAL CENTER
RESIDENCY IN EMERGENCY MEDICINE

Document Type: **Policies and Procedures**

Regarding: **Occupational Health Procedures**

Last Revised: 2/**2017**

Scope: Unfortunately, several cases of resident occupation health bill's being sent to collections by other hospitals have occurred. Residents must be aware of and follow the Denver Health Policies and Procedures document Occupational Health issues (namely needle sticks). It is important to note the Denver Health's Occupational Health System is completely different and separate from all other affiliated hospital Occupational Health Systems.

The below policy (P&P 6-101) represents DHHA's Occupational Health Policy as of 7/2006. It is the residents responsibility to be familiar with the most up to date version of this policy. Under this policy, any employee who has an injury or exposure is required to notify his/her supervisor (the attending on in the ED you are working in) and then call the Denver Health OUCH line (303.436.OUCH) prior to seeking medical care. (Life threatening emergencies exempt)

The OUCH line nurse will follow established protocols. In exposure and needle stick cases, the nurse may require rapid HIV testing of the donor's blood. Once the status of the donor's risk is communicated to the OUCH line nurses from the lab, they will direct you to report to the appropriate gatekeeper for workers' compensation, which may be an authorization for ED care or you may be directed to the OHSC (employee's clinic) for follow up care. In any case, follow up care at the OHSC is mandatory to avoid personal responsibility for the billing of this care.

Resident physicians should not assume that ED care is automatically authorized as the use of prophylactic medications may be avoided if the rapid HIV results are negative. Time is of the essence in this process, so the OUCH line call must be a priority in all exposure cases.

Denver Health Policy:

#6-101

CSA/DHA
Supersedes: New Principle

Effective Date:

Approval:

Chapter: Health/Safety

Subject: Employee On-the-Job Injuries

1. **Principle**:

   To outline the procedures to be followed at Denver Health (DH) to ensure that all on-the-job injuries are promptly and properly reported to the appropriate authorities.

2. **Practice**:

   A. All on-the-job injuries or accidents shall be reported immediately to the employee's immediate supervisor. This includes all exposures to communicable diseases, needle sticks and other potential exposures. If there are questions regarding what constitutes a communicable disease, refer to the DH Administrative Policy Manual on the Employee Health Program for Infection Control, Section VII, C-2.

   B. The injured employee shall follow established reporting procedures for on-the-job injuries in accordance with this policy.

   C. The Occupational Health and Safety Clinic (OHSC) is considered the designated medical provider for all Denver Health employee workers' compensation related treatments. All authorizations for work-related time off, medical treatments, therapies or referrals must be made by the designated treating physician, which could be the OHSC caregiver. The OHSC will retain the permanent employee medical record.

   D. All employees employed by Denver Health shall be identified in this policy by Denver Health Career Service Authority, hereafter (Denver Health CSA) and Denver Health Authority employees hereafter (Authority). Except where noted, the procedures apply to both Denver Health CSA and Authority employees.

   E. Efficient administrative case management shall be accomplished through a cooperative effort between the DH Risk Management Department, the employee and the supervisor, as well as the Occupational Health and Safety Clinic, the Denver Workers' Compensation Unit (for Denver Health CSA employees) and the Denver Health third party insurance administrator (for Authority employees).

3. Responsibility:

   A. All employees and supervisors shall be responsible for knowing the procedures to be followed for reporting on-the-job injuries and obtaining required medical attention.

   B. The Denver Health Risk Management Office shall be responsible for the overall coordination of the program with Denver Health payroll and leave accounting, the City Workers' Compensation Claims Unit or the Authority third party insurance administrator, as appropriate. This responsibility includes the training of employees and supervisors, claims monitoring, administrative case management and problem solving. The office will also monitor and track

Clinic Passes, Work Injury Reports (ADM-4 and F20-306), Supervisor's Reports (ADM-4A), Return-to-Work Passes and the Weekly Work Related Lost Time Reports.

C. Workers' Compensation claims will be evaluated and processed by the Workers' Compensation Claims Unit, Office of the City Attorney for Denver Health CSA employees. Claims by Authority employees will be evaluated by the Denver Health third party insurance administrator.

4. Procedures:

A. Reporting On-the-Job Injuries:

1. The injured party shall notify the supervisor immediately. If the employee is unable to notify the supervisor immediately, notice shall be given within 24 hours of the claimed injury.

2. Denver Health CSA employees who have an injury shall immediately complete in writing all applicable sections of the Work Injury Report (ADM-4). Authority employees who have an injury shall complete in writing all applicable sections of the Authority Work Injury Report (F20-306). Denver Health CSA and Authority employees will present their respective Work Injury Report to OHSC. OHSC will forward the ADM-4 or the F20-306 form to the Risk Management Department (mail code 5015).

3. The supervisor is required to issue an injured employee a Clinic Pass, whenever possible, indicating that an alleged work-related incident has been reported and that appropriate medical evaluation and possible treatment are requested. This Clinic Pass also authorizes temporary absence from normal work duties by the employee's supervisor.

a. In some cases, a Clinic Pass cannot be provided. The employee will need to visit the Denver Health Emergency Department when incidents occur outside OHSC business hours or when there is a true emergency requiring immediate care. (Note: The OHSC will not refuse to see someone just because they do not have a Clinic Pass).

b. As soon as possible, but no later than the next business day after the incident, the employee is required to report to OHSC, even if the employee has been seen in the Emergency Department.

4. The employee's supervisor is also required to complete a Supervisor's Report of Employee Injury (ADM-4A) no later than three (3) days from the date of injury, but preferably as soon as possible. This form is to be forwarded to the Safety Office, Mail Code 1413.

5. The injured employee shall be evaluated at OHSC and disposition shall be one of the following: returned to regular duty, referral for additional immediate care, sent home, or referred for modified duty.

a. A Return to Work Pass shall be initiated at the conclusion of the medical evaluation. This form is to be returned to the supervisor by the employee indicating that he/she may return to work.

b. The supervisor shall not allow any employee who has been off work for work related injury or illness 8 hours or more to return to work without a Return to Work Pass signed by a medical provider in the OHSC or other primary provider as designated by the OHSC.

c. A copy of the Return To Work Pass must be sent by the employee's supervisor to Risk Management at Mail Code 5015.

d. When an employee is unable to report to work due to a work injury, the employee is required to report to OHSC, the Emergency Department or the designated treating physician. Written documentation must be provided to the Risk Management Office from the employee's designated treating physician to excuse time off from work. If an employee is unable to physically report to

these designated providers, the employee must call the treating physician to seek documentation to be excused from work.

e. If an employee cannot provide documentation to support the time taken off for the work injury, sick time, leave without pay or unauthorized leave time will be reported on the payroll sheet for Denver Health CSA employees or paid time off (PTO), leave without pay or unauthorized leave for Authority employees.

6. For work related incidents, if the employee is off for either full or partial work shifts at any time past the day of the initial OHSC visit, or for intermittent absences for medical treatments, Risk Management shall be notified by the supervisor and the employee via the completion of the Weekly Work Related Lost Time Report. This report, along with the Return to Work Pass shall be sent to Risk Management on a weekly basis at Mail Code 5015. These items will be tracked and processed as necessary, depending on the disposition of the Workers' Compensation case.

a. Time lost during the determination of compensability shall be taken from the Denver Health CSA employee's sick and vacation bank or the Authority employee's PTO bank. If the employee has insufficient personal leave balances, the employee will have to take leave without pay. Once the employee's claim has been deemed compensable, sick and vacation time will be reimbursed at 80 percent for Denver Health CSA employees or 66 2/3 percent for Authority employees. If the Worker's Compensation Unit determines the Denver Health CSA employee's claim is not compensable, leave time will not be reimbursed. If the third party administrator determines the Authority employee's claim is not compensable, PTO time will not be reimbursed.

b. Denver Health CSA employees will be paid at 80 percent of their gross wages when the Workers' Compensation Unit has made an Admission of Liability. Authority employees will be paid 66 2/3 percent of their gross wages by the insurance carrier.

c. Denver Health CSA employees who continue to be disabled beyond the maximum disability leave period of ninety consecutive calendar days will be paid from the Workers' Compensation Fund at 66 2/3 percent of the employee's wages.

d. Whenever possible, the employee should schedule intermittent absences during non-working hours for Workers' Compensation medical and therapy appointments. When an employee must schedule medical and therapy appointments during his/her regular work hours, he/she will be compensated portal to portal for his/her time

away from work at his/her regular rate of pay. It shall be the employee's responsibility to present written justification showing arrival, departure, and driving times whenever requested by management. Management may disallow any time which can not be adequately documented. No overtime, shift differential, or hours beyond the normally scheduled work day will be paid for such absence.

If an employee does not report for work on any specific day, that day will be considered "non-working hours". This shall apply to vacation, regular days off, sick days, personal time off (PTO), Family Medical Leave Act (FMLA) time, or any other paid or unpaid time off. Employees are not compensated for medical and therapy appointments during non-working hours.

e. If an employee fails to report an on-the-job injury, the employee risks the assignment of penalties to his/her claim by the Colorado State Division of Workers' Compensation.

7. Medical Care

a. If an injury is sustained between 7:00 a.m. and 4:30 p.m., Monday through Friday, excluding holidays, the employee shall receive initial evaluation and medical care at the OHSC.

b. At all other times, medical treatment shall be received at the Denver Health Emergency Department. The employee shall then schedule an appointment in the OHSC on the next business day.

c. Obviously, major or severe injuries or illnesses and true emergencies should be directed to the Denver Health Medical Center if feasible. However, in the true emergency situation caused by an on-the-job injury, the employee shall report to the nearest appropriate medical facility (i.e., hospital emergency department) for treatment, even if it is not Denver Health Medical Center.

Denver Health Medical Center
Residency in Emergency Medicine

Document Type: **Supervisory Lines of Responsibility**

Program: **Denver Health Medical Center Residency in Emergency Medicine**

Program Director: **Maria Moreira**

Year of Training: **EM 1-4**

Last Revised: **2/2017**

This document is designed to meet the ACGME Emergency Medicine Program Requirements to have written supervisory lines of responsibility (Program Requirements Emergency Medicine 2007 IIA4q).

Below are the supervisory lines of responsibility for emergency medicine and non-emergency medicine rotations for Denver Health Medical Center's Residency in Emergency Medicine. These lines of responsibility are reiterated in each Clinical Rotation Summary and each EM levels job description. Please refer to those documents for signature of receipt.

I. Emergency Medicine Rotations:

a. Supervisory lines of responsibility for the care of patients by EM-1 residents:

i. At Denver health, either the on-duty EM attending or the EM-4 (senior) resident supervises all patient care activities performed by the EM-1 on shift..

ii. At University Hospital, either the EM attending on duty or the EM-3 (senior) resident on duty supervises all patient care activities performed by the EM-1 on shift.

b. Supervisory lines of responsibility for the care of patients by EM-2 residents:

i. At Denver Health, either the EM attending on duty or the EM-4 (senior) resident on duty supervises all patient care activities performed by the EM-2 on shift.

ii. At University Hospital, either the EM attending on duty or the EM-3 (senior) resident on duty supervises all patient care activities performed by the EM-2 on shift.

iii. At the private or community hospitals, the EM attending on duty supervises all patient care activities performed by the EM-2 on shift.

c. Supervisory lines of responsibility for the care of patients by EM-3 residents:

i. At Denver Health either the EM attending on duty of the EM-4 (senior) resident on duty supervises all patient care activities performed by the EM-3 on shift.

ii. At University Hospital, the EM attending on duty supervises all patient care activities performed by the EM-3 on shift.

iii. At the private or community hospitals, the EM attending on duty supervises all patient care activities performed by the EM-3 on shift.

d. **Supervisory lines of responsibility for the care of patients by EM-4 residents:**

i. At Denver Health, the EM attending on duty supervises all patient care activities performed by the EM-4 on shift.

ii. At the private or community hospitals, the EM attending on duty supervises all patient care activities performed by the EM-4 on shift.

II. Non-Emergency Medicine Rotations:

a. Supervisory lines of responsibility for the care of patients for EM1-4 residents:

i. The attending staff will provide supervision, teaching, and performance evaluation, under the overview of the Rotational Service Director.

ii. When applicable Physician Fellows in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on duty attending staff as outlined in the above point (II.a.i).

iii. When applicable Chief Residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on duty attending staff as outlined in the above point (II.a.i).

iv. When applicable Senior Level residents in the service of the rotation will also provide supervision, teaching, and performance evaluation, under the overview of the on duty attending staff as outlined in the above point (II.a.i).

Either the resident or members of service on which the resident is rotating should bring any concerns of inadequate or inappropriate supervision of residents to the immediate attention of the Program Director.

Denver Health Medical Center
Residency in Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Individualized Interactive Instruction (Asynchronous Activity)**

Last Revised: **2/2017**

POLICY:

As per the ACGME, programs must provide on average at least 5 hours per week of planned didactic experiences. Residents must participate on average, in at least 70 percent of the planned didactic experiences offered. Individualized interactive instruction must not exceed 20 percent of the planned didactic experiences. In order to qualify as individualized interactive instruction, the following four criteria must be met:

1) The program director must monitor resident participation
2) There must be an evaluation component
3) There must be faculty oversight
4) The activity must be monitored for effectiveness

PROCEDURE:

In order to receive Individualized Interactive Instruction Credit the activity needs to comply with the following criteria as delineated below:

1) The program director must monitor resident participation – prior to allowing credit for an asynchronous activity the program director must receive a plan for the activity including the method of evaluation of the activity and the method of monitoring for effectiveness. The program director will review the activity information and will approve the activity accordingly and will determine the appropriate number of credit hours. An attendance sheet for each activity must be handed in with the evaluation forms.
2) There must be an evaluation component – There has to be a way for the resident to evaluate the activity. It is useful for the evaluation to include a question of what the resident learned from the activity or how it will impact their clinical practice. This evaluation must be filled out at the completion of the activity and needs to be returned to the program coordinator within a week of the activity.
3) There must be faculty oversight – Faculty members must be present and involved in activities in order for them to be appropriate for individualized interactive instruction. The attendance sheet should also include the faculty members involved.
4) The activity must be monitored for effectiveness – Common ways to monitor for effectiveness are either through a quiz at the end of the activity, oral boards cases, or simulation. At the end of each activity an evaluation must be turned in of the resident and their performance on the activity. That could be in the form of an evaluation of the resident and a quiz.

Within a week of the activity the following should be turned into the coordinator: 1.) an attendance sheet including residents and faculty present 2.) all evaluations filled out by the residents about the activity 3.) The quizzes with grades and the evaluations of the resident if there is an extra evaluation other than the quiz. All components need to be turned in together in one packet.

Denver Health Medical Center
Residency in Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Retreats**

Last Revised: **2/2017**

GOALS/OBJECTIVES: The purpose of the retreats has been two-fold:

1) To provide individual class education not already provided in the general curriculum
2) Provide an opportunity for class team building

PROCEDURE: Previously, classes were excused from 3 days of clinical activity to receive class-specific education, participate in a team-building activity and have dinner with the faculty. Considering the difficulty in scheduling from both a resident and faculty standpoint, as well as wellness issues surrounding retreat schedules, the Residency Leadership decided to change the retreat process as specifically outlined below:

- The Annual Residency Wide Retreat will continue as usual. This retreat provides a great opportunity for bonding at the beginning of the year and serves as a great welcome for our interns and farewell to our seniors
- The class specific retreats will be replaced by the following:
  - Class Specific Education:
    - Class specific education previously placed in the retreats will occur during Wednesday didactics
    - There will be a class specific curriculum for each level and classes will be divided according to their level quarterly to be provided this curriculum.
    - If a resident misses part of the class specific education, there will be opportunities to be exposed to this curriculum and obtain asynchronous credit
    - ATLS and PALS will continue to be provided
  - Team Building
    - Each class will be given 36 hours free from duty once a year (example 12pm Wednesday after conference until 11pm Thursday)
    - This time can be used for team building as a class or to spend with family and other friends.
    - The residency will not be responsible for activities during this day

- Dinners with Faculty
    - ATLS is 2 days. During ATLS there will be a dinner with faculty with the 2nd year class
    - PALS will most likely occur on a Wednesday morning. We will have a lunch with the faculty on that day for the 3rd year class
    - The 4th year class have lunch with the faculty and alumni at ACEP
    - We will attempt to schedule a dinner with the interns at the beginning of the year to serve as a check-in and to familiarize the interns with the EM faculty

Denver Health Medical Center
Residency in Emergency Medicine

Document Type: **Policy and Procedure**

Regarding: **Social Media**

Last Revised: **2/2017**

The Residency in Emergency Medicine at Denver Health acknowledges social networking sites are important means of communication for its residents. Used effectively and properly, they can be helpful in bolstering resident morale and can enhance the reputation of the Residency Program. However, as our residents are hospital employees and handle sensitive situations as they relate to both the organization and patient care, there are rules that must be followed to ensure proper usage of these sites. The following are guidelines we expect all Denver Health Emergency Medicine residents to comply with:

1. Social Networking sites include facebook, myspace, twitter, linkedin, flickr, livejournal, personal blogs and any other sites that allow other users access to information written online.
2. Information published must comply with HIPAA and patient confidentiality requirements. Specifically, information that could be used to ascertain the identity of a patient or particular incident that occurred on the premises of Denver Health or any other patient care site, including elective sites, is strictly prohibited. This includes referencing patient encounters, posting patient complaints and noting unusual circumstances in the ED or hospital, including patient volume and noteworthy events.
3. Be respectful to the organization, department and other employees.
4. Do not post pictures regarding patient care taken on the hospital property.
5. Do not use company logos or trademarks without prior written consent.
6. Respect copyright laws, and reference or cite sources appropriately.
7. Personal blogs should have clear disclaimers that the views expressed by the author are the author’s alone and do not represent the views of the organization. Be clear and write in the first person.