Brigham and Women's Hospital
Founding Member, Mass General Brigham

BWH Long Term (Over 48hrs) Clinical Observational Experience Policy:

Statement of Policy/Purpose:

The Brigham and Women's Hospital takes enormous pride in training and educating the next generation of physicians and healthcare workers. Most such training occurs as part of formal training arrangements such as medical student clerkships, ACGME accredited internships and residency training programs, and ACGME accredited fellowship programs. However, certain BWH Departments also offer non-credit, informal observation experiences for trainees not enrolled in the above entities but who desire to learn or gain basic exposure to the clinical environment. The purpose of this document is to ensure that all trainees, including those pursuing clinical observational experiences, are documented and abide by BWH Hospital policy ensuring no adverse impact on patient care or the academic environment. This policy pertains to experiences where observers are involved with the BWH clinical environment for more than 48hrs.

Clinical Observational Experiences (COE) at Brigham and Women's Hospital will: (1) provide observers with appropriate educational observations in a closely supervised safe environment, (2) protect the rights and dignity of the BWH patient without adversely impacting clinical care, and (3) maintain the confidentiality and security of protected health information (PHI), and other proprietary or confidential information. COE's are not training programs, and therefore do not provide BWH credit or any type of certification for trainee skills, level of training, or educational time.

Clinical Observational Experiences (COE's) at BWH are not affiliated with any Harvard Medical School program or clerkships(s). Participation in a BWH COE will not have a preferential impact on any pending or future training applications. Upon successful completion of a COE, observers will receive an acknowledgement of COE attendance from the offering Department, confirming the observer's dates of attendance. However, there is no formal credit provided. Prospective observers should also note that it will not be possible for professional or administrative staff to verify observers' clinical skills based on participation in a clinical observership or provide a grade. Likewise, BWH professional staff will not be expected to write letters of recommendation for clinical observers.

Observer Participation & Limitations:

- The observer may join patient rounds and/or clinic opportunities under the direction of their BWH Faculty Supervisor but cannot ask questions or interrupt workflow. If there is time after rounds/clinic, questions can be directed to the Faculty member or medical team. The observer must note that they are not fulfilling a role as a medical or nursing student. Medical or nursing students (different from clinical observers) are enrolled in a formal training program, and thus may have a direct role in patient care as part of the credentialed medical team.
- The observer can introduce themselves to a patient, but in no way can participate in the care of the patient, documentation of care, or give even the appearance of being a caregiver. Importantly, the observer may not take a medical history, or touch or examine a patient. The observer should not interact with family members of the patient. Observers are not allowed to place medical orders, provide verbal orders, or convey medical recommendations to other patients or other healthcare

members. The observers are not hospital employees or members for the professional staff, and may not represent themselves as such.

- The observers' activities must not interfere with the education or activities of medical students or graduate medical education trainees.
- Clinical observers cannot participate in research* activities. Similarly, Clinical observers cannot publish any works that imply a formal affiliation with BWH

**Non-employees who expect to participate in research should be onboarded through BWH OSSVS as a Research Trainee*

Observer Participation and Limitations in the Operating Room, PACU, Labor & Delivery:
Access to these locations is granted only by unique circumstance with awareness and approval by the Department Chair overseeing the Faculty Sponsor. In the Operating Room, PACU, and Labor & Delivery, observers must always be in the company of the Faculty Sponsor and/or the designee.

International Observers

- International physicians entering the country on either B1 or Visa Waiver/Business (WB) are welcome to seek observerships. Although the hospital cannot sponsor visas for non-employees, including clinical observers, the Sponsor can provide a formal letter of invitation upon request.

Current BWH Employees

- Current BWH employees not involved in clinical care (e.g. research trainees, research assistants) can apply for long term clinical observation in BWH Departments that will approve employee clinical observations. Note that not all BWH Departments allow clinical observation, and approval from the Chairperson, Vice-Chair of Education, or their delegate must be obtained. The duration of any clinical observation period will be <u>firmly capped at 3 months</u> without exception given the impact longer observation has on the broader education mission and other students. Employees must fully complete their long term observation packet. Departments will then follow this guide to complete the clearance process with the Office of Sponsored Staff.

Harvard Medical School Students

- Harvard Medical Students that are participating in POM or PCE at Brigham & Women's Hospital may clinically observe within a department so long as they have approval and oversight from a supervising physician who takes responsibility for their observation and participation. Departments will be responsible for tracking and overseeing all efforts during the observation period.
- Harvard Medical Students that are participating in POM or PCE at a different Harvard Affiliated Hospital must contact the department in which they wish to clinically observe (seeking approval), as well as the Brigham & Women's Hospital Undergraduate Medical Education (UME) Manager. If the student is not already onboarded as a BWH medical student, the UME Manager will complete the onboarding of the student. <u>Note that paperwork for this must be submitted 3 or more weeks in advance of the clinical observation date, similar to onboarding for all HMS students</u>. Departments will be responsible for requesting any additional resources needed to complete the clinical observation inclusive of scrubs and badges. Departments will be responsible for tracking the observation period.

Please note that the BWH Observational Experience Policy is subject to change based on hospital policies.

Process for Applying for an Observational Experience:

Termination of Clinical Observership Experience:

BWH reserves the right to terminate a clinical observership **at any time** in the event of observer non-compliance with the terms of the Observership Agreement or if the observer becomes an obstacle to trainee, learning, or patient well-being.

Questions regarding clinical observers at BWH can be directed to Karen Bruynell or Alex McGillivray at the Brigham Education Institute, and Taraye Preston at The Office of Sponsored Staff

BRIGHAM AND WOMEN'S HOSPITAL

POI FORM

To be completed by Manager or Department Administrator

Forms Checklist:

- CORI Request Form ☐
- CORI Request (Child contact) ☐
- Confidentiality Agreement ☐
- Research Trainee Letter ☐
- Pre-placement Health Screens ☐
- Minor Consent OHS) ☐
- Lab Minor Consent Form ☐

Start Date _____

Biographical Information -PeopleSoft Required Fields

First Name _____ _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Gender _____ Social Security Number _____ Ethnicity _____

Address _____ City _____

State/ Country _____ Zip _____ Phone _____ Email _____ End Date(approximate) _____

License Information *(skip this section if it does not apply to you)* Does the POI hold a work related license? ☐

License Type _____ License Number _____ Expiration Date _____ Issuing Agency _____ Issuing State _____

US Citizen? _____ f no, authorized to work in U.S? _____ Work Visa/Authorization Type *(include permanent resident)* _____

Work Authorizing Document # _____ Expiration Date _____

Emergency Contact(optional) _____ Phone _____

FOR ALL POI's:
I understand that before I begin, I will participate in an on-site orientation. I understand I must complete immunization screening and obtain clearance. I certify that the information provided on this application is true and correct. I understand that any deliberate, incomplete, incorrect or false statements may result in dismissal. I understand that all offers to participate in a BWH Sponsored activity are conditional upon receipt of satisfactory CORI background check. I hereby release Brigham and Women's Hospital and any persons or organizations that provide information from all legal responsibility or liability that may arise from conducting an investigation of my service.

Signature/Date _____

FOR PHYSICIANS, PHYSICIAN ASSISTANTS, AND ADVANCED PRACTICE REGISTERED NURSES ONLY: I understand that I must be licensed and credentialed in the state of Massachusetts in order to provide any type of medical care or guidance at Brigham and Women's Hospital (BWH). I understand that I must complete a formal BWH credentialing process and be approved for clinical privileges prior to engaging in any clinical activities.

Signature/Date _____

To be Completed by Manager or Department Administrator

HR department (BR# or BD#) _____ Department name _____

Is the POI being Compensated? ☐ Pay Source _____

Will the person be practicing medicine &/or assuming clinical duties? _____ Will the person have contact with children? _____

What is the POI's Role? _____

Work Schedule *(hours per day & day of the week)* _____

Please describe duties/responsibilities:

Access to Partners Network needed? _____ Email account needed? _____ Is the POI Working Remotely? ☐

Primary Work Location *(address, building name & floor)* _____

Requesting Manager/Dept Administrator _____ Signature _____ Form completed by _____

OSSVS/ HR Section

POI Type: _____ ☐ CORI- Date Submitted _____ CORI- Date Received _____

OHS Clearance Date _____ Orientation Date _____ PeopleSoft ID# _____

Confidentiality Agreement ☐ Type of Volunteer _____ ☐

POI OSSVS- Revised by BWH Operations 02/10/12

Effective 1/01/2023

Brigham and Women's Hospital
Founding Member, Mass General Brigham

Clinical Observational Experience (COE) Application:
Checklist and Cover Sheet

*This form **must** be completed, submitted and approved before any outside* individual can enter any BWHC facility functioning in the capacity of a learner, an observer, a visiting student/physician, or any other activity whereby such an outside* individual **enters an area where healthcare is delivered**.*

Complete this form completely with necessary attachments and submit to the BEI at least one month prior to any desired rotation start date. Please place all paperwork in the order listed on this form. Do not include any paperwork in this packet that is not listed below.

Please submit all documents as single-sided document with original signatures.

Clinical Observer Name: _____ Current Date: _____

BWH Department: _____ Experience Dates: _____

Division/Program: _____ Coordinator Email: _____

Faculty Supervisor: _____ Coordinator Phone: _____

Brigham and Women's Hospital
Founding Member, Mass General Brigham

Clinical Observation Experience Policy & Agreement

CLINICAL OBSERVERS ARE NOT ELIGIBLE FOR CLINICAL PRIVILEGES

- The observer may join rounds but cannot ask questions or interrupt workflow. If there is time after rounds, questions can be directed to the senior resident.
- The observer can introduce themselves to a patient, but in no way can participate in the care of the patient, the documentation of the care, or give even the appearance of being a caregiver. In particular, the observer may not ask questions, take history, or touch or examine the patient.
- The observer should not interact with ancillary staff and should never be a transmitter of medical information.
- The observer should not interact with family members of the patient.
- The observer should not attend family meetings.
- The observer should not be confused with students, who are participating in a formal training program or under a formal affiliation agreement.
- The observers' activities must not interfere with the education or activities of medical students or graduate medical education trainees.
- The observers are not hospital employees or members for the professional staff and may not represent themselves as such.
- Observers are not allowed to place medical orders, provide verbal orders, or convey medical recommendations to other patients or other healthcare members
- Observers cannot participate in research activities
- Observers cannot publish any works that imply a formal affiliation with BWH
- Observers cannot suggest or imply that they are acting with authority of BWH

If an observer is unable to adhere to these guidelines, BWH reserves the right to terminate the observational experience.

_____ _____

Clinical Observer's Signature Date

_____

Clinical Obserer's Name

_____ _____

Faculty Supervisor Signature Contact Phone Number

Clinical Observership Experience Application
BRIGHAM AND WOMEN'S HOSPITAL

This application must be completed for individuals who would like to observe patient care at Brigham and Women's Hospital. For medical students from other institutions who are interested in participating in the care of patients or seek to receive clerkship credit for this experience, please contact the HMS Registrar's Office at *exchangeclerkship@hms.harvard.edu* for more information regarding elective clerkship rotations. For residents and fellows from other institutions who are interested in participating in the care of patients, please contact the Graduate Medical Education office for more information regarding elective rotations. Please submit this application and all required supporting documentation (see checklist) to BWH Office of Sponsored Staff.

Section 1 - To be completed by visiting scholar:

First Name _____ Last Name _____

Date of Birth _____ Gender _____ Social Security Number _____ Ethnicity _____

Home Address _____

State/Country/Zip Code _____ Email _____

Phone Number _____ US Citizen

I _____ ("Clinical Observer") understand that this observational experience is being made available to me based upon BWH's interest in training future health care professionals. I understand that this experience is solely for my educational benefit and that my status is that of an observer. I understand and acknowledge that I do not have an employment or volunteer relationship with BWH/HMS and that I will not be providing any services to BWH/HMS during the course of my observational experience.

Clinical Observer's Signature: _____ Date: _____

Section 2 - To be completed by BWH Department:

BWH Contact Person/Program Coordinator: _____ Phone number: _____

BWH Faculty Supervisor: _____ Phone number: _____

The above-named Clinical Observer would like to apply for an observational experience in the BWH Department of

_____ in _____(division or program), for the period

from _____to _____ at (hospital) _____ (location/ward) _____% _____

from _____to _____ at (hospital) _____ (location/ward) _____% _____

Educational goals of the proposed observership: _____

_____

_____

BWH Signatures:

Faculty Supervisor: _____ Date: _____

Dept Chair/Assoc Chief Nurse Officer or Designee_____ Date: _____

PARTNERS HEALTHCARE SYSTEM
PARTNERS COMMUNITY HEALTHCARE

CONFIDENTIALITY AGREEMENT

Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare must assure the confidentiality of its employee, payroll, fiscal, research, computer systems, and management information. In the course of my employment/assignment at a Partners organization/practice, I may come into the possession of confidential information. In addition, my personal access code [User ID and Password] used to access computer systems is also an integral aspect of this confidential information.

By signing this document I understand the following:

1. Access to confidential information without a patient care/business need-to-know in order to perform my job---whether or not that information is inappropriately shared---is a violation of this policy. I agree not to disclose confidential or proprietary patient care and/or business information to outsiders (including family or friends) or to other employees who do not have a need-to-know.
2. I agree not to discuss confidential patient, employee, payroll, fiscal, research or administrative information where others can overhear the conversation, e.g., in hallways, on elevators, in the cafeterias, on the shuttle buses, on public transportation, at restaurants, at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.
3. I agree not to make inquiries for other personnel who do not have proper authority.
4. I know that I am responsible for information that is accessed with my password. I am responsible for every action that is made while using that password. Thus, I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own.
5. I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Partner's computer systems to unauthorized locations, e.g., home.
6. I agree to log off a Partners workstation prior to leaving it unattended. I know that if I do not log off a computer and someone else accesses confidential information while the computer is logged on with my password, I am responsible for the information that is accessed.

Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare have the ability to track and monitor access to on-line records and reserves the right to do so. Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare can verify that those who accessed records did so appropriately.

I have read the above special agreement and agree to make only authorized entries for inquiry and changes into the system and to keep all information described above confidential. I understand that violation of this agreement may result in corrective action, up to and including termination of employment and/or suspension and loss of privileges. I understand that in order for any User ID and/or Password to be issued to me, this form must be completed.

_____ _____

Signature of Employee / Physician / Student / Volunteer / Non-Partners Personnel — Date

_____

Print Name

To Be Filed in Employee's Personnel Record

Mass General Brigham

Infection Control Standards for Health Clearance

- **Tuberculosis (TB) Screening Required**
  One of the following is required:
  a. Documentation of TB skin test within 3 months of screening date
     OR
  b. Documentation of a negative IGRA (QFT or T-Spot) within 3 months of screening date
     OR
  c. For individuals known to be TB skin test positive or who have positive IGRA, documentation of a chest x-ray report which rules out active tuberculosis is required and a completed TB symptom survey

- **Measles, Mumps, and Rubella Immunity Required**
  One of the following is required:
  a. Documentation of two MMR vaccines **OR** two measles vaccines, two mumps vaccine, and one rubella vaccine
     OR
  b. Proof of immunity to measles, mumps, and rubella by IgG antibody titer (blood test).

- **Chicken Pox (Varicella) Immunity Required**
  One of the following is required:
  a. History of Varicella
  OR
  b. Proof of immunity to chicken pox by IgG antibody titer (blood test)
  OR
  c. Documentation of two varicella vaccinations

- **Influenza Vaccination Required**
  Mass General Brigham requires all health care workers to receive a **seasonal** flu vaccine.

- **COVID Vaccination Required**
  Mass General Brigham requires all health care workers to be up to date with COVID-19 vaccinations.

Mass General Brigham

Health Screening Requirements

Observer Name:_____ **Date of Birth:**_____

Must be Completed by Personal Health Care Provider or School Health Office:

All personnel who will work, volunteer, or observe at a Mass General Brigham healthcare facility are required to meet the minimal infection control standards on page 1.

Tuberculosis (TB):

BAMT within 3 mos. of screening date	QFT Date: _____ Result: _____	OR	T-Spot Date: _____ Result: _____
For history of +TST or +BAMT a Chest X-Ray (CXR) is required	CXR Date: _____		Chest X-Ray Result_____
LTBI TX	Dated of Completion: _____	OR	LTBI TX Not Completed_____
Symptom Review *(Only for applicants who have a history of a positive PPD)*	Loss of appetite ☐ Yes ☐ No Unexplained weight loss ☐ Yes ☐ No Night Sweats ☐ Yes ☐ No		Fever ☐ Yes ☐ No Fatigue ☐ Yes ☐ No Productive Cough ☐ Yes ☐ No

TB SCREENING:

Have you lived for more than one month in a country with a high rate of TB? (Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe) YES ☐ NO ☐

Are you immunosuppressed? YES ☐ NO ☐

Have you had close contact with someone who had infectious TB disease since your last TB screening? YES ☐ NO ☐

Other Requirements

		Date		Date	Titer Result	Date
MMR	MMR #1	_____	MMR #2	_____	POS NEG	
Measles	Measles #1	_____	Measles #2	_____	P ☐ / N ☐	_____
Mumps	Mumps #1	_____	Mumps #2	_____	P ☐ / N ☐	_____
Rubella	Rubella #1	_____			P ☐ / N ☐	_____
Hx of Varicella	Yes___		No____			
Varicella	Varicella #1	_____	Varicella #2	_____	P ☐ / N ☐	_____
COVID 19	COVID 19 #1	_____	COVID19 #2	_____	Booster:	_____
	Manufacturer:	_____	Manufacturer:	_____	Manufacturer:	_____
Influenza (Seasonal)	Influenza	_____				

Provider Name (Print): _____ **Phone:** _____

Provider Signature: _____ **Date** _____