



EISENHOWER HEALTH

GME Policies

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EISENHOWER MEDICAL CENTER

Policy

Effective Date: 4/24/17

Title: Resident Eligibility and Selection

Home Department: Office of Graduate Medical Education

I. POLICY

The Program Director is responsible for the selection and ranking of all candidates that meet the programs eligibility and selection criteria. Input is gathered from other members of the teaching faculty and residents as an important part of the selection process. The Sponsoring Institution must ensure that all residents and fellows selected are eligible as defined below.

II. PURPOSE

To establish guidelines pertaining to the selection of residents and fellows who will participate in Eisenhower Medical Center's residency programs.

III. PROCEDURES

Eisenhower Medical Center residency programs will comply with ACGME standards when selecting Resident and Fellow applicants. Programs will participate in the National Resident Matching Program where applicable and will abide by its rules and regulations. All PGY I positions in each program will be listed with the NRMP as part of the All-In policy.

The program director is responsible to ensure that each resident or fellow who is considered for admission fully meets the standards and criteria.

A. Resident eligibility/qualifications:

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

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME); or
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA); or,

3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:

- a. Holds a currently-valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or,
- b. Holds a full and unrestricted license to practice medicine in a US licensing jurisdiction in the ACGME specialty/subspecialty program in which they are in training; or,
- c. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.

B. Resident Selection:

- 1. Eisenhower Medical Center will ensure that its ACGME-accredited programs select from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Eisenhower Medical Center shall not discriminate with regard to race, color, sex, gender, gender identity, gender expression, national origin, disability, age, religion, religious creed, military or veteran status, marital status, physical or mental medical condition, genetic information, pregnancy, ancestry, sexual orientation or any other characteristic protected by State or Federal law.
- 2. In selecting from among qualified applicants, Eisenhower Medical Center programs will participate in the National Resident Matching Program (NRMP).
- 3. Programs do not accept J-1 Visa (Exchange Visitor) holders or sponsor for H-1B Visas.
- 4. Programs use the Electronic Residency Application Service (ERAS); candidates must submit all documents through ERAS as required by the program. Those selected for further consideration by the department must appear for a personal interview.

5. If there is a question regarding the eligibility of an applicant, the final decision will rest with the Designated Institutional Official for Graduate Medical Education.

a. Eisenhower Medical Center will conduct background checks on all residents, verify previous educational experiences and work history.

C. Benefits and Conditions of Appointment

Candidates for hospital-accredited programs (applicants who are invited for an interview) will be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment, including financial support; PTO and other leaves of absence; professional liability, hospitalization, health, disability and other insurance provided for the residents and their families. All of these elements may be found in the contract, and GME P&P Manual. Depending upon the timing of the interview, some of the data furnished are subject to change due to new or change in policy, laws, and other events that cannot be predicted at that time.

POLICY APPROVAL(S)

Graduate Medical Education Committee

April 24, 2017



Policy

Effective Date: 03/14/2016

Title: Promotion of Residents / Appointment Renewal

Home Department: Office of Graduate Medical Education

I. PURPOSE:

Resident physicians may be promoted to the next year of training if their performance indicates their ability to perform at the subsequent level as outlined in the conditions for reappointment in the resident agreement. Promotion to the next level of training and/or reappointment is made annually based on consideration of evaluation results and at the discretion of the Program Director and the Clinical Competence Committee.

II. PROCEDURE:

1. The Program Director will obtain from the faculty, as well as from other pertinent sources and/or relevant committees, information on the performance of each resident.
2. Each program must determine the criteria for promotion and/or renewal of a resident's appointment. Promotion will be based on performance evaluations and an assessment of the resident's readiness to advance to the next year of post graduate training (including, but not limited to, attainment of the ACGME Competencies at the respective level of education, achievement of specialty specific milestones, experience, demonstrated ability, clinical performance, and professionalism). The Program Director will also take into account the appropriate program and institutional guidelines set by the Residency Review Committee (RRC), specialty board guidelines, institutional resources, and the relative merit of the individual compared to other residents.
3. Prior to considering promotion, the Program Director may offer a resident additional time in any given Post Graduate Year to allow the resident to achieve the required level of proficiency for promotion. A resident accepting this condition must be given a written summary of deficiencies, a delineation of the remediation program and the criteria for advancement.
4. Programs will provide a resident with a written notice of intent when that resident's agreement will not be renewed, when that resident will not be promoted to the next level of training, or when that resident/ will be dismissed. Such written notice of intent will be provided in a reasonably timely manner. Decisions resulting in suspension, non-promotion, non-renewal, or dismissal are subject to the Due Process procedures set forth in the GME policies. A resident may choose to implement the Due Process procedure upon receipt of written notice of intent of non-promotion/non-renewal.

POLICY APPROVAL

Graduate Medical Education Committee

March 14, 2016



Policy

Effective Date: 12/5/2016

Title: Supervision of Residents

Home Department: Office of Graduate Medical Education

I. POLICY

- A. Supervision is to be readily available to residents on duty. Appropriate supervision is to be provided at all times for all residents such that the following is maintained:
 - 1. Quality patient care;
 - 2. Standards of patient, physician and employee safety; and
 - 3. Quality educational experience.
- B. Medical Staff (teaching and non-teaching):
 - 1. Members of the teaching staff must be licensed independent practitioners with appropriate clinical privileges granted by the Medical Staff Office commensurate with the patient care activities which they are supervising.
 - 2. Medical staff members who choose not to participate in the teaching program, are not subject to denial or limitations of privileges for this reason alone.
 - 3. Residents at the Medical Center shall not normally be granted specific clinical privileges.
- C. Residents are to be supervised in such a way that they assume progressively increasing responsibility, including that for teaching and supervising PGY-1 residents and medical students, according to their level of education, ability and experience.
 - 1. Level of Responsibility for Patient Care:
 - a. The level of responsibility accorded to each resident is to be determined by individual members of the teaching staff.
 - b. The level of responsibility of the Program Director, is to ensure that each member of the teaching staff is familiar with the program's written description of the roles, responsibilities and patient care activities expected of residents at each training level of the program (e.g., goals and objectives, curriculum), as well as criteria used to determine competency and promotion, to guide the teaching staff in determining the appropriate level of responsibility for individual program residents.

Title: Supervision of Residents

2. Level of Responsibility for Teaching and Supervising PGY-1 Residents and Medical Students:
 - a. Determination of a resident's readiness for teaching and supervising PGY-1 residents and medical students is to be made by the Program Director or his/her designee and faculty.
 - b. It is the responsibility of each program Director to ensure that a written policy exists for the program or department that provides guidance for determining a resident's readiness to assume responsibility for teaching and supervising PGY-1 residents and medical students.
 - c. The Program Director shall ensure that all members of the program's teaching staff review and are familiar with the written policy and are informed of the program residents' current level of responsibility with regard to teaching.
3. Level of Responsibility for Patient Care Documentation:
 - a. It is expected that residents will write orders for patients under their care, with appropriate supervision by the attending physician. This in no way interferes with the right of the members of the medical staff to write orders for their patients who are seen by residents, however, it is expected that such occurrences will be infrequent, and that the attending physician will communicate his or her action to the resident in a timely manner.
 - b. Residents may make any chart entry without direct supervision. Counter-signature, as appropriate, is the responsibility of the patient's attending physician.
 - c. Specific limitations regarding resident entries in the patient record may be made by individual departments and programs as they deem appropriate. Such regulations will be communicated to all residents and faculty affected.
 - d. Residents and fellows may write admitting and consultation notes (including History & Physical) for patients as per departmental policies. Each note is to be written with the date and time, following hospital requirements for documentation. Residents must contact the responsible member of the medical staff (attending physician) and put the date and time of such contact into the medical record. The attending physician will then see the patient, evaluate the patient, and document the evaluation with a note, to be placed within 24 hours of the patient's admission or sooner, if clinically indicated as per medical staff rules and regulations.

Title: Supervision of Residents

- e. Consultations that are done for teaching purposes only, will be identified as "Teaching Consultations," and do not require an attending physician not to follow.
 - f. Progress notes written by residents will be regularly reviewed by the attending physician, after the attending physician has evaluated the patient and documented his/her patient evaluation in the medical record.
 - g. Departments will audit medical records of teaching patients at least every six months to determine attending physician compliance with the above documentation requirements. These audits will be coordinated through the GME Office.
 - h. Program directors will report to the GME Office on a weekly basis about any violations of the supervision policy.
 - i. Violations of the supervision policy will be communicated, as soon as they become evident, to the Program Director and the Department Chair and/or Clinical Chief, to assure that the patient is seen appropriately by an attending physician.
4. Rotators into EMC may be subject to more stringent supervision rules if their program's policies so state.

D. Outpatient Activities:

New patients seen in outpatient clinics should be seen by, or discussed with the responsible member of the medical staff at the initial visit. This is to be documented in the patient medical record, either by the member of the medical staff, or by the resident with a summary of the discussion. Return patients should be seen by, or discussed with, the responsible member of the medical staff, at such a frequency to ensure that the course of treatment is effective and appropriate. This will be documented in the medical record by the resident or by the member of the medical staff.

E. Resident Patient Care Activity Approvals:

1. All training programs shall maintain a current listing of the program's residents (including both residents and fellows) indicating which patient care activities each individual is approved to perform without direct supervision.

Title: Supervision of Residents

2. It is the responsibility of the Program Director to determine by what criteria a resident qualifies for approval to perform a given patient care activity.
3. The listing of each resident's approvals shall be made available to all Medical Center patient care staff and administration.
4. If the listing does not show a resident as approved for a given activity, that resident may perform the activity, if either:
 - a. The resident can present an "approvals" notice signed by his/her program director (or designee) indicating he/she is qualified to perform the activity unsupervised: OR
 - b. The resident is supervised by another resident who is approved to perform the activity unsupervised.
5. The Program Director shall ensure that all program residents are informed of the need for approval to perform certain activities unsupervised. If a resident knowingly performs a given activity without appropriate approval (or as given in D.4. above), he/she shall be counseled by his/her program director and may be subject to disciplinary action (see GME Policy "Grievance/Due Process/Appeal of Adverse Action.")

F. Supervision of Residents in the Emergency Room:

1. If there is a disagreement about the disposition or management of a patient being seen in the Emergency Room between a resident and the ER attending physician, then the discussion must be carried along the chain-of-command.
2. The Emergency Room attending physician may, depending on the clinical situation, request that the attending physician on-call (who is providing oversight to the resident within the department) be physically present to evaluate the patient.

G. Oversight and Communications:

1. Oversight of adherence to this policy is the responsibility of the Graduate Medical Education Committee (GMEC).
2. Performance Improvement (PI) and Quality Assurance (QA) Committees are expected to identify problems resulting from inadequate supervision and to report these problems to the appropriate program director and the Medical Director, Graduate Medical Education. The Medical Director, GME shall report to the GMEC on issues brought to him by the PI and QA Committees.

Title: Supervision of Residents

3. The Chair of the GMEC, the DIO, will actively participate on the Executive Committee (MEC).
4. The Chair of the GMEC shall ensure that feedback from the MEC, as well as other communication that impacts resident activities, is communicated to the Program Directors.
5. All members of the medical staff will sign a letter attesting to their understanding of their responsibilities under this policy for the supervision of residents. All residents will sign a letter attesting to their understanding of their responsibilities under this policy. Signing of these letters will be required for participation in teaching and in training, respectively.
6. Each training program will have a program-specific policy further detailing responsibilities for the supervision of residents. Specifically, the departmental policies will include the requirements for credentialing of procedures, a program-specific chain of command document, a list of procedures which require credentialing, and a year-by-year description of patient care activities for residents in that program.
7. Each training program will develop and distribute on-call schedules for teaching staff that ensure that qualified supervising faculty will be continuously and immediately available to any resident who is on duty or on call, and that a means for rapid communication with that faculty member will be made available to the resident.

II. PURPOSE

- A. To ensure that residents are provided with an amount of supervision that encourages their professional growth without diminishing patient care quality, in accordance with requirements of the Accreditation Council for Graduate Medical Education (ACGME).
- B. To ensure that responsibility for the supervision of residents is clearly delineated, and that a resident's level of responsibility can be readily determined by patient care providers and administrators within Eisenhower Medical Center, in accordance with the requirements of the Joint Commission.
- C. To ensure that effective communication occurs between the GMEC and the MEC regarding quality of patient care, educational needs and other issues as they relate to residents.

Title: Supervision of Residents

III. RESPONSIBILITIES

- A. Although it is expected that as residents and fellows proceed through a training program, the patient care responsibilities assigned to them will reflect their professional growth, Eisenhower Medical Center must bear the ultimate responsibility for assuring the delivery of quality patient care in all teaching programs. The attending physician has ultimate responsibility for the care of the patient.
- B. Program directors are responsible for the establishment of departmental or programmatic policies to insure that all Residents are adequately supervised in their treatment of patients. These policies should provide:
 - 1. Written descriptions of supervisory lines of responsibility for the care of patients (i.e., "chain of command");
 - 2. Procedure to ensure a patient's continuity of care;
 - 3. Structure of on-call scheduling such that supervision is readily available to residents on duty;
 - 4. Prompt, reliable systems for communicating with supervisory physicians, either in emergency situations or in situations where a resident has questions or concerns about the appropriate treatment of a patient;
 - 5. Obligation of Residents to communicate with attending staff on a regular basis regarding the progress of their patients; and
 - 6. Appropriate levels of staffing so that at no time is there excessive reliance on residents to fulfill service obligations;
 - 7. Brief statements regarding the roles, responsibilities and patient care activities of residents and written goals and objectives for the program, (see GME Policy "Program Goals & Objectives"), program curriculum and competency/advancement criteria (see GME Policy "Promotion & Renewal of Resident Agreement.")

IV. PROCEDURES

- A. The GMEC shall oversee adherence to the Supervision Policy via the internal review process. (See GME Policy "GME Internal Program Review" for details on the review process.)
- B. Resident Approvals:
 - 1. Program directors determine, based on departmental criteria, who qualifies for approval for given patient care activities.

Title: Supervision of Residents

1. The GME Office coordinates the collection of data (list of activities and approved residents) from programs.
2. The GME Office Compiles the data from all programs into a single document and publishes it to the EMC Intranet.
3. Approximately every two months, the GME Office contacts programs to update the data. Programs may also submit additional data changes at any time.
4. For approvals granted in between publications of updates, program directors shall issue to newly approved residents, a signed notice indicating which approval(s) have been granted.
5. For rotators who are at EMC for one month or less, program directors shall issue a signed notice of approvals. For rotators who are at EMC for more than one month, the program director shall include the individual's name and approvals on the list provided to the GME Office.

POLICY APPROVAL(S)

Graduate Medical Education Committee

August 19, 2010

Updated: December 5, 2016



EISENHOWER MEDICAL CENTER

Policy

Effective Date: 12/5/2016

Title: Duty Hours, Work Environment and Fatigue

Home Department: Office of Graduate Medical Education

I. POLICY

Program directors are responsible for ensuring that resident/fellow duty hours meet limits on their assigned responsibilities, including, but not limited to, assignments to care for new patients. Such responsibilities may change over the course of the on-duty assignment. Each Program director shall direct that the resident/fellow schedules be retained on file for no less than three years.

II. PURPOSE

Resident/fellow duty hours will foster optimum conditions for provision of safe patient care, education and resident/fellow well-being. It is the policy of the Eisenhower Medical Center to prohibit resident/fellow from working in excess of those hours permitted under the ACGME Institutional and Common Requirements.

III. DEFINITION

- A. Duty Hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (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. Duty hours do not include reading and preparation time spent away from the duty site.
- B. In-house Call is defined as those duty hours when resident/fellows are required to be immediately available within the assigned institution.
- C. At-home (pager) Call is defined as call taken from outside the assigned institution.

IV. PROCEDURES

A. Oversight

The program director is responsible for establishing and implementing formal written policies and procedures governing resident/fellow duty hours in compliance with the requirements of ACGME Institutional Requirements. Resident/fellow on-call or duty hours should reflect an educational rational and patient need (including continuity of care).

1. The program must ensure that the resident/fellows are provided with appropriate back-up support when patient care responsibilities are especially difficult or prolonged.
2. The program must monitor duty hours and call schedules, and make adjustments as necessary to address excessive service demands and resident/fellow fatigue.
3. Work that is extraneous to the resident/fellow's educational program must be minimized.

B. Monitoring

All programs must establish a method for obtaining resident/fellow duty hour data. Each resident/fellow is responsible for providing accurate and timely data to the program director or his/her designee.

During orientation each year, the resident/fellows will be instructed in the duty hours logging process in MedHub. Resident/fellows are required to log in their duty hours on a daily basis. The Program Manager will collate the data and submit a summary to the Program Director and Clinical Competency Committee. In between those meetings, should a duty hour violation be noted, the Program Manager will notify the Program Director, who will review the issues with the resident/fellow at that time.

The duty hour summaries will be submitted for review at the quarterly GMEC meetings for review and documentation. They will also be summarized as part of the Annual Program Evaluation process and will be made available to the ACGME, if requested.

C. Duty Hour Requirements

1. The duty hours are limited to 80 hours per week as averaged over a 4-week period inclusive of all in-house call activities.
2. The GME program ensures that resident/fellow have 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.
3. A 10-hour time period is provided between all daily duty periods and after in-house call.
4. Continuous on-site duty, including in-house call does not exceed 16 hours for the PGY-1 resident. For PGY-2-5 resident/fellows, continuous on-site duty, including in-house call, does not exceed 24 consecutive hours. PGY-2-5 resident/fellow may remain on duty, in rare circumstances, for up to an additional four hours, to provide continuity of care to patients who require it.

D. Call Activity

1. In-house call is not more than every 3rd night, averaged over a four-week period.

2. While the frequency of at-home call is not subject to every 3rd night limitations, it should not be so frequent as to preclude rest and reasonable personal time.
3. Resident/fellows taking at-home call are provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
4. When resident/fellows are called into the hospital from home, the hours spent in-house are counted toward the 80-hour limit.
5. The program director and faculty monitor the demands of at-home call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

E. Resident/Fellow Fatigue

If patient care responsibilities are especially difficult and prolonged or if unexpected needs create fatigue sufficient to jeopardize the safety of the resident/fellow or of patient care during or following on-call period, a resident/fellow may require added consideration.

1. The resident/fellow should discuss any problem with the supervising physician;
2. The supervising physician will review with the resident/fellow any issues that may have caused the fatigue and make appropriate arrangements to address the immediate problem.
3. Round trip transportation reimbursement is available to any resident/fellow that elects to use a transportation service to get home instead of drive their vehicle while fatigued.

F. Moonlighting

1. Moonlighting that occurs within the training program, sponsoring institution i.e. internal moonlighting must be counted in the total weekly duty hours.
2. Requests for resident/fellow moonlighting must be approved, in writing, by the program director in advance of such activity. Programs may prohibit a resident/fellow from engaging in moonlighting. If moonlighting activities impact a resident/fellow's performance the program director may rescind permission for that resident/fellow to engage in moonlighting activities.
3. Resident/fellows are not required to moonlight.

G. Duty Hour Exception

The GMEC will consider requests for duty hour exceptions from eligible programs. The program director must submit required documentation to the GMEC for consideration by the ACGME, as follows:

1. Patient Safety: Information must be submitted that describes how the program will monitor, evaluate, and ensure patient safety with extended resident/fellow hours.
2. Educational Rationale: The request must be based on sound educational rationale which should be described in relation to the program's stated goals and objectives for the particular assignments, rotations and level(s) of training for which the increase is requested. Blanket exceptions for the entire educational program are considered the exception, not the rule.
3. Moonlighting Policy: The program (and institution) must have moonlighting policies for the periods in question.
4. Call Schedules: Specific information regarding the resident/fellow call schedules during the times specified for the exception must be provided.
5. Faculty Monitoring: Evidence of faculty development activities regarding the effects of resident/fellow fatigue and sleep deprivation must be appended.
6. If the GMEC approves the exception request, the DIO will oversee the process on Web Ads to forward the request to the RRC.

WORK ENVIRONMENT

1. Resident/fellows must be provided with a sound didactic and clinical education.
2. Resident/fellow work education must be balanced with concerns for patient safety and resident/fellow well-being.
3. Didactic and clinical education must have priority of resident/fellows' time allotments.
4. Learning objectives must not be compromised by service obligations.
5. Duty hour assignments must recognize that resident/fellows and faculty collectively have responsibility for the safety and welfare of patients.
6. Faculty and resident/fellow must be educated to recognize the signs of fatigue, and adopt and apply policies to present and counteract its potential negative side effects.

POLICY APPROVAL(S)

Graduate Medical Education Committee

August 13, 2010

Updated: December 5, 2016



EISENHOWER HEALTH

Graduate Medical Education

Policy

Effective Date: Aug. 6, 2018

Title: Moonlighting and Other Outside Activities

Home Department: Office of Graduate Medical Education

I. POLICY

Eisenhower Medical Center is committed to providing meaningful and enriching educational experiences for residents in compliance with the ACGME Institutional and Program requirements governing the performance of moonlighting activities by residents enrolled in GME programs.

II. PURPOSE

Any resident enrolled in a program at Eisenhower Medical Center who requests permission to engage in moonlighting activities must adhere to the moonlighting policy of Eisenhower Medical Center.

III. DEFINITIONS

1. **External Moonlighting**: Voluntary, compensated, medically-related work performed outside the institution where the resident is in training or at any of its related participating sites.
2. **Internal Moonlighting**: Voluntary, compensated, medically-related work (not related with training requirements) performed within the institution in which the resident is in training or at any of its related participating sites.

III. PROCEDURES

- A. No resident may be required, as a condition of his or her training program, to perform moonlighting activities.
- B. Residents may moonlight, but only after receiving the prior written/signed approval of his/her program director. The Approved Internal/External Moonlighting Request Form (attached) should be used for this purpose and should become a part of the resident's file.
- C. No resident may moonlight without first having obtained an unrestricted license to practice medicine in the state in which the moonlighting activity is to take place.
- D. No resident may moonlight without first having been appropriately credentialed by the hospital or facility where the moonlighting is to occur.

- E. The number of hours worked by a resident in all moonlighting activities (internal and external), together with the hours worked in his/her training program may not exceed the ACGME guidelines for duty hours. The program director of the resident must approve and monitor the number of hours that the resident may engage in moonlighting activities. Residents will submit a log of their moonlighting hours to the residency coordinator at least quarterly and on request.
- F. All requests to moonlight must go to the residency coordinator on the application form at least 10 days before the event and be approved by the advisor or program director prior to the activity. New moonlighting sites may need more investigation before approval than those previously utilized for this activity.
- G. Residents must be in good academic standing and have achieved the minimum acceptable score on the most recent ITE or have completed remediation as demonstrated by active participation in Challenger or other assigned remediation.
- H. R1s are not allowed to moonlight. R2s may moonlight in situations where there is another physician working on site. R3s may moonlight if there is telephone back up.
- I. Moonlighting during regular duty hours is explicitly forbidden, regardless of rotation schedule. There must be adequate travel time allowed between the end of residency activity and starting moonlighting. At no time will moonlighting activities interrupt residency program requirements. Specifically, residents may not depart early or return late from moonlighting activities.
- J. Residents' moonlighting privileges may be denied or curtailed if there are academic concerns, for disciplinary reasons, signs of fatigue or poor functioning, or for cutting work hours.
- K. There is no moonlighting allowed during leaves of absence.
- L. Moonlighting activities, whether internal or external, are prohibited if they are inconsistent with the principles of providing residents with sufficient time for rest and restoration to promote the resident's educational experience and safe patient care. The program director shall monitor the effect of moonlighting activities on the resident's performance. The program director may withdraw permission for moonlighting activities at any time if he/she determines that the moonlighting activity is having an adverse effect upon the resident's participation in the GME educational program in which he/she is enrolled.
- M. Failure to adhere to program moonlighting requirements, as outlined above, will result in disciplinary action up to and including probation and termination from the program.

Fully executed copies will be returned to the Program Director and Resident

POLICY APPROVAL(S)

Graduate Medical Education Committee

**December 14, 2015
Updated: August 6, 2018**



EISENHOWER HEALTH

EXTERNAL MOONLIGHTING REQUEST FORM

NAME: _____ PGY LEVEL: _____

PROGRAM: _____

PROGRAM DIRECTOR: _____

1. I am considering the following moonlighting activity (please describe location and anticipated activity):

2. I wish to perform this activity at:

3. The proposed moonlighting schedule is as follows:

4. Backup at site:

On-site? _____ Phone? _____ Who provides? _____

5. The chairman/division chief/medical director in the department/division/hospital/ facility where I wish to moonlight is: _____

6. I understand that the total number of hours to be worked in my moonlighting activities (internal and external), together with the hours worked in my educational program, may not exceed the ACGME guidelines for duty hours. I understand that my program director must approve the specific number of hours that I may engage in moonlighting activities per week.

7. I understand that my program director will monitor my performance for the effect of moonlighting activities on my performance in my training program. I understand that the program director may withdraw permission for moonlighting activities at any time if he/she determines, at their sole discretion, that the moonlighting activity is having an adverse effect upon my performance in my training program.

8. I understand that I may not moonlight until my program director signs this Moonlighting Request Form.
9. I have obtained an unrestricted license to practice medicine in the state in which the moonlighting is to take place.
10. I have obtained my own DEA number.
11. I understand that I must receive an appointment letter and a privilege delineation form from the moonlighting hospital/facility before I begin moonlighting activities.
12. I understand that even though my moonlighting activities at institutions other than Center count toward compliance with the duty hours rules, **I AM NOT COVERED BY THE EISENHOWER MEDICAL CENTER'S PROFESSIONAL LIABILITY INSURANCE FOR MOONLIGHTING ACTIVITIES AT THOSE INSTITUTIONS.** I understand that I am responsible for obtaining my own professional liability insurance for moonlighting activities at institutions other than the Eisenhower Medical Center. I will provide a copy of the insurance certificate.
12. I understand that Eisenhower Medical Center's DEA number may not be used for moonlighting activities at other institutions.

Resident/Fellow

Date

APPROVAL OF REQUEST TO PERFORM MOONLIGHTING ACTIVITIES

This approval covers the above described moonlighting activity for the period from

_____ to _____.

Program Director

Date



EISENHOWER HEALTH

INTERNAL MOONLIGHTING REQUEST FORM

I, _____, hereby request permission from the _____ (Program), and _____ (Program Director) to be able to "moonlight" at _____ (Facility), in the capacity of resident/fellow at the compensation rate of "time and a half" of the current resident/fellow hourly rate.

I understand the ACGME Common Program Requirements (VI.F.5.a, b, c) state: "Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. Time spent by residents in internal and external Moonlighting (as defined by the ACGME and noted within this policy) must be counted towards the 80-hour maximum weekly limit. PGY-1 residents are not permitted to moonlight." Performance in my training program will be monitored closely for the effect of these activities and adverse effects may lead to withdrawal of this permission.

Further, I understand residency/fellowship education is a full-time endeavor and my Program Director must ensure that moonlighting does not interfere with my ability to achieve the goals and objectives of my training program. Moonlighting is a privilege and is at the discretion of the program director. The program director can deny any moonlighting request for any reason.

1. Describe Moonlighting Service: _____
2. List Moonlighting Site: _____
3. Date of Moonlighting: _____ Number of Hours Worked: _____

REQUIRED SIGNATURES AND APPROVALS:

Resident/Fellow

Date

Program Director

Date

Designated Institutional Official

Date



EISENHOWER HEALTH

Policy

Effective Date: June 24, 2019

Title: Resident/Fellow Leave of Absence – Procedural Requirements

Home Department: Office of Graduate Medical Education

I. PURPOSE:

The ACGME requires that sponsoring institutions provide written instructional policies on residents/fellows vacation and other leaves of absence. These policies should encompass the specifics of its Specialty Board certification requirements.

II. POLICY:

Each program and resident/fellow is subject to and will abide by this institutional policy regarding leaves of absence.

III. PROCEDURES:

Vacation, Illness, and Other Short-Term Absences:

- a. Residents/Fellows are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one (1) month per academic year.
- b. All residents/fellows are provided with a total of 21 working days of paid vacation/sick time at the beginning of each residency term. Paid vacation/sick time may be used for any purpose listed in the Eisenhower Medical Center Sick Pay Policy #122509. Vacation periods may not accumulate from one year to another. Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of the PGY2 year and first month of the PGY3 year in sequence) and a resident does not have the option of reducing the total time required for residency (36 calendar months) by relinquishing vacation time.
- c. **In case of absence for illness, the resident/fellow must email their program (i.e., IMAway, FM Away, EM Away, PM Away) and inform (i) the supervising physician on assigned service, (ii) Program Manager or their appointed designee, (iii) chief residents, and (iv) external clinics. Direct communication is required before 6:30am on the day of the absence.**
- d. Absence from residency/fellowship education, in excess of 1 month within the academic year must be made up before the resident/fellow completes or advances to the next training level, and the time may be added to the projected date of completion of the required training at the discretion of the Program Director.

Long-Term Leaves of Absence:

- a. Individual residency/fellowship review committee (RRC) and/or specialty board criteria for satisfactory completion of each residency program will determine the amount of additional training required due to leaves of absence.
- b. Leave time under any of these categories will not be credited as time toward Board eligibility. When the need/request for leave is foreseeable, the request should be submitted at least thirty (30) days prior to the leave. When the need for the leave is unforeseeable or the thirty days' notice cannot be given, the request should be submitted as soon as practical.
- c. In cases where a resident/fellow is granted a leave of absence by the program, or must be away because of illness or injury, the Program Director is expected to inform the Specialty Board promptly by electronic mail of the date of departure and expected return date. It should be understood that the resident may not return to the program at a level beyond that which was attained at the time of departure.

Educational Leave:

- a. Time away from the residency/fellowship program for educational purposes, such as workshops or educational conferences, are not counted in the general limitation on absences but should not exceed 5 days annually. Attendance at educational, scholarly, and professional activities is scheduled by mutual agreement with the Program Director.

Jury Duty:

- a. The Program Director must be notified as soon as a jury summons is received. Resident/Fellow's should refer to Eisenhower Medical Center's Jury Duty Policy#2414 for additional information.

Bereavement:

- a. After completion of 90-days of employment, residents/fellows may use up to 24 hours of bereavement pay for time off in the event of a death in the immediate family. "Immediate family" includes current spouse, parent, step-parent, grandparent, current parent-in-law, child, step-child, sibling or registered domestic partner. Bereavement time is limited to a total of forty-eight (48) hours of paid time per calendar year in the event of more than one death in the employee's immediate family. Residents/Fellows must contact their Program Director and Program Manager as soon as practical when bereavement time is being requested.

Family and Medical Leave:

- a. Twelve weeks of unpaid leave under the Family and Medical Leave Act ("FMLA") may be available to eligible employees. Resident/Fellow's should refer to Eisenhower Medical Center's Leave of Absence Policy #2433 for additional information.

Request for Time Away:

- a. Other requests for time off must be in writing using the "Resident/Fellow Time Away Request" form available from the Program Coordinator. Residents are required to turn in a time away form in order to cancel clinics **no later than 30-90 days (depending on each program requirements)** prior to the month of the requested leave. If the Coordinator does not receive a leave request form in the required time frame, your leave may be denied. In approving leave request, consideration is given to adequate clinic staffing and patient care. As a result, the residency/fellowship program must limit the number of residents scheduled out of clinic at any one time.

Unexcused Absence & Tardiness:

- a. When a resident/fellow is absent or has multiple instances of tardiness and does not observe the formal notification process, they may impair patient care and also put undue burden on their colleagues. Observing this process is viewed as an important measure of professionalism. In the event, a letter of concern will be placed in the resident/fellow's permanent file and a meeting with the Program Director to discuss possible probation, at the discretion of the Program Director.

Links of Reference:

ACGME - https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf

ABIM - <http://www.abim.org/~media/ABIM%20Public/Files/pdf/publications/certification-guides/policies-and-procedures.pdf>

ABFM - <https://www.theabfm.org/cert/absence.aspx>

Eisenhower IkeNet Human Resources - <http://ikenet/body.cfm?id=212>

POLICY APPROVAL(S)**Graduate Medical Education Committee****September 26, 2016****Update: June 24, 2019**



EISENHOWER HEALTH

Policy

Effective Date: June 24, 2019

Title: Remediation & Disciplinary Action Policy

Home Department: Office of Graduate Medical Education

I. PURPOSE

The purpose of this policy and process is to describe any remediation (informal, formal, and probation) and disciplinary actions (suspension, renewal without promotion, nonrenewal or termination) for all Graduate Medical Education (GME) training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) to follow if a Resident/Fellow's training in such a program fails to meet academic expectations and/or engages in misconduct.

II. POLICY

Each Program Director (PD) is responsible for assessing and monitoring a resident/fellow's academic and professional progress in clinical competence, the ACGME core competencies, attitudes and adherence to departmental, institutional and hospital policies and procedures. Each training program must have a Clinical Competency Committee (CCC) that is charged with advising the PD about resident/fellow performance and progress and make recommendations to the PD regarding promotion, remediation, and dismissal decisions. Failure of a resident/fellow to meet expectations in these areas may result in disciplinary action being taken by the resident/fellow's PD.

III. REMEDIATION

All residents/fellows should be provided routine feedback that is consistent with the educational program. Feedback techniques include verbal feedback, rotational evaluations and summative evaluations. Remediation is not a disciplinary action, but rather an educational tool to correct areas of unsatisfactory academic performance by a resident/fellow. Therefore a resident/fellow may not appeal a remediation under the Grievance Policy and Due Process Policy. Below is the remediation schema for residents/fellows at risk of not meeting educational milestones during their training. The GME Program reserves the right to take action outside of the standard process and/or to bypass the steps below as the Program deems necessary to carry out the intent of this policy and appropriately address the resident/fellow performance/behavior.

1. **Warning/Informal Remediation** is initiated when a resident/fellow's performance is deficient in one or more of the outcomes-based milestones established by the ACGME, but not significant enough to trigger formal remediation. A **Performance Improvement Plan (PIP)** documenting the resident/fellow's strengths, deficiencies, expectations for improvement, an observation period, and progress during remediation. During the informal remediation, the Program Director (PD), resident/fellow, and CCC are engaged, but not the GME office. Provided the resident remediates, informal remediation is not disclosed in the final verification of training or employment letters.
2. **Formal Remediation** occurs when the PD/CCC determines that the deficiency is significant enough to warrant something more than the informal remediation. An updated PIP should be documented with expected outcomes, a time frame for reassessment, and potential consequences if the remediation is not successful and signed by both parties to acknowledge receipt and understanding. The process includes documentation in the resident/fellow's file and notification of the GME office; however, the documentation is not disclosed if the resident successfully remediates.
3. **Probation** occurs when the PD/CCC determines that the resident/fellow has failed to satisfactorily cure the deficiency and/or improve his/her overall performance or behavior to an acceptable level. The PD/CCC may elect to take further action, which may include one or more of the following steps:
 - a. Issuance of a new PIP
 - b. Requiring the repeat of a rotation that in turn extends the required period of training
 - c. Denial of credit for previously completed rotations
 - d. Extension of contract, which may include extension of the defined training period

IV. DISCIPLINARY ACTION

Disciplinary Action occurs when a Program Director places a resident/fellow on: renewal without promotion, non-renewal of agreement, suspension or dismissal from a residency / fellowship training program. The decision to place a resident/fellow on disciplinary action must be approved by the Designated Institutional Official (DIO), reviewed by the Legal Department, and Human Resources, prior to the implementation of the disciplinary action. All disciplinary actions require written notices are grievable under the Grievance Policy and Due Process Policy. The GME Program reserves the right to take action outside of the standard process and/or to bypass the steps below as the Program deems necessary to carry out the intent of this policy and appropriately address the resident/fellow performance/behavior.

1. **Renewal without Promotion** means the resident/fellow will not be promoted to the subsequent PGY-year at the completion of the current year of training. Renewal without promotion should be used when a resident/fellow has not been able to clearly demonstrate the knowledge, skills, or behaviors required to advance to the next level of training and responsibility.
2. **Non-Renewal of Agreement** means the training program has decided not to offer a contract to the resident/fellow for the next academic year or training period for any of the following reasons below. A written notice of non-renewal four (4) months prior to the end of the Initial Term or any renewed term is required, as applicable. However, if the primary reason(s) for the non-renewal occurs within the four (4) months prior to the end of the Initial Term or any renewed term, the PD shall provide the resident/fellow with as much written notice of non-renewal as the circumstances will reasonably allow.
 - a. Consistent less than satisfactory or below average evaluations by the faculty;
 - b. Failure to correct deficiencies during the remediation/ disciplinary period;
 - c. Consistent and multiple complaints about interpersonal relationships with patients, peers, professional staff, support staff, or physicians with whom the resident/fellow interacts during the resident/fellow's training program;
 - d. Consistent delinquent episodes in the completion of medical records;
 - e. Failure to comply with the special requirements of the residency/fellowship program (i.e. procedure documentation, research projects, conference attendance, etc.)
 - f. Violation of hospital rules or regulations; or such other cause as, in the opinion of the PD, makes it advisable to decide not to renew the agreement.
3. **Suspension** from the program involves removal from the program for an indefinite period of time without prior notice due to serious deficiencies in knowledge, performance, or behavior. The decision to suspend a resident/fellow from the program may be made at the discretion of the PD with the prior approval of the DIO. During the period of suspension from the program, usually not to exceed 30 days, the PD and DIO must determine whether the resident/fellow should be reinstated to the Program or terminated.
4. **Dismissal** involves immediate and permanent removal of the resident/fellow from the educational program for failing to maintain academic and/or other professional standards required to progress in or complete the program, by the PD and DIO. A resident/fellow may be dismissed for any of the following reasons:
 - a. Failure to correct deficiencies during the remediation/ disciplinary period;
 - b. Unprofessional or dishonorable conduct or professional incompetence;

- c. Conviction of a felony, as defined by the applicable state and federal laws, during the period of residency training;
- d. Inability to participate in the essential functions of the Residency/Fellowship Training Program, with or without accommodations, due to mental or physical condition or impairment;
- e. Participation in non-sanctioned activities (i.e., moonlighting) without written permission of the PD;
- f. Violation of hospital rules or regulations; or such other cause as, in the opinion of the PD, makes it advisable to dismiss the resident/fellow.

A resident/fellow will be notified in writing from the program or the GME office of his/her dismissal thirty (30) days prior to the dismissal date but may be suspended from any participation in the program during this thirty (30) day period upon recommendation of the Program Director. Abusive, profane, threatening, demeaning language, and/or language resulting in violation of HIPPA regulations or compromising patient safety and/or confidentiality can result in immediate termination. Termination of a resident/fellow's participation in a program requires written notice as described in Section V.

V. Notice of Disciplinary Action

A resident/fellow against whom disciplinary action has been taken shall be given written notice of the intended action from the PD or their designee. The written notice shall include a concise statement of the resident/fellow's alleged acts or omissions or other reasons for the action and must be signed by the PD and DIO. The notice shall be given to the resident/fellow either by sending a copy of the notice to the resident/fellow by certified mail (return receipt requested), or by hand-delivering a copy to the resident/fellow and, if possible, obtaining the resident/fellow's signed receipt for the notice. If the resident/fellow refuses to sign the hand-delivered receipt, then such refusal shall be considered as an acknowledgment of delivery and noted on the receipt. A copy of the notice shall also be given to the DIO.

VI. Request for Hearing

A resident/fellow shall have ten (10) working days following receipt of such notice to file a written request for a hearing and begin the grievance process as outlined in the GME Grievance Policy. Such request shall be delivered to the DIO, or designee, either in person or by certified or registered mail. A resident/fellow who fails to request a hearing within the time and in the manner specified waives any right to such hearing and to any review to which he/she might otherwise have been entitled.

POLICY APPROVAL(S)

Graduate Medical Education Committee

June 24, 2019

PERFORMANCE IMPROVEMENT PLAN (PIP) LETTER

Resident/Fellow: _____ **Date:** _____

This is to notify you of deficiencies in complying with the academic requirements of your residency/fellowship training program and inform you of expectations for improvement. Information is detailed below regarding the reasons for this official notice of Performance Improvement status, measures to improve performance, timeframe for meeting expectations, and consequences of not addressing these issues.

Reason(s) for PIP:

These deficiencies include (check all that apply):

PATIENT CARE: *Resident/Fellow must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health and to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.*

Resident/Fellow is expected to:

☐ Write in deficiency [as further specified by specialty]

Describe in further details:

MEDICAL KNOWLEDGE: *Resident/Fellow must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.*

Resident/Fellow is expected to:

☐ Write in deficiency [as further specified by specialty]

Describe in further details:

PRACTICE-BASED LEARNING AND IMPROVEMENT: *Resident/Fellow must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning*

Resident/Fellow is expected to develop skills and habits to be able to:

- ☐ identify strengths, deficiencies, and limits in their knowledge and expertise;
- ☐ set learning and improvement goals;
- ☐ identify and perform appropriate learning activities;
- ☐ systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- ☐ incorporate formative evaluation feedback into daily practice;
- ☐ locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- ☐ use information technology to optimize learning; and,
- ☐ participate in the education of patients, families, students, Resident/Fellow, and other health professionals.
- ☐ Write in deficiency [as further specified by specialty]

Describe in further details:

INTERPERSONAL AND COMMUNICATION SKILLS: *Resident/Fellow must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals*

Resident/Fellow is expected to:

- ☐ communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- ☐ communicate effectively with physicians, other health professionals, and health related agencies;
- ☐ work effectively as a member or leader of a health care team or other professional group;
- ☐ act in a consultative role to other physicians and health professionals; and,
- ☐ maintain comprehensive, timely, and legible medical records, if applicable.
- ☐ Write in deficiency [as further specified by specialty]

Describe in further details:

PROFESSIONALISM: *Resident/Fellow must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.*

Resident/Fellow is expected to demonstrate:

- ☐ compassion, integrity, and respect for others;
- ☐ responsiveness to patient needs that supersedes self-interest;
- ☐ respect for patient privacy and autonomy;
- ☐ accountability to patients, society, and the profession; and,
- ☐ sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender (including gender identity and expression), age, culture, race, religion, disabilities, and sexual orientation.
- ☐ Write in deficiency [as further specified by specialty]

Describe in further details:

SYSTEMS-BASED PRACTICE: *Resident/Fellow must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.*

Resident/Fellow is expected to:

- ☐ work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- ☐ coordinate patient care within the health care system relevant to their clinical specialty;
- ☐ incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- ☐ advocate for quality patient care and optimal patient care systems;
- ☐ work in interprofessional teams to enhance patient safety and improve patient care quality; and
- ☐ participate in identifying system errors and implementing potential systems solutions.
- ☐ Write in deficiency [as further specified by specialty]

Describe in further details:

Plan for Improvement and Evaluation Criteria

(Description of what the resident/fellow must do or cease doing to show that the problem(s) have been corrected. You should give him/her very clear cut activities and assessment expectations. This will make the decision easier for you.)

Deficiencies selected from above	Improvement Activities	Assessment Method
<i>Example: Identify strengths, deficiencies and limits in one's knowledge and expertise</i>	<i>Write a reflection paper that: reflects on your underlying motives/reasons for lapse in professionalism, describe the impact on relationship with other healthcare professionals, identify ideal professional behavior, outline corrective actions and summarize any insight you gained through this self-reflective activity.</i>	<i>Submission of reflection paper</i>

Timeframe for Performance Improvement (include the amount of time that the resident/fellow has to demonstrate his/her ability to satisfy the plan's requirements.

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Consequences

- Failure to successfully meet all of the requirements for performance improvement will result in repeating rotation(s), non-promotion, non-renewal or immediate termination from the program.

Resident/Fellow & Program Director Acknowledgement:

On this date, I have met with the program director to discuss my performance in the residency training program. I have read this Academic Performance Improvement Plan and the expectations for improvement listed above. I understand that needed improvement must be achieved and maintained and failure to correct areas of marginal/unsatisfactory performance or behavior will result in repeating rotation(s), non-promotion, non-renewal or immediate termination from the program.

Resident/Fellow Signature

Date

Program Director Signature

Date



EISENHOWER HEALTH

Policy

Effective Date: June 24, 2019

Title: Grievance and Due Process Policy

Home Department: Office of Graduate Medical Education

I. POLICY

The Accreditation Council for Graduate Medical Education (ACGME) requires that sponsoring institutions provide fair and reasonable written institutional policies and procedures for grievance and due process, which may be utilized when a disciplinary action has been taken against a resident/fellow who could result in renewal without promotion, non-renewal of agreement, suspension or dismissal from a residency/fellowship training program.

If the cause for suspension or dismissal is a legal or Human Resources issue, the applicable statute supersedes GME policy.

II. PURPOSE

To offer an appeal and review process to a resident/fellow whose professional conduct or academic performance has resulted in a disciplinary action as described in the Disciplinary Action Policy.

III. PROCEDURES

- A. At the time a resident/fellow is notified of the disciplinary action, the Program Director (PD) will also advise them of the right to an unbiased appeal by invoking the Appeals Procedure. The written notice of the disciplinary action decision will include both a copy of this procedure and the specific deficiencies against the resident/fellow, which resulted in the disciplinary action. At this time the resident/fellow will be required to turn in their ID Badge to the PD.
- B. During the appeals process, the resident/fellow will be considered to be on suspension with continued salary/benefits until the date of the final disposition of the appeal.
- C. To activate the Appeals Procedure, the resident/fellow must make a written request within ten (10) working days of the issuance of the disciplinary action decision. The written request is made to the Designated Institutional Officer (DIO) or designee. A Human Resources representative will be regularly informed of the status of the appeal. Failure of the resident/fellow to request the Appeals Procedure within ten (10) working days of the issuance of the disciplinary action decision constitutes a waiver of the right to an appeal and review.

- D. In the period between the request for an appeal and the appeal hearing, the resident/fellow will have a right to make reasonable request for documents for presentation.
- E. The Appeals Panel will be coordinated and chaired by the DIO or designee, who will preside at the hearing and provide guidance on the process but will not be a voting participant. The appeal hearing will be scheduled within thirty (30) working days of the resident/fellow's request.
- F. An Appeals Panel is established to meet and review information, question individuals, and review all of the documentation that applies to the issues that resulted in the disciplinary action. The Appeals Panel will consist of at least three (3) members of the GMEC: two faculty physicians, and one resident/fellow. One member of the panel is selected by the DIO (or designee), one by the resident/fellow, and one by the PD. Panel members cannot have been involved directly with the incident(s) that resulted in the disciplinary action.
- G. The resident/fellow and PD are given an opportunity to appear before the panel to answer questions, respond to the information, question key individuals, and to present witnesses and pertinent documentation. Both the resident/fellow and PD may be present during the fact-finding portion of the appeal and shall have the opportunity to present written submissions in support of their respective positions.
- H. The decision of the panel is based solely on information presented at the appeal. The panel is authorized to uphold, reject, or modify the disciplinary action decision. The decision is made by majority vote of the panel through secret ballot.
- I. The panel has ten (10) working days to conduct and conclude the appeal and report its decision to the DIO (or designee), who will forward the report to the resident/fellow and PD via certified mail or in person, and also communicate the status to the Human Resources Representative.
- J. The time limits identified in this policy may be reasonably extended by the panel, resident/fellow, or PD via a formal request. Requests for extensions are presented to the DIO (or designee) for review and determination.

POLICY APPROVAL(S)

Graduate Medical Education Committee

April 24, 2017

Update: June 24, 2019



EISENHOWER HEALTH

Policy

Effective Date: December 9, 2019

Title: Well-Being Policy

Home Department: Office of Graduate Medical Education

I. POLICY

The Accreditation Council for Graduate Medical Education (ACGME) requires that sponsoring institution recognizes that Resident/Fellows are at increased risk for burnout and depression, Eisenhower Medical Center will prioritize efforts to foster Resident/Fellow well-being while ensuring the competence of its trainees.

II. PURPOSE

To enhance well-being initiatives (burnout, promoting well-being, assessing and addressing emotional and psychological distress, depression, suicide, substance abuse, improving the learning and work environment, and coping with tragedy) at the individual and system level for all residency and fellowship programs at Eisenhower.

III. PROCESS

Programs will enhance the meaning a Resident/Fellow finds in being a physician by delineating manageable patient care responsibilities. Manageable patient care responsibilities are not defined in the common program requirements as these are the purview of each specialty. Each Program will adhere to the manageable patient care responsibilities as defined by the review committee for their individual specialty. These will be included in their learning objectives.

I. Regarding these responsibilities, each Program must:

- A. Insure protected time dedicated to patient care
- B. Minimize non-physician obligations (patient transport, administrative/clerical duties, allied health responsibilities)
- C. Provide administrative support
- D. Promote progressive autonomy and flexibility
- E. Enhance professional relationships
- F. Provide oversight of scheduling, work intensity and work compression that may negatively impact a Resident/Fellow's well-being
- G. Provide access to food while on duty.
- H. Ensure Resident/Fellows have access to refrigerators in which they may store food.

- I. Provide facilities for lactation with refrigerators.
 - J. Provide facilities for rest and fatigue mitigation even when overnight call is not required.
 - K. Provide education to faculty members and Resident/Fellows on alertness management and fatigue mitigation processes. Faculty and Resident/Fellows must also recognize the signs of fatigue and sleep deprivation.
 - L. Provide facilities for adequate sleep and rest as well as transportation options (Uber, Lyft, Taxi) for those too fatigued to safely travel to and from the work environment. Resident/Fellows will be reimbursed for transportation.
 - M. Encourage fatigue mitigation strategies. Examples include:
 - Strategic napping
 - Caffeine
 - Availability of other caregivers
 - Time management
 - Self-monitoring
- II. Each Program will maintain attention to Resident/Fellow and faculty member burnout, depression and substance abuse.
- A. The Program and Institution will educate faculty members and Resident/Fellows on identification of the symptoms of burnout, depression, and substance abuse, including the means to assist those who experience these conditions.
 - B. Resident/Fellows and faculty members will also be educated on recognizing those symptoms in themselves and how to seek appropriate care. Self-assessment resources are also available on the GME & MedHub Website.
- III. Resident/Fellows must demonstrate competence in the ability to recognize and develop and plan for one's own personal and professional well-being.
- A. The Program and Institution will:
 - 1. Encourage Resident/Fellows and faculty members to alert the Program Director or other designated personnel or programs when they are concerned that another Resident/Fellow or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.
 - 2. Provide access to appropriate tools for self-screening.
 - 3. Provide access to confidential, affordable mental health counseling and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. Employee Assistance Program (EAP) can be reached 24 hours a day at (800) 227-8830 Code: Eisenhower.

- A Resident/Fellow may contact the EAP at any time to initiate a referral. The Resident/Fellow is not required to disclose the referral to the Program Director or any faculty member in the program.
 - The Program Director or a faculty member may approach a Resident/Fellow who appears distressed to suggest a Formal Referral to EAP or other counseling services. The faculty member or Program Director may not force the Resident/Fellow to initiate or complete the referral.
- IV. Resident/Fellows will be provided the opportunity to attend medical, mental health and dental health appointments and should work with their Program Directors when scheduling these if time off from work is needed for these visits. If a medical condition requires multiple days off for treatment, then the Program Director should work with the Resident/Fellow to initiate FMLA (Family Medical Leave Act).
- V. Each Program will have a policy/procedure in place that ensures coverage of patient care in the event that a Resident/Fellow is unable to perform their patient care responsibilities.

Link of Reference:

GME Wellness Website: <https://www.eisenhowerhealth.org/gme/about-gme/wellness/>

EAP: <https://ikeapps/?id=3517&action=download&dataRef=704>

Other Self-Assessment Tools:

<https://wellmd.stanford.edu/test-yourself.html>

POLICY APPROVAL(S)

Graduate Medical Education Committee

Approved: December 9, 2019



Andre Hamil
We help our MHN
members get the
support they need.

Your Employee Assistance Program

How can we help?

Life can be complicated. With MHN, getting help is easy.

Your EAP is here to help with life's many challenges. MHN provides the following services, paid for by your employer.

Problem-solving support

Call us for help with life's ups and downs. We're here 24/7 to connect or refer you to a professional who can help with:

- Marriage, family and relationship issues.
- Problems in the workplace.
- Stress, anxiety and sadness.
- Grief, loss or responses to traumatic events.
- Concerns about your use of alcohol or drugs.

When you call, you can make an appointment that works for you:

- **Face-to-face sessions** – Meet with a provider from our network (for example, a counselor, marriage and family therapist, or psychologist) in his or her office. We can provide a referral when you call us. You can also search for a provider on our member website.
- **Phone or web-video consultations** – Easily accessed support provided by a network provider or MHN consultant.

Remember that EAP services are not medical care or mental health treatment of any kind. If, in the course of a consultation, clinical problems are suspected, including drug or alcohol problems, we will offer a referral to appropriate medical or mental health services.

Work and life services

Our experts can help you balance your work with your life!¹ Call us for:

- **Childcare and eldercare assistance** – We'll find out what kind of help you need caring for children or elders in your life. Then we'll give you names and numbers of providers in your area with confirmed openings.
- **Financial services** – Talk to an advisor over the phone about:
 - Budgeting
 - Credit and financial questions (investment advice, loans and bill payments not included)
 - Retirement planning
- **Legal services** – Talk to a lawyer over the phone or face to face about:
 - Civil, consumer and criminal law
 - Personal and family law, including adoption, divorce and custody issues



(continued)

¹Please contact us for details, including limitations and exclusions.

- Financial or tax matters. (Business matters are excluded. Also excluded are any disputes or actions between members and their employer, business partners, MHN, Health Net, or their affiliates.)
- Real estate
- Estate planning

- **Identity theft recovery services** – Speak with a certified consumer credit counselor who can learn more about your situation and help you create a plan. If there is a potential of ID theft, we'll connect you to an identity recovery specialist.
- **Daily living services** – Need help with errands? Planning an event or a vacation? We'll track down businesses and consultants for you. (MHN does not cover the cost nor guarantee delivery of vendors' services.)



Our member website can help with:

- Childcare and eldercare directories.
- Tips, tools and calculators to help you with finances, legal issues and retirement planning.

Health and wellness resources

Take charge of your well-being! MHN can help. Just register on our member website to:



- Assess your health and get tips for living better.
- Track progress toward your wellness goals.
- Take advantage of interactive e-learning programs.
- Find articles and videos about health topics.

Call your EAP number to learn more about our wellness coaching services – personalized support to help you set and reach your wellness goals.

This is just a summary. For details about services and eligibility, please contact MHN or your employer, or check your plan documents (such as an *Evidence of Coverage* booklet or *Summary Plan Description*).

Your privacy

EAP services are confidential. Your privacy is important to us, and it is protected by state and federal laws.

Need help?

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TTY users should call 1-800-327-0801.

Or visit us at: members.mhn.com

and register with the company code: eisenhower

You are entitled to 3 face-to-face sessions or telephonic or web-video consultations per incident, per plan period.

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EISENHOWER HEALTH

Policy

Effective Date: June 24, 2019

Title: Resident/Fellow Education Fund Policy

Home Department: Office of Graduate Medical Education

I. POLICY

The educational fund was established to encourage attendance to regional and national academic conferences and to ensure access to educational resources, which will contribute to practice, based learning. Funds will be made available to all Resident/Fellow's. The actual amount per Resident/Fellow is proportional to the anticipated duration of training at the rate of \$2,500.00 per year.

II. PURPOSE

To establish guidelines and define available reimbursement for individual Resident/Fellow expense items regarding the use of the Resident/Fellow Educational Funds.

III. GUIDELINES

- A. All reimbursable expenses must comply with established Eisenhower Medical Center (EMC) and Graduate Medical Education (GME) guidelines and regulations. Funds will be made available to all Resident/Fellow's at the beginning of their academic year. Receipts that fail to document acceptable expenses may be refused. Original receipts will not be returned. Each Resident/Fellow is allowed a maximum of \$2,500 annual education fund allowance for reimbursement of out-of pocket expenses. All items over \$500 must be pre-approved by the Director.
- B. Resident/Fellow funds do not roll over from contract year to contract year. Reimbursement has to be made during the same fiscal year of purchase (EMC fiscal year runs 7/1-6/30) and turned in within the deadline that is set each year.
- C. GME reserves the right, in its sole discretion, to deny reimbursement for any unreasonable expenses or any expenses lacking sufficient justification or documentation.
- D. Expenses for regional and national academic conferences will not be submitted until after they take place. Proof of attendance is required.

- E. Senior Resident/Fellows are allowed an additional \$3,000 Board fund for all Board related purchases or courses, such as: Board Exam Fees, travel expenses, books, Apps, etc.

Allowable Education Expenses:

- Regional and National Academic Conferences (*only if Resident/Fellow is not presenting*): registration, airfare, mileage, car rental, lodging, and meals (The Travel and Entertainment Policy should be referred to in its entirety in the General Administrative Policies on IkeNet.)
- Medical books, medical journals, Apps, and online journal subscriptions.
- Professional medical society dues or fees that enhance Resident/Fellow education.
- Medical equipment like surgical loupes, stethoscopes, indirect ophthalmoscopes and lenses and other similar medical items.
- MKSAP Upgrade (complete package)
- Electronic equipment & supplies: Laptops, Desktop, Flash Drives
- Away Elective Rotations: airfare, mileage, car rental, lodging, and daily allotted meal stipend
- Uniform/White Coat Alterations
- If Board funds are exhausted, the Education Fund may be utilized

Non Allowable Education Expenses:

- Electronic Equipment: iPhone/iPad Cases, USB cords, Keyboards, Printers
- Alcoholic beverages
- Personal entertainment expenses (including cover charges)
- Travel expenses for spouses and other dependents
- Loss or damage to personal property
- All reservation and cancellation charges
- Clothing/Apparel, Scrubs, Shoes
- Other Misc.: Gifts, laundry, and dry cleaning expenses

IV: REIMBURSEMENT PROCESS

General Requirements:

1. All receipts must show name of the location, date, time, proof of payment, item purchased and amount of payment.
2. Provide justification for expenses (no abbreviations).
3. If expenses include other participants, please write down the names of those who attended.
4. All receipts must be secured flat with scotch tape on all 4 sides of the receipt on letter size paper on one side only (not back to back). Staples are not to be used, as Accounts Payable cannot scan pages with staples.
5. Do not use a highlighter or place tape on the ink since it will erase the ink.

6. Loose receipts will not be accepted. Receipts that are longer than the letter size paper, must be cut and continued to tape it alongside or next sheet.
7. Receipts must be placed in chronological order by date.
8. No "Pictures" of the receipt. Clear "Scanned" receipts are acceptable.
9. For Conferences, you must provide proof of attendance and justification.
10. Submitting loose receipts to the office will only delay your reimbursement, as we will have to return them to you so that you can organize them properly.
11. **All expenses must be verified with an original receipt.**
12. Credit Card/Bank statements are not allowed as a replacement for the receipt. Only as a back-up for proof of payment along with purchased receipt.
13. Please complete a "Check Request" form and submit all pasted receipts and other reimbursement items to the Finance Coordinator.
14. If receipt is emailed to the Finance Coordinator, a check request form is not necessary.

Meals:

1. Up to \$50 a day while traveling.
2. If receipt shows more than 1 guest, please mark with a pen (not highlighter) the items that belong to you.
3. Cross out any items that are reimbursable.
4. If you are requesting reimbursement for others, please note their name, reason, and amount per person.

Mileage:

1. All mileage must start from EMC to destination.
2. Must submit the "Directions" from Google Maps (Map not needed).

Travel:

1. Upgrades and Insurance are not covered. One check baggage is reimbursable.
2. Air travel must show location and date of travel.
3. Land Travel (car rental, taxi, uber, etc) must submit original receipts, email confirmations are accepted.

Lodging:

1. Checkout receipt must show "Charges by Date"
2. If receipt shows more than one guest or shared room and if you are requesting reimbursement for others please provide their name and reason.
3. If split cost receipt, must provide split payment.

Links of Reference:

EMC Travel & Entertainment Policy #2214 - <https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:10476>

POLICY APPROVAL(S)

Graduate Medical Education Committee

July 24, 2017

Updated: June 24, 2019



EISENHOWER HEALTH

Policy

Effective Date: December 9, 2019

Title: Didactic/Conference Attendance Policy

Home Department: Office of Graduate Medical Education

I. POLICY

The Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements: (IV. Educational Program) entails that resident/fellows participate in structured didactic activities throughout their years of residency/fellowship.

II. PURPOSE

The policy is intended that resident/fellows will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

III. PROCESS

I. Conference Attendance Requirements

- a. Residents are required to attend 70% of conferences.
- b. Morning Report (For Internal Medicine) - attendance at morning reports is required of all residents; Residents are excused from morning reports only when on off-site rotations, or on vacation or in the event of attending to a major medical emergency.

II. Tracking Conference Attendance

- a. Core conference attendance will be recorded and kept with the Residency Program Coordinator. Residents who are more than 20 minutes late to any conference are encouraged to attend and participate but will not be given credit for attendance. Residents may ask to view their attendance at any time.

III. Exceptions to Conference Attendance

- a. Extenuating circumstances, to be determined individually, may limit a resident/fellow's ability to meet the conference requirement.
- b. During particular times/services, resident/fellows may be unable to attend conferences. This includes:
 - i. Any service or shift on which attending conference directly contributes to a work hour violation.
 - ii. Electives/Scheduled rotations outside EMC.
 - iii. Vacation, illness, patient emergencies, or other reasons. Resident/Fellows on authorized medical or maternity leave are excused from conference attendance.
 - iv. If a resident is unable to attend conference for other reasons outside those listed above they may contact program leadership and request an excused absence (in writing via email).

IV. Remedial Action for Not Meeting Conference Requirements

- a. A resident/fellow may track their core conference attendance at any time through their coordinator. This data will be reviewed at mid-year and end-of-year reviews with the program director.
- b. If the minimum yearly requirement is not met, a memo will be placed in the resident/fellow's file reflecting the professionalism considerations as well as the loss of educational opportunities for that resident/fellow. This will be considered in the overall competency score of professionalism of the resident/fellow.
- c. In addition, the Department Clinical Competency Committee will assess all resident/fellows not meeting attendance requirements and will make further recommendations for remedial work based on the individual resident/fellow's performance in the program.

Link of Reference:

ACGME Common Program Requirements:

<https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf>

<https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRFellowship2019.pdf>

POLICY APPROVAL(S)

Graduate Medical Education Committee

Approved: December 9, 2019



EISENHOWER HEALTH

Policy

Effective Date: December 9, 2019

Title: Didactic/Conference Attendance Policy

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 - i. Any service or shift on which attending conference directly contributes to a work hour violation.
 - ii. Electives/Scheduled rotations outside EMC.
 - iii. Vacation, illness, patient emergencies, or other reasons. Resident/Fellows on authorized medical or maternity leave are excused from conference attendance.
 - iv. If a resident is unable to attend conference for other reasons outside those listed above they may contact program leadership and request an excused absence (in writing via email).

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- a. A resident/fellow may track their core conference attendance at any time through their coordinator. This data will be reviewed at mid-year and end-of-year reviews with the program director.
- b. If the minimum yearly requirement is not met, a memo will be placed in the resident/fellow's file reflecting the professionalism considerations as well as the loss of educational opportunities for that resident/fellow. This will be considered in the overall competency score of professionalism of the resident/fellow.
- c. In addition, the Department Clinical Competency Committee will assess all resident/fellows not meeting attendance requirements and will make further recommendations for remedial work based on the individual resident/fellow's performance in the program.

Link of Reference:

ACGME Common Program Requirements:

<https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf>

<https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRFellowship2019.pdf>

POLICY APPROVAL(S)

Graduate Medical Education Committee

Approved: December 9, 2019



EISENHOWER HEALTH

Policy

Effective Date: June 24, 2019

Title: Educational Conference Policy

Home Department: Office of Graduate Medical Education

I. POLICY

Eisenhower Medical Center (EMC) recognizes the educational value of, and supports resident participation in or attendance at, professional conferences and other similar outside educational activities.

II. PURPOSE

To provide guidelines on, and establish limits to residents participation in outside educational activities, and to minimize travel expenses while at the meeting, in accordance to ACGME requirements.

III. APPROVAL PROCESS

- A. Residents must have approval from the Program Director prior to registering for a conference. Residents are required to ask for time off to attend a conference no later than 90 days (contingent on each program requirements) of the requested leave (Refer to GME: Resident Leave of Absence Policy). If the conference does not meet acceptable educational standards, their request to attend may be denied.
- B. The choice of conference/educational activity, the content of the presentation, and the number of such presentations must be made in consultation with and the approval of the Program Director. Prior to any approval, the Program Director must determine that the duration of absence(s) will not impact patient care.
- C. A resident who has conducted research, applied for a paper/poster presentation, must get approval from the Program Director prior to accepting the invitation.
- D. The conference must be located within the continental United States. International conferences will need to be approved by the Graduate Medical Education Committee (GMEC).

- E. Residents must inform the Program Manager and/or Residency Coordinator of their presentation and provide their confirmation letter with the conference name, title of presentation (poster or platform presentation). Documentation will be placed in the resident's academic file.

IV: TIME AWAY

- A. Per ACGME Common Program Requirement: [One-Year Common Program Requirement: VI.F.1.], "If attendance at the conference is required by the program, or if the resident/fellow is a representative for the program (e.g., he/she is presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of "clinical and educational work hours" in the ACGME requirements." The presentation day should be included in the clinical and educational work hours. The non-mandatory days at the conference when the resident is not presenting, would not be counted towards the clinical and educational work hours. But, this doesn't preclude the PD from allowing the resident to attend other portions of the conference.
- B. Time away from the residency program for educational purposes, such as workshops or educational conferences, are not counted in the general limitation on absences but should not exceed 5 days annually. Attendance at educational, scholarly, and professional activities is scheduled by mutual agreement with the Program Director.
- C. Attendance at educational meetings for which the resident is not presenting is only permitted at the discretion of the Program Director. Time away to attend will be determined by each program requirements.

V: SCHEDULING OF CONFERENCES

- A. Residents must review their yearly schedule before applying to present at regional and national conferences. Avoiding dates during required rotation (i.e., ICU, Wards, etc.) is highly desirable.
- B. Conferences may be included in an elective with rotation attending approval, e.g. Diabetes conference during Endocrine elective, Sports Medicine conference during Sports Medicine elective. This will count as "elective time".
- C. Residents presenting during a required rotation (i.e., Wards, ICU, Night Service, etc.) must inform their attending, senior resident, Residency Office, and continuity clinic, if applicable. Residents must ensure their clinic is covered by another resident.

VI: REIMBURSEMENT

- A. The Office of Graduate Medical Education will provide reimbursement for those residents who are presenting as a representative of Eisenhower Medical Center.

- B. Registration, air, hotel, poster fees, and ground transportation will be reimbursed only after submission of all original receipts with proof of acceptance.
- C. Hotel expenses will be reimbursed up to \$300 (exclusive of taxes) per night. If two residents are traveling to the same conference, it is recommended to share a hotel room when appropriate to minimize travel expenses.
- D. Food reimbursement will be limited to \$50 per day. (Refer to EMC Travel & Entertainment Policy)
- E. If a resident would like to stay past the conference date, any additional charges incurred during that time will be the responsibility of the resident.
- F. Residents that are not presenting may use their Education Fund to pay for attendance at approved conferences (Refer to GME: Education Fund Policy).

Link of Reference:

ACGME Common Program Requirement: [One-Year Common Program Requirement]
<https://www.acgme.org/Portals/0/PDFs/FAQ/CommonProgramRequirementsFAQs.pdf>

ABIM:

<http://www.abim.org/~media/ABIM%20Public/Files/pdf/publications/certification-guides/policies-and-procedures.pdf>

ABFM:

<https://www.theabfm.org/cert/absence.aspx>

EMC Travel & Entertainment Policy - <https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:10476>

POLICY APPROVAL(S)

Graduate Medical Education Committee

Updated January 22, 2018
June 24, 2019



EISENHOWER HEALTH

Policy

Effective Date: September 21, 2020

Title: Licensure Policy

Home Department: Office of Graduate Medical Education

I. PURPOSE

To establish the requirements that residents/fellows must complete in regards to exams, licensing, and registration in the Medicare Provider, Enrollment, Chain and Ownership System in order to participate in a training program at Eisenhower Medical Center.

II. POLICY

All residents/fellows are required to do the following: (1) Obtain a National Provider Identifier (NPI); (2) Possess a Postgraduate Training License (PTL) for the first 36 months of training and a Physician's and Surgeon's license within 90 days from July 1st for fellows; (3) Obtain a DEA Controlled Substance Permit/License; (4) Register with Medicare as an ordering/referring provider in the Provider Enrollment, Chain, and Ownership System (PECOS); and (5) Pass USMLE Step III, (or equivalent exams for DOs).

III. PROCEDURES

1. NPI Requirements

All PGY-1 residents must apply for and obtain an NPI number within 30 days after the hire date. Instructions for obtaining an NPI number are sent to PGY-1 residents with the Welcome Packet. The NPI number must be provided to the GME Office.

2. Postgraduate Training License (PTL)

A PTL must be obtained by the resident within 180 days after enrollment in an ACGME accredited training program and will not be required to be renewed. Interns starting their residency program on July 1st, will be required to have the PTL issued by December 31st. (The 180 days starts on their first day of clinical training).

The Program Director (PD) will be required to submit the PTL Enrollment EF Form, directly to the Medical Board of California (MBC) to verify that the resident is enrolled in an ACGME-accredited program. Once the PTL is issued, the PD must notify the MBC within 30 days of any status changes that would affect the resident's anticipated end date of the program, such as transfers to another program,

termination, resignation, placement on probation and/or completion of remediation, or a leave of absence.

3. DEA Controlled Substance Permit

Once a resident has obtained a PTL, they can apply for a DEA Controlled Substance Permit. **A copy of the DEA permit must be on file in the GME Office by the end of the PGY 2 year.** The resident may engage in the practice of medicine only in connection with their duties as a resident in an ACGME-accredited postgraduate training program, including its affiliated sites, or under those conditions as are approved in writing by their PD. Duties include, but are not limited to, the following:

- Diagnose and treat patients.
- Prescribe medication without a cosigner, including prescriptions for controlled substance, if the licensee has the appropriate Drug Enforcement Agency registration or permit and is registered with the Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES).
- Sign birth and death certificates without a cosigner.

4. PECOS

All residents/fellows must register with Medicare PECOS as ordering/referring providers, after receipt of a PTL or California Medical License and DEA permit/license. Medicare PECOS registration instructions will be sent to all residents by the GME Office.

5. PGY-1 Exam Requirements

All PGY-1 residents are required to have taken and passed Step 3 of the USMLE examination and/or the COMLEX Level 3 CE and PE for DOs, and provide evidence to the GME Office **before promotion to their PGY-2 year of residency.** If a resident does not pass the exam, at the discretion of the PD, consequences may include one or more of the following:

- Remediation/Disciplinary action for non-academic deficiency; and/or
- Delay or cancellation of appointment or promotion.

6. Fellows

Fellows will be required to obtain a California medical license within 90 days from July 1st. This allows the fellow to complete the 36 months of required residency training for licensure and grants the fellow 90 days to obtain the physician's and surgeon's license while they continue their training. If a license is not granted within the 90 days, the fellow must cease all clinical activities until the license is issued.

7. Full/Renewal Licensure

Eisenhower expects all trainees to receive and renew their licensure as soon as possible and within indicated deadlines. Residents/Fellows are professionally responsible for receiving and maintaining a current, valid medical license.

Practicing without a valid license may lead to disciplinary action. California state law specifically prohibits unlicensed physicians, and those required to have a license to continue training, from practicing without a valid license. It is the expectation of each residency training program to require trainees to meet the state law and have no clinical contact if they do not have a valid license.

IV: LICENSE REIMBURSEMENT

1. The GME Office will reimburse California Medical License initial application fee, the license fee, and the DEA new registration fee, only if applied while employed at EMC. All reimbursements must be submitted to the GME Office.

V. CONSEQUENCES OF FAILURE TO SATISFY REQUIREMENTS

1. Any resident/fellow who fails to comply with this policy, or who is ineligible for licensure at the required time as set forth in this policy, may be required to discontinue training and/or be subject to suspension of employment without pay until a valid license has been obtained, or the resident/fellow's employment is terminated at the discretion of the PD.
2. Any resident/fellow who is dismissed from a training program for failure to meet licensure requirements may re-apply to that program following successful completion of the requirements. Re-acceptance into a program is at the discretion of the PD.

POLICY APPROVAL(S)

Graduate Medical Education Committee

Update: September 21, 2020
October 23, 2017



EISENHOWER HEALTH

Policy

Effective Date: June 24, 2019

Title: Meal Policy

Home Department: Office of Graduate Medical Education

I. POLICY

Per ACGME, Residents and Fellows must have access to food while on duty in all participating sites (Institutional Requirement II.F.2.a). Meals will be provided for Residents and Fellows while assigned to Eisenhower Medical Center (EMC). Residents and Fellows shall be reimbursed for their daily meal stipend when they are on duty at other participating sites under the circumstances described below.

II. PURPOSE

To establish guidelines of the ID Badge/Meal Card and off site meal reimbursement for all Residents and Fellows.

III. MEAL CARD

- A. The Residents and Fellows will be provided an ID Badge/Meal Card with an allotted daily meal stipend. It is the responsibility of the cardholder to ensure the ID Badge/Meal Card is not lost or stolen. In the event of a lost or stolen ID Badge/Meal Card, please contact your Residency Coordinator. Meal cost data will be reviewed annually by the Graduate Medical Education (GME) in order to develop guidelines to determine future meal allowances and adjust them as necessary. Current daily rates for AY19 are as follows:
 - 1. Internal Medicine - \$15
 - 2. Family Medicine/Emergency Medicine - \$18
 - 3. Sports Medicine/Pulmonary Disease Fellows - \$18
 - 4. Medical Students - \$15
- B. ID Badge/Meal Cards are not transferable, i.e., they are personal forms of identification. ID Badge/Meal Cards cannot be loaned to, shared with, or used by any person other than the cardholder originally issued the ID Badge/Meal Card by the GME. Any attempt to use another person's card will be reported to the GME.

- C. ID Badge/Meal Cards must be presented at the point of sale (cash register) to be valid. If the Resident or Fellow does not present a valid hospital ID badge, the cafeteria staff will be unable to charge the Resident's account.
- D. Rollover meal allowance is not permitted.
- E. ID Badge/Meal Cards may be used at the Employee Cafeteria (Café 34), located in the EMC Wright Building. Residents and Fellows also receive a 10% discount at Café Eisenhower.

Café 34
Daily Hours of Operation
Breakfast: 7:00 A.M. - 10:00A.M.
Lunch: 11:00 A.M. - 2:00 P.M.
Dinner: 4:00 P.M. - 7:00 P.M.

- F. Refrigerators in the Residency Lounge located on 3 South of the Main Hospital will be stocked with snacks and drinks.
- G. Residents will be allowed in the Physician's Dining Room, only if accompanied by an attending.

IV: OFF SITE MEAL REIMBURSEMENT

- A. Residents and Fellows on duty at other participating sites off campus will be compensated at the rate of their daily allotted meal stipend.
- B. Original receipts must be submitted to the Graduate Medical Education.
- C. Reimbursements need to be submitted at the end of a full block rotation, as they will only be processed once each month.

Link of Reference:

ACGME Institutional Requirements:

<https://www.acgme.org/Portals/0/PFAssets/InstitutionalRequirements/000InstitutionalRequirements2018.pdf?ver=2018-02-19-132236-600>

POLICY APPROVAL(S)

Graduate Medical Education Committee

January 22, 2018
Update: June 24, 2019



EISENHOWER MEDICAL CENTER

POLICY

Effective Date: 12/5/2016

Title: Clinical Competency Committee (CCC)

Home Department: Graduate Medical Education

I. SCOPE

All ACGME-accredited residency and fellowship programs sponsored by Eisenhower Medical Center.

II. PURPOSE

The assessment of trainees by the Clinical Competency Committee (CCC) is a key element of the Next Accreditation System (NAS). The CCC is designed to bring insight and perspectives of a group of faculty members to the trainee evaluation process. The CCC also serves as an early warning system if a trainee fails to progress in the educational program, and assists in his/her early identification and move toward improvement and remediation.

III. POLICY

The program director must appoint a CCC, and develop and maintain a written description of the CCC's responsibilities, including charge, membership and procedures [Common Program Requirements V.A.1. & V.A.1.b)]. This policy must be provided to the GME Office.

IV. MEMBERSHIP

The CCC must be composed of at least three faculty members, one of whom may be the program director, who have the opportunity to observe and evaluate trainees [Common Program Requirement V.A.1.a)]. Faculty members should represent all major training sites and should include both junior and senior faculty.

Other members of the CCC may include other physician faculty members from the same program or other programs, or health professionals (e.g., nursing staff, physician assistants) who have extensive contact and experience with trainees in patient care and other health care settings [Common Program Requirement V.A.1.a)(1)(a)].

Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the CCC [Common Program Requirement V.A.1.a)(1)(b)]. Residents who do not meet all of the above criteria, including chief residents in the accredited years of the program, may not serve as CCC members or attend CCC meetings.

The chair of the committee may be either the program director or a faculty member appointed by the program director or voted on by the committee, depending on the program's Review Committee requirements.

Program Administrators may attend CCC meetings to provide administrative support and help document CCC deliberations and decisions. However, program administrators may not serve as members of the CCC.

V. CHARGE

The members of the CCC are expected to provide honest, thoughtful evaluations of the competency level of trainees. They are responsible for reviewing all assessments of each trainee at least semiannually, and for determining each trainee's current performance level by group consensus [Common Program Requirement V.A.1.b).(1).(a)]. Larger programs may schedule meetings more frequently. The CCC consensus decision will initially be based on existing, multi-source assessment data and faculty member observations. As programs enter the NAS, the CCC will use the Milestone evaluations to inform this process.

The committee must prepare and ensure the reporting of Milestones evaluations of each trainee to the ACGME semiannually in December and June [Common Program Requirement V.A.1.b).(1).(b)]. Milestones evaluations must be submitted by the program director or designee(s) via the Accreditation Data System (ADS) website.

The committee is responsible for making recommendations to the program director on promotion, remediation and dismissal based on the committee's consensus decision of trainees' performance [Common Program Requirement V.A.1.b).(1).(c)]. However, the program director has final responsibility for the evaluation and promotion of trainees.

The committee should inform, where appropriate, the Program Education Committee (PEC) of any potential gaps in curriculum or other program deficiencies that appear to result in a poor opportunity for trainees to progress in each of the Milestones.

The program director or designee(s) must provide feedback to each trainee regarding his/her progress in each of the Milestones. This feedback must be documented in the trainee's file.

The committee is also responsible for providing feedback to the program director on the timeliness and quality (e.g., rating consistency and accuracy) of faculty's documented evaluations of trainees, in order to identify opportunities for faculty training and development.

Finally, the committee is responsible for giving feedback to the program director to ensure that the assessment tools and methods are useful in distinguishing the developmental levels of behaviors in each of the Milestones.

VI. GUIDELINES

The following guidelines are recommended for conducting the CCC review process:

1. The committee must meet at least semiannually, and may meet more often for larger programs.
2. Meetings should be kept to two hours or less.
3. The chair serves to guide the committee in its work to provide a consensus decision for Milestones evaluations.
4. Committee members must be oriented to each assessment tool and its relationship to the Milestones evaluations.
5. All committee members should be required to participate in committee deliberations regularly (at least 75% of all meetings).
6. Depending on the size of the program, review of each trainee's evaluations should be assigned to specific committee members. For small programs, all members may be assigned to review all trainees. For larger programs, two or three CCC members who have worked with the trainee may be assigned to prepare a recommendation to the committee. Committee members should be responsible for:
 - a. Reviewing all evaluations (e.g., faculty evaluations, multisource assessments, case/clinical experience logs, in-service exam scores) and performance data for the last six months of training in advance of the meeting, and
 - b. Completing the Milestones evaluation for each trainee in advance of the meeting.
7. Reviews should be presented by training year.
8. The committee must form a consensus Milestones evaluation based on member reviews and the committee's discussion for each trainee.

RESOURCES:

ACGME recommendations for the CCC can be found at:

<https://www.acgme.org/Portals/0/ACGMEClinicalCompetencyCommitteeGuidebook.pdf>

ACGME Common Program Requirements (effective July 1, 2016)

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_07012016.pdf

ACGME Institutional Requirements (effective July 1, 2015)

http://www.acgme.org/Portals/0/PDFs/FAQ/InstitutionalRequirements_07012015.pdf

ACGME NAS FAQ: Clinical Competency Committees and Program Evaluation Committees

http://www.acgme.org/acgmeweb/Portals/0/PDFs/FAQ/CCC_PEC_FAQs.pdf

POLICY APPROVAL(S)

Graduate Medical Education Committee

December 5, 2016



EISENHOWER MEDICAL CENTER

POLICY

Effective Date: 12/5/2016

Title: Annual Program Evaluation (APE)

Home Department: Graduate Medical Education

I. PURPOSE

To establish guidelines for the ACGME Institutional Requirement of I.B.4.a).(4) regarding GMEC oversight of the ACGME-accredited programs' annual evaluation and improvement activities i.e. an Annual Program Evaluation (APE).

At least annually, each program must conduct a self-review that includes the following:
ACGME Common Program Requirement V.C.2.- The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written Annual Program Evaluation (APE).

- a. Resident/Fellow performance using aggregated resident data;
- b. Faculty development;
- c. Graduate performance including performance of program graduates on the certification examination
- d. Program quality

II. POLICY

Each Program Director is responsible for appointing Program Evaluation Committee (PEC) to conduct an APE of the residency/fellowship program. This process must include at least two faculty and one peer-selected resident/fellow(s). The evaluation will proceed according to the ACGME Common Program Requirements listed above using the representative check list of items to review at the end of this document. All residents/fellows and faculty will be given the opportunity to participate by completing a confidential evaluation. The pooled information from these evaluations will be given due consideration by the PEC, and will be used to improve of the program. Resident/Fellows(s) will be peer-selected to participate in the review.

III. PROCEDURE

A. The Program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and will render a full, written, annual program evaluation (APE).

B. The annual program evaluation will be conducted between April – May each year to allow programs the opportunity to assess the current academic year and potential changes for the upcoming academic year.

C. Approximately two months prior to the established review date, the Program Director will:

1. Facilitate the Program Evaluation Committee's process to establish and announce the date of the APE meeting;
2. Request the residency coordinator to assist with organizing the data collection, review process, and report development; and,
3. Solicit written confidential evaluations from the Program faculty and Resident/Fellows prior to the review.
4. At the time of the initial meeting, the Committee should at least consider:
 - a. Achievement of action plan improvement initiatives identified during the last annual program evaluation;
 - b. Achievement of correction of citations and concerns from last accreditation site visit;
 - c. Residency program goals and objectives;
 - d. Faculty members' confidential written evaluations of the program;
 - e. The Residents'/Fellows' annual confidential written evaluations of the program;
 - f. The Residents'/Fellows' evaluation of the rotations to date;
 - g. Resident/Fellow performance and outcome assessment, as evidenced by:
 - i. Aggregate data from general competency assessments;
 - ii. Aggregate data from Milestones;
 - iii. In-training examination performance;
 - iv. Case/procedure logs;
 - v. Graduate performance, including performance on the certification examination;
 - vi. Faculty development/education needs and effectiveness of faculty development activities during the past year;
 - h. Other data points collected by the ACGME in WebADS;
 - i. Other items that are pertinent to the program/specialty;
5. Additional meetings may be scheduled, as needed, to continue to the APE, discuss concerns and potential improvement opportunities, and to make recommendations. Written minutes must be taken of all meetings.
6. As a result of the information considered and subsequent discussion, the Committee will prepare a written plan of action to document initiatives to improve performance in at least one or more of these areas:
 - a. Resident/Fellow performance
 - b. Faculty development
 - c. Graduate performance
 - d. Program quality
 - e. Continued progress on the previous year's action plan if applicable.
7. The plan will delineate how those performance improvement initiatives will be measured and monitored and include a time-line.

8. The final report and action plan will be reviewed and approved by the program's teaching faculty, and documented in faculty meeting minutes.

D. A final copy of the APE and action plan/time-line will be sent to the GME Office. Each APE will be on a future GMEC agenda. The GMEC will review and accept as written or propose changes in the action plan and/or time-line.

E. Using the GME Annual Program Evaluation format provided by the GME Office, the following areas should be analyzed to enhance program strengths and, in one or more areas, implement plans for improvement:

1. Resident performance:

- In-training exam results
- Resident assessment data
- Resident research presentations/publications
- Resident procedure/case log
- Resident skills/simulation lab performance
- On-line curriculum performance
- Milestone achievement
- Rotation evaluation
- 360/multi-rater (patient, peer, nursing, etc.)
- Oral exams(mock)
- Resident self-assessment, goal setting, and individual learning plans
- Skills/Simulation results
- Chart audit
- QI projects
- Participation on hospital committees
- Didactic/conference attendance
- CEX observe patient encounter
- Standardized patient
- Evaluation of presentations
- Technical skills and abilities
- Compliance with administrative tasks

2. Faculty development

- Results of annual confidential evaluation of faculty by residents
- Review of updated CVs including faculty scholarly activity and publications
- Teaching strategies/methods
- Completion of educational modules
- Completion of courses on how to be a teacher
- Mentoring
- Faculty meeting attendance
- Local, regional and national meeting educational committee participation
- Participation in resident conferences/didactics
- Maintenance of certification
- Quality of providing formative feedback
- Participation on Clinical Competency Committee or PEC

3. Graduate Performance

- Board pass rate/how many sit for Boards
- Graduate survey
- Fellowship match results
- Graduate interviews vs positions offered
- On time graduation and program completion
- Scholarly activity
- Attrition
- Employment—academics, private, research, GME

4. Program quality

- Results of annual confidential evaluation of program by residents and faculty
- ACGME resident and faculty survey results
- Program rotation goals and objectives
- Program evaluations
- Resident evaluations/assessment methods
- Outcomes measures
- Conference topics/frequency
- Skills/simulation curriculum
- Survey data from recent graduates
- Review of status of any citations or concerns from previous accreditation letter
- Review of program policies and procedures and specialty-specific program requirements
- Program's process on the previous year's action plan(s)
- Resident/Faculty attrition
- Program board pass rate
- Match results
- Post-match survey
- Board pass rate
- Case logs/procedure logs
- Scholarly activity
- ACGME WebADS /Self-Study
- Clinical quality measures/patient care outcomes
- In service exams
- QI activities
- Milestones

RESOURCES:

ACGME Common Program Requirements (effective July 1, 2016)

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_07012016.pdf

ACGME Institutional Requirements (effective July 1, 2015)

http://www.acgme.org/Portals/0/PDFs/FAQ/InstitutionalRequirements_07012015.pdf

POLICY APPROVAL(S)

Graduate Medical Education Committee

December 5, 2016



EISENHOWER MEDICAL CENTER

POLICY

Effective Date: 12/5/2016

Title: Program Evaluation Committee (PEC)

Home Department: Graduate Medical Education

I. PURPOSE

This policy is to establish that each accredited Residency/Fellowship program sponsored by Eisenhower Medical Center establish a Program-specific policy to establish the composition and responsibilities of the training program's Program Evaluation Committee. This Program-specific policy must also establish a formal, systemic process to annually evaluate the educational effectiveness of the Residency/Fellowship program in accordance with the program evaluation and improvement requirements of the ACGME, the program specific Residency Review Committee (RRC), other accreditation entities, and the Graduate Medical Education Committee (GMEC) policy.

II. POLICY

Each Program Director is responsible for appointing Program Evaluation Committee (ACGME Common Program Requirement V.C.) to conduct an annual evaluation of the residency program. This process must include both faculty and residents. The evaluation will proceed according to the ACGME Common Program Requirements listed below:

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written Annual Program Evaluation (APE).

The program must monitor and track each of the following areas:

V.C.2.a) resident performance;

V.C.2.b) faculty development;

V.C.2.c) graduate performance, including performance of program graduates on the certification examination;

V.C.2.d) program quality; and,

V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

V.C.2.d).(2) The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program.

V.C.2.e) progress on the previous year's action plan(s).

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored.

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

Residents/Fellows and faculty will be given the opportunity to participate by completing a confidential evaluation. The pooled information from these evaluations will be given due consideration by the PEC, and will be used to improve of the program. Resident(s) will be peer-selected to participate in the review.

PROGRAM EVALUATION COMMITTEE

A. In accordance with this policy, each Program Director shall appoint a Program Evaluation Committee (PEC) to participate in the development of the Program's curriculum and related learning activities. In addition, the PEC will:

1. Annually evaluate the program to assess the effectiveness of the Program's curriculum.
2. Identify actions needed to foster continued program improvement and correction of areas of non-compliance with ACGME standards.

B. The Program Evaluation Committee shall be composed of at least 2 members of the Program's faculty, and include at least 1 peer-selected Resident/Fellow.

1. Program Directors are generally discouraged from being a member of the PEC. However, in the case of a small Program, Program Directors may become members upon approval by the DIO.
2. Should there not be any Residents/Fellows enrolled in the program, the Resident/Fellow membership requirement will be waived until such time that peer-selected residents can be chosen.

C. The PEC will function in accordance with the written description of its responsibilities, as specified below and actively participate in:

1. Planning, developing, implementing, and evaluating all educational activities of the program;
2. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
 - a. Trainee performance;
 - b. Faculty development;
 - c. Graduate performance, including performance of program graduates on the certification examination and;
 - d. Program quality, specifically:
 - i. residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually and;
 - ii. the program must use the results of the trainees' assessments of the program together with other program evaluation results to improve the program
 - iii. Progress on the previous year's action plan(s)

D. Each residency/fellowship program must use resident/fellow evaluations and feedback of the program including curriculum, working environment, scholarly environment, evaluation systems, and other items deemed important by the program. These evaluations are confidential.

E. Resident/Fellow evaluations combined with faculty input are key to evaluating the educational effectiveness of the training program.

F. The program should prepare a written plan of action to document initiatives to improve performance in at least two areas. The action plan should document how improvement initiatives will be measured and monitored. The action plan must be reviewed and approved by the teaching faculty and documented in the meeting minutes.

G. All programs must submit a copy of the program evaluation agenda, minutes and a Program Evaluation and Improvement Plan to the GME office by August 15th of the academic year.

RESOURCES:

ACGME Common Program Requirements (effective July 1, 2016)

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_07012016.pdf

ACGME Institutional Requirements (effective July 1, 2015)

http://www.acgme.org/Portals/0/PDFs/FAQ/InstitutionalRequirements_07012015.pdf

POLICY APPROVAL(S)

Graduate Medical Education Committee

December 5, 2016



EISENHOWER MEDICAL CENTER

Policy

Effective Date: 4/24/2017

Title: Special Review Policy

Home Department: Office of Graduate Medical Education

I. POLICY

The GMEC must demonstrate effective oversight of underperforming programs through a Special Review process. The Special Review process must include a protocol that:

- (1) establishes criteria for identifying underperformance;
- (2) address the procedure to be utilized when a residency/fellowship program undergoes a Special Review;
- (3) results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes.

II. PURPOSE

To ensure effective oversight of underperforming Graduate Medical Education programs by the Sponsoring Institution via the Designated Institutional Official and the Graduate Medical Education Committee. Specifically, this policy address the procedure to be utilized when a residency/fellowship program undergoes a Special Review.

III. PROCEDURE

The GMEC will identify underperformance through the following established criteria, which may include, but are not limited to, the following:

A. Program Attrition

1. Change in program director more frequently than every 2 years.
2. Greater than 1 resident/fellow per year resident attrition (withdrawal, transfer or dismissal) over a 2-year period.

B. Loss of Major Education Necessities

1. Changes in major participating sites, including primary care clinics and subspecialty clinics.

2. Consistent incomplete resident complement.
 3. Major program structural change.
 4. Loss of or lack of recruitment of core faculty.
- C. Recruitment performance
1. Unfilled positions over three years
- D. Evidence of scholarly activity (excluding typical and expected departmental presentations)
1. Graduating residents - minimum of 50% scholarly activity.
 2. Faculty (Core) - demonstrate one of more of the following: peer-reviewed funding; publications of original research or review articles in peer-reviewed journals, or chapters in textbooks; publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or participation in national committees or educational organizations
- E. Board pass rate - acceptable by ACGME specialty standards.
- F. Declining cumulative performance over a three-year period.
- G. Clinical experience - acceptable by ACGME specialty-specific standards.
- H. ACGME surveys
1. Resident survey - Less than 85% completion rate. Less than 100% completion rate for the programs that have less than 4 residents/fellows.
 2. Resident overall dissatisfaction with the program, including but not limited to, single year issues and issues that extend over more than one year.
 3. Faculty survey - Less than 85% completion rate.
- I. Administrative non-compliance with responsibilities
1. Failure to submit milestones data to the ACGME and to the GMEC.
 2. Failure to submit data to requesting organizations or GMEC.
- J. Inability to demonstrate success in the CLER focus areas:
1. Integration of residents/fellows into institution's Patient Safety Programs;

2. Integration of residents/fellows into institution's Quality Improvement Programs and efforts to reduce disparities in health care delivery;
 3. Establishment and implementation of Supervision policies;
 4. Transitions in Care
 5. Duty hours' policy and/or fatigue management and mitigation; and
 6. Education and monitoring of Professionalism
- K. Inability to meet established ACGME common and program specific requirements
- L. Notification from RRC requests for progress reports and site visits, unresolved citations or new citations or other actions by the ACGME resulting from annual data review or other actions
- M. Communications about or complaints against a program indicating potential egregious or substantive noncompliance with the ACGME Common, specialty/subspecialty-specific Program, and/or Institutional Requirements; or noncompliance with institutional policy;
- N. Self-report by a Program Director or Department Chair.

Procedure

1. Designation: When a residency/fellowship program is deemed to have met the established criteria for designation as an underperforming program, the DIO/Chair of the GMEC shall schedule a Special Review. Special Reviews shall occur within 60 days of a program's designation as 'underperforming.'
2. Special Review Panel: Each Special Review shall be conducted by a panel including at least one member of the GMEC who shall serve as Chair of the panel, one additional faculty member from within the Residency Program and one resident/fellow. Additional reviewers may be included on the panel as determined by the DIO/GMEC. Panel members shall be from within the Sponsoring Institution, but shall not be from the program being reviewed or, if applicable, from its affiliated subspecialty programs.
3. Preparation for the Special Review: The Chair of the Special Review panel, in consultation with the DIO/GMEC and/or other persons as appropriate, shall identify the specific concerns that are to be reviewed as part of the Special review process. Concerns may range from those

that broadly encompass the entire operation of the program to single, specific areas of interest. Based on identified concerns, the program being reviewed may be asked to submit documentation prior to the actual Special Review that will help the panel gain clarity in its understanding of the identified concerns.

4. The Special Review: Materials and data to be used in the review process shall include:

- a) the ACGME Common, specialty/subspecialty-specific Program, and Institutional Requirements in effect at the time of the review;
- b) accreditation letters of notification from the most recent ACGME reviews and progress reports sent to the respective RRC;
- c) reports from previous internal reviews of the program (if applicable);
- d) previous annual program evaluations;
- e) results from internal or external resident surveys, if available; and,
- f) any other materials the Special Review panel considers necessary and appropriate.

The Special Review panel will conduct interviews with the Program Director, key faculty members, at least one resident from each level of training in the program, and other individuals deemed appropriate by the committee.

5. Special Review Report: The Special Review panel shall submit a written report to the DIO and GMEC that includes, at a minimum, a description of the review process and the findings and recommendations of the panel. These shall include a description of the quality improvement goals, any corrective actions designed to address the identified concerns, and the process for GMEC monitoring of outcomes. The GMEC may, at its discretion, choose to modify the Special Review Report before accepting a final version.

6. Monitoring of Outcomes: The DIO and GMEC shall monitor outcomes of the Special Review process, including actions taken by the program and/or by the institution with special attention to areas of GMEC oversight, including:

- a) the ACGME accreditation status of the Sponsoring Institution and its ACGME-accredited programs

- b) the quality of the GME learning and working environment within the Sponsoring Institution, its ACGME-accredited programs, and its participating sites;
- c) the quality of educational experiences in each ACGME accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty/subspecialty specific Program Requirements;
- d) the ACGME-accredited programs' annual evaluation and improvement activities; and,
- e) all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution.

POLICY APPROVAL(S)

Graduate Medical Education Committee

April 24, 2017



EISENHOWER MEDICAL CENTER

Policy

Effective Date: 6/24/19

Title: Physician Impairment (Resident/Fellow Well-Being & Counseling Services)

Home Department: Office of Graduate Medical Education

I. POLICY

Physician health is essential to quality patient care. Eisenhower Medical Center (EMC) strives to create an environment to assist resident/fellow's in maintaining wellness and in proactively addressing any health condition that could potentially affect their health, well-being, and performance. Most health conditions do not affect workplace performance or impair the practice of medicine. For the purposes of this policy and procedure, a health condition is defined as including (but not limited to) any physical health, mental health, substance use/abuse, or behavioral condition that has the potential to adversely affect the practice of medicine and/or impair the resident/fellow's performance in the program.

II. PURPOSE

- To ensure that the resident/fellow's well-being is appropriately monitored and addressed.
- To ensure the existence of a counseling program for all resident/fellows.
- To ensure a drug-free and alcohol-free environment which is safe for resident/fellows, patients and all other potentially impacted individuals.
- To ensure that required documentation procedures for handling physician impairment are followed.
- To ensure that an educational program on the subject is included in all resident/fellow's training.

III. PROCEDURES

A. Monitoring of Resident/Fellow Well-Being

1. It is the responsibility of each training program director to monitor resident/fellow stress, including sleep deprivation and other mental or emotional conditions inhibiting performance or learning, and drug or alcohol-related dysfunction.
2. Program directors shall ensure that program faculty and trainees are educated to recognize the signs of fatigue by implementing institutional fatigue education plans as available and/or other program-based fatigue education plans. Round trip transportation reimbursement is available to any resident/fellow that elects to use a transportation service to get home instead of drive their vehicle while fatigued.
3. Situations that demand excessive service or that consistently produce undesirable stress on resident/fellow's, must be evaluated and modified.

B. Institutional/Program Support & Counseling

1. EMC sponsors Five Star Wellness Program Residents/Fellows will be introduced to new programs focused on the Five Pillars of Wellness including: Exercise, Nutrition, Pulmonary Health/Smoking Cessation, Stress Reduction and Weight Management. Information on Five Star Wellness is provided at orientation and is available to resident/fellows through IkeNet.
2. Employee Assistance Program provides a full range of confidential and free counseling and referral services to resident/fellows. The services have been tailored to meet the needs of the resident/fellows, and include services relating to dealing with impairment due to drugs or alcohol, or with any emotional difficulty irrespective of the nature or degree of seriousness of the problem. To reach the Employee Assistance Program please call 1-800-227-8830.
 - a. Utilization of counseling and related services is generally at the discretion of the resident/fellow, however, the Program Director or the DIO have the right to require an individual's participation.
3. Occurrence Reporting: Patient and employee safety reporting for actual events and near misses. All resident/fellows are educated during general orientation on how to file an incident report in Midas for adverse events, near misses, and/or unsafe conditions. An accessible link to the incident reporting system, Midas, available on IkeMD for residents. All reporting can be done anonymously.
4. Resident/Fellows may become members of, or participate in, the Resident/Fellow Well-Being Committee. The committee is composed of a group of peer-elected representatives from each of the residency/fellowship programs which comes together to discuss issues affecting Resident/Fellow life. The committee seeks to promote harmonious and collaborative relationships amongst Resident/Fellows, faculty and staff and enhance the Resident/Fellow community through advocacy, volunteer, and social activities.
5. There are circumstances in which Resident/Fellows may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program has procedures in place to ensure coverage of patient care in the event that a Resident/Fellow may be unable to perform their patient care responsibilities. These procedures will be implemented without fear of negative consequences for the Resident/Fellow whom is unable to provide the clinical work.
6. Resident/Fellows have the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their work hours. Resident/Fellows must follow the program's procedures for scheduling and notification of these appointments.
7. Resident/Fellows are encouraged to alert the Program Director, a faculty mentor or Chief Resident when they have concern for themselves, a Resident/Fellow colleague or a faculty member displaying signs of Burnout, depression, substance abuse, suicidal ideation or potential for violence.

C. Physician Impairment & Drug and Alcohol Free Environment

1. Eisenhower Medical Center maintains a drug and alcohol-free workplace for the safety of employees, patients, and visitors. Unlawful solicitation, manufacture, distribution, dispensing, diversion or use of controlled or dangerous substances or alcohol is prohibited. No employee may report to or remain at work impaired by any substance, lawful or unlawful, or if the employee is unable to perform his or her work duties and may endanger his or her own health or safety, and the health or safety of others. Violations of this policy are serious and will result in appropriate discipline which may include immediate termination. Appropriate licensing authorities will be notified where appropriate or required.
2. Resident/Fellow's should refer to Eisenhower Medical Center's "Fitness-For-Duty/Reasonable Suspicion Drug Testing #26989" policy which outlines the protocol and actions to follow when employees are suspected to be under the influence of drugs and/or alcohol.
3. If a resident/fellow refuses to submit to testing, Employee Health or Occupational Health will notify Human Resources immediately and employee will be placed on immediate suspension without pay pending further investigation and appropriate discipline, which may include termination (refer to Drug/Alcohol Free Workplace Policy #20098).

POLICY APPROVAL(S)

Graduate Medical Education Committee

**Updated: June 24, 2019
April 24, 2017**



Respectful Workplace, Violence Prevention, Cultural Diversity & Anti-Harassment

Eisenhower Health expects every employee to be treated with respect and dignity at all times. Eisenhower provides an environment free from discriminatory, harassing, bullying, disruptive or inappropriate actions and behaviors including undue imposition of any kind for employees, applicants, patients, visitors, vendors, physicians and all others with whom we conduct business. Eisenhower is committed to a safe working environment and has “zero tolerance” for actual or threatened violence or intimidation, discrimination, or harassment against co-workers, patients, visitors, or any other persons who are either on Eisenhower’s premises or who have contact with employees in the course of their duties.

Eisenhower is committed to creating a culture of diversity and inclusion, a workplace in which behaviors, practices, and policies promote access, career development, performance improvement, respect and success, regardless of cultural background. In order to create a culture of diversity and inclusion, all healthcare workers should be culturally competent. In healthcare, as in all other areas, people are diverse. This is true among patients, workers, providers, visitors, and vendors. They have varied backgrounds, heritages, and needs. Our employees' ability to recognize, understand, and appreciate this diversity will provide benefits for patients and for Eisenhower. The importance of being culturally competent cannot be overemphasized. Cultural competence includes, but is not limited to, being comfortable with differences, even if one does not agree with them, respecting and appreciating the values and beliefs of others, thinking flexibly and not using stereotypes, and behaving flexibly by adapting our behavior to meet the needs of patients.

In keeping with this commitment, Eisenhower maintains a strict policy prohibiting all forms of unlawful harassment, including sexual harassment. No form of harassment or discrimination based on race, color, sex, gender, gender identity, gender expression, national origin, age, religion, religious creed, military or veteran status, marital status, physical or mental disability, medical condition, genetic information, pregnancy, ancestry, sexual orientation or any other characteristic protected by State or Federal law will be tolerated. This policy applies to all agents and employees of the company, including supervisors/managers and non-supervisory employees, and prohibits harassment of employees in the workplace by any person, including non-employees. This policy also extends to harassment of or by vendors, independent contractors, volunteers, interns, and others doing business with Eisenhower. It also prohibits unlawful discrimination against or by employees and others covered by this policy, consistent with applicable law. Furthermore, this policy prohibits unlawful harassment in any form, including verbal, physical and visual harassment. Eisenhower will conduct a fair, timely, and thorough investigation of any allegations of harassment, discrimination, disruptive or inappropriate actions and behaviors. If it is determined that such conduct has occurred, Eisenhower will take appropriate action up to and including termination or exclusion of privileges of the offender. The investigation will be kept as confidential as possible, but cannot be kept completely confidential.

No form of violent, intimidating, unprofessional, disruptive or inappropriate behavior of any kind will be tolerated. Examples of workplace violence include, but are not limited to all threats or acts of violence occurring at any Eisenhower entity, regardless of the relationship between Eisenhower and parties involved in the incident; all threats or acts of violence occurring off Eisenhower premises involving an employee who is acting in the capacity of a representative of Eisenhower or in their usual course of duty; any acts or threats resulting in the conviction of an employee or representative of Eisenhower, or of an individual performing services for Eisenhower on a contract or temporary basis, under any criminal code provision relating to violence or threats of violence which adversely affect the legitimate interests and goals of Eisenhower. In addition, bullying or abusive conduct is prohibited. This consists of conduct in the workplace that occurs with malice or any other form of inappropriate intent that is hostile or offensive, and unrelated to Eisenhower's legitimate business interests. Examples of abusive conduct that are prohibited include (1) repeated infliction of verbal abuse, such as derogatory remarks, insults, and epithets, (2) verbal or physical conduct that is threatening, intimidating, or humiliating, and (3) the gratuitous sabotage or undermining of a person's work performance. Unless it is especially severe and egregious, a single, isolated act will not be considered abusive conduct.

Specific examples of conduct which may be considered threats or acts of violence include, but are not limited to hitting or shoving an individual, fighting or provoking a fight, actual or implied threat of harm to any individual or his/her family, friends or property, destruction or threat of destruction of Eisenhower property, harassing or threatening phone calls, faxes or electronic mail, surveillance or stalking, and possession or inappropriate use of firearms or weapons, knives, explosives, company equipment or other dangerous devices. A weapon is defined as any

firearm, knife, chemical spray or device that can cause bodily harm or injury. Weapons (including firearms, knives or any devices that could cause bodily harm or injury) are not permitted on the Eisenhower campus and all Eisenhower offsite locations. All staff are considered to be representatives of Eisenhower when on duty. As such, no Eisenhower staff member will carry any weapons on their person when conducting Eisenhower business, whether or not they are visiting an Eisenhower facility.

Any employee or person who observes or believes that he/she is the victim of, has been subjected to, has experienced or has knowledge of harassment, discrimination, threats, aggressive, violent, disruptive, unprofessional or inappropriate behaviors by a patient, visitor, employee, physician or others with whom we conduct business shall immediately report the suspected violation or incident to either his/her Supervisor, Department Director, Security, Human Resources, Administration, Legal Department, Compliance Hotline (1-877-363-3067), or other appropriate management personnel. All supervisors are obligated to report any and all complaints immediately to Human Resources.

This policy prohibits retaliation of any kind against individuals who file complaints in good faith or who assist in a company investigation. Retaliation against anyone who brings forward a good faith complaint, of any kind, is against Eisenhower policy and may be in violation of State and Federal laws. Appropriate corrective action up to and including immediate termination may result.

Full cooperation by all employees is necessary for the hospital to accomplish its goal of maximizing the security and safety of its employees. Employees should direct any questions they have regarding safety and/or security to their immediate supervisor or they may contact Eisenhower's Safety Director, Security, Legal/Compliance Department or Human Resources. Employees can report violations of this and other safety policies and raise any questions regarding their obligations to our policies without fear of reprisal of any kind.

In cases where it is determined that an employee has violated this policy by threatening another individual with violence or engaging in violent behavior, disciplinary action will be imposed, up to and possibly including immediate termination. In situations where it is found appropriate to do so, an individual who violates this policy may be required to obtain counseling or other available assistance.

The process for managing harassing, discriminatory, disruptive or inappropriate behaviors will require an immediate investigation be initiated by Security, Human Resources, Compliance or the appropriate management personnel. The appropriate Eisenhower individual or department will contact local, state and federal law agencies when appropriate. Corrective action, up to and including immediate termination or exclusion of privileges, may be taken against any employee or individual who violates this policy. All employees must agree to abide by this policy along with the Code of Conduct, Sexual Harassment Prevention, Non Discrimination & Equal Employment Opportunity, Counseling and Corrective Action, and Open Door Issue Resolution policies. Complaints involving physicians and residents shall be reported to appropriate leaders.

References

Reference Type	Title	Notes
Documents which reference this document		
Referenced Documents	Social Media Policy	
Document Owner	Kowalczyk, David	Original Effective Date 11/02/2007
Signed by	(07/28/2020 11:08AM PST) David Kowalczyk,	This Revision Effective 08/11/2020
	V.P. Human Resources	Last Reviewed/Revised
	(07/28/2020 11:12AM PST) Martin Massiello,	Next Review Date 08/11/2022
	Exec. V.P. Chief	
	Operating Officer	
	(07/28/2020 11:37AM PST) Samantha	
	Heckman, Esq., Senior	
	Counsel-Chief	
	Compliance Officer and	
	Information Priv	
	(07/30/2020 05:13PM PST) James Reed,	

Esq., Sr. Vice
President/General
Counsel
(07/31/2020 03:59PM
PST) Ann Mostofi, V.P.
Patient Care/CNO
(08/03/2020 07:02AM
PST) Ali Tourkaman,
Vice President, Support
Services, V.P. Support
Services
(08/11/2020 11:48AM
PST) Timothy Beringer,
Director-Safety/Security
& Emergency
Management

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<https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:20063>.



Eisenhower Medical Center Policies Sexual Harassment Prevention

Policy

Human Resources Department

2406

Official (Rev: 8)

Eisenhower Health is committed to providing a work environment that is free of Sexual Harassment. This policy applies to all agents and employees of the organization, including supervisors and non-supervisors and prohibits harassment of employees in the workplace by any person, including non-employees. Harassment based on sex includes sexual harassment, gender harassment and harassment based on pregnancy, childbirth, or related medical conditions, unwanted sexual advances or visual, verbal or physical conduct of a sexual nature. Unwelcome sexual advances are prohibited, as are any physical or verbal acts that can be construed as sexually intimidating or hostile, or which make others uncomfortable. Unlawful harassment may take many forms, including but not limited to verbal conduct, such as epithets, derogatory comments, slurs, or unwanted sexual advances, invitations or comments; visual conduct, such as derogatory posters, cartoons, drawings, or gestures; physical conduct, such as assault, blocking movements, inappropriate contact or proximity, staring, conversations, or interference with work directed at an employee because of the employee's sex or other protected characteristic; threats and demands to submit to sexual requests in order to keep one's job or avoid some loss, and offers of job benefits in return for sexual favors. Retaliation against any individual who has reported harassment or been involved in a sexual harassment investigation will not be tolerated and employees who engage in retaliation will be subject to disciplinary action up to and including termination.

Sexual harassment includes, but is not limited to, making unwanted sexual advances and requests for sexual favors where either (1) submission to such conduct is made an explicit or implicit term or condition of employment; (2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individuals; or (3) such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment. Individuals who violate this policy are subject to discipline up to and including the possibility of immediate termination.

Any person who believes that he or she has been the subject of sexual harassment should report the alleged act(s) as soon as possible to Human Resources. If the employee chooses to disclose to someone other than Human Resources, the informed Supervisor/Director must inform HR immediately. Human Resources will immediately initiate an investigation that will be kept as confidential as possible. A determination must be made and the results communicated to the complainant, to the alleged harasser, and as appropriate, to all others directly concerned. All appropriate remedial measures will be taken promptly.

Any employee who has been found to have sexually harassed another employee will be subject to disciplinary action up to and including termination. In cases where sexual harassment has occurred, the organization will take appropriate action to prevent any further harassment and appropriate action to remedy the complainant's loss, if any.

In the event a sexually hostile environment is created by anyone other than an Eisenhower employee (patient, physician, contractor, volunteer, etc.) on Eisenhower property, the subject employee should follow the same process for notification as previously specified. Any sexual activity in the hospital or clinic setting is prohibited.

References

Reference Type	Title	Notes
Document Owner	Kowalczyk, David	Original Effective Date 06/19/2007
Signed by	(07/28/2020 08:56AM PST) David Kowalczyk, V.P. Human Resources	This Revision Effective 08/03/2020
	(07/28/2020 10:30AM PST) Samantha Heckman, Esq., Senior Counsel-Chief Compliance Officer and Information Priv	Last Reviewed/Revised
	(07/28/2020 10:42AM PST) Martin Massiello, Exec. V.P. Chief	Next Review Date 08/03/2022

Operating Officer
(07/30/2020 05:13PM
PST) James Reed,
Esq., Sr. Vice
President/General
Counsel
(07/31/2020 04:00PM
PST) Ann Mostofi, V.P.
Patient Care/CNO
(08/03/2020 07:02AM
PST) Ali Tourkaman,
Vice President, Support
Services, V.P. Support
Services

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<https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:20064>.



Eisenhower Medical Center Policies

Policy

Travel and Entertainment Reimbursement Policy

Finance

EMC 2214

Official (Rev: 1)

PURPOSE

To establish policies for reimbursement of authorized travel and entertainment expenses incurred while on Medical Center business.

SCOPE AND RESPONSIBILITY

This policy is applicable to all entities and employees of the EMC campus, and pertains to all business-related travel including the attendance at educational programs and seminars.

IT WILL BE THE RESPONSIBILITY OF THE DEPARTMENT DIRECTOR AND THE APPROPRIATE VICE PRESIDENT TO ENSURE THAT SUFFICIENT FUNDS ARE IN THE BUDGET FOR ALL TRAVEL AND ENTERTAINMENT EXPENSES.

1.0 TRAVEL

1.1 The Medical Center requires that all employee education, training and business related travel expenses be pre-approved per department travel policy. (All tuition fees and housing allowances must continue to be authorized by the Administrative Director of Human Resources.)

1.2 All expenses must be verified with an original receipt. (See exceptions noted under 5.0 GROUND TRANSPORTATION).

1.3 With the exception of section 4. expenses will be reimbursed upon submission of a completed check request (Form EMC 1, 7/04) and an expense summary stapled to check request. (Form EMC 2, 7/04)

2.0 TRAVEL ADVANCE

A travel advance is not encouraged and should be used only in extreme situations. All travel advances must be approved by a Vice President. A check request must be completed for cash advances. The basis for travel advance should be listed on the check request (i.e., meals-4 days x \$50, + \$20 cab). The advance is charged to a separate general ledger account (#78808). The directors are responsible for monitoring the account to insure it periodically zeros out. All policy guidelines are to be followed and upon completion of travel, an expense summary must be completed and submitted to Accounts Payable with all appropriate receipts. A check to reimburse EMC for any advance not used, must be submitted with the supporting documents. Per IRS Regulation No. 26CFR1.62-2 any amount not substantiated by a receipt is reported as taxable wages on the employees W-2.

3.0 PREPAID EXPENSES

3.1 All pre-travel expenses should be prepaid whenever possible. EMC will prepay hotel and conference fees with a check issued to the applicable vendor. Supporting documents (i.e., registration forms, conference forms, etc.) must be attached to the check request and submitted to accounts payable at least two weeks before required mailing date.

3.2 If a trip is cancelled or changed, it is the employee's responsibility to cancel any arrangements that may result in a "no-show" charge. These charges will not be reimbursed unless documentation can support the expense was incurred through no fault of the employee and approved by the appropriate Vice President.

4.0 AIR TRAVEL

4.1 All commercial air travel is to be Coach Class or other special low-cost fares. Ticket upgrades to Business Class or First Class will not be reimbursed and will be at the employee's expense.

4.2 Arrangements may be made through an approved EMC travel agency with established billing procedures that accommodate our payment process.

4.3 In the interest of obtaining best pricing, employee may choose to use a personal credit card and make arrangements via internet. This expense will be reimbursed to employee upon submission of a check request with an attached confirmation of payment via credit card. It is the department Directors responsibility to monitor and control travel changes for internet bookings that may increase the initial costs or cause the ticket to be unused. It is the responsibility of the employee to return any credits or refunds related to the original credit card transaction, to EMC. To maximize productivity while searching for best pricing, EMC has approved the following websites: www.cheapseats.com ; www.sidestep.com ; www.orbitz.com

4.4 Travel for employee's spouse or family is at the employee's expense and should not be billed to EMC. Any exception must receive prior approval by the entity Chief Executive Officer.

5.0 GROUND TRANSPORTATION

5.1 When employees use their personal vehicles for company business, they will be reimbursed at the current IRS rate for miles traveled. (Effective cents per mile.) If not departing from and returning to the EMC campus, normal work miles are to be deducted from the traveled miles.

5.2 Rental vehicles should not be used unless the cost of other available transportation, such as airport/hotel limousine, shuttle or taxi, will exceed \$35 per day. If a car rental is necessary, the expense of an economy class automobile will be reimbursed. Personal accident, liability insurance, collision damage waiver, and personal property insurance is the responsibility of the employee. The employee should verify with their insurance agent the coverage in regards to rental vehicles. In the event of an accident, the employee's automobile insurance is primary. The employee must notify Risk Management of any accidents that occur during company business.

5.3 A receipt for gas or refueling charges on a rental car must be attached to the expense summary. Rental cars should be refueled before returning to the rental agency whenever possible.

5.4 Taxis, buses, shuttles, and all other forms of ground transportation fares will be reimbursed upon submission of the expense report with supporting receipts attached.

5.5 Items such as turnpike and bridge tolls, and parking meters fees are not included in the mileage reimbursement and must be listed separately on the expense summary. Receipts are not required.

6.0 HOTEL ACCOMMODATIONS

6.1 Reservations are the employee's responsibility. When a training event or business meeting is being held in a specific hotel, it is acceptable to stay at that hotel, using the group rate for the event. (For prepaid, see Section 3.1)

6.2 Since EMC provides a \$50 allowance per day for meals, (see Section 8.0) meals that are charged directly to the hotel bill must comply with the meal allowance. **If the meals charged exceed the approved amount they will be the responsibility of the traveler.** Miscellaneous items charged to the room, such as movies, will be the traveler's responsibility. Beverages and supplies from the honor bar must be included in the Daily Meal Allowance totals.

7.0 WEEKEND TRAVEL

7.1 When the employee elects to achieve a lower overall trip cost with the use of restricted discounted air fares for weekend travel, reimbursement is made for the additional hotel room and meals expenses incurred by the extended travel.

8.0 MEAL ALLOWANCE

8.1 Meals, snacks, etc., including tips, will be reimbursed up to \$50 per day with the appropriate receipts. Employees are responsible for all amounts over \$50.

8.2 If the traveler has a business meal during the trip then the allowable reimbursement for the day should be reduced by one of the following amounts depending when the business meal occurred.

Breakfast \$ 8.00

Lunch \$15.00

Dinner \$27.00

9.0 BUSINESS MEALS/ENTERTAINMENT EXPENSES

9.1 When business meals/entertainment expenses are incurred, the name of the individuals involved, plus their company and title is required. (Per IRS Regulation Sec. 274)

9.2 To qualify an expense as a business meal the non-EMC employee must be from a company that has a business relationship with EMC. A receipt (including tip) is mandatory for reimbursement.

9.3 Generally, entertainment expenses are not reimbursed when only EMC personnel are involved. However, if a business lunch or dinner meeting is in the best interest of EMC, it may be reimbursed if approval is obtained from a management level higher than that of any person in the entertainment group. The most senior level employee must incur the expense and be reimbursed. If not in compliance, the expense summary will be returned to the traveler for the appropriate approval.

10.0 MISCELLANEOUS EXPENSES

10.1 Employees traveling on EMC business away from home will also be reimbursed for the following expenses:

10.1.1 Laundry and dry cleaning will be reimbursed only on assignments lasting more than five (5) consecutive days.

10.1.2 Tips for valets, skycaps, bellhops and maids are reimbursable.

(Receipts not required)

10.1.3 Telephone and faxes are reimbursed when incurred in connection with EMC business. This also includes 1 phone call per day to employees family.

11.0 EXPENSE SUMMARY

11.1 Expense summaries must be accompanied by a check request signed by the employee incurring the expense, and approved by the department director. The director's expense must be approved by the appropriate Vice President and Vice President expenses by the entity Chief Executive Officer or Chief Operating Officer.

11.2 Expense summaries should be completed and submitted to Accounts Payable within ten (10) working days after actual completion of travel.

11.3 When an employee anticipates frequent small trips, (i.e., various one-day meetings), the expenses should be accumulated in a list and submitted once a month on an expense summary. Each trip should be itemized on the expense summary with the date, mileage and purpose.

11.4 Falsification of an expense summary will result in a formal counseling with intent-to-terminate.

11.5 No travel or entertainment expenses greater than \$10.00 will be reimbursed from petty cash. Reimbursement will require original receipt and authorization by requesting employees Director or Vice President.

12.0 NON-REIMBURSABLE EXPENSES

Thomas J
Tokheim,
Executive Vice
President and
COO
(03/10/2005
12:00AM PST) Liz
Guignier, Vice
President, Human
Resources
(03/10/2005
12:00AM PST)
Louise White, Vice
President, Nursing
(03/10/2005
12:00AM PST)
Lynn Hart,
Associate Vice
President, Clinic
Division
(03/10/2005
12:00AM PST)
Mary Ann
McLaughlin,
Administrative
Director
(03/10/2005
12:00AM PST)
Mary Ellen
Fontana, Vice
President,, Lucy
Curci Cancer
Center
(03/10/2005
12:00AM PST)
Joseph V Truhe,
Jr., General
Counsel

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<https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:10476>.



EISENHOWER MEDICAL CENTER

Policy

Effective Date: 03/14/2016

Title: Restrictive Covenants

Home Department: Office of Graduate Medical Education

I. PURPOSE:

This policy is to ensure that the Graduate Medical Education Committee (GMEC) is providing appropriate oversight regarding the use of restrictive covenants in trainee agreements per Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements.

II. POLICY SCOPE:

The policy applies to all ACGME-accredited residency and fellowship programs at Eisenhower Medical Center

III. DEFINITIONS:

Resident: any physician in an accredited graduate medical education program, including interns, residents, and fellows.

Restrictive Covenant: a non-competition guarantee

IV. POLICY STATEMENT:

- The ACGME specifically prohibits the use of restrictive covenants in trainee agreements.
- Neither the Sponsoring Institution nor any of its ACGME-accredited training programs may require residents to sign a non-competition guarantee.

POLICY APPROVAL(S)

Graduate Medical Education Committee

March 14, 2016



Policy

Effective Date: 03/14/2016

Title: Disaster Policy

Home Department: Office of Graduate Medical Education

I. PURPOSE:

The Sponsoring Institution must maintain a policy consistent with ACGME Policies and Procedures that addresses administrative support for ACGME-accredited programs and residents/fellows in the event of a disaster or interruption in patient care.

II. POLICY GUIDELINES:

The Sponsoring Institution in conjunction with the ACGME is committed to assisting in reconstituting and restructuring residents/fellows' educational experiences as quickly as possible after a disaster. Following the declaration of a disaster, the DIO, in conjunction with the Program Directors, will determine whether existing educational and training programs can continue with or without restructuring within the Sponsoring Institution; or whether temporary or permanent transfer of residents/fellows to another institution will be necessary.

In the event, or set of events, causing significant alteration to the residency/fellowship experience within one or more training programs, the ACGME Executive Director will make a declaration of a disaster and a notice will be posted on the ACGME website with information relating to the ACGME's response to the disaster.

Within 10 days after the declaration of a disaster, the DIO will contact the ACGME to discuss and establish due dates for the following: a) deadlines to submit program reconfiguration requests to ACGME and b) deadlines to inform each program's residents/fellows of the plans. The deadlines should be no later than 30 days after the disaster, unless other due dates have been approved by the ACGME.

1. Communication

a) It is the responsibility of every individual (faculty, staff, and residents/fellows) to ensure that his/her personal contact information is current and on-file with the residency program and the GME Office. This includes cell phone number, emergency contact person and outside e-mail address if possible.

b) In the event of a disaster involving the Sponsoring Institution and its residency/fellowship programs, each individual has the responsibility to monitor the Eisenhower Medical Center website for specific instructions.

c) The ACGME website will provide phone numbers and email addresses for emergency and other communication with the ACGME from disaster affected institutions and programs. The ACGME website will provide instructions for changing resident/fellow email information on the ACGME Web Accreditation Data System (ADS).

1. The DIO, should call or email the Institutional Review Committee Executive Director with information and/or requests;
 2. The Program Directors should call or email the appropriate RRC Executive Director with information and/or requests;
 3. Residents/fellow should call or email the appropriate RRC Director with information and/or requests.
2. Resident/Fellow Transfers if a program cannot provide at least an adequate educational experience for each of its residents/fellow because of a disaster it must arrange either a temporary transfer for each of its residents/fellows, or assist the residents/fellow in permanent transfers to other ACGME-accredited programs in which they can continue their education.

a) Temporary Transfer

1. A temporary transfer is defined as an assignment or rotation that will not continue for the duration of the resident/fellow's training.
2. To initiate a temporary transfer, a Program Letter of Agreement for Elective Rotations should be completed for residents/fellows rotating to programs at other institutions with the following signatures: Program Director, DIO and Supervising Physician. The Program Letter of Agreement can either be faxed or emailed to the host institution if U. S. mail is significantly delayed in our area. Confirmation from the host institution must be received before the temporary transfer is approved.
3. Residents/fellows who temporarily transfer to other institutions remain employees of the Sponsoring Institution and continue to receive their salary and benefits from the Sponsoring Institution. No interruption is anticipated.

b) Permanent Transfer

1. A permanent transfer is defined as an assignment that will continue for the duration of the resident/fellow's training. The resident/fellow will no longer be enrolled in a residency program at the Sponsoring Institution.
2. To initiate a permanent transfer, the resident/fellow sends a written request for a permanent transfer to the Program Director. The name of the program accepting the resident/fellow should be stated.
3. Residents/fellows who permanently transfer to other institutions will not remain employees of the Sponsoring Institution and will not continue to receive salary or benefits from this Sponsoring Institution

POLICY APPROVAL(S)
Graduate Medical Education Committee

March 14, 2016



EISENHOWER MEDICAL CENTER

Policy

Effective Date: 4/24/2017

Title: Vendors Policy

Home Department: Office of Graduate Medical Education

I. PURPOSE

The purpose of the policy is to ensure that GME activities at Eisenhower Medical Center and affiliated institutions are not compromised through vendor influence, either collectively or through interactions with individual residents and fellows.

II. POLICY

It is the policy of Eisenhower Medical Center GME that clinical decision-making, education, and research activities be free from influence created by improper financial relationships with, or gifts provided by, Industry. For purposes of this policy, "Industry " is defined as all pharmaceutical manufacturers and biotechnology, medical device, and hospital equipment supply industry entities and their representatives.

Although many aspects of these interactions are positive and important for promoting the educational and clinical mission, these interactions must be ethical and cannot create conflicts of interest that could endanger patient safety, data integrity, and the integrity of the education programs. Any interaction with industry and its vendors should be conducted so as to avoid conflicts of interest.

1. The resident should not accept gifts from industry vendors regardless of the nature or dollar value of the gift.
2. Textbooks, modest meals and other gifts are appropriate only if they serve an educational function.
3. The resident may not accept gifts or compensation for listening to a sales talk by an industry representative.
4. The resident may not accept gifts or compensation for prescribing or changing a patient's prescription.
5. The resident must consciously separate clinical care decisions from any perceived or actual benefits expected from any company.
6. It is unacceptable for patient care decisions to be influenced by the possibility of personal financial gain.
7. Vendor support of educational conferences involving the resident may be used only if the funds are provided directly to the institution, not to the resident. The program director should determine if the funded conference or program has educational merit.

8. The resident will be informed by the teaching faculty of the potential conflicts of interest during interactions with industry vendors.
9. Residents will comply with all EMC vendor policies

POLICY APPROVAL(S)

Graduate Medical Education Committee

April 24, 2017