EISENHOWER HEALTH

Graduate Medical Education Manual 2023-2024

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EISENHOWER HEALTH

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EISENHOWER HEALTH

Policy **Effective Date: July 31, 2023**

Title: Resident/Fellow Eligibility & Selection Policy

Home Department: Office of Graduate Medical Education

I. PURPOSE:

The purpose of this policy is to establish standards for recruitment, selection and appointment of residents and fellows (trainees) as performed by the ACGME Residency and Fellowship Program Directors with oversight by the Institution's GMEC and in accordance with ACGME, California physician licensing requirements, and Visa requirements.

II. POLICY:

Eisenhower Health Graduate Medical Education Residency/Fellowship programs will comply with ACGME standards when selecting Resident and Fellow applicants. Programs will participate in the National Resident Matching Program (NRMP) where applicable and will abide by its rules and regulations.

The Program Director (PD) is responsible for the selection and ranking of all candidates that meet the program's eligibility and selection criteria. Input is gathered from other members of the teaching faculty and residents as an important part of the selection process.

III. PROCEDURES:

1. Eligibility applicants must meet one of the following qualifications:
   - Graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME)
   - Graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA)
   - Graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:
     - valid certification from the Educational Commission for Foreign Medical Graduates (ECFMG), and/or
     - valid full and unrestricted California medical license
2. Selection
   - Each program is responsible for the selection of their trainees, and will have a selection committee that will review the credentials of all applicants.
   - Programs that participate in the NRMP or another Specialty Match program must adhere to the respective match policies. Participation in the NRMP does not prohibit a

program from offering a contract to an eligible and qualified applicant who is legally a nonparticipant in the NRMP.

- Programs will select from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, and communication skills. The Program Director or his/her designee will have final responsibility for judging the aforementioned qualities based upon the individual's written application, reference letters, personal interview, and performance during any clerkship or externship rotations at Eisenhower Health, if applicable.
- Programs will not discriminate with regard to age, ancestry, ethnicity, national origin, type of California driver's license, color, race, religion, religious creed, military service/veteran status, marital status, sex, sexual orientation, gender identity, gender expression, transgender status, genetic information, medical condition, mental or physical disability, family care or medical leave, pregnancy (and related conditions), breastfeeding, political affiliation, victims of crime, or any other legally impermissible factor.
- Visa sponsorship is only considered at the level of fellowship. The Educational Commission for Foreign Medical Graduates (ECFMG) is the sole sponsor of J-1 physicians in clinical training programs. For more information, please visit www.ecfmg.org.

3. Appointment

- An applicant invited to interview for a resident/fellow position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of the applicant's eventual appointment.
- Information that is provided must include: stipends, benefits, vacation, leaves of absence, professional liability coverage, and disability insurance accessible to the residents and their eligible dependents. All of these elements may be found in the contract, and GME Policy 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.
- For appointment, trainees must comply with State of California Physician Licensure requirements.
- Eisenhower Health will conduct background checks on all trainees, verify previous educational experiences and work history, and conduct pre-employment drug testing.
- Matched applicants will be required to provide evidence that they have received required immunizations and must comply with Eisenhower's policies regarding vaccinations prior to the first day of employment.

POLICY APPROVAL(S)

Graduate Medical Education Committee

Original Effective Date: April 24, 2017
Updated: July 31, 2023

EISENHOWER MEDICAL CENTER

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 polices. 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**

EISENHOWER HEALTH

Policy **Effective Date: October 23, 2023**

Title: Supervision of Residents and Fellows
Home Department: Office of Graduate Medical Education

I. PURPOSE

This policy is intended to provide a framework for the supervision of residents and fellows (collectively referred to as "trainees") at Eisenhower Health (EH), to ensure patient safety, quality of care, and the educational development of Trainees, in compliance with the Accreditation Council for Graduate Medical Education (ACCGME) guidelines.

II. POLICY

Eisenhower Health is committed to providing a training environment that ensures the safe and effective care of patients, the professional development of trainees, and compliance with the ACGME requirements for supervision.

III. SUPERVISION AND ACCOUNTABILITY

1. All trainees providing care to patients will be supervised by an available attending physician. As trainees demonstrate competence in their ability to care for patients, it is important to foster their progression to higher levels of autonomy by providing them with clinical roles with greater independence, and the opportunity to supervise less experienced trainees.
2. While first year trainees initially require direct supervision, more senior trainees often can operate with more autonomy under indirect supervision or continued faculty oversight, as defined below.
3. Trainees may always call their attending physicians on any areas of uncertainty. Attending physicians will treat trainees with respect and patience. Planned communication to discuss patient progress and management plan changes is encouraged.
4. Trainees and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

IV. SUPERVISION LEVELS

1. The following supervision levels are defined by current ACGME common program requirements and the institutional supervision guidelines. According to the ACGME, each patient must have an identifiable and credentialed attending physician who is responsible and accountable for the patient's care.
    a. **Direct Supervision**:
        i. The supervising physician is physically present with the trainee during the key portions of the patient interaction.
        ii. The supervising physician and/or patient is not physically present with the trainee and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

b. **Indirect Supervision**:
   i. The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the trainee for guidance and is available to provide appropriate direct supervision.

c. **Oversight**:
   i. The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

V. OBLIGATIONS OF THE PROGRAM/SUPERVISING PHYSICIAN

1. The program must define when physical presence of a supervising physician is required.

2. The privilege of progressive authority and responsibility, conditional independence and a supervisory role in patient care delegated to each trainee must be assigned by the program director and faculty members.
   a. The program director must evaluate each trainees' abilities based on specific criteria, guided by the Milestones.
   b. Faculty members functioning as supervising physicians must delegate portions of care to trainees based on the needs of the patient and the skills of each trainee.
   c. Senior trainees should serve in a supervisory role to junior trainees in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual trainee.

3. Programs must set guidelines for circumstances and events in which the trainee must communicate with the supervising faculty member(s).
   a. Each trainee must know the limits of their scope of authority, and the circumstances under which the trainee is permitted to act with conditional independence.
   b. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each trainee and to delegate to the trainee the appropriate level of patient care authority and responsibility.

Link of Reference:
ACGME Common Program Requirement:
https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023.pdf
https://www.acgme.org/globalassets/pfassets/programrequirements/cprfellowship_2023.pdf

POLICY APPROVAL(S)

Graduate Medical Education Committee **October 23, 2023**

EISENHOWER HEALTH

Policy **Effective Date: December 14, 2020**

Title: The Learning & Working Environment

Home Department: Office of Graduate Medical Education

A. Patient Safety, Quality Improvement, Supervision and Accountability

1. Patient Safety and Quality Improvement

   Each resident/fellow will be educated on patient safety goals, tools and techniques, and trained on how to report patient safety concerns. Each resident/fellow will also complete a quality improvement project that includes participation in inter-professional quality improvement activities.

2. Supervision and Accountability

   All residents/fellows providing care to patients will be supervised by an available attending physician. As residents/fellows demonstrate competence in their ability to care for patients, it is important to foster their progression to higher levels of autonomy by providing them with clinical roles with greater independence, and the opportunity to supervise less experienced residents/fellows. While first year residents/fellows initially require direct supervision, more senior residents/fellows often can operate with more autonomy under indirect supervision or continued faculty oversight, as defined below. Residents/fellows may always call their attending physicians on any areas of uncertainty. Attending physicians will treat trainees with respect and patience. Planned communication to discuss patient progress and management plan changes is encouraged.

   a. Supervision Levels
      The following supervision levels are defined by current ACGME common program requirements and the institutional supervision guidelines. According to the ACGME, each patient must have an identifiable and credentialed attending physician who is responsible and accountable for the patient's care.
      i. ***Direct supervision***:
         - The supervising physician is physically present with the resident/fellow during the key portions of the patient interaction.
         - The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
      ii. Indirect supervision:
         - The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.
      iii. Oversight:
         - The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

b. The privilege of progressive authority and responsibility, conditional independence and a supervisory role in patient care delegated to each resident/fellow must be assigned by the program director and faculty members.
    i. The program director must evaluate each resident's/fellow's abilities based on specific criteria, guided by the Milestones.
    ii. Faculty members functioning as supervising physicians must delegate portions of care to residents/fellows, based on the needs of the patient and the skills of each resident/fellow.
    iii. Senior residents/fellows should serve in a supervisory role to junior residents/fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident/fellow.
c. Programs must set guidelines for circumstances and events in which residents/ fellows must communicate with the supervising faculty member(s).
    i. Each resident/fellow must know the limits of their scope of authority, and the circumstances under which the resident/fellow is permitted to act with conditional independence.
    ii. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident/fellow and to delegate to the resident/fellow the appropriate level of patient care authority and responsibility.

B. Professionalism

1. Professionalism and learning objectives are accomplished through supervised patient care responsibilities, clinical teaching and didactics.
2. Emphasis is placed on a learning environment free of excessive reliance on residents/fellows to fulfill non-physician obligations and ensure manageable patient care responsibilities.
3. Each resident/fellow must assure personal fitness before, during and after clinical assignments as a responsibility of patient- and family-centered care.
4. Recognition of impairment from illness, fatigue and substance abuse in oneself, peers or other members of the health care team is a personal responsibility.
5. Professionalism involves accurate reporting of clinical and educational work hours, patient outcomes and clinical experience data.
6. Programs must provide a professional, equitable, respectful and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse or coercion of students, residents, faculty and staff.
7. In addition to the above, residents/fellows should make themselves aware of hospital-specific code of conduct, dress code, personal appearance guidelines, standards for professional behavior and confidential reporting policies, and adhere to the same.

C. Well-being

1. So that residents, fellows and faculty are better prepared to manage their own well- being, each program will organize educational sessions on well-being to bring attention to burnout, depression and substance abuse and the related symptoms.
2. To protect the resident/fellow work environment, each program will focus on ensuring a meaningful physician experience, which includes protection of time with patients, minimization of non-physician obligations and promotion of progressive autonomy.
3. In addition to the above, all Eisenhower Health employees have access to the Employee Assistance Program (EAP). The EAP is accessible 24 hours a day, seven days a week. Call (800) 227-8830 Code: Eisenhower. All communication between you and EAP counselors is strictly private and confidential, and all records pertaining to EAP participation are kept by an outside vendor. EAP

participation does not adversely affect job security or advancement opportunities.

4. Residents/fellows have the opportunity, after consulting with their program director, to attend medical, mental health and dental care appointments during work hours. It is also understood that there are circumstances in which residents/fellows may be unable to attend work, including but not limited to fatigue, illness and family emergencies, without fear of negative consequences. The resident/fellow must still communicate with their program director as far in advance of their shift as possible if they will not be able to report to work.

D. Fatigue Mitigation

Adequate sleep facilities are provided to residents/fellows as needed and transportation for residents/fellows too fatigued to return home will be provided, along with transportation back to work. Education on fatigue and the signs of fatigue will be provided for awareness and proper management.

During orientation, each resident/fellow will complete the Fatigue didactic course. This training occurs annually, at the beginning of each academic year, and is made available to all residents/fellows and faculty.

E. Clinical Responsibilities, Teamwork and Transitions of Care

1. Clinical Responsibilities
   Clinical responsibilities for each resident/fellow are defined in the curriculum goals and objectives and are specific to each PGY level and specialty as it relates to personal ability, patient safety, severity and complexity of the patient illness/condition and available support services.

2. Teamwork
   Residents/fellows must care for patients in an environment that maximizes communication and opportunity to work as a member of effective inter-professional teams that are appropriate for specialty-specific delivery of care.

3. Transitions of Care
   a. Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency and structure.
   b. Programs, in partnership with their sponsoring institutions, must provide and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
   c. Programs must ensure that residents/fellows are competent in communicating with team members in the hand-over process, and monitor that process.
   d. Programs and clinical sites must maintain and communicate schedules of attending physicians and residents/fellows currently responsible for each patient's care.
   e. Each program must monitor continuity of patient care, consistent with the program's policies and procedures.
   f. A transition of care ("hand-off") is defined as:
      - Change in level of patient care, including inpatient admission from the ambulatory setting, outpatient procedure or diagnostic area
      - Inpatient admission from the emergency department
      - Transfer of a patient to or from a critical care unit
      - Transfer of a patient from the intensive care unit to an inpatient unit when a different physician will be caring for that patient
      - Transfer of care to other healthcare professionals within procedure or diagnostic areas

- Discharge, including discharge to home or another facility such as skilled nursing care
- Change in provider or service, including resident/fellow sign-out, inpatient consultation sign-out, and rotation changes for residents/fellows

F. Clinical Experience and Education

1. Maximum Hours of Clinical and Educational Work Per Week
   Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home and all moonlighting.

2. Mandatory Time Free of Clinical Work and Education
   a. The program must design an effective program structure that provides residents/fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
   b. Residents/fellows should have eight hours off between scheduled clinical work and education periods.
      - There may be circumstances when residents/fellows choose to stay to care for their patients or return to the hospital withfewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off- in-seven requirements.
   c. Residents/fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
   d. Residents/fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At- home call cannot be assigned on these free days.

3. Maximum Clinical Work and Education Period Length
   a. Clinical and educational work periods for residents/fellows must not exceed 24 hours of continuous scheduled clinical assignments.
   b. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident/fellow education.
   c. Additional patient care responsibilities must not be assigned to a resident/fellow during this time.

4. Clinical and Educational Work Hour Exceptions
   After handing off all other responsibilities, a resident/fellow, on their own initiative, may elect to remain or return to the clinical site in the following rare circumstances:
   a. To continue providing care to a single severely ill or unstable patient
   b. Humanistic attention to the needs of a patient or family
   c. To attend a unique educational event

   These additional hours of care or education will be counted toward the 80-hour weekly limit.

5. Moonlighting
   See Moonlighting Policy

6. In-house Night Float
   Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.

7. Maximum In-house On-call Frequency
   Residents/fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

8. At-home call
    a. Time spent on patient care activities by residents/fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.
        - At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each resident/fellow.
    b. Residents/fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient care must be included in the 80-hour maximum weekly limit.

G. Disclosure Pursuant to Eisenhower Health's Graduate Medical Education's Obligations to Support Legitimate Educational Interests

Eisenhower Health's GME goal is to continually improve the clinical and educational environment in which residents train. The GME office may use residents/fellows' education records and personally identifiable information including but not limited to clinical outcomes data, in-training exam performance, formative and summative evaluation results, curriculum outcomes, etc., to support this goal. The only persons or offices with legitimate educational interests in reviewing resident education records and personally identifiable information include but are not limited to those employed by the hospital or Eisenhower Health's GME in an administrative, supervisory, academic or research, or support staff positions, contractors, consultants, and other outside service providers with whom the organization has contracted, who must review may utilize the educational record in order to fulfill their professional responsibilities.

POLICY APPROVAL(S)

Graduate Medical Education Committee **December 14, 2020**

EISENHOWER HEALTH

Policy

Effective Date: March 16, 2022

Title: Moonlighting

Home Department: Office of Graduate Medical Education

I. POLICY

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

II. PURPOSE

Any resident/fellow (trainee) 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 trainee is in training or at any of its related participating sites. Trainees are not covered under EMC's professional liability insurance program as the activity is outside the scope of EMC's employment. Trainees are responsible for their own professional liability coverage (either independently or through the entity for which the trainee is moonlighting), DEA licensure, Medicare (or other governmental) provider number and billing training, and licensure requirements by the California Medical Board, and any other requirements for clinical privileging at the employment site.

2. **Internal Moonlighting:** Voluntary, compensated, medically-related work (not related with training requirements) performed within the institution in which the trainee is in training or at any of its related participating sites. This activity must be supervised by faculty and is not to exceed the level of clinical activity currently approved for the trainee. While performing internal moonlighting services, trainees are not to perform as independent practitioners.

IV. ELIGIBILITY

A. Only trainees who have obtained an unrestricted license to practice medicine in the State of California are permitted to moonlight.

B. PGY1's are not permitted to moonlight.

C. Trainees may not be required to engage in moonlighting.

D. All trainees must comply with the rules of their residency/fellowship program and will also comply with any applicable ACGME, State or Federal regulations setting limitations on Clinical Experience and Education (CEE) hours.

E. Trainees must be in good academic standing determined at the discretion of the Program Director (PD).

F. Trainees must receive the written/signed approval from their program director. The Approved Internal/External Moonlighting Request Form (attached) should be used for this purpose and should become a part of the trainee's file.

G. Moonlighting during regular duty hours is explicitly forbidden, regardless of rotation schedule. There must be adequate travel time allowed between the end of work hour activity and starting moonlighting. At no time will moonlighting activities interrupt residency/fellowship program requirements. Specifically, in reference to scheduled CEE responsibilities, trainees may not depart early or return late due to moonlighting activities.

H. No trainee may moonlight without first having been appropriately credentialed by the hospital or facility where the moonlighting is to occur.

V. MAXIMUM HOURS WORKED

A. All time spent by trainees in internal and external moonlighting must be counted toward the 80-hour maximum weekly limit, averaged over a four-week period.

B. Mandatory time free of duty: trainees must have a minimum of one day in seven days free of duty (when averaged over four weeks).

C. All trainees are required to accurately record all of their moonlighting hours on MedHub.

VI. PROGRAM DIRECTOR RESPONSIBILITIES

A. The PD must provide a written or electronic approval.

B. The program director will monitor trainee performance to ensure that moonlighting activities do not interfere with the ability of the trainee to achieve the goals and objectives of the educational program, and must not interfere with the trainee's fitness for work nor compromise patient safety. If the program director determines that the trainee performance is deficient, the permission to moonlight will be revoked and/or disciplinary actions will be taken.

C. The PD may require detailed information on the timing and level of activity in order to ensure moonlighting does not cause fatigue or interfere with patient care and trainee education.

VII. PROCEDURE

A. Internal/External Moonlighting form must be completed and submitted to PD and Designated Institutional Official (DIO) for approval and a copy will be placed in the trainee's file.

B. There must be an Internal Moonlighting form submitted for every instance, as needed for Payroll purposes.

C. There must be one (1) External Moonlighting Form submitted for each participating site.

D. The PD must be informed of any activity changes in Moonlighting, including hours, location, type of activity, and supervisor. The resident/fellow must submit a new moonlighting form and the PD and DIO must approve any said changes prior to the start of the new activity.

EISENHOWER HEALTH

REFERENCES:

ACGME Common Program Requirements (VI.F.5):

- Moonlighting must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program, and must not interfere with the resident's/fellow's fitness for work nor compromise patient safety.
- Time spent by residents/fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.
- PGY-1 residents are not permitted to moonlight.

POLICY APPROVAL(S) by Graduate Medical Education Committee

- **August 6, 2018**
- **December 1, 2021**
- **Updated: March 16, 2022**

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 understand that I must receive an appointment letter and a privilege delineation form from the moonlighting hospital/facility before I begin moonlighting activities.

11. I understand that even though my moonlighting activities at institutions other than Eisenhower Medical 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.**

12. I understand that I am responsible for obtaining my own professional liability insurance for moonlighting activities at institutions other than Eisenhower Medical Center. I will provide a copy of the insurance certificate.

13. 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

_____ _____

Designated Institutional Official 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 $120 per hour.

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 20, 2022**

Title: Trainee Leave of Absence – Procedural Requirements

Home Department: Office of Graduate Medical Education

I. PURPOSE:

The ACGME requires that sponsoring institutions provide all residents/fellows (trainees) with financial support and benefits to ensure they are able to fulfill the responsibilities of their ACGME-accredited program. Further, sponsoring institutions are required to have adequate systems and supports in place to minimize the impact to clinical assignments resulting from leaves of absence.

II. POLICY:

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

III. PROCEDURES:

Vacation & Sick Time:

1. All trainees are provided with a total of 21 working days of paid vacation time and 3 working days of paid sick time at the beginning of each residency/fellowship term. Any sick pay balance that is not used prior to the last day of employment is lost at the time of resignation, termination, retirement, layoff, or other separation from employment. If a trainee is rehired within one (1) year of the date of separation, any lost sick pay will be reinstated and available for the trainee to use.

2. Vacation and sick time may not accumulate from one year to another and must be taken in the year of the service for which the time is granted. Trainees do not have the option of reducing the total time required for residency/fellowship by relinquishing vacation time.

3. **In case of absence for illness or emergencies, the trainee must email their program (i.e., IMAway, FMAway, EMAway, PMAway, SMAway, IDAway) and inform the supervising physician on assigned service and co-residents/fellows, if applicable. Direct communication is required before 6:30am on the day of the absence.**

Parental, Medical, & Caregiver Leave:

1. Per ACGME regulations, starting with their first day of employment, every trainee is entitled to a six-week of paid leave at any time during the entirety of their residency or fellowship program for parental, medical, or caregiver leave.
2. This leave must be for a medical, parental, or caregiver leave of absence and must be approved by the Program Director (PD) and Designated Institutional Official (DIO)/GME Director. Supporting documentation will be required.

3. During this leave period, trainees will be paid 100% of their salary. Health and disability insurance benefits for trainees and their eligible dependents will continue.
4. If sick time, Extended Leave Bank (ELB) and/or Paid Time Off (PTO) are available, they will be applied to supplement part of this leave; however one week of PTO will be reserved for use during the academic year in which their six-week leave was taken.
5. Additional weeks of leave beyond a trainee's "once in training program" six weeks of leave will be covered through use of vacation, sick days, and/or short-term disability insurance.
6. Other leaves including twelve weeks of unpaid leave under the Family and Medical Leave Act ("FMLA") and California Family Rights ("CFRA") may be available to eligible employees. Trainees should refer to Eisenhower Medical Center's Leave of Absence Policy #2433 for additional information.
7. Our goal is for our trainees who take leave to graduate on time. However, these leaves may impact a trainee's ability to graduate on time or impact board eligibility in the following ways:
    a. If a trainee is not in good standing in their residency or fellowship and is not meeting ACGME milestones, PDs and Clinical Competency Committees may require an extension of training to meet milestones required for successful graduation.
    b. The Medical Board of California requires verification of 36 months of board approved postgraduate training, including at least 24-continuous months of training within the same program to receive an unrestricted license. A longer leave of absence could impact California's licensure and could require additional months of training to receive an unrestricted license.
8. The impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a trainee's eligibility to participate in examinations by the relevant certifying board(s) must be discussed with the trainee and documented by the Program Director before the trainee's leave begins whenever feasible, and otherwise as soon as possible after the leave begins.
9. Though all efforts will be taken to minimize impact to clinical assignments resulting from leaves of absence, trainees taking leave may be required to complete service blocks that are required for successful residency completion or to ensure equity between a program's trainees.

Process for Parental, Medical, & Caregiver Leave:
Refer to Eisenhower Leave of Absence Policy 2433 Approval Procedure (Medical, Family Leaves).

Compliance with Board Requirements for Absence from Training:

1. It is the responsibility of each PD to verify the effect of absence from training for any reason on the individual's educational program and, if necessary, to establish make-up requirements that meet RRC or board requirements of the specialty. All extensions of training necessary to meet board eligibility are paid with full benefits. Board certification eligibility information should be provided to trainees by each program and can also be accessed through the specialty board's website and the website of the American Board of Medical Specialties: http://www.abms.org.

Educational Leave:

1. 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:
The PD must be notified as soon as a jury summons is received. Trainees should refer to Eisenhower Medical Center's Jury Duty Policy#2414 for additional information.

Bereavement:

1. After completion of 90-days of employment, trainees 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. If additional time is needed, the trainee will have to utilize their PTO. Trainees must contact their Program Director and Program Manager as soon as practical when bereavement time is being requested.

Request for Time Away:

1. Other requests for time off must be submitted via email to the Program Manager or their appointed designee, and PD **no later than 30-90 days (depending on each program requirements)** prior to the month of the requested leave. If the program does not receive a request in the required time frame, your leave may be denied. In approving request for time away, consideration is given to adequate staffing and patient care. As a result, the residency/fellowship program must limit the number of trainees scheduled away from training at any one time.

Unexcused Absence & Tardiness:

1. When a trainee 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 of unexcused absence or repeated tardiness, a letter of concern will be placed in the trainee's permanent file and the trainee will be required to attend a mandatory meeting with the Program Director to discuss potential disciplinary action, including possible probation, at the discretion of the Program Director.

Links of Reference:

- ACGME - https://www.acgme.org/globalassets/pfassets/programrequirements/800_institutionalrequirements_2022.pdf
- ABMS - https://www.abms.org/policies/parental-leave/
- Eisenhower IkeNet Human Resources - http://ikenet/body.cfm?id=212

POLICY APPROVAL(S)

Graduate Medical Education Committee	**September 26, 2016**
	June 24, 2019
	Updated: June 20, 2022

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
Example: *Identify strengths, deficiencies and limits in one's knowledge and expertise*	*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.*	*Submission of reflection paper*

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.

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**

EISENHOWER HEALTH

Policy **Effective Date: June 15, 2021**

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, 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, Medical bags and other similar medical items. No PPE unless prior approval by GME Director.
- Electronic equipment & supplies: :
  - 1 Per GME Program : 1- Laptop or Desktop, 1- Tablet/IPAD, iPen, 1- Phone/Upgrade
  - Cases for tablet & phone, Headset/Air pods, Webcam, Flash Drives and relatable software.
  - **(No other accessories unless preapproved by GME Director)**
- Away Elective Rotations: airfare, mileage, lodging
- Pre-Approved Jackets, Vest and Scrubs must be Graphite Grey.
  i. (Pulmonary only – Light Blue - ok)
- Alterations for approved uniforms (Whitecoats, scrubs, jacket)
- Senior year - If Board funds are exhausted, the Education Fund may be utilized

Non Allowable Education Expenses:

- Electronic Equipment: USB cords, Keyboards, Printers, Watches
- Alcoholic beverages
- Personal entertainment expenses (including cover charges)
- Personal expenses (Shampoo, detergent, gum, mints, vitamins etc.)
- Travel expenses for spouses and other dependents
- Loss or damage to personal property
- All reservation and cancellation charges
- Upgrades and Insurance, toll fees are not covered.
- Clothing/Apparel; Shoes, under garments such as socks, shirts, leggings etc.
- No PPE unless prior approval by GME Director.
- Other Misc.; Gifts, gift cards, laundry, and dry cleaning expenses, furniture

IV: REIMBURSEMENT PROCESS

General Requirements:

1. Include reason, dates of event. Provide justification for expenses (no abbreviations).
2. Receipt must show the meal/items purchased.
3. Purchases must have "Proof of payment". This may sometimes mean including the credit card info/credit card statement showing the charge
4. **Credit Card/Bank statements** are not allowed as a replacement for the receipt. Only as a back-up for proof of payment. Must provide an actual receipt.
5. Proof of Delivery. The actual delivery tracking status showing "Delivered". Not a picture of the item.
6. Name of Fund (if any)
7. Be E-mailed to the Finance Coordinator.
8. SCAN as ONE PDF File when possible. (Recommend using the NOTES App on your iPhone)
9. Easy to read (CLEAR and not too small)
10. DO NOT use a HIGHLIGHTER. It makes the ink fade.
11. Must e-mail. (PDF/WORD doc.)
12. No Paper/loose receipts accepted. Be sure to keep your paper/electronic receipts until you are reimbursed in case of any questions or new copy needed.
13. Receipts must be placed in **chronological order** (by date).
14. All expenses must be verified with an original receipt.
15. If you take a picture it should look like it was scanned. Place on a WHITE sheet/background.
16. If your receipts are e-mailed to you, you can forward it to me with a small description on what it is for and any additional information I need to know.
17. For Conferences or other events, you must provide proof of attendance and justification.

Meals:

1. Up to $50 a day while traveling for Conferences, Exams.
2. Rotations meals; $18 each scheduled 8 hour workday when food is not available to you. (Some exceptions apply).
3. Place an "X" on the receipt to the right of the item that is NOT reimbursable.
4. Pay only for yourself.
    a. If in a special case you had to pay for another Resident/fellow, please note their name, reason, and amount per person.

Mileage:

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

Travel:

1. Upgrades and Insurance, toll fees are not covered.
2. One check baggage is reimbursable.
3. Air travel must show location and date of travel.
4. Land Travel (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**

June 24, 2019

Updated: June 15, 2021

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 **January 22, 2018**

Updated **June 24, 2019**

EISENHOWER HEALTH

Policy **Effective Date: August 20, 2022**

Title: Licensure Policy

Home Department: Office of Graduate Medical Education

I. PURPOSE

To establish the requirements that residents/fellows (trainees) 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 trainees are required to do the following: (1) Obtain a National Provider Identifier (NPI); (2) Possess a Postgraduate Training License (PTL); (3) Obtain a Physician's and Surgeon's license within required timeframe stated by Medical Board of California (MBC); (4) Obtain a DEA Controlled Substance Permit/License; and (5) Pass USMLE Step 3/COMLEX Level 3.

III. PROCEDURES

1. **NPI Requirements**
   All PGY-1 trainees 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 trainees with the Welcome Packet. The NPI number must be provided to the GME Office.

2. **PGY-1 Exam Requirements**
   All PGY-1 trainees are required to have taken Step 3 of the USMLE examination and/or the COMLEX Level 3 for DOs, and provide evidence to the GME Office **by December 31st**. If a trainee does not pass the exam by the end of PGY1 year, 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.

3. **Postgraduate Training License (PTL)**
   A PTL must be obtained by the incoming trainee within 180 days from the start of enrollment in a postgraduate training program in California, otherwise, the resident must cease all clinical service at that time until a PTL has been issued by the Board.

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).

A PTL is valid for 12 months for U.S. or Canadian medical school graduates or 24 months for international medical school graduates (IMGs) only while enrolled in a California ACGME-accredited postgraduate training program. The PTL is not renewable.

The Board may issue a PTL for up to 90 days after a resident has received credit for either 12 or 24 months of Board-approved postgraduate training and continues enrollment in a California ACGME-accredited postgraduate training program. If a Physician's and Surgeon's License is not obtained by the PTL expiration date, the physician must cease all clinical services in California.

The Program Director (PD) will be required to submit the PTL Enrollment EF Form, directly to the MBC to verify that the trainee 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 trainee'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.

4. **Physician & Surgeon License**

A PTL holder who receives either 12 months (U.S. and Canadian medical school graduates) or 24 months (IMGs) credit of Board-approved postgraduate training with at least four months of general medicine training, may apply for a Physician's and Surgeon's License through the transition process. A PTL will be valid until 90 days after the 12 / 24 month requirement to allow an applicant time to obtain a California Physician and Surgeon License. The expiration date listed on the PTL will be inclusive of this 90 day window.

Incoming Trainees (Fellows) applying for a California Physician and Surgeon License have 180 days to secure the license if entering an ACGME program. California Physician and Surgeon License must be renewed every 24 months.

Eisenhower expects all trainees to receive and renew their licensure as soon as possible and within indicated deadlines. Trainees 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/fellowship training program to require trainees to meet the state law and have no clinical contact if they do not have a valid license.

5. **DEA Controlled Substance Permit**
   Once a trainee 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 trainee may engage in the practice of medicine only in connection with their duties as a trainee 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.

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 trainee 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 trainee's employment is terminated at the discretion of the PD.

2. Any trainee 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:**	**August 20, 2022**
		September 21, 2020
		October 23, 2017

EISENHOWER HEALTH

Policy **Effective Date: October 23, 2023**

Title: GME Reimbursable Expense Policy
Home Department: Office of Graduate Medical Education

I. POLICY

To establish guidelines and define available reimbursements (out of pocket expenses) for individual Resident/Fellow and GME faculty expenses.

II. PURPOSE

The purpose of this policy is to define funding to residents/fellows ("trainees") and Graduate Medical Education (GME) faculty, including how the funding can be used and reimbursed. The four different types of funding available are Relocation Expenses, Education, Board Fund and GME Faculty.

III. GME FUNDING

A. Relocation Expenses

a. Eisenhower Medical Center (EMC) will reimburse new trainees for expenses incurred in the process of relocating to the Coachella Valley up to a pre-determined amount.
b. Expenses must be submitted within 90 days of relocation.
c. All relocation reimbursement expenses are taxable and will be taxed by the Payroll department.
d. All reimbursement expenses must comply with the established EMC's Relocation Expense Reimbursement Policy

B. Education Fund

a. Trainees may be reimbursed up to the below amounts per academic year for expenses related to educational resources/materials, conferences, professional society memberships (not covered by the program), and licensing fees incurred while completing their training within the policy guidelines.
b. Senior trainees may be reimbursed up to the below amount for Board-related purchases or courses, such as: board exam and review fees, travel expenses incurred during residency/fellowship training, books, Apps, etc.

PGY	Amount
PG1	$2,500
PG2	$2,500
PG3	$4,000
PG4 (Pulm, Infectious Disease, EM Ultrasound)	$2,500
PG4 (Sports Med, Geriatric, Addiction Med)	$4,500
PG5 (Pulm, Infectious Disease)	$4,500

C. **GME Faculty**
   a. Per academic year, GME Program Directors, APD's and Core Faculty are eligible to be reimbursed up to $4,000 for specialty/educational conferences, professional society memberships, and educational resources or materials.
   b. Purchases must be related to GME teaching.
   c. Expenses must be submitted through Concur within 30 days of the purchase date and/or event.
   d. No Licensing, Board Certification and DEA or other personal expenses.

IV. GUIDELINES

A. All funding and reimbursements are issued concurrent with the fiscal year (**July 1 – June 30**). Funds must be spent on items purchased during that year and do not roll over to the following academic year; although some exceptions may apply.
B. Deadline to submit a reimbursement is May 15th each year. If an event occurs between May 15-June 30th, all reimbursements must be submit within 10 days after event ends.
D. All reimbursable expenses must comply with established EMC, GME, and EMA guidelines and regulations.
E. The purchase of items and attendance at events must occur during the duration of their Agreement of Appointment, and are not permitted during a leave of absence; with the exception of the Board exam and Board review, which can be purchased after the agreement period.
F. Reimbursements must be submitted within 30 days of purchase/delivery date, at the end of each block, and after each + 1 week rotation for IM residents.
G. Receipts that fail to document acceptable expenses may be refused. All items over $500 may require approval by the GME Director/DIO.
H. GME reserves the right, in its sole discretion, to deny reimbursement for any unreasonable expenses or any expenses lacking sufficient justification or documentation.
I. Proof of attendance is required for regional and national academic conferences. Expenses may not be submitted until after the event has taken place.
J. EMC will not cover the extra charges to accommodate non-employees or extra fees due to negligence.
K. All trainees and faculty will be reimbursed for individual expenses only, unless pre-approved by the GME Director.
L. Refer to the **Reimbursement Process and Procedure** attachment for further information.

<u>Allowable Education Expenses:</u>

a. Regional and National Academic Conferences:
   - Registration, airfare, mileage, lodging, parking and meals (The Travel and Entertainment Policy should be referred to in its entirety in the General Administrative Policies on IkeNet).
b. Medical books, medical journals, Apps, and online journal subscriptions.
c. Professional medical society dues or fees that enhance trainee's education.
d. Medical equipment such as surgical loupes, stethoscopes, Medical bags and other similar medical items.
e. Electronic equipment & supplies:
   - Limited to 1 of each item through the duration of training: Laptop or Desktop, Tablet, IPen. Upgrades for iPhone/IPad.
   - Cases for tablet & phone, Headset/Air pods, Webcam, Flash Drives and related software.

- **No other items or accessories without preapproval by the GME Director**

f. Away Elective Rotations: travel and lodging
g. Additional apparel (scrubs, jackets, vest, and white coats) must be purchased in the color scheme designated to the trainee. Jacket and vest are limited to one each, per year.
h. Alterations for approved uniforms (white coats, scrubs, and jacket).

Non Allowable Education Expenses:

- Electronic Equipment: any item not mentioned under allowable such as USB cords, keyboards, printers, watches, external hard drives, etc.
- Alcoholic beverages
- Personal entertainment expenses (including cover charges)
- Personal expenses (shampoo, detergent, gum, mints, insurances/warranties, vitamins etc.)
- Travel expenses for others such as spouses and other dependents
- Loss or damage to personal property
- Any cancellation charges
- Travel Upgrades and Insurance
- Non-uniform apparel, shoes, under garments such as socks, shirts, leggings etc.
- No PPE without prior approval by the GME Director.
- Miscellaneous: Gifts, gift cards, laundry and dry-cleaning expenses, furniture

V. REIMBURSEMENT PROCESS

A. General Requirements:

1. All expenses must be submitted with a scanned full receipt.
2. **Credit Card/Bank statements** are **not** allowed as a replacement for the receipt. They may only be used as a back-up for proof of payment.
3. Purchases must have "Proof of payment."
4. Must provide the following: (1) name, date/date range, location of the receipt/expense, (2) justification, (3) proof of attendance, and (4) fund being used, if applicable. Abbreviations/acronyms (i.e. ACP) are not acceptable.
5. Receipts must be placed in **chronological order** by date.
6. Receipt must be itemized (show items purchased).
7. Proof of Delivery must show the actual delivery tracking status as "Delivered" and not a photo of the item or packing slip.
8. For Conferences or other events, you must provide justification and proof of attendance. If presented, show proof of acceptance.
9. Easy to read (CLEAR and not too small)
10. No paper/loose receipts accepted. Be sure to keep your paper/electronic receipts until you are reimbursed in case of any questions or new copy needed.
11. If your receipts are e-mailed to you, you can forward it to the GME Finance Coordinator with a small description on what it is for and any additional information related to the expense.
12. SCAN all receipts/documents as a <u>File, if possible.</u> (Recommend using the NOTES App on your iPhone or scanning app).
13. E-mail PDF/WORD doc to the GME Finance Coordinator.
14. If a photo of the receipt is taken, it should look like a scanned document with a **white sheet/background**.

B. Meals:

1. Up to $69 or going rate a day while traveling for Conferences, Exams.
2. Meal itemized receipts for room service are required.
3. Receipts need to match the date/time of travel/rotation.
4. Rotation meals: $18 (or going rate) for each scheduled 8 hour workday when food is not available to you. (Some exceptions apply).
5. Rotation meal from a restaurant must be during your scheduled work time. Limit to 1 main course, 1 side, 1 desert, 1 drink.
6. Place an "X" on the receipt to the right of the item that is **not** reimbursable. Do **not** strikethrough.
7. Pay only for yourself and will be reimbursed for yourself only.
    a. If in a **special case** you had to pay for another trainee, please note their name, reason, and amount per person.

C. Travel (Outside of Coachella Valley):

1. All travel must be basic/coach class. Upgrades and Insurance/Warranty, toll fees, and car rentals, gas (unless pre-approved) are not covered.
2. One standard checked bag is reimbursable.
3. Air travel receipts must show traveler's name, to/from destinations, airline and date of travel.
4. Land Travel (i.e., taxi, ride-share, etc.) must be related to the reason of travel, submit receipts with dates of travel, to/from destination addresses, amount and proof of payment. Emailed receipts are acceptable. No toll fees unless it is the only available road and must show proof.
5. Mileage
    a. Mileage should start from Eisenhower to destination. If not departing from and returning to the EMC campus and other location is more miles the difference in miles is to be deducted. Must provide Google maps direction and mileage for both.
    b. Must submit the "Directions" from Google Maps showing the mileage and dates of travel. (Map not needed).
    c. For required "away rotations," standard mileage is automatically applied.

D. Lodging:

1. Daily lodging cost should not exceed the standard per day or basic/group rate (unless pre-approved).
2. Checkout receipt must show breakdown of charges and by date.
3. If receipt shows more than one guest or shared room and if you are requesting reimbursement for others, please provide their name and reason.
4. If split cost receipt, must provide proof of split payment.
5. Internet & Wi-Fi, add-ons or upgrades etc. are not covered

Links of Reference:

1. EMC Relocation Expense Reimbursement Policy #2426 - https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:20050
2. EMC Travel & Entertainment Policy #2214 - https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:10476

POLICY APPROVAL(S)

Graduate Medical Education Committee **10/23/23**

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 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 HEALTH

Policy **Effective Date: January 22, 2024**

Title: Policy and Procedure for Utilizing Biostatistical Support Services
Home Department: Office of Graduate Medical Education

I. PURPOSE

The purpose of this policy is to establish guidelines for Eisenhower Health's Residents, Fellows, and Faculty utilizing the services of our in-house statistician to assist with their research projects and data management. This policy aims to ensure the proper handling, protection, and privacy of all data involved in these interactions.

II. POLICY

A. Requesting Statistician Services

1. All requests for statistical support should be made via the designated form on the Eisenhower Health intranet - Biostatistics Support Request Form
2. The form must specify the nature of the request, the type of data involved, and the expected timeline for completion.

B. Data Handling and Sharing

1. All data shared with the statistician must be de-identified prior to transfer. This means that any identifying details (like names, addresses, social security numbers, etc.) must be removed or replaced with anonymous identifiers. This is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations. Personal Health Information (PHI) should under no circumstances be shared.
2. Only data necessary for the completion of the statistical task should be shared with the statistician. It is recommended that prior to sharing data, careful consideration be given to what information is actually required for statistical analysis and all extraneous details should be removed.

C. Data Security

1. Data transfers must be conducted using the approved Eisenhower Health secure data transfer systems and Eisenhower email.
2. Unsecured transfer methods, such as personal email, should never be used for sharing data with the statistician.

D. Data Privacy

1. The statistician is subject to the same confidentiality agreements as all other Eisenhower Health employees and is prohibited from sharing data or research findings outside of the project team without explicit permission.
2. If a privacy breach or incident is suspected, it must be reported immediately to Eisenhower Health’s HIPPA Breach Notification via Eisenhower Health’s intranet.

E. Project Collaboration

1. The statistician should be recognized as a part of the project team and included in all relevant communication and meetings.
2. Proper acknowledgement of the statistician's work should be included in any resulting publications or presentations.

F. Feedback and Complaints

1. Concerns or issues related to interactions with the statistician should be reported promptly to the Chief Administration Officer of Graduate Medical Education or Designated Institutional Official.

III. NON-COMPLIANCE

1. Failure to adhere to this policy and procedure may result in disciplinary action. This is necessary to uphold the security of our data and the privacy of our patients.

Conference Request Form Link: Biostatistics Support Request Form

QR Code to Request Form:

POLICY APPROVAL

Graduate Medical Education Committee

Eisenhower Medical Center
Patient Privacy and HIPAA Fact Sheet

Handling Confidential Patient Information

Conversations

- Minimize conversations with patients or about patients in areas where unauthorized people can over hear, especially when discussing highly sensitive clinical information.
- Never discuss patient information with anyone who does not have a business need to know.

Electronic Messaging

- All emails sent to persons outside of EMC's email system that contain patient information must be encrypted.

Paper Documents

- Check the name on After Visit Summaries for the correct name before handing it over to the patient.
- Highlight in yellow the name of the patient on each AVS or Discharge Instructions sheet before stapling, to assure correct documents.
- Keep confidential documents secure, turned over and never leave them unattended.

Copy/Scan/Print/Fax machines

- Never leave PHI on unsecured machines.
- Verify the target fax number before sending.
- Use an Eisenhower Fax coversheet every time.

HIPAA and You

- HIPAA is a federal law that protects patient privacy and places responsibility for confidentiality and security on all EMC employees.
- HIPAA establishes civil and criminal fines for violations of patient privacy.
- All EMC employees are required to complete HIPAA training on an annual basis via our computer based learning modules.
- Managers are to consult with EMC Legal department when hiring a vendor who is provided access to EMC protected health information; an appropriate Business Associate Agreement must be included in the contract.

Uses and Disclosures of Patient Information

- EMC staff may access, use and disclose patient information only for authorized purposes, such as when providing healthcare services, processing payments or when conducting hospital operations such as quality reviews.
- When an employee accesses patient information as part of their job, they must make every reasonable effort to use and disclose only the minimum amount of patient information needed to accomplish the intended task.
- Patients are informed of their rights on how to access their health information and how their information is used in EMC's Notice of Privacy Practices (NPP); which is available on the public EMC website and can be found in Policy # 45849.
- Patient authorized release of information is performed by EMC's Release of Information/Medical Records office, located on the first floor of the Wright Building, #104.
- Employee violations of EMC's patient privacy policies may result in disciplinary action, up to and including termination.
- Employees are required to report suspected or actual violations of EMC's privacy policies to the Information Privacy Officer (IPO) using the HIPAA Breach Questionnaire, which can be found on Ike Net under Quick Links **or by** calling the IPO at ext. 8604.

Patient Privacy and Security Resources

- Privacy related Policies and Procedures can be found in Luci Doc, beginning with the Patient Information Policy, # 34851; other policies are searchable by key words within Luci Doc policies.
- Contact the Information Privacy Officer:
  Larry Stahl at lstahl@eisenhowerhealth.org
- Contact the Chief Information Security Officer:
  Jehremiah Fix at Jfix@eisenhowerhealth.org
- Contact the Chief Compliance Officer:
  Jason Ainge at j.ainge@eisenhowerhealth.org.

Suspect a patient privacy violation? Go to: Ike Net > Quick Links > Breach Notification form

LS/12.20.23

EISENHOWER MEDICAL CENTER

Policy **Effective Date: 03/14/2016**

Title: GMEC Special Review Process & Protocol

Home Department: Office of Graduate Medical Education

IMPORTANT NOTICE: The official version of this Policy is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.

I. PURPOSE:

To ensure effective oversight from the GMEC and DIO of underperforming Graduate Medical Education programs within the Sponsoring Institution by (1) establishing the necessary criteria for identifying an underperforming program and (2) establish the procedure when a residency/fellowship program undergoes a Special Review.

II. CRITERIA:

A variety of informational and statistical information can be used to determine if a residency or fellowship program is underperforming. These items include, but are not limited to:

1. A significant change, as noted in the Annual Program Evaluation, in standard performance indicators such as:
    a. In-training exam scores;
    b. Resident's Clinical Experience (patient census, types, disease, procedural volume);
    c. Resident progress in the Competencies;
    d. Resident aggregate progress in the Milestones;
    e. Program Attrition (resident and/or faculty, program director);
    f. Resident or Faculty Survey Results (ACGME, program, or institutional surveys);
    g. Scholarly Activity (residents and faculty);
    h. Faculty Development;
    i. Significant changes in program educational content, structure and/or resources;
    j. CLER Site Visit results specific to a particular program that has not been resolved.

2. Evidence 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; or significant issue(s) as may be brought forth by the GMEC.

3. A program's inability to demonstrate success in any of the following Clinical Learning Environment Review (CLER) focus areas:

    a. Integration of residents/fellows into institution's **Patient Safety Programs**;
    b. Integration of residents/fellows into institution's **Quality Improvement Programs** and efforts to reduce Disparities in Health Care Delivery;
    c. Establishment and implementation of **Supervision** policies;

d. **Transitions in Care**;
e. **Duty hours** policy and/or **fatigue management and mitigation**; and
f. Education and monitoring of **Professionalism.**

4. Self-report by a Program Director.

III. PROCEDURE:

1. **Designation:** When the GMEC has determined that a residency or fellowship program is deemed underperforming or failing, the DIO as Chair of the GMEC shall schedule a Special Review. The Special Review shall begin within 30 days of a program being designated as "underperforming" or "failing" with a final report and recommendations within 60 days of the start of the Special Review.

2. **Special Review Committee:** 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, at least one additional core faculty member, and one resident/fellow not from within the department of the program under review. 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 will clarify the specific concerns 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 a single, specific area 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 for 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. Letters from the RRC with citations or areas of concern;
   d. Reports from previous internal reviews of the program (if applicable);
   e. Previous annual program evaluations;
   f. Results from the most recent internal or external resident surveys,
   g. Results from the most recent ACGME faculty survey, and,
   h. Any other materials the Special Review panel considers necessary and appropriate.
   i. The Special Review panel will conduct interviews with the Program Director, key/core faculty members, at least one peer-selected 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 Program Director, the DIO and GMEC that includes, at a minimum; a description of their view process, the panel's findings, and recommendations. These shall include a description of the quality improvement goals, any corrective actions designed to address the identified concerns, a recommended time-line, and the process for the GMEC to monitor outcomes. The GMEC may, at its discretion, choose to modify the Special Review Report before accepting a final version.

6. **Special Review Follow-Up:** The program director will be required to submit a progress report to the GME Office addressing the findings and recommendations for improvement as designated by the Special Review Panel. The Special Review panel will review the progress/follow-up report for progress. The Chair of the Special Review panel will report all activities and progress at each GMEC meeting until such time that the GMEC is satisfied with the progress and compliance of the program. The program director from the underperforming program will participate in all GMEC discussions related to the Special Review.

7. **Monitoring:** 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.

8. **Disclosure**: Participants in the Special Review Panel and GMEC shall not use or disclose to others, except in connection with the duties and responsibilities outlined in this Protocol, any information related to the Special Review, including but not limited to, the Special Review materials, data, and written report.

GMEC Special (Focused) Review Committee Guidelines/Responsibilities

(Supplement to GMEC Special Review Policy)

Designation: When the GMEC has determined that a residency or fellowship program is deemed underperforming or failing, the DIO as Chair of the GMEC shall schedule a Special Review. The Special Review shall begin within 30 days of a program being designated as "underperforming" or "failing" with a final report and recommendations within 60 days of the start of the Special Review.

Special Review Committee: Each Special Review shall be conducted by a panel including at least one member of the GMEC who may also serve as the Chair of the committee. The committee shall include at least two additional core faculty members and, for a residency program review at least one resident in the PGY 2 year or higher. 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.

Preparation for the Special Review: The Chair of the Special Review committee, in consultation with the DIO/GMEC and/or other persons as appropriate, will clarify the specific concerns 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 a single, specific area 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.

The Review Process:
Approximately two weeks prior to the Special Review, the Chair of the Special Review Committee and the Director of Graduate Medical Education will meet with the Program Director and support staff to review the curriculum, policies and procedures, evaluation forms, Web ADS, milestone submissions, etc. This part of the review and the findings will be shared with the Special Review Committee members as well as the GMEC.

1. The day of the Special Review will be very similar to the ACGME site visit. The committee will meet, review the findings regarding the program surveys and documents, and spend the day interviewing the Program Director, faculty and residents from within the program. See example of the day's events below:

- Committee discussion of the documentation – 1 hour
- Committee meets with the Program Director and Program Coordinator –1 hour
- Committee meets with PGY 1 residents – 30 minutes
- Committee meets with PGY 2 and PGY 3 residents – 30 minutes
- Committee meets with PGY 4 and PGY 5 residents – 30 minutes
- Committee meeting with program faculty – 45 minutes

- Committee creates a preliminary list of findings – 45 minutes
- Committee re-convenes with Program Director and Program Coordinator – 1 hour

2. A clear, concise summary of the Special Review will be completed with recommendations and a time-line.

3. The Special Review template will be completed by the Committee and will include:

- The name of the program reviewed with the date the Special Review was completed
- Names and titles of Special Review committee members
- A brief description of how the review process was conducted including a list of those interviewed and documents reviewed
- Assessment of how the program has addressed previous citations
- Other issues or areas of concern noted by the Special Review committee in addition to previous RRC citations
- Final Recommendations/Requirements which may include a request for a progress report (timeframe to be determined by GMEC).

4. The summary report will be presented by the Special Review Committee Chair/or DIO in his/her absence at the subsequent GMEC meeting. The GME Committee will review and discuss the findings. The Program Director will have the opportunity to respond to the findings in the report. A copy of the final report will be given to the Program Director with a copy on file in the Graduate Medical Education office.

5. Following the Special Review, the Program Director will be asked to provide a progress report to the GMEC addressing areas of concern. The timeframe for this report will be determined by the GMEC. The GMEC may continue to ask for the Program Director to report on areas of concern on a regular basis until the GMEC is satisfied that the issue(s) has/have been adequately addressed.

6. All residency programs supported by Eisenhower Medical Center will be reviewed when necessary in the same manner and expected to provide the same quality of education and clinical experience.

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

Eisenhower Medical Center Policies Policy

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

Human Resources Department 20063 **Official** (Rev: 10)

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 of 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, V.P. Human Resources (07/28/2020 11:12AM PST) Martin Massiello, 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,	**This Revision Effective**	08/11/2020
		Last Reviewed/Revised	
		Next Review Date	08/11/2022

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

Eisenhower Medical Center Policies Policy

Sexual Harassment Prevention

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 (07/28/2020 10:30AM PST) Samantha Heckman, Esq., Senior Counsel-Chief Compliance Officer and Information Priv (07/28/2020 10:42AM PST) Martin Massiello, Exec. V.P. Chief	**This Revision Effective**	08/03/2020
		Last Reviewed/Revised	
		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

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

The following expenses will not be reimbursed:

12.1 Personal items (haircuts, shoe shines, gifts, souvenirs, etc.) and expenses not specifically related to the purpose of the trip.

12.2 Tours.

12.3 Theater, shows, movies, and sporting events, **unless clearly** business entertainment.

12.4 The cost of parking tickets or traffic violations is not reimbursable.

12.5 Travel/Accident Insurance is automatically provided for employees engaged in official travel. Additional insurance purchased will be at individual's expense. Car rental insurance is the responsibility of the employee. The employee's personal coverage is primary. Purchase of additional coverage will be at the employee's expense.

13.0 MISCELLANEOUS

It is recognized that this policy cannot cover all contingencies/situations explicitly, and that common sense and good judgement need to be applied. Any exceptions must be explained or noted on the Expense Report and initialed by the appropriate Vice President.

Attachment: Check Request

Referenced Documents

Reference Type	Title	Notes
Documents which reference this document		
Applicable Documents	Continuing Education Conferences Application for Support	

Document Owner	Parham, Jeanette	**Original Effective Date**	11/22/2004
Signed by	(03/10/2005 12:00AM PST) Ali Tourkaman, Vice President Facilities Management & Construction (03/10/2005 12:00AM PST) Brian Helleland, Vice President, Ancillary & Support Services (03/10/2005 12:00AM PST) Craig Owens, Chief Operating Officer (03/10/2005 12:00AM PST) Dave Perez, Vice President, IS (03/10/2005 12:00AM PST) G. Aubrey Serfling, Proxy for Board of Directors, President/CEO (03/10/2005 12:00AM PST)	**This Revision Effective**	11/22/2004
		Last Reviewed/Revised	06/07/2012
		Next Review Date	12/15/2012

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

EISENHOWER HEALTH

Policy **Effective Date: March 22, 2021**

Title: Disruptions in Patient Care or Education

Home Department: Office of Graduate Medical Education

I. Purpose

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

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 or other substantial disruption in patient care or education. Following the declaration of a disaster or disruption in patient care or education, the Designated Institutional Officer (DIO), in conjunction with the Program Directors (PD's), 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.

A. A comprehensive record of resident/fellow evaluations, procedures, duty hours, scholarly activity, training history, certification documentation, milestones and competency-based curriculum and achievements, must be maintained in the online residency/fellowship management suite. In addition, contact information, including email addresses, personal phone numbers and emergency contacts, must be maintained within the residency/fellowship management suite.

B. PD's must first contact the DIO with questions regarding the disaster. If DIO is unavailable, the program may contact the Chief Executive Officer (CEO) for direction. Residents/fellows must first attempt to contact their program director or the GME office.

C. The Graduate Medical Education Committee (GMEC) will meet as soon as possible following declaration of a catastrophic event. The GMEC will determine whether existing programs can continue with or without restructuring and whether temporary or permanent transfer of residents/fellows to another institution will be necessary.

D. If the hospital must reduce the size, close or substantially alter training in any of its sponsored programs due to a disaster, the following policies/procedures shall be implemented:

1. The DIO, in partnership with the GMEC, PD's, and hospital administrative staff, are responsible for determining when conditions exist that require the relocation of residents and/or fellows so their educational programs can continue.

2. If conditions prohibit maintenance of applicable ACGME standards and guidelines for any GME program, the DIO shall notify the CEO, PD's, and GME Director that there is a need to relocate residents/fellows in order to continue their educational program.
3. Upon notification of disaster status from the DIO, each PD will immediately determine the location and status of all trainees under his/her supervision and report this information to the DIO.
4. PD's must maintain operational awareness of the location of all residents/fellows within their programs as well as methods of contacting each individual during time of disaster.
5. The DIO will maintain communication with each PD regarding the need to relocate trainees either on a temporary or permanent basis. Once this decision is made, trainees will be notified immediately by their PD.

E. In the event of program closure due to substantial disruption in patient care or education:

1. For short-term closure or reduction, the PD shall assist the resident/fellow in locating institutions that can provide short-term training.
    a. Residents/fellows who temporarily transfer to other institutions remain employees of the Sponsoring Institution and continue to receive their salary, benefits, and professional liability coverage from the Sponsoring Institution. No interruption is anticipated.
2. For longer-term closures, which may outlast a trainee's remaining time in residency/fellowship training, the DIO and PD's will make every effort to assist trainees in identifying suitable programs for permanent transfer.
    a. Residents/fellows who permanently transfer to other institutions will not remain employees of the Sponsoring Institution and will not continue to receive salary, benefits, and professional liability from the Sponsoring Institution.
3. All applicable records from the residency/fellowship management suite will be made available to accepting programs.

F. Within 10 days of a disaster that prompts program closure or complement reduction, the DIO (after conferring with the CEO) will contact the ACGME to discuss due dates for programs to submit reconfiguration requests to the ACGME and to inform each program's residents/fellows of the need to transfer to another program. The DIO will also notify the executive director of the institutional review committee (IRC) of the situation necessitating program reconfiguration or closure.

G. Each PD will notify the appropriate executive director of the residency review committee (RRC) about the need to locate positions for each resident/fellow and the expected duration of time needed for relocation.

H. The PD will provide residents/fellows the contact information for the RRC member who will coordinate relocation efforts as well as a list of potential programs accepting residents/fellows. PD's will assist each resident/fellow in contacting the PD at each of these programs.

I. PD's will complete transfer letters using backup information available from the residency/fellowship management suite.

J. Receiving hospitals or institutions are responsible for requesting temporary complement increases from the RRCs.

K. In the event of permanent transfers, the hospital chief financial officer (CFO) and the CFOs of receiving institutions will work together to assess the process of transferring funded positions.

POLICY APPROVAL(S)

Graduate Medical Education Committee **March 22, 2021**

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**

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**