



EISENHOWER  
HEALTH



**Graduate Medical Education  
Policy Manual  
2026 – 2027**



# EISENHOWER HEALTH

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## Annual Program Evaluation

- I. **POLICY STATEMENT:** 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 the program. Resident/Fellows(s) will be peer-selected to participate in the review.

**SCOPE AND APPLICABILITY:** To establish guidelines for the ACGME Institutional Requirement of I.B.4.a).(4) regarding GMCE 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. **DEFINITIONS:** *Not Applicable*

III. **POLICY:**

### 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.



## Annual Program Evaluation

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;
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 determine how those performance improvement initiatives will be measured and monitored and include a time-line.



## Annual Program Evaluation

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

9. A final copy of the APE and action plan/timeline 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 timeline.

10. 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



## Annual Program Evaluation

- 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
5. 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
6. 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



## Annual Program Evaluation

- Scholarly activity
- ACGME WebADS /Self-Study
- Clinical quality measures/patient care outcomes
- In service exams
- QI activities
- Milestones

IV. **ADDITIONAL INFORMATION:** *Not Applicable*

V. **REFERENCES AND RELATED DOCUMENTS:**

- A. [https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency\\_2023.pdf](https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023.pdf)
- B. [https://www.acgme.org/globalassets/pfassets/programrequirements/cprfellowship\\_2023.pdf](https://www.acgme.org/globalassets/pfassets/programrequirements/cprfellowship_2023.pdf)
- C. [https://www.acgme.org/globalassets/pfassets/programrequirements/800\\_institutionalrequirements2022.pdf](https://www.acgme.org/globalassets/pfassets/programrequirements/800_institutionalrequirements2022.pdf)
- D.



## Clinical Competency Committee

I. **POLICY STATEMENT:** 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.

II. **SCOPE AND APPLICABILITY:** All ACGME-accredited residency and fellowship programs sponsored by Eisenhower Medical Center.

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. **DEFINITIONS:** *Not Applicable*

IV. **POLICY:**

### 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.



## Clinical Competency Committee

### 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.

### PROCEDURE

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.



## Clinical Competency Committee

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.

#### **IV. ADDITIONAL INFORMATION: N/A**

#### **V. REFERENCES AND RELATED DOCUMENTS:**

- <https://www.acgme.org/Portals/0/ACGMEClinicalCompetencyCommitteeGuidebook.pdf>
- [https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency\\_2023.pdf](https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023.pdf)
- [https://www.acgme.org/globalassets/pfassets/programrequirements/800\\_institutionalrequirements2022.pdf](https://www.acgme.org/globalassets/pfassets/programrequirements/800_institutionalrequirements2022.pdf)



## Code of Conduct for Scholarly Activities

- I. **POLICY STATEMENT:** This Code of Conduct outlines the principles and standards to guide all members of Eisenhower Health in their scholarly activities, including research, case reports, and quality improvement projects. Adherence to these guidelines ensures ethical conduct, compliance with regulatory requirements, and the promotion of high-quality scholarly work.
- II. **SCOPE AND APPLICABILITY:** Not applicable.
- III. **DEFINITIONS:** Not applicable.
- IV. **POLICY:**
  - A. **Integrity and Honesty:** Conduct all scholarly activities with the highest level of integrity and honesty. Misrepresentation of data, plagiarism, and falsification of information are strictly prohibited.
  - B. **Respect for Participants:** Ensure the dignity, rights, and welfare of participants in all scholarly activities. Obtain informed consent when required and maintain confidentiality and privacy.
  - C. **Compliance with Regulations:** Adhere to all applicable local, state, and federal regulations, as well as institutional policies governing research, case reports, and quality improvement.
- V. **PROCEDURE:**
  1. **Specific Guidelines**
  2. **Patient Health Records:**
    - Do not access, transfer, or analyze patient health records for the purpose of research without prior approval from the Institutional Review Board (IRB).
    - Always maintain strict confidentiality of patient health information.
  2. **Principal Investigators:**
    - Only faculty members are authorized to serve as principal investigators in research and quality improvement projects. Students and trainees may participate under the supervision of a faculty member.
  3. **IRB Approval:**
    - Obtain approval from the IRB before initiating any research project involving human subjects.
    - Obtain approval from the IRB for all observational studies including retrospective chart reviews, cohort studies, case-control studies, cross-sectional studies.
    - If the intent of your inquiry changes from quality improvement to research, seek and obtain approval from the IRB prior to proceeding with the project.
  4. **Conflict of Interest:**
    - Disclose any potential conflicts of interest that may affect your scholarly activities. Avoid situations where personal interests could compromise the integrity of your work.



## Code of Conduct for Scholarly Activities

### 5. Authorship and Acknowledgment:

- Assign authorship based on substantial contributions to the conception, design, execution, or interpretation of the scholarly work. Acknowledge all contributors appropriately.
- Ensure that all authors have reviewed and approved of the final version of any publication or presentation.

### 6. Data Management:

- Collect, store, and manage data responsibly. Ensure accuracy, reliability, and reproducibility of data.
- Do not store patient data on personal computers or google drive.
- Retain research data in accordance with institutional policies and regulatory requirements.

### 7. Publication and Dissemination:

- Disseminate findings through appropriate channels, including peer-reviewed journals and conferences. Share results transparently and ethically.
- Avoid duplicate publication of the same findings without proper acknowledgment.

### 8. Monitoring and Compliance:

- Regular audits of research practices and scholarly activities will be conducted to ensure compliance with the Code of Conduct.
- Clear mechanisms will be established for reporting breaches of the Code of Conduct. Reports will be handled confidentially and investigated thoroughly.

### 9. Training and Education:

- Eisenhower Health GME will provide ongoing training on research ethics, responsible conduct of research, and best practices in scholarly activities for all faculty, residents, and fellows.
- Resources and support will be available to help individuals understand and comply with the Code of Conduct.

### 10. Disciplinary Actions:

- Violations of the Code of Conduct will result in disciplinary actions, which may include retraction of publications, suspension of research activities, or other penalties as deemed appropriate.

**VI. ADDITIONAL INFORMATION:** Responsible parties: Director of Scholarly Activities & Faculty Development, Chief Administrative Officer, Graduate Medical Education, Designated Institutional Officer.

**VII. REFERENCES AND RELATED DOCUMENTS:** Not applicable.



## Conference Policy

**POLICY STATEMENT:** Eisenhower Health recognizes the educational value of and supports resident/fellow (trainee) participation in or attendance at professional conferences and other similar outside educational activities.

**SCOPE AND APPLICABILITY:** To provide guidelines on and establish limits to the trainee's participation in outside educational activities, and to minimize travel expenses while at the meeting, in accordance with ACGME requirements.

### I. **DEFINITIONS:** *Not Applicable*

1. **POLICY:** Each trainee in good standing may attend one major conference during the entirety of their training program, provided the attendance is approved by the Program Director (PD). A "major conference" is defined as a national or international society conference that aligns with the trainee's specialty or subspecialty. Examples of major conferences include those organized by recognized professional bodies, such as the American Medical Association, American College of Physicians, American Academy of Family Physicians, or similar organizations. These conferences typically feature renowned speakers, plenary sessions, and opportunities for networking and professional development. Additionally, trainees may attend one additional conference per year if they are presenting at the conference. If presenting, the trainee will be allowed to attend on the day of their presentation plus travel time one day before and one day after the presentation day. Additional days and/or additional conferences must be approved in advance via email by the PD and the Designated Institutional Official (DIO) prior to registration. The presenter must be an active trainee at Eisenhower and presenting on behalf of Eisenhower

### IV. **PROCEDURE**

#### CONFERENCE SELECTION AND APPROVAL

1. Trainees are encouraged to attend conferences that align with their specialty or area of interest and contribute to their professional development.
2. Trainees **must submit a request** Resident/Fellow Conference Request Form detailing but not limited to the following: conference name, dates, location, objectives, anticipated benefits, and confirmation letter which includes the conference name along with the title of your presentation (either poster or platform presentation).
3. PD's will review conference requests, considering factors such as educational value, relevance to the trainee's specialty, schedule, and available funding.
4. Conference requests **must be submitted a minimum of 90 days prior** to the conference (contingent on each program requirements) to allow for proper planning and approval.



## Conference Policy

5. The conference must be located within the continental United States, excluding Alaska and Hawaii. Conferences in Alaska, Hawaii or International conferences will need to be pre-approved by the Program Director and the DIO.
6. Email approval is required prior to purchase and reimbursement.

### V. TIME AWAY

1. Per ACGME Common Program Requirement FAQs, [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., 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 days at the conference when the trainee is not presenting, would not be counted towards the clinical and educational work hours.
2. Time away from the training program for educational purposes, such as workshops or educational conferences, are not counted in the general limitation on absences but cannot exceed 5 days annually. Any days exceeding the 5 days, will be counted as Paid Time Off and will need to be pre-approved by the PD. Attendance at educational, scholarly, and professional activities is scheduled by mutual agreement with the PD.
3. Attendance at educational meetings for which the trainee is not presenting is only permitted at the discretion of the PD. Time away to attend will be determined by each program requirement.

### VI. SCHEDULING OF CONFERENCES

1. Trainees 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.
2. 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".

### VII. REIMBURSEMENT

1. Trainees will be reimbursed up to \$2,500 each year for conference(s) at which they present and up to \$4,000 to attend one major conference during the entirety of their training program. These stipend amounts are designed to cover the most basic conference expenses.
2. Registration fees, flights, lodging, poster fees, and ground transportation will be reimbursed only after submission of all itemized receipts along with proof of acceptance.



## Conference Policy

3. Trainees may use their Educational Fund stipend to supplement any additional conference related expenses once the designated conference stipend has been exhausted.
4. Lodging expenses will be reimbursed up to the standard rate per night listed for the conference, which is the most basic accommodation option available at the hotel. Any upgrades to higher room categories or additional services beyond the standard room may not be eligible for reimbursement unless explicitly approved in advance by the PD or GME Director/DIO.
5. Must provide email proof of approval along with your reimbursement request.
6. Meal reimbursement will be limited to \$75 (or going rate) for in-person conference only, and this amount must be covered within the allocated \$2,500 or \$4,000 conference stipend. (Refer to EMC Travel & Entertainment Policy).
7. If a trainee would like to arrive or stay past the conference dates, prior approval is required from the PD. Any additional charges incurred past the approved time will be the responsibility of the trainee.

II. **ADDITIONAL INFORMATION:** *Not Applicable*

III. **REFERENCES AND RELATED DOCUMENTS:**

<https://forms.gle/ifFqXS2Fvb7HBjmx8>

<https://www.acgme.org/globalassets/pdfs/faq/common-program-requirements-faqs.pdf>

<https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:109149>

<https://forms.gle/wy69KTvWEPPCxZo17>

<https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:156132>

<https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:145013>



## Didactic Conference Attendance

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY:** 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. **DEFINITIONS:** *Not Applicable*
- IV. **POLICY:** N/A
- V. **Procedure**
  - a. **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.



### **Didactic Conference Attendance**

- 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.

#### **VI. ADDITIONAL INFORMATION:** *Not Applicable*

#### **VII. REFERENCES AND RELATED DOCUMENTS:**

- [https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency\\_2023.pdf](https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023.pdf)
- [https://www.acgme.org/globalassets/pfassets/programrequirements/cprfellowship\\_2023.pdf](https://www.acgme.org/globalassets/pfassets/programrequirements/cprfellowship_2023.pdf)



## Disruptions in Patient Care or Education

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY:** 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.
- III. **DEFINITIONS:** *Not Applicable*
- IV. **POLICY:**
  - 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



## Disruptions in Patient Care or Education

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.



## Disruptions in Patient Care or Education

- 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.
- V. Procedure:** Not applicable
- VI. ADDITIONAL INFORMATION:** *Not Applicable*
- VII. REFERENCES AND RELATED DOCUMENTS:**  
[https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency\\_2023.pdf](https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023.pdf)  
[https://www.acgme.org/globalassets/pfassets/programrequirements/cprfellowship\\_2023.pdf](https://www.acgme.org/globalassets/pfassets/programrequirements/cprfellowship_2023.pdf)



## GME Faculty Policy: Faculty Roles, Responsibilities & Evaluation

- I. **POLICY STATEMENT:** Eisenhower Health’s Graduate Medical Education (GME) Faculty Policy aims to ensure academic and professional excellence through the designation and support of Program Directors, Associate Program Directors, Core Faculty, and Faculty. This policy also outlines faculty responsibilities as required by the ACGME and details parameters for faculty evaluation.
- II. **SCOPE AND APPLICABILITY:** To define the classifications, responsibilities, and expectations for Faculty, Core Faculty, Associate Program Directors, and Program Directors and to establish clear guidelines for faculty evaluation.
- III. **DEFINITIONS**
  - A. Faculty: refers to the entire teaching force responsible for educating residents. The term “faculty”, including “core faculty”, does not imply or require an academic appointment. Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients.
- IV. **POLICY:** *In this section include mandated, specified, or prohibited behavior, “what” should be done and when applicable, “why” it should be done (requirements staff must adhere to; regulatory requirements).*
  - A. Faculty Responsibilities
    - i. Faculty members must be role models of professionalism.
    - ii. Faculty members must demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care.
    - iii. Faculty members must demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities.
    - iv. Faculty members must administer and maintain an educational environment conducive to educating residents.
    - v. Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.
    - vi. Faculty members must pursue faculty development designed to enhance their skills at least annually
  - B. Faculty Member Qualifications
    - i. All physician faculty members must have current certification in their specialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess qualifications judged acceptable to the ACGME Review Committee.
    - ii. Faculty who are not certified but are under board-eligible status must be actively working toward certification. For subspecialty faculty, subspecialty certification by the appropriate ABMS or AOA board is expected.



## GME Faculty Policy: Faculty Roles, Responsibilities & Evaluation

- iii. In special cases, faculty without U.S. board certification must have equivalent qualifications formally approved by the program's Review Committee through submission of a letter of support signed by the Program Director and Designated Institutional Official (DIO), along with the faculty CV. Exceptions must be clearly documented in the ACGME ADS system.
- iv. Programs must ensure that faculty certifications are reviewed and accurately updated during the ACGME Annual Update process or when onboarding new faculty.

### C. Program Leadership and Faculty Roles

#### i. Program Director

1. The Program Director is the physician designated with authority and accountability for the operation of the residency or fellowship program. This individual must:

- a. Be certified by an appropriate American Board or possess equivalent qualifications
- b. Have at least three years of participation in GME
- c. Demonstrate leadership, teaching, and scholarly experience
- d. Commit sufficient time to program administration and supervision
- e. Ensure compliance with ACGME program requirements and institutional policies

#### ii. Associate Program Director (APD)

The APD assists the Program Director with oversight of the residency or fellowship. This role:

- a. Supports curriculum development, teaching, evaluation, and program administration.
- b. Must be identified in the ACGME ADS system if formally recognized by the program

#### ● Core Faculty

Core Faculty are integral to the education, evaluation, and mentoring of residents or fellows. To qualify as Core Faculty, individuals must:

- a. Be board-certified in their respective specialty or possess equivalent qualifications formally approved by the program's ACGME Review Committee. Faculty who are board-eligible must be actively pursuing certification.
- b. Devote a significant portion of their professional effort to residency/fellowship education and scholarly activity.
- c. Participate actively in didactic teaching, inpatient and/or outpatient clinical teaching, and supervision of residents/fellows.
- d. Must complete the annual ACGME Faculty Survey.



## GME Faculty Policy: Faculty Roles, Responsibilities & Evaluation

- e. Serve on the Clinical Competency Committee (CCC) and Program Evaluation Committee (PEC), as appropriate.
- f. Complete formal evaluations of trainees in a timely and constructive manner.
- g. Engage in at least one scholarly activity annually, such as publications, presentations, QI projects, curriculum development, or educational research.
- h. Attend at least 75% of core faculty meetings and scheduled academic activities.
- i. Demonstrate professionalism and ethical conduct, serving as role models to trainees.
- j. Participate in annual program review and contribute to continuous program improvement.
- k. Attend faculty development sessions related to teaching, feedback, DEI, or other academic initiatives organized by GME.

### V. PROCEDURE:

#### A. Faculty Evaluation

Each program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. Feedback should be provided to faculty on their evaluations and contributions to the program's mission at least annually.

The evaluation process may include, but is not limited to:

- i. Clinical teaching evaluations
- ii. Quality and frequency of feedback
- iii. Lectures and didactics evaluations
- iv. Engagement with the educational program
- v. Participation in faculty development
- vi. Clinical performance
- vii. Professionalism
- viii. Scholarly activities
- ix. Recognition and awards

#### B. Reimbursement & Evaluation Completion

To promote accountability and timely feedback, the following process will be implemented:

- i. **Reimbursement/Payment Hold:** Reimbursement for faculty members will be **suspended** until all trainees' evaluations and procedural assessments for each rotation or educational activity are **completed**.
- ii. **Evaluation Timeline:** Faculty are expected to **complete and submit** all evaluations **within two weeks** of the end of each rotation or educational activity.



## **GME Faculty Policy: Faculty Roles, Responsibilities & Evaluation**

- iii. **Trainee Feedback:** Faculty are encouraged to review evaluation results with trainees at the end of each rotation to facilitate feedback, identify areas for improvement, and support trainee development.
- iv. **Monitoring:** The PD or designee will monitor evaluation completion and follow up with faculty to ensure compliance within the timeline.

**VI. ADDITIONAL INFORMATION:** Not Applicable

**VII. REFERENCES AND RELATED DOCUMENTS:**

[ACGME Faculty Member Qualifications](#)

[ACGME Common Program Requirements](#)



## GME Faculty Reimbursement Guidelines

**I. PURPOSE:** Eisenhower Health’s Graduate Medical Education (GME) Faculty Education fund encourages faculty participation in national/regional conferences and acquisition of educational resources that support practice-based learning and teaching. Eligible faculty include:

- i. Program Directors
- ii. Associate Program Directors
- iii. Core Faculty with a GME FTE

**II. DEFINITIONS:** Not Applicable

**III. GENERAL PRINCIPLES:** GME Faculty Education Funding

A. Program Directors (PD’s) can attend the ACGME Conference each year or similar program specialty conference with prior written approval from the DIO.

I) PD Conference	II) Amount
III) Conference	IV) \$4,000

GME Faculty 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) within the policy guidelines.

V) GME Faculty Funds – FTE .051 or more	VI) Amount
VII) PD’s	VIII) \$3,500
IX) Associate Program Directors (APD’s)	X) \$3,500
Core Faculty	XI) \$3,500
XII) GME Faculty Funds – FTE .050 or less	XIII) Amount
XIV) Associate Program Directors (APD’s) & Core Faculty	XV) \$1,750

**A. CONFERENCE SELECTION AND APPROVAL:**

- a. GME Faculty are encouraged to attend conferences that align with their specialty or area of interest and contribute to their professional development.
- b. The conference must be located within the continental United States, excluding Alaska and Hawaii. Conferences in Alaska, Hawaii or International conferences will need to be pre-approved by the Program Director and the DIO.

**B. CONFERENCE GUIDELINES:**

- a. GME Faculty will be reimbursed up to the amount stated above. These funds are designed to cover the most basic conference expenses.



## GME Faculty Reimbursement Guidelines

- b. Registration fees, flights, lodging, poster fees, and ground transportation will be reimbursed only after submission of all itemized receipts along with proof of acceptance.
- c. Any exceptions approved must provide the emailed proof of approval along with your reimbursement request.

### C. REIMBURSEMENT 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 at the beginning of their fiscal year (**July 1 – June 30**). Receipts that fail to document acceptable expenses may be refused. Original receipts will not be returned.
- b. **Deadline to submit a reimbursement is May 15<sup>th</sup> each year** (Subject to change). If a conference occurs between May 15 and June 30 the request must be submitted within 10 days after the conference ends.
- c. All reimbursement requests should be submitted within 30 days of purchase.
- d. Reimbursement for faculty members will be suspended until all trainees' evaluations and procedural assessments for each rotation or educational activity are completed. Faculty are expected to complete and submit all evaluations within two weeks of the end of each rotation or educational activity.
- e. All conference and education funds must be related to GME Teaching.
- f. The purchase of items and attendance at events must occur during the duration of their Appointment Agreement and are not permitted during a leave of absence.
- g. Funds do not roll over from contract year to contract year. Reimbursement must be made during the same fiscal year of purchase and turned in within the deadline.
- 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. Expenses for regional and national academic conferences will not be submitted until after they take place. Proof of attendance is required.
- j. Receipts that fail to document acceptable expenses may be refused.
- k. Submitting fraudulent reimbursement requests will be grounds for termination.
- l. If a physician receives reimbursement and subsequently cancels the course or activity, returns the material/media/item, or fails to attend the live event, the



## GME Faculty Reimbursement Guidelines

physician must return all reimbursements immediately. Contact [gmepayments@eisenhowerhealth.org](mailto:gmepayments@eisenhowerhealth.org) for more details.

- m. Each fund is for that individual and may not be transferred or donated to another person.
- n. Additional travel and meals related to weather or mechanical delay may qualify for reimbursement with the GME Director's approval.
- o. Limited exceptions to this policy may be allowed by written approval of the GME DIO.
- p. If a physician is uncertain whether an expense may be eligible for reimbursement, the physician is encouraged to obtain written approval for the expense from the DIO or GME CAO prior to incurring the expense.
- q. EMC will not cover the extra charges to accommodate non-employees or extra fees due to negligence.
- r. Will be reimbursed for their individual expenses only, unless pre-approved by the GME Director or using a separate program fund such as a "Retreat fund".
- s. Please allow 30 days from processing from the last day all the necessary documents and provided.

### IV. CONTENT:

#### A. Allowable Education Expense (Guide)

- i. Regional and National Academic Conferences:
  - 1. Registration, airfare, mileage, lodging, parking and meals. (Refer to GME Reimbursable Expense Policy)
- ii. Allowable conferences expenses such as course add-ons and books.
- iii. Medical books, medical journals, Apps, and online journal subscriptions.
- iv. Professional medical society dues or fees that enhance your or the trainee's (resident and fellows) education.
- v. Electronic equipment & supplies:
  - 1. With DIO approval - laptop or desktop, tablet, iPen and relatable software.
  - 2. No other items or accessories without preapproval by the GME Director

#### B. Non-Allowable Education Expense (Guide)

- i. No Licensing, Board Certification, Board study and DEA for yourself or other personal expenses.



## GME Faculty Reimbursement Guidelines

- ii. Electronic Equipment: any item not mentioned under allowable such as USB cords, keyboards, watches, external hard drives, storage/memory space, headset/Air pods, Webcam, Flash Drives, non-relatable software, etc.
- iii. Travel expenses for others such as spouses, other dependents and guests
- iv. Travel Upgrades and Insurance
- v. Travel expenses to get to/from work such as public transportation/Uber's, car rentals, traffic/parking violations and car repairs
- vi. Any cancellation charges
- vii. Loss or damage to personal property
- viii. Shoes, undergarments such as socks, shirts, leggings, head gear etc.
- ix. No PPE without prior approval by the GME Director.
- x. Alcoholic beverages, food
- xi. Personal entertainment expenses (including cover charges)
- xii. Personal expenses (shampoo, detergent, gum, mints, insurances/warranties, vitamins etc.)
- xiii. Miscellaneous: Gifts, gift cards, laundry and dry-cleaning expenses, furniture, ticket violations, medical bills, office supplies, etc.

### C. Reimbursement Process:

#### i. **Concur**

1. GME Faculty that is an EMA Physician, will submit all expenses through **Concur**. Non-EMA Physician's will need to send an invoice detailing all the expenses along with their receipts and documents.
2. All related expenses should be in one request. For example, if you attended a conference all the Conference expenses should be in the same request.
3. Each receipt should be a separate line in the expense organized in order by type of expense and date
4. The 'Report name' or 'Subject' in your request should be the reason or type of expense. Such as Education Fund, ACGME Conference, Mentor Mentee Meeting, Recruiting Conference.
5. Include a comment about which Budget or Fund is being used for each expense.
6. Use the Expense Type starting with "GME-" for GME related expenses.

#### ii. **General Requirements:**

1. Must provide a purchase receipt with details of what was purchased, store name, proof of payment, location, time, and date.



## GME Faculty Reimbursement Guidelines

2. It is your responsibility to request a copy or obtain a replacement for any receipt that is not provided or is lost to seek reimbursement.
  3. Credit card slips, or bank statements may only be used as a back-up for proof of payment, however; the itemized receipt is also required.
  4. Purchases must have “**Proof of payment.**” Proof of payment generally refers to any document that confirms a payment has been made. Common examples include receipts showing the credit card transaction (last 4 of credit card), bank statements, and payment confirmations. These documents serve as evidence that funds have been transferred from one party to another.
  5. Receipts must be placed in **chronological order** by date and expense type.
  6. Receipts longer than letter page size, cut the receipt in half and place side by side on the same page.
  7. Unreasonable or excessive gratuity are not reimbursable. In California, a customary tip is generally 15-20% for good service at restaurants. For average service, 15% is often appropriate. For exceptional service, tipping 20% or more is considered good practice. It's also common to tip 10-12% for takeout or delivery.
  8. Expenses covered by a third party are not reimbursable.
- iii. **Proof of Delivery** must show the actual delivery tracking status as “Delivered” on the order/receipt or the shipping company such as FedEx/UPS tracking number status and not a photo of the item or packing slip. Proof of Pick-up when applicable. For example, an online order picked up at store.
1. For Conferences or other events, you must provide justification and proof of attendance, agenda/dates, and location.
  2. When receipts include guests other than the physician seeking reimbursement, the receipt submitted must identify those items for which the physician is requesting reimbursement for themselves or the total expense may automatically be divided by the number of parties/meals to estimate the physician’s expense.
  3. Easy to read (CLEAR and not too small, faded or blurry).
  4. 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.
  5. If a photo of the receipt is taken, it should look like a scanned document with a **white sheet/background**.



## GME Faculty Reimbursement Guidelines

6. Provide name of fund it should be paid out of.
7. If you have any questions, please e-mail [gmepayments@eisenhowerhealth.org](mailto:gmepayments@eisenhowerhealth.org).

### iv. MEALS:

1. Itemized receipts are required. For room service meals ask the hotel for a copy, if not provided.
2. Receipts need to match the date/time of travel/event.
3. Meal reimbursement will be limited to \$100 (or going rate) for in-person conference, only. (Refer to EMC Travel & Entertainment Policy).
4. Place an “X” on the receipt to the right of the item amount that is **not** to be reimbursed or not reimbursable. Do **not** strike through the amount. The amount must be visible.
5. Pay only for yourself and will be reimbursed for yourself only.
6. If you are required to cover the costs for another person in a specific situation, please ensure to document the individual's name, the justification for the expense, and the amount charged per person and provide the “approved” budget that will be covering that extra expense. It is important to clarify that this should not be considered standard practice.

### v. Travel (Outside of Coachella Valley):

1. All travel must be basic/economy/coach class. Upgrades, extra charges such as seat selection and Insurance/Warranty are not covered.
2. One standard checked bag is reimbursable each way.
3. Air travel receipts must show full itinerary such that includes the traveler’s name, to/from destinations, airline and date of travel.
4. Land Travel (i.e., taxi, ride-share, etc.) must be a basic car and related to the reason for travel, submit full receipts with dates of travel, 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. Car rentals and gas (unless pre-approved by the GME director) are not covered.
5. Mileage
6. GME will reimburse for the use of their personal automobile based on the IRS mileage rate times the actual miles driven for business purposes.



## **GME Faculty Reimbursement Guidelines**

7. Must submit the “Directions” from Google Maps
8. showing the to and from addresses, mileage and dates of travel. (Map is not needed).
9. Mileage to and from work is considered your daily commute and as such is not reimbursable.
10. Employees required to report to a location other than their designated home worksite(s) may be eligible for reimbursement of mileage that exceeds their typical daily commute. This policy also applies to travel expenses incurred for conferences or educational purposes.
11. Example: Employee’s home location is 5 miles away from their home, so the daily (one-way commute) is 5 miles. If the employee is asked to report to a different location that is 50 miles away from their home, the employee may be reimbursed for 45 miles more than the daily one-way commute.
12. Provide mileage from your residence to primary work location as well as from primary work location to your travel destination/hotel.

### **vi. Lodging:**

1. Lodging expenses will be reimbursed up to \$250 (or standard group rate). This is the “early” standard hotel rate per night listed for the conference, which is the most basic accommodation option available at the hotel. Any upgrades to higher room categories or additional services beyond the standard room may not be eligible for reimbursement unless explicitly approved in advance by the PD or GME Director/DIO.
2. Receipts/Checkout receipt must show breakdown of charges and by date. Receipts for room service, meals, or other qualified expenses charged to the room listed on the hotel guest folio must be accompanied by a point of service receipt with itemized details of purchased items.
3. If shared or split payment, you must provide proof of receipt and payment for your portion.
4. Add-ons or upgrades, hotel concierge, spa services, gym access or rollaway beds etc. are not covered.

### **REFERENCES AND RELATED DOCUMENTS:**

[Travel and Expense Reimbursement Policy](#)



## GME Reimbursable Expense Policy

- I. **POLICY STATEMENT:** To establish guidelines and define available reimbursements (out of pocket expenses) for individual Resident/Fellow (“trainees”).
- II. **SCOPE AND APPLICABILITY:** The purpose of this policy is to define procedure and requirements for all reimbursements.
- III. **DEFINITIONS:** Not applicable.
- IV. **POLICY:**

### 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. If a predetermined payment for relocation is made, it is the party's responsibility to provide the information specified below if requested thereafter.
- e. All reimbursement expenses must comply with the established EMC’s Relocation Expense Reimbursement Policy

#### B. Education Fund: Refer to Resident/Fellow Education Policy

### 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 for submitting a reimbursement is May 15<sup>th</sup> each year.** If an event occurs between May 15- June 30<sup>th</sup>, all reimbursements must be submitted within 10 days after event ends.
- C. All reimbursable expenses must comply with established EMC and GME guidelines and regulations.
- D. The purchase of items and attendance at events must occur during the duration of their Appointment Agreement and are not permitted during a leave of absence.
- E. After receiving a fully executed Appointment Agreement, incoming trainees may seek reimbursement for the USMLE/COMLEX Step 3 exam fee and any California state licensing fees, including the Postgraduate Training License (PTL) or the Physician and Surgeon License, upon submission of appropriate documentation to Eisenhower Health. If a trainee voluntarily chooses not to commence employment with Eisenhower Health or voluntarily resigns from employment with Eisenhower Health prior to completing 45 days of training, the trainee must repay



## GME Reimbursable Expense Policy

Eisenhower Health the full amount of any pre-employment expenses paid or reimbursed on their behalf.

- F. Proof of attendance is required for all conferences.
  - G. Registration, flights, and lodging fees for conferences, as well as board exam and review fees, can be reimbursed prior to the events. However, if the trainee decides not to attend the conference, they will be responsible for reimbursing the hospital for any pre-paid expenses that were covered by the hospital. Any additional related expenses must be submitted for reimbursement upon their return.
  - H. Reimbursements must be submitted within 30 days of purchase/delivery date. Trainees after at the end of each block (monthly), and after each + 1 week rotation for IM residents.
  - I. Receipts that fail to document acceptable expenses may be refused.
  - J. GME reserves the right, in its sole discretion, to deny reimbursement for any unreasonable expenses or any expenses lacking sufficient justification or documentation.
  - K. EMC will not cover the extra charges to accommodate non-employees or extra fees due to negligence.
  - L. The trainees will be reimbursed for their individual expenses only, unless pre-approved by the GME Director.
  - M. Refer to the **Reimbursement Process and Procedure** attachment for further information.
  - N. Submitting fraudulent reimbursement requests will be grounds for termination.
  - O. If a physician receives reimbursement and subsequently cancels the course or activity, returns the material/media/item, or fails to attend the live event, the physician must return all reimbursements immediately. Contact [gmepayments@eisenhowerhealth.org](mailto:gmepayments@eisenhowerhealth.org) for more details.
  - P. Each trainee fund is for that individual and may not be transferred or donated to another trainee.
  - Q. Additional hotel and meals related to weather or mechanical delay may qualify for reimbursement with the GME Director's approval.
  - R. Limited exceptions to this policy may be allowed by written approval of the GME DIO.
  - S. If a physician is uncertain whether an expense may be eligible for reimbursement, the physician is encouraged to obtain written approval for the expense from the DIO or GME CAO prior to incurring the expense.
- V. PROCEDURE:**
- V. Reimbursement PROCESS:**
- A. **General Requirements:**
    - 1. Each receipt must be itemized showing the items purchased for up to the allowable amount.



## GME Reimbursable Expense Policy

2. Trainees must provide a purchase receipt with details showing store name, proof of payment, time, and date.
3. Credit card slips, or bank statements may only be used as a back-up for proof of payment.
4. Purchases must have “Proof of payment.” Proof of payment generally refers to any document that confirms a payment has been made. Common examples include receipts, bank statements, and payment confirmations. These documents serve as evidence that funds have been transferred from one party to another.
5. Trainees must provide the following: (1) trainee name, name of rotation, date/date range, address/city 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. For rotations include a screenshot of your schedule in Amion.
6. Receipts must be placed in **chronological order** by date and expense type.
7. Receipts longer than letter page size, cut the receipt in half and place side by side on the same page.
8. Unreasonable or excessive gratuity are not reimbursable
9. Expenses covered by a third party are not reimbursable.
10. Proof of Delivery must show the actual delivery tracking status as “Delivered” and not a photo of the item or packing slip. Proof of Pick-up when applicable. For example, an online order picked up at store.
11. For Conferences or other events, you must provide justification and proof of attendance, agenda/dates, and location. If presented, show proof of acceptance.
12. When receipts include guests other than the physician seeking reimbursement, the receipt submitted must identify those items for which the physician is requesting reimbursement or the total expense may be divided by the number of parties/meals to estimate the physician’s expense.
13. Easy to read (CLEAR and not too small, faded or blurry).
14. 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.
15. If a photo of the receipt is taken, it should look like a scanned document with a **white sheet/background**.
16. Provide name of fund it should be paid out of.
17. If your receipts are e-mailed to you, you can forward it to the GME Finance Analyst with all required information, a small description of what it is for and any additional information related to the expense.
18. SCAN all receipts/documents into **one file**, if possible. (Recommend using the NOTES App on your iPhone or scanning app).



## GME Reimbursable Expense Policy

19. E-mail PDF/WORD doc to the GME Finance Analyst at [gmepayments@eisenhowerhealth.org](mailto:gmepayments@eisenhowerhealth.org).

### B. Meals:

1. Itemized receipts for room service meals are required. Ask hotel for a copy, if not provided.
2. Receipts need to match the date/time of travel/rotation.
3. Rotation meals: \$18 (or going rate) for each scheduled 8-hour workday when food is not available to you. (Grocery receipts preferred)
4. Rotation meals from a restaurant up to \$18 a day and must be during your scheduled work time.
  - a. Limit to 1 main course, 1 side, 1 desert, 1 drink.
5. Up to \$86 (or going rate) a day while traveling for Conferences, Exams.
6. Place an "X" on the receipt to the right of the item amount that is **not** to be reimbursed or not reimbursable. Do **not** strike through the amount. The amount must be visible.
7. Pay only for yourself and will be reimbursed for yourself only.
8. If you are required to cover the costs for another trainee in a specific situation, please ensure to document the individual's name, the justification for the expense, and the amount charged per person. It is important to clarify that this should not be considered standard practice.
9. More than 1 receipt per page is preferred to help reduce file size.

### C. Travel (Outside of Coachella Valley):

1. All travel must be basic/coach class. Upgrades, extra charges such as seat selection and Insurance/Warranty are not covered. As well as car rentals, gas (unless pre-approved by the GME CAO) are not covered.
2. One standard checked bag is reimbursable each way.
3. Air travel receipts must show full itinerary such that includes the traveler's name, to/from destinations, airline and date of travel.
4. Land Travel (i.e., taxi, ride-share, etc.) must be a basic car and related to the reason of travel, submit full 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. Car rentals and gas (unless pre-approved by the GME director) are not covered.
5. Mileage
  - a. Mileage to and from work is considered your daily commute and as such is not reimbursable.



## GME Reimbursable Expense Policy

- b. Employees required to report to a location other than their designated home worksite(s) may be eligible for reimbursement of mileage that exceeds their typical daily commute. This policy also applies to travel expenses incurred for conferences or educational purposes.
  - c. Example: Employee's home location is 5 miles away from their home, so the daily (one-way commute) is 5 miles. If the employee is asked to report to a different location that is 50 miles away from their home, the employee may be reimbursed for 45 miles more than the daily one-way commute.
  - d. Provide mileage from your residence to primary work location as well as from primary work location to your travel destination/hotel.
  - e. Must submit the "Directions" from Google Maps
    - i. showing the mileage and dates of travel. (Map is not needed).
  - f. For required "away rotations," outside the Coachella Valley/Riverside standard mileage is automatically applied. E-mail [gmepayments@eisenhowerhealth.org](mailto:gmepayments@eisenhowerhealth.org) for specifics.
  - g. GME will reimburse employees for the use of their personal automobile based on the IRS mileage rate times the actual miles driven for business purposes.
- D. Lodging:**
- 1. Daily lodging cost should not exceed \$250 (or standard group rate) per day unless pre-approved by the program director. Must provide proof of pre-approval.
  - 2. Checkout receipt must show breakdown of charges and by date. Receipts for room service, meals, or other qualified expenses charged to the room listed on the hotel guest folio must be accompanied by a point of service receipt with details of purchased items.
  - 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 payment, you must provide proof of receipt and payment for your portion.
  - 5. Internet & Wi-Fi, add-ons or upgrades, hotel concierge, spa services, gym access or rollaway beds etc. are not covered.
- VI. ADDITIONAL INFORMATION:** Not applicable.
- VII. REFERENCES AND RELATED DOCUMENTS:**

[EMC Travel & Entertainment Policy #2214](#)

[Conference Policy](#)

[Resident/Fellow Education Fund](#)



## Grievance and Due Process

- I. **POLICY STATEMENT:** 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 of suspension or dismissal is a legal or Human Resources issue, the applicable statute supersedes GME policy.
  - A. 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.
- II. **SCOPE AND APPLICABILITY:** *Not applicable*
- III. **DEFINITIONS:** Not applicable
- IV. **POLICY:** *Not applicable*
- V. **PROCEDURE:**
  - 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.



## Grievance and Due Process

- 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.
- VI. ADDITIONAL INFORMATION:** Not applicable.
- VII. REFERENCES AND RELATED DOCUMENTS:** Not applicable.



## Learning & Work Environment

- I. **POLICY STATEMENT:** 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.
- II. **SCOPE AND APPLICABILITY:** Not applicable
- III. **DEFINITIONS:** Not applicable
- IV. **POLICY:**
  - A. Supervision and Accountability
    - i. 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.
  - B. **A. Supervision Levels**
    - i. 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.
  - C. **Direct supervision:**
    - i. The supervising physician is physically present with the resident/fellow during the key portions of the patient interaction.
    - ii. 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.
  - D. **Indirect supervision:**
    - i. 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.
  - E. **Oversight:**
    - i. The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.



## Learning & Work Environment

- ii. 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.
  - iii. The program director must evaluate each resident's/fellow's abilities based on specific criteria, guided by the Milestones.
  - iv. 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.
  - v. 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.
  - vi. Programs must set guidelines for circumstances and events in which residents/fellows must communicate with the supervising faculty member(s).
  - vii. 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.
  - viii. 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.
- F. Professionalism:**
- i. Professionalism and learning objectives are accomplished through supervised patient care responsibilities, clinical teaching and didactics.
  - ii. 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.
  - iii. Each resident/fellow must assure personal fitness before, during and after clinical assignments as a responsibility of patient- and family-centered care.
  - iv. Recognition of impairment from illness, fatigue and substance abuse in oneself, peers or other members of the health care team is a personal responsibility.
  - v. Professionalism involves accurate reporting of clinical and educational work hours, patient outcomes and clinical experience data.
  - vi. 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.
  - vii. 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.
- G. Well-being:**
- i. So that residents, fellows and faculty are better prepared to manage their own well-being, each program will organize educational



## Learning & Work Environment

sessions on well-being to bring attention to burnout, depression and substance abuse and the related symptoms.

- ii. 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.
- iii. 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.
- iv. 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.

### H. **Fatigue Mitigation:**

- i. 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.
- ii. 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.

### I. **Clinical Responsibilities, Teamwork and Transitions of Care:**

- i. Clinical Responsibilities
  1. 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.
- ii. Teamwork
  1. 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.

### J. Transitions of Care



## Learning & Work Environment

- i. Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency and structure.
- ii. 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.
- iii. Programs must ensure that residents/fellows are competent in communicating with team members in the hand-over process, and monitor that process.
- iv. Programs and clinical sites must maintain and communicate schedules of attending physicians and residents/fellows currently responsible for each patient's care.
- v. Each program must monitor continuity of patient care, consistent with the program's policies and procedures.
- vi. A transition of care ("hand-off") is defined as:
  1. Change in level of patient care, including inpatient admission from the ambulatory setting, outpatient procedure or diagnostic area
  2. Inpatient admission from the emergency department
  3. Transfer of a patient to or from a critical care unit
  4. Transfer of a patient from the intensive care unit to an inpatient unit when a different physician will be caring for that patient
  5. Transfer of care to other healthcare professionals within procedure or diagnostic areas
  6. Discharge, including discharge to home or another facility such as skilled nursing care
  7. Change in provider or service, including resident/fellow sign-out, inpatient consultation sign-out, and rotation changes for residents/fellows

### **K. Clinical Experience and Education:**

#### **L. Maximum Hours of Clinical and Educational Work Per Week**

- i. 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.

#### **M. Mandatory Time Free of Clinical Work and Education**

- i. 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.
- ii. Residents/fellows should have eight hours off between scheduled clinical work and education periods.
- iii. There may be circumstances when residents/fellows choose to stay to care for their patients or return to the hospital with fewer 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.



## Learning & Work Environment

- iv. Residents/fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
- v. 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.
- N. Maximum Clinical Work and Education Period Length
  - i. Clinical and educational work periods for residents/fellows must not exceed 24 hours of continuous scheduled clinical assignments.
  - ii. 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.
  - iii. Additional patient care responsibilities must not be assigned to a resident/fellow during this time.
- O. Clinical and Educational Work Hour Exceptions
  - i. 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:
    - 1. To continue providing care to a single severely ill or unstable patient
    - 2. Humanistic attention to the needs of a patient or family
    - 3. To attend a unique educational event
- P. These additional hours of care or education will be counted toward the 80-hour weekly limit.
- Q. Moonlighting
  - i. *See Moonlighting Policy*
- R. In-house Night Float
  - i. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.
- S. Maximum In-house On-call Frequency
  - i. Residents/fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).
- T. At-home call
  - i. 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.
    - 1. At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each resident/fellow.
  - ii. 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.
- U. **Disclosure Pursuant to Eisenhower Health's Graduate Medical Education's Obligations to Support Legitimate Educational Interests:**

## Learning & Work Environment

- i. 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.

- V. **PROCEDURE:** Not applicable.
- VI. **ADDITIONAL INFORMATION:** Not applicable.
- VII. **REFERENCES AND RELATED DOCUMENTS:**

[Moonlighting](#)



## Licensure Policy

- I. **POLICY STATEMENT:** To establish the requirements that residents/fellows (trainees) must complete in regard to exams, licensing, and registration in the Medicare Provider Enrollment, Chain and Ownership System in order to participate in a training program at Eisenhower Health.
- II. **SCOPE AND APPLICABILITY:** Not applicable
- III. **DEFINITIONS:** Not applicable
- IV. **POLICY:**

All trainees are required to:

  1. Obtain a **National Provider Identifier (NPI)**;
  2. Pass **USMLE Step 3** or **COMLEX Level 3** as outlined.
  3. Possess a **Postgraduate Training License (PTL)** within required timeframes.
  4. Transition to a full **Physician's and Surgeon's License** as required by the Medical Board of California (MBC) or the Osteopathic Medical Board of California (OMBC);
  5. Obtain a **DEA Controlled Substance Permit** and register with the **Controlled Substance Utilization Review and Evaluation System (CURES)**;
- V. **PROCEDURE:**
  1. **NPI Requirements**
    1. All PGY-1 trainees must apply for and obtain an NPI number within 30 days of their hire date. Instructions for obtaining an NPI number are included in the Welcome Packet. The NPI number must be provided to the GME Office.
  2. **PGY-1 Exam Requirements**
    2. PGY-1 trainees must take and pass USMLE Step 3 or COMLEX Level 3, and provide evidence to the GME Office **by the end of their first postgraduate year.**
    3. Program Directors may implement remediation or disciplinary actions for those who fail to meet these requirements, including delaying or canceling promotion or appointment.
  3. **Postgraduate Training License (PTL)**
    4. Trainees must obtain a PTL within **180 days of starting clinical training**. A PTL is valid for **36 months** while enrolled in a California ACGME-accredited postgraduate training program. The PTL is **non-renewable**. Failure to obtain a PTL within the required timeframe will result in cessation of all clinical services until a PTL is issued.
    5. Program Directors (PDs) are responsible for submitting required enrollment forms to the MBC/OMBC and notifying the board within 30 days of any status changes that would affect the trainee's anticipated end date of the program,



## Licensure Policy

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

6. All PTL holders must transition to a full **Physician's and Surgeon's License** after completing **36 months of Board-approved postgraduate training**, regardless of medical school location. Trainees must meet the following criteria to apply for a full license:

- Completion of at least **4 months of general medicine training**
- Completion of **12 or 24 months of PTL-valid training**, with an additional 90-day window to transition to a full license.

7. A full license must be renewed every **24 months** as required by California state law. Failure to secure a full license within the required timeframe will result in suspension of clinical privileges

### 5. DEA Controlled Substance Permit and CURES Registration

8. Once a trainee has obtained a PTL, they may apply for a DEA Controlled Substance Permit.

9. Trainees must register with CURES immediately upon obtaining their DEA permit, as mandated by California law. A copy of the DEA permit and CURES registration must be provided to the GME Office **by the end of the PGY 2 year**.

## VI. ADDITIONAL INFORMATION:

### A. LICENSE REIMBURSEMENT:

i. The GME Office will reimburse the following fees: USMLE/COMLEX Examination; Initial PTL; California Medical License Application; Physician's and Surgeon's License; and DEA Registration.

ii. Reimbursements are only provided if the applications are submitted while employed at Eisenhower Medical Center. Requests for reimbursement must be submitted to the GME Office with appropriate documentation.

### iii. CONSEQUENCES OF FAILURE TO SATISFY REQUIREMENTS:

Trainees who fail to comply with the licensing requirements may face disciplinary action, including:

1. Suspension without pay
2. Termination of employment
3. Discontinuation of training

iv. **Trainees dismissed for failing to meet licensure requirements may re-apply after addressing deficiencies, subject to the discretion of the Program Director.**

## VII. REFERENCES AND RELATED DOCUMENTS:

[NPPES](#)



**Licensure Policy**

[USMLE](#)

[COMPLEX](#)

[MEDICAL BOARD OF CA](#)

[OSTEOPATHIC MEDICAL BOARD OF CA](#)

[DEA](#)

[CURES](#)



## Moonlighting

- I. **POLICY STATEMENT:** 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.

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.
- II. **SCOPE AND APPLICABILITY:** Not applicable
- III. **DEFINITIONS:**
  - A. **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.
  - B. **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. **POLICY:** *In this section include mandated, specified, or prohibited behavior, "what" should be done and when applicable, "why" it should be done (requirements staff must adhere to; regulatory requirements).*
  - A. **ELIGIBILITY:**
    - i. Only trainees who have obtained an unrestricted license to practice medicine in the State of California are permitted to moonlight.
    - ii. PGY1's are not permitted to moonlight.
    - iii. Trainees may not be required to engage in moonlighting.
    - iv. 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.
    - v. Trainees must be in good academic standing determined at the discretion of the Program Director (PD).



## Moonlighting

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

### B. Maximum Hours Worked

- i. 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.
- ii. Mandatory time free of duty: trainees must have a minimum of one day in seven days free of duty (when averaged over four weeks).
- iii. All trainees are required to accurately record all of their moonlighting hours on MedHub.

### C. PROGRAM DIRECTOR RESPONSIBILITIES:

- i. The PD must provide a written or electronic approval.
- ii. 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.
- iii. 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.

## V. 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

moonlighting form and the PD and DIO must approve any said changes prior to the start of the new activity.

VI. **ADDITIONAL INFORMATION:** *Not Applicable*

VII. **REFERENCES AND RELATED DOCUMENTS:**

A. [ACGME Common Program Requirements](#)

[Learning & Work Environment](#)



## Physician Impairment

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY**
  - A. To ensure that the resident/fellow's well-being is appropriately monitored and addressed.
  - B. To ensure the existence of a counseling program for all resident/fellows.
  - C. To ensure a drug-free and alcohol-free environment which is safe for resident/fellows, patients and all other potentially impacted individuals.
  - D. To ensure that required documentation procedures for handling physician impairment are followed.
  - E. To ensure that an educational program on the subject is included in all resident/fellow's training.
  
- III. **DEFINITIONS:** Not applicable.
  
- IV. **POLICY:** *In this section include mandated, specified, or prohibited behavior, "what" should be done and when applicable, "why" it should be done (requirements staff must adhere to; regulatory requirements).*
  - 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**



## Physician Impairment

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



## Physician Impairment

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).

**V. PROCEDURE:** Not Applicable

**VI. ADDITIONAL INFORMATION:** Not Applicable

**VII. REFERENCES AND RELATED DOCUMENTS:**

[Fitness-For-Duty/Reasonable Suspicion Drug Testing](#)

[Drug/Alcohol-Free Workplace](#)



## Program Evaluation Committee

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY:** *Not applicable*
- III. **DEFINITIONS:** *Not applicable*
- IV. **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:

  - A. 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).
  - B. The program must monitor and track each of the following areas:
    - C. resident performance;
    - D. faculty development;
    - E. graduate performance, including performance of program graduates on the certification examination;
    - F. program quality; and,
    - G. (1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
    - H. (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.
    - I. progress on the previous year's action plan(s).
    - J. 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.
    - K. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.



## Program Evaluation Committee

- L. 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

- M. (PEC) to participate in the development of the Program's curriculum and related learning activities. In addition, the PEC will:
  - i. 1. Annually evaluate the program to assess the effectiveness of the Program's curriculum.
  - ii. 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.

  - iii. 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.
  - iv. 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.
  - v. The PEC will function in accordance with the written description of its responsibilities, as specified below, and actively participate in:
  - vi. Planning, developing, implementing, and evaluating all educational activities of the program.
  - vii. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives.
    - 1. Trainee performance.
    - 2. Faculty development.
    - 3. Graduate performance, including performance of program graduates on the certification examination and;
    - 4. Program quality, specifically:
      - a. residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually and;



### Program Evaluation Committee

- b. the program must use the results of the trainees' assessments of the program together with other program evaluation results to improve the program
  - c. Progress on the previous year's action plan(s)
- N. 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.
- O. E. Resident/Fellow evaluations combined with faculty input are key to evaluating the educational effectiveness of the training program.
- P. 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.
- Q. 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.

V. **PROCEDURE:** *Not applicable*

VI. **ADDITIONAL INFORMATION:** Not applicable

VII. **REFERENCES AND RELATED DOCUMENTS:**

[Common Program Requirements - Residency](#)

[Common Program Requirements - Fellowship](#)

[ACGME Institutional Requirements](#)



## Promotion of Residents/ Appointment Renewal

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY:** Not applicable.
- III. **DEFINITIONS:** Not applicable.
- IV. **POLICY:** Not applicable.
- V. **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 consider 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 residents to achieve the required level of proficiency for promotion. A resident accepting this condition must be given a written summary of deficiencies, a delineation of the remediation program and the criteria for advancement.
  4. Programs will provide a resident with a written notice of intent when that resident's agreement will not be renewed, when that resident will not be promoted to the next level of training, or when that resident/ will be dismissed. Such written notice of intent will be provided in a reasonably timely manner. Decisions resulting in suspension, non-promotion, non-renewal, or dismissal are subject to the Due Process procedures set forth in the GME policies. A resident may choose to implement the Due Process procedure upon receipt of written notice of intent of non-promotion/non-renewal.
  
- VI. **ADDITIONAL INFORMATION:** Not applicable.
  
- VII. **REFERENCES AND RELATED DOCUMENTS:** Not applicable.



## Remediation & Disciplinary

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY:** Not applicable.
- III. **DEFINITIONS:** Not applicable.
- IV. **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.

V. **PROCEDURE:**

1. 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 for remediation under the Grievance Policy and Due Process Policy. Below is the remediation scheme for residents/fellows at risk of not meeting educational milestones during their training. The GME Program reserves the right to act 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.

- a. **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 with the resident remediates, informal remediation is not disclosed in the final verification of training or employment letters.
- b. **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



## Remediation & Disciplinary

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.

- c. **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:
- d. Issuance of a new PIP
- e. Requiring a repeat of a rotation that in turn extends the required period of training
- f. Denial of credit for previously completed rotations
- g. Extension of contract, which may include extension of the defined training period

### 2. **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.



## Remediation & Disciplinary

- 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 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.

### 5. Notice of Disciplinary Action



## Remediation & Disciplinary

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.

### 6. 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.

**VI. ADDITIONAL INFORMATION:** Not applicable.

**VII. REFERENCES AND RELATED DOCUMENTS:** Not applicable.



## Resident Eligibility & Selection

- I. **POLICY STATEMENT:** 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.

- II. **SCOPE AND Applicability** 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.

- III. **DEFINITIONS:** *Not Applicable*

- IV. **POLICY:** Eligible 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. PROCEDURE

### 1. Selection

- A. Each program is responsible for the selection of their trainees and will have a selection committee that will review the credentials of all applicants.
- B. 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.
- C. Programs will select from among eligible applicants based on their preparedness, ability, aptitude, academic credentials, and communication skills. The Program Director or his/her designee will have final responsibility for judging the qualities based upon



## Resident Eligibility & Selection

the individual's written application, reference letters, personal interview, and performance during any clerkship or externship rotations at Eisenhower Health, if applicable.

- D. 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.
- E. 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 the ECFMG website.

### 3. Appointment

- A. 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.
- B. 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.
- C. For appointment, trainees must comply with State of California Physician Licensure requirements.
- D. Eisenhower Health will conduct background checks on all trainees, verify previous educational experiences and work history, and conduct pre-employment drug testing.
- E. 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.

**V. ADDITIONAL INFORMATION:** *Not Applicable*

**VI. REFERENCES AND RELATED DOCUMENTS:**

<https://www.ecfm.org/>



**Resident/ Fellow Education Fund**

- I. **POLICY STATEMENT:** 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 (“trainees”). The actual amount per Resident/Fellow is proportional to the anticipated duration of training. See below Education Fund.
- II. **SCOPE AND APPLICABILITY:** To establish guidelines and define available reimbursement for individual Resident/Fellow expense items regarding the use of the Resident/Fellow Educational Funds.
- III. **DEFINITIONS:** Not applicable.
- IV. **POLICY:**

**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 amounts which includes Board-related purchases or courses, such as: board exam and review fees and travel expenses incurred during residency/fellowship training.
- C. Dependent on the training program and year the funding amount will vary.

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

- V. **PROCEDURE: REIMBURSEMENT PROCESS**  
“Refer to “GME Reimbursable Expense Policy”
- VI. **ADDITIONAL INFORMATION:**
- IV. **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



## Resident/ Fellow Education Fund

reimbursement of out-of pocket expenses. All items over \$500 must be pre-approved by the Director. Except pre-approved items stated on allowable expenses.

- 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.

### Allowable Education Expense (Guide):

1.
  - Regional and National Academic Conferences:
    - Registration, airfare, mileage, lodging, parking and meals. (Refer to GME Reimbursable Expense Policy)
  - Medical books, medical journals, Apps, and online journal subscriptions.
  - Professional medical society dues or fees that enhance trainee's education including fellowship application fees.
  - Medical equipment such as surgical loupes, stethoscopes, medical bags and other similar medical items, limit 1 per year
  - Electronic equipment & supplies:
    - Limited to 1 of each item through the duration of training: laptop or desktop, tablet, iPen and relatable software.
    - Limited to 1 of each item through the duration of training: a case for work phone, a laptop/desktop, a tablet and a work phone charge.
    - **No other items or accessories without preapproval by the GME Director**
  - Away Elective Rotations: travel and lodging
  - Additional apparel (scrubs and white coats) must be purchased in the color scheme designated by GME to the trainee. Jacket and vest, limit to 1 each year.
  - Alterations for approved uniforms (white coats, scrubs, and jacket).
  - If funds are exhausted for allowable conferences expenses such as course add-ons and books.
  - Expenses related to rotations that are **not already covered by the program**. This may include costs such as mileage, parking fees, fees, and lodging for both elective and required rotations, as well as any specific lodging preferences.



## Resident/ Fellow Education Fund

### V. Non Allowable Education Expense (Guide):

- Electronic Equipment: any item not mentioned under allowable such as USB cords, keyboards, printers, watches, external hard drives, storage/memory space, headset/Air pods, Webcam, Flash Drives, non-relatable software, etc.
- Travel expenses for others such as spouses, other dependents and guest
- Travel Upgrades and Insurance
- Travel expenses to get to/from work such as public transportation/Ubbers, car rentals, traffic/parking violations and car repairs
- Any cancellation charges
- Loss or damage to personal property
- Non-uniform apparel, shoes, under garments such as socks, shirts, leggings, head gear etc.
- No PPE without prior approval by the GME Director.
- Alcoholic beverages
- Personal entertainment expenses (including cover charges)
- Personal expenses (shampoo, detergent, gum, mints, insurances/warranties, vitamins etc.)
- Miscellaneous: Gifts, gift cards, laundry and dry-cleaning expenses, furniture, ticket violations, medical bills, office supplies, etc.

### VII. REFERENCES AND RELATED DOCUMENTS:

[GME Reimbursable Expense Policy](#)

[Conference Policy](#)



## Resident/ Fellow Leave of Absence

- I. **POLICY STATEMENT:** Each program and trainee is subject to and will abide by this institutional policy regarding leaves of absence.
- II. **SCOPE AND APPLICABILITY:** 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.
- III. **DEFINITIONS:** Not applicable.
- IV. **POLICY:**

### Vacation & Sick Time:

1. All trainees are provided with a total of 20 working days of paid vacation time and 5 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.



## Resident/ Fellow Leave of Absence

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:**



## Resident/ Fellow Leave of Absence

2. 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.

V. **PROCEDURE:** Not applicable.

VI. **ADDITIONAL INFORMATION:** Not applicable.

VII. **REFERENCES AND RELATED DOCUMENTS:** Not applicable.



## Restrictive Covenants

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY:** 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:**

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.
- V. **PROCEDURE:** Not applicable.
- VI. **ADDITIONAL INFORMATION:** Not applicable.
- VII. **REFERENCES AND RELATED DOCUMENTS:** Not applicable.



## Special Review Committee Policy

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY:** Not applicable.
- III. **DEFINITIONS:** Not applicable.
- IV. **POLICY:** 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.
    - a. 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**.



## Special Review Committee Policy

- e. **Duty hours** policy and/or **fatigue management and mitigation**; and
  - f. Education and monitoring of **Professionalism**.
2. 4. Self-report by a Program Director.

### V. PROCEDURE:

- A. **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.
- B. **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.
- C. **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.
- D. **The Special Review:** Materials and data for the review process shall include:
  - i. The ACGME Common, specialty/subspecialty-specific Program, and Institutional Requirements in effect at the time of the review.
  - ii. Accreditation letters of notification from the most recent ACGME reviews and progress reports sent to the respective RRC;
  - iii. Letters from the RRC with citations or areas of concern.
  - iv. Reports from previous internal reviews of the program (if applicable);
  - v. Previous annual program evaluations.
  - vi. Results from the most recent internal or external resident surveys,
  - vii. Results from the most recent ACGME faculty survey, and,
  - viii. Any other materials the Special Review panel considers necessary and appropriate.



## Special Review Committee Policy

- ix. 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 timeline, 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 led 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.



## Special Review Committee Policy

### VI. ADDITIONAL INFORMATION:

#### 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



## Special Review Committee Policy

- 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 timeline.
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.

**VII. REFERENCES AND RELATED DOCUMENTS:** Not applicable.



## Supervision of Residents and Fellows

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY:** 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. **DEFINITIONS:** Not applicable.

IV. **POLICY:**

### **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.

### **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.



## Supervision of Residents and Fellows

- 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.

### 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.

### Oversight:

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

### 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.
- V. **PROCEDURE:** Not applicable.
- VI. **ADDITIONAL INFORMATION:** Not applicable
- VII. **REFERENCES AND RELATED DOCUMENTS:**

[ACGME Common Program Requirements Residency](#)

[ACGME Common Program Requirements Fellowship](#)



## Vendors Policy

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY:** Not applicable.
- III. **DEFINITIONS:** Not applicable.
- IV. **POLICY:**
  1. 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.
  2. 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 to avoid conflicts of interest.
  3. The residents should not accept gifts from industry vendors regardless of the nature or dollar value of the gift.
  4. Textbooks, modest meals and other gifts are appropriate only if they serve an educational function.
  5. The residents may not accept gifts or compensation for listening to a sales talk by an industry representative.
  6. The resident may not accept gifts or compensation for prescribing or changing a patient's prescription.
  7. The resident must consciously separate clinical care decisions from any perceived or actual benefits expected from any company.
  8. It is unacceptable for patient care decisions to be influenced by the possibility of personal financial gain.
  9. Vendor support of educational conferences involving the residents may be used only if the funds are provided directly to the institution, not to the residents. The program director should determine if the funded conference or program has educational merit.
  10. The residents will be informed by the teaching faculty of the potential conflicts of interest during interactions with industry vendors.
  11. Residents will comply with all EMC vendor policies.
- V. **PROCEDURE:** Not applicable.
- VI. **ADDITIONAL INFORMATION:** Not applicable.
- VII. **REFERENCES AND RELATED DOCUMENTS:** Not applicable.



## Well-Being Policy

- I. **POLICY STATEMENT:** 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. **SCOPE AND APPLICABILITY:** 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. **DEFINITIONS:** Not applicable.
- IV. **POLICY:**
  - I. 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.
  - II. 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.



## Well-Being Policy

- 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:
  - o Strategic napping
  - o Caffeine
  - o Availability of other caregivers
  - o Time management
  - o 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.
      - o 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.
      - o 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 with the opportunity to attend medical, mental health and dental health appointments and should work with their Program Directors when scheduling



## Well-Being Policy

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 if a Resident/Fellow is unable to perform their patient care responsibilities.

V. **PROCEDURE:** Not applicable.

VI. **ADDITIONAL INFORMATION:** Not applicable.

VII. **REFERENCES AND RELATED DOCUMENTS:**

[GME Wellness Website](#)

[Employee Assistance Program](#)

[Other Self-Assessment Tools:](#)



# EISENHOWER HEALTH

## Policy

Effective Date:

**Title: Guidelines for Publishing Case Reports of Patients Receiving Clinical Care at Eisenhower Health**

**Home Department: Office of Graduate Medical Education**

### I. POLICY:

All trainees and faculty are subject to and will abide by this institutional policy regarding publication of case reports of patients receiving clinical care at Eisenhower Health.

### II. DEFINITIONS:

- **Case Report:** A retrospective analysis of clinical symptoms, signs, diagnosis, treatment, and outcomes of an individual case. This definition includes case series describing up to three unique cases.
- **Research:** A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. Case reports involving more than three patients are considered research and require Institutional Review Board (IRB) approval.
- **Patient Identifiers:** Any information that can be used to identify an individual patient, including but not limited to names, contact details, medical record numbers, or photographic images.

### III. PURPOSE:

This policy provides guidance on patient consent requirements for publishing case reports. Case reports are not classified as research and do not require IRB submission. However, specific journals may require documentation of patient consent or an attestation of consent for publication, regardless of de-identification.

### IV. PROCEDURES:

The publishing requirements regarding consent for case reports differ from journal to journal. While the author must adhere to any rules and requirements mandated by the publisher, they should not assume that any given journal's requirements would fully protect themselves, their patient(s), or the Institution from risk.

#### A. Removal of Patient Identifiers

All patient identifiers must be removed or anonymized in case reports prior to publication. This applies to both written content and images.

#### B. Types of Patient Identifiers

The HIPAA Privacy Rule lists the following 18 identifiers. All of these identifiers must be removed or masked for a case report to be considered de-identified, and therefore not requiring the patient's consent:

1. Names;
2. All geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. Phone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code (note this does not mean the unique code assigned by the investigator to code the data)

Any questions regarding patient identifiers should be directed to the Privacy Officer or designated HIPAA authority prior to submission of the case report to ensure proper authorization has been obtained. If a case report contains one or more patient identifiers as defined under the HIPAA Privacy Rule, the author must not publish the report without either acquiring the patient's consent or obtaining approval from the Program Director. **If the patient is unable to provide consent or is unavailable, the author must submit the case report to the Program Director for review and approval prior to publication.**

### **C. Consent Requirements**

1. If patient identifiers cannot be fully anonymized, consent must be obtained from the patient or their legal representative before publication.
2. When seeking consent, patients should be informed about:
  - The journal where the case report will appear
  - How the report will be accessed (e.g., online, print)
  - Potential audiences (e.g., practitioners, general public)
  - The impossibility of guaranteeing full anonymity
3. Consent discussions should be documented in the patient's medical record.

### **D. Deceased or Minor Patients**

Consent for deceased patients should be obtained from next of kin or legal representatives. For minors, consent must be obtained from a parent or guardian.

**E. Documentation of Consent**

Document patient consent in the medical record, either as a provider entry or by uploading a signed consent form.

**F. Trainee and Faculty Collaboration**

All trainees (medical students, residents, and fellows) must collaborate with a faculty or attending physician as a co-author when publishing case reports of patients receiving care at Eisenhower Health.

**Links of Reference:**

- *Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule - <http://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/>*

**POLICY APPROVAL(S)****Graduate Medical Education Committee****Original Effective Date:**



## Case Report Review Form - Eisenhower Health

A case report is defined as a retrospective analysis of one, two or three clinical cases. A case report is a description of (a) the course of medical treatment with one or more patients that has a unique outcome or (b) the handling of a unique clinical case; which in either case did not involve the investigator having any research intent at the time of the intervention.

A case report is intended to share medical information with, or to provide education to, other providers; it is not designed to answer a specific question. Case reviews are not considered "research" as they do not meet the Federal Policy for the Protection of Human Subjects definition of Research, which requires an investigation that contributes to generalizable knowledge about a disease or condition.

**Title:** \_\_\_\_\_

**Author(s):** \_\_\_\_\_

---

- The Case Report has been reviewed for clinical appropriateness and accuracy.
- The Case Report is not considered research as it does not meet the Federal Policy for the Protection of Human Subjects definition of Research, which requires an investigation that contributes to generalizable knowledge about a disease or condition.
- The Case Report does not contain any of the 18 identifiers that cause medical information to be considered PHI under HIPAA. The Case Report is considered de-identified, and its presentation or publication does not require a HIPAA authorization and there is no need to obtain the patient's signed authorization or to contact the HIPAA Privacy Officer.

**Signature Clinical Advisor:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Name of Patient:**

**Title of Publication/Conference:**

**Title of article/presentation:**

**Author:**

**Author Mailing Address:**

I, \_\_\_\_\_ give my consent for this information about MYSELF to appear in the above-identified journal and/or conference.

**By signing this form, I understand that:**

- I have been informed of the risks and benefits, if any, of allowing my information to be used in this case report. I understand this case report may describe sensitive topics such as HIV, substance use disorders, and/or behavioral/mental health topics.
- I have been informed that I do not have to participate in this case report.
- I have agreed to participate in this case report.
- The information may be published in a print journal, which is read worldwide, an online journal or presented at a conference. Journals and conferences are aimed mainly at health care professionals but may be seen by many non-doctors, including journalists.
- I can change my mind about participation at any time. I do not need to give a reason to withdraw my consent, but once the information has been committed to publication or presented, it will not be possible to withdraw the consent. A request to withdraw consent must be submitted in writing to the **author**.
- I understand that I will not receive any financial benefit from publication or presentation.
- The Information will be published or presented without my name attached. Every attempt will be made to ensure anonymity. I understand, however, that complete anonymity cannot be guaranteed.
- A copy of this consent will be maintained as part of my Eisenhower Medical Center medical record.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Author Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_



**EISENHOWER HEALTH**

39000 Bob Hope Drive, Rancho Mirage, CA 92270

**PATIENT CONSENT FOR CASE REPORT  
PUBLICATION/PRESENTATION**





# Eisenhower Medical Center Policies

## Sexual Harassment Prevention

Policy

Human Resources Department

2406

Official (Rev: 9)

Eisenhower Health (EH) 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 EH employee (patient, physician, contractor, volunteer, etc.) on EH 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
<b>Document Owner</b>	Kowalczyk, David	<b>Original Effective Date</b> 06/19/2007
<b>Signed by</b>	( 07/29/2024 03:47PM PST ) David Kowalczyk, V.P. Human Resources	<b>This Revision Effective</b> 08/06/2024
	( 07/29/2024 03:58PM PST ) Martin Massiello, President/CEO	<b>Last Reviewed/Revised</b>
	( 07/31/2024 08:09AM PST ) Ali Tourkaman, Vice President, Support Services, S.V.P./Ancillary Services & Chief Construction Executive	<b>Next Review Date</b> 08/06/2026

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PST ) Benjamin Farber,  
V.P. Patient Care/CNO

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**Eisenhower Medical Center Policies**  
**Travel and Expense Reimbursement Policy**

Accounts Payable

Policy

Official (Rev: 0)

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**PURPOSE OF TRAVEL AND EXPENSE POLICY #2214**

This document provides guidelines and procedures for employees incurring business travel and other expenses on behalf of Eisenhower Medical Center (the Company) and sets the following objectives:

- Ensure employees have a clear and consistent understanding of policies and procedures for securing business travel
- Provide best practice methodology for cost efficiencies while ensuring travel is both safe and productive
- Ensure employees have a clear and consistent understanding of policy and procedures for reimbursement of travel and other business expenses
- Employees are expected to familiarize themselves with this document. Lack of knowledge will not be an acceptable reason for non-compliance

**SCOPE**

This policy has been authorized by Executive Management and applies to all EMC Hospital Employees. Exceptions may be approved at the discretion of the appropriate Vice President. ACHS employees will follow their Corporate Travel Policy.

**POLICY STATEMENT**

Eisenhower Medical Center follows the requirements of the Internal Revenue Service (IRS) Code Section 62 on Accountable Plans. An Accountable Plan is a method of reimbursing individuals such that the reimbursement does not count as taxable income, provided the following three requirements are met:

- **Business Purpose:** Expenses incurred are necessary, reasonable, and appropriate for Company business
- **Substantiation:** Sufficient supporting documentation is submitted to the Company to enable the nature of each expense to be identified and deemed a legitimate business expense within 60 days of its incurrence.
- **Return of excess amounts:** Employees must return any excess reimbursement or refunds received for items paid personally within a reasonable amount of time.

Unsubstantiated amounts and excess amounts not returned within a reasonable time frame are considered gross income subject to withholding and must be reported on Form W-2.

**GENERAL POLICY RULES & REQUIREMENTS**

**Access to the Expense & Travel Modules**

- Access to the Workday Expense Module is a self-service process, available to all employees.
- Access to the Concur Travel Module must be requested via email to the Accounts Payable Manager

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**Receipt Requirements**

- Receipts are not required for reimbursement for Mileage, Tolls, and Tips.
- Itemized receipts are required for all other expenses.
- Because personal credit card statements and summary credit card receipts lack the detail necessary for the approver to validate the expense is in compliance with the policy, neither will be accepted as a valid receipt.

**Cash Advance**

Cash advances are not permitted.

**Time Limits For Filing Expense Report**

- Monthly mileage expense reports not submitted within 30 days may jeopardize your reimbursement if the approver is unable to validate the expense.
- Trip-related expenses should be submitted for reimbursement no later than 30 days from the last date traveled (per IRS Rule 2003-106).

**APPROVAL REQUIREMENTS**

- The minimum level of authority to approve expenses is a Director
- Employees may not approve their own expenses and therefore must route the reimbursement request to the appropriate higher level of authority.
- Exceptions to the policy may be allowed at the discretion and approval of the appropriate VP.

**RESPONSIBILITY AND ENFORCEMENT**

Every employee is responsible for controlling expenses and complying with EMC Policies. Expense report approval is more than a formality. It indicates expenses are properly documented, have been reviewed, and comply with policies regarding travel and authorized business expenses.

**TRAVEL/TRIP AUTHORIZATION**

- All business trips shall be discussed with the employee's supervisor to ensure the benefits of the trip are justified in relation to the time and expense required.
- Employees should consider whether alternate meeting options could satisfy the objectives in lieu of travel (e.g., Teleconference/Webinar, Use of on-site conference rooms, etc.)

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**TRAVEL RESERVATIONS****Reservation Booking Policy**

- For the purpose of securing airline, hotel and car rental reservations, **ALL** EMC employees must use the contracted travel agency linked within our Concur module.
- Reservations required for external clients should be made through Concur whenever possible. In the event that is not possible, reservations may be made through our local "Direct Bill" agencies only. Commercial internet sites are not to be used and therefore do not qualify for reimbursement.

**AIRLINE TRAVEL****Airline Booking Guidelines**

- Tickets should be purchased at least 14 days in advance.
- Domestic flights within the US (including Alaska and Hawaii) and flights to/from Canada and Mexico are to be booked in Coach Class.
- International flights (excluding Canada and Mexico) may be booked in Business Class.
- Employees are expected to purchase the least expensive logical airfare available at the time of booking. Employees should consider flight options within a two-hour window of desired departure time.
- Employees should consider flight options that involve a connection.
- Employees should consider alternate airports serving the same destination. (Example-Chicago O'Hare and Chicago Midway)

**Non-reimbursable Commercial Airline Fees**

Non-reimbursable items include, but may not be limited to:

- Fees for a specific type of seat (e.g., bulk-head, window, exit row, aisle)
- Early boarding or pre-boarding fees
- Fees associated with upgrades for purchase
- Fees associated with airport security clearance programs (e.g., TSA Pre-check/Global Entry)
- Fees associated with airline affinity program upgrades

**Unused Tickets**

- Non-refundable ticket - When a non-refundable ticket is reusable, the Concur Travel Profile of the original passenger will store the unused ticket information for reuse until 2 months prior to the expiration date determined by the carrier. It will then be placed into a ticket pool to be used at the discretion of the Company to mitigate loss. (See Exchanged Ticket below)
- Refundable ticket - The value of the ticket is credited back to the original form of payment by the airline.
- Unused tickets purchased outside of Concur will not be reimbursed until the ticket has actually been used.

**Exchanged Ticket**

Unused ticket credits are stored in the Concur Travel Profile of the original passenger. Concur electronically monitors when to apply a credit to a new reservation. When this takes place, the electronic invoice (einvoice) will include information about the additional charge, if any, that was incurred to reuse the credit.

**Luggage Fees**

Airline-imposed checked luggage fees are reimbursable.

**Frequent Flyer/Personal Airline Credits**

Frequent flyer miles/points or companion tickets are not to be used for business travel. Unused personal tickets are not to be used for business travel. If they are used, they carry no value and therefore, no reimbursement is allowed.

**CAR RENTAL****Car Rental Booking Guidelines**

Car rental reservations should be made on Concur Travel to receive contract benefits with the preferred car rental vendor.

- A standard mid-size, non-luxury, vehicle is recommended for individual travel. A larger vehicle is acceptable when three or more are present. Unauthorized vehicle upgrades may not be fully reimbursed, and are subject to VP approval.
- For loss prevention and data protection, it is recommended a vehicle with a trunk is rented so items can be locked and out of sight.

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- Insurance coverage should be declined for all domestic and international rentals. EMC has an auto insurance policy that covers this requirement. If purchased, the expense will not be reimbursed.
- Refueling prepaid options should be declined. GPS rental is acceptable when necessary.
- Select states operate with manned and unmanned toll booths. For this reason, toll fees are reimbursable without a receipt.

**Rental Car Refueling**

- Employees are expected to refuel prior to returning the rental car. This expense is reimbursable.

**OVERNIGHT ACCOMMODATIONS/HOTEL**

**Hotel Booking Guidelines**

- For employee safety and security and to receive hotel contract benefits, hotel reservations should be made through the Concur travel module. All hotels that are available for the travel dates selected will appear in Concur travel module during the search function.
- Hotel reservations made outside of the Concur module are only permitted when the employee is required to follow specific booking procedures to obtain a special group rate while attending seminars, classes, association meetings, conventions, etc. For these situations the hotel deposit is reimbursable at the time the expense is incurred.
- Non-refundable/prepaid hotel rates are not recommended due to the probability of changes to business travel plans.

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**Hotel Cancellation**

- Employees are responsible for understanding the cancellation policy of each hotel at the time the reservation is made and must cancel the reservation by the hotel policy deadline to avoid hotel imposed cancellation fees.
- Employees will not be reimbursed for hotel no-show charges in the event a hotel reservation is not cancelled by policy deadline.

**Complimentary Lodging**

- When a relative or friend provides lodging without a charge, an employee may invite the host to share a single thank you meal and receive reimbursement for the meal.
- The expense report should document the name of the host and include a comment stating meal was in lieu of hotel expense.
- Cash gifts are not acceptable or reimbursable.

**MEAL GUIDELINES**

- Meal expense (breakfast, lunch, dinner) is reimbursable, with the exclusion of alcoholic beverages.
- Daily meal per diems will be reimbursed at a rate of \$75 per day (rate as of 3/1/24). Daily meal totals exceeding the established rate will require a valid explanation and may be approved or declined at the discretion of the approver. The Workday Expense Report Module will have the updated rate.
- Mini bar and snack items will be included in the total daily meal allowance calculation.
- Alcoholic beverages will not be reimbursed unless consumed as part of properly documented entertainment expense or an EMC approved special event.

**BUSINESS ENTERTAINMENT GUIDELINES**

Entertainment includes meals provided to a customer or client or any activity generally considered to provide entertainment, amusement, or recreation.

**Employees Only**

- Prior to incurring an entertainment expense involving employees only, the group should make every effort to conduct the business meeting on site.
- When it is in the best interest of EMC to hold the event off-site, an itemized receipt is required and must include a brief explanation as to the business being conducted and a list of attendees.
- Excursions, tours, tourist attraction fees, movies, etc. are considered personal expenses when the only attendees are employees traveling as part of the same business trip. These expenses are not reimbursable.
- The employee with the highest level of approval authority within the group must incur the expense.
- Expense reports not in compliance with this requirement must include an explanation and then be routed to an approver with a level higher than the most senior employee in the group.

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**Employees and Clients**

In addition to the itemized receipts, these expenses also require the name of the associated company, a list of attendees, and a brief explanation as to the related business purpose.

**MISCELLANEOUS TRAVEL EXPENSES****Airport Parking**

Employees are expected to utilize the most economical parking option when using airport parking lots.

**Conference Registration Fees**

- EMC will prepay registration fees associated with conferences/seminars/meetings directly to the vendor with a properly completed Supplier Invoice Request and supporting documentation submitted to Accounts Payable through Workday.
- Should the employee choose to pay for such an expense with a personal check or credit card, the expense will be reimbursed, subject to proper approval. If the event is canceled and the employee receives a refund for registration fees after being reimbursed, the employee is expected to submit these funds to the company for reimbursement.

**General Ground Transportation**

While taxis and Uber or Lyft may be used, employees are expected to consider all reasonable ground transportation options including hotel and airport shuttle services whenever possible.

**Gratuities**

Reasonable tipping is reimbursed.

**Hotel/Airline Internet Fees**

Hotel and airline internet access fees are an allowable expense when used for business purposes.

**Laundry**

Laundry expenses for a trip longer than five (5) business days are reimbursable.

**Mileage Reimbursement**

- The Company will reimburse employees for the use of their personal automobile based on the IRS mileage rate times the actual miles driven for business purposes. The mileage rate is preloaded into Workday.
- Mileage reimbursement for travel between officially recognized EMC locations is reimbursable and must be entered on the Workday Expense Report.
- Mileage to and from work is considered your daily commute and as such is not reimbursable.
  - Employees asked to report to a different location from their home location may be reimbursed for the mileage *in excess* of their daily commute. This includes travel for conferences or education.
  - Example: Employee's home location is 5 miles away from their home, so the daily (one-way commute) is 5 miles. If the employee is asked to report to a different location that is 10 miles away from their home, the employee may be reimbursed for the 5 miles in excess of the daily one-way commute.
  - Workday has a feature where you can input your daily commute and it will deduct from the calculated travel if necessary.
- Employees who frequently travel are permitted to turn in a weekly or monthly travel log instead of using the calculated mileage feature.

**OTHER BUSINESS EXPENSES**

Whenever possible employees are expected to use previously established methods of purchasing items that can be routed through our Accounts Payable system for direct payment to the suppliers. Expense reimbursement is not intended for routine purchase of office supplies or other business-related expenses.

**Business Expenses**

Necessary work-related expenses may include, but are not limited to:

- Tools and equipment required to perform the employee's job
- Fees for required certifications and related educational materials
- Uniforms (if unable to get through purchasing department)
- Postage and mailing
- Urgent patient-related expenses (clothing, medication, supplies)

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**Employee Appreciation (Gift Cards)**

Gift cards should be purchased through Accounting. Any gift card purchases on expense reimbursements will be subject to VP Approval.

**Remote/Hybrid Workers Home Office Expenses**

Employees who work from home on a full-time or hybrid basis are not eligible for reimbursement of internet or other home office expenses. *Please refer to the Remote Work policy for further details.*

**Unallowable Expenses**

Certain Expenses are not reimbursable, including, but not limited to the following:

- Transactions determined to be for personal use
- Payment of independent contractor services

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[https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:109149\\$0](https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:109149$0).

**References**

Reference Type	Title	Notes
<b>Documents referenced by this document</b>		
Referenced Documents	<a href="https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:109149\$0">https://www.lucidoc.com/cgi/doc-gw.pl?ref=emcorg5:109149\$0</a>	
<b>Documents which reference this document</b>		
Related Documents	Conference Policy	
<b>Document Owner</b>	Havens, Janet	<b>Original Effective Date</b> 04/23/2024
<b>Signed by</b>	( 04/09/2024 03:19PM PST ) Janet Havens, Manager-Accounts Payable	<b>This Revision Effective</b> 04/23/2024
	( 04/09/2024 03:24PM PST ) Sarah Olson, Director-Corporate Accounting	<b>Last Reviewed/Revised</b>
	( 04/09/2024 03:29PM PST ) Melanie Long, V.P./Chief Financial Officer	<b>Next Review Date</b> 04/23/2026
	( 04/23/2024 11:43AM PST ) Ken Wheat, Exec. V.P. Chief Operating Officer	

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# 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(S)**  
**Graduate Medical Education Committee**

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

# 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](mailto:lstahl@eisenhowerhealth.org)
- Contact the Chief Information Security Officer:  
**Jehremiah Fix** at [jfix@eisenhowerhealth.org](mailto:jfix@eisenhowerhealth.org)
- Contact the Chief Compliance Officer:  
**Jason Ainge** at [j.ainge@eisenhowerhealth.org](mailto:j.ainge@eisenhowerhealth.org).

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



## Scholarly Activity

- I. **POLICY STATEMENT:** This policy establishes institutional standards for the conduct, oversight, and dissemination of scholarly work, including research, quality improvement, case reports, and educational scholarship.
  
- II. **SCOPE AND APPLICABILITY:** This policy applies to all individuals engaged in scholarly activity at Eisenhower Health (EH) to include faculty, residents, fellows, medical students, undergraduate students (including EMRAP participants), and research staff or volunteers.
  
- III. **DEFINITIONS:**
  - A. **Scholarly Activity:** Systematic efforts to develop, analyze, or disseminate knowledge, including research, QI, case reports, and educational scholarship.
  - B. **Research:** A systematic investigation designed to contribute to generalizable knowledge; requires Institutional Review Board (IRB) oversight or formal IRB determination.
  - C. **Quality Improvement (QI):** Systematic efforts to improve institutional processes or outcomes; may require IRB review depending on intent and methodology.
  - D. **Case Report/Case Series:** Descriptions of clinical cases; may require IRB determination depending on identifiability and scope.
  - E. **Principal Investigator (PI):** EH approved faculty member responsible for the conduct, integrity, and compliance of a scholarly project.
  
- IV. **POLICY:**
  - A. All scholarly activity must be conducted with professionalism, integrity, and accountability. Individuals are expected to act honestly in the design, conduct, and reporting of their work while maintaining respect for patients, colleagues, and collaborators.
  - B. **Participant Expectations**
    - i. Maintain accuracy and transparency in data collection and reporting
    - ii. Protect patient privacy, confidentiality, and autonomy
    - iii. Comply with all IRB, HIPAA, and institutional requirements
    - iv. Demonstrate respectful, professional, and collaborative behavior
    - v. Seek guidance when uncertainty arises
  - C. **Prohibited Misconduct**
    - i. Data fabrication or falsification
    - ii. Plagiarism
    - iii. Misrepresentation of authorship
    - iv. Unauthorized electronic health record (HER) access
    - v. Misuse of patient data
    - vi. Dissemination without required approvals
  - D. **IRB Oversight**
    - i. IRB approval or formal determination is required for all human subject research, including prospective studies, retrospective reviews, observational studies, and interventional trials.



## Scholarly Activity

- ii. QI projects that evolve toward research intent must obtain IRB approval before continuing.
- E. PI Requirements**
  - i. Only EH approved faculty may serve as PIs.
  - ii. Trainees and students must work under faculty supervision.
  - iii. Trainees may serve as sub investigators when approved by the IRB and supervising faculty.
- F. Faculty Responsibilities**
  - i. Ensure regulatory compliance and data integrity
  - ii. Provide appropriate supervision and timely feedback
  - iii. Define roles and authorship expectations at project initiation
  - iv. Support trainee development and progressive responsibility
  - v. Review and approve all dissemination materials
- G. Resident and Fellow Responsibilities**
  - i. Engage a faculty mentor before initiating any scholarly project
  - ii. Complete required research ethics and compliance training
  - iii. Access patient data only for clinical care or approved scholarly activities
  - iv. Obtain faculty and program leadership approval before dissemination
- H. Medical Student Responsibilities**
  - i. Participate under direct faculty supervision
  - ii. Complete required institutional training
  - iii. Not independently conduct human subject research
- I. Undergraduate Students (including EMRAP)**
  - i. Undergraduate students may participate in scholarly activity in a structured and supervised manner. Given their level of training, they are held to additional onboarding and training requirements compared to medical students.
  - ii. With appropriate supervision, students may assist with literature review, data collection, and study support activities. However, they may not independently access or use patient data outside of approved protocols.
  - iii. Required Training
    - 1. Good Clinical Practice (GCP)
    - 2. Information Privacy and Security
    - 3. Conflict of Interest and Informed Consent
    - 4. CRC Foundations/Advanced (as applicable)
    - 5. Project-specific IRB training
- J. Authorship, Dissemination, and Disputes**
  - i. Authorship must reflect meaningful contributions and follow accepted academic standards.
  - ii. Authorship expectations should be defined at project initiation.
  - iii. All dissemination—including Research Day—requires PI approval and must comply with IRB determinations.
  - iv. Trainees and students may not present independently without faculty oversight.



## Scholarly Activity

- v. In the event of authorship disputes, concerns should be addressed through the following pathway:
  1. Supervising Principal Investigator
  2. Department leadership
  3. Office of Academic Affairs (final authority)

### K. Use of Artificial Intelligence (AI)

- i. The use of AI must comply with the EH Artificial Intelligence (AI) Acceptable Use policy. Artificial intelligence tools may be used to support scholarly work in limited and appropriate ways, such as editing, formatting, or literature organization. However, AI must not be used to generate original data, fabricate results, or replace critical thinking and analysis.
- ii. All individuals remain responsible for the accuracy and integrity of their work. The use of AI must be appropriate, transparent when applicable, and must never involve identifiable patient information.

### L. Oversight and Governance

- i. The Office of Academic Affairs establishes oversight across undergraduate, medical student, and graduate medical education programs. GME collaborates to ensure alignment with accreditation requirements and trainee oversight.
- ii. An institutional oversight structure may be utilized to monitor compliance, address concerns, and support scholarly activity across programs.

### M. Education & Training

- i. All individuals must complete required onboarding prior to engaging in scholarly activity. Ongoing education and refresher training may be required depending on the scope and nature of the work.

### N. Monitoring, Reporting, and Enforcement

- i. EH may audit scholarly activity to ensure compliance with this policy. Individuals are expected to report concerns or violations through appropriate channels, including faculty leadership, Academic Affairs, or the Compliance Office.
- ii. Violations may result in:
  1. Removal from scholarly activity
  2. Revocation of EMR access
  3. Mandatory retraining
  4. Disciplinary action
  5. Retraction of scholarly work
- iii. Eisenhower Health will track and report:
  1. Scholarly activity participation
  2. IRB compliance rates
  3. Publications and presentations
  4. Policy violations and trends
- iv. Reports will be shared with institutional leadership and oversight committees.

## V. PROCEDURE:

### A. Project Initiation and Approval Process – Standardized Institutional Pathway



## Scholarly Activity

- i. Project Proposal Submission: Submitted through the designated institutional portal.
- ii. Project Classification: Determination of Research vs. QI vs. Case Report by appropriate institutional authorities (IRB) and policies.
- iii. Faculty Mentorship: Assignment Required before any project involving learners may begin.
- iv. Regulatory Review: IRB review, exemption, or non-research determination as applicable.
- v. Project Registration: All projects must be registered and tracked internally for compliance and reporting.

**VI. ADDITIONAL INFORMATION:** N/A

**VII. REFERENCES AND RELATED DOCUMENTS:**

- A. [California Code, PROB 330.](#)



## Establishment and Governance of GMEC Subcommittees

- I. **POLICY STATEMENT:** This document reviews the policy for establishment and governance of Graduate Medical Education Committee (GMEC) standing and ad hoc subcommittees at Eisenhower Health (EH).
- II. **SCOPE AND APPLICABILITY:**
  - A. Department(s): Graduate Medical Education
  - B. Type of Patient: N/A
  - C. Responsible Parties: Graduate Medical Education Committee (GMEC)
- III. **DEFINITIONS:** N/A
- IV. **POLICY:**
  - A. **Establishment of Subcommittees**
    - i. The Graduate Medical Education Committee (GMEC) may establish standing and ad hoc subcommittees when specialized focus, technical expertise, or dedicated workstreams are required to fulfill GMEC responsibilities and sponsoring institution obligations. Subcommittees ensure effective governance of graduate medical education programs and provide structured mechanisms for focused oversight, analysis, and recommendations in key domains.
    - ii. Subcommittees may be established by GMEC vote or written proposal. Each subcommittee must have a charter approved by GMEC.
    - iii. All subcommittees are advisory to the GMEC unless delegated authority is granted by GMEC vote. Subcommittees operate under the authority of the GMEC and support its oversight, accreditation, quality improvement, risk management, and strategic priority.
  - B. **Membership Standards**
    - i. Membership should include interdisciplinary representation appropriate to the subcommittee's scope.
    - ii. Members must comply with institutional confidentiality, and conflict-of-interest requirements.
  - C. **Meetings, Minutes, and Documentation**
    - i. Each subcommittee meets at the cadence defined in its charter.
    - ii. Minutes will be maintained by the designated administrative leader and retained by the institutional records retention policy.
    - iii. Action items, votes, and recommendations must be clearly documented.
  - D. **Reporting Requirements**
    - i. Subcommittees will provide written updates to GMEC at least quarterly (or more frequently as required).
    - ii. Recommendations requiring GMEC action must be submitted in a standardized format (background, rationale, risk assessment, resource needs, implementation plan, and metrics).
  - E. **Oversight, Evaluation, and Renewal**



**Establishment and Governance of GMEC Subcommittees**

- i. Subcommittee performance will be reviewed annually by GMEC, including progress on deliverables and impact metrics.
- ii. Standing subcommittees require annual reaffirmation by GMEC; ad hoc subcommittees sunset per charter unless renewed.

**V. PROCEDURE: N/A**

**VI. ADDITIONAL INFORMATION: N/A**

**VII. REFERENCES AND RELATED DOCUMENTS: N/A**



## Policy: GMEC Artificial Intelligence (AI) Subcommittee Charter

- I. **POLICY STATEMENT:** The AI Subcommittee is established to provide structured oversight, guidance, and strategic recommendations to the GMEC regarding the integration, evaluation, governance, and impact of artificial intelligence tools and technologies within graduate medical education (GME) and the clinical learning environment.

The Subcommittee ensures that AI-related activities support:

- High-quality resident and fellow education
- Patient safety and ethical practice
- Compliance with ACGME Institutional and Program Requirements
- Alignment with institutional digital strategy and clinical operations

- II. **SCOPE AND APPLICABILITY:** The GMEC Subcommittee on Artificial Intelligence (AI) is responsible for providing oversight, guidance, and strategic recommendations regarding the integration and governance of AI within GME. Its scope includes:  
any exclusions.

### 1. Educational Integration

- Recommend and review AI-related curricular content for residents, fellows, and faculty.
- Promote AI literacy, professionalism, and responsible use.
- Advise on AI-enabled assessment tools and define competency expectations when AI-assisted technologies are used in patient care.

### 2. Clinical Learning Environment

- Monitor AI tools that influence clinical decision-making, documentation, workflow, or supervision.
- Identify risks and opportunities related to patient safety, bias, and equity.
- Collaborate with clinical operations and informatics leadership to ensure safe and ethical implementation.

### 3. Governance, Compliance, and Policy

- Develop and recommend institutional policies for AI use in GME, ensuring alignment with ACGME requirements, HIPAA, and institutional risk profiles.
- Review AI-related concerns or incidents affecting trainees.
- Collaborate with IT, Legal, and Compliance to maintain adherence to privacy and security standards.

### 4. Innovation, Evaluation, and Quality Improvement

- Act as a clearinghouse for AI-related proposals or pilot projects within GME programs.
- Establish evaluation metrics for AI tools used in education or clinical care.
- Promote responsible innovation and continuous improvement in AI integration.



## Policy: GMEC Artificial Intelligence (AI) Subcommittee Charter

### III. DEFINITIONS:

- Artificial Intelligence (AI): Tools or systems that perform tasks commonly associated with human intelligence (e.g., content generation, summarization, decision support, predictive analytics).
- Generative AI: AI that creates content such as text, images, audio, or code.
- AI in GME: Use of AI tools in resident/fellow education, assessment, patient-care training environments, administrative workflows, research, quality improvement, patient safety, and scholarly activity.

### IV. POLICY:

- Patient safety first: AI augments; it does not replace clinical judgment.
- Privacy and confidentiality: protected information may not be entered into non-approved systems.
- Transparency: appropriate disclosure and documentation of AI assistance.
- Equity and bias awareness: identify and mitigate potential disparate impacts.
- Educational integrity: clear boundaries for assignments, assessments, and evaluations.
- Accountability: humans remain responsible for final decisions and outputs.

### V. PROCEDURE:

Membership will be multidisciplinary and appointed by the GMEC Chair or DIO.

- Chair (faculty leader appointed by GMEC Chair/DIO).
- Vice Chair (faculty or senior administrator).
- Program Director representative(s) (at least one).
- Core Faculty representative(s) (at least one).
- Resident/Fellow representative(s) (at least one).
- Quality and Patient Safety representative.
- Clinical Informatics or Health IT representative.
- Ex Officio Members: GMEC Chair, DIO, GME Office representative (CAO/designee).

Non-voting/advisory members (as needed):

- Privacy Officer / HIPAA representative.
- Information Security representative.
- Legal/Compliance representative.
- Risk Management representative.
- IRB representative (consultative).
- Data/Analytics representative.



## **Policy: GMEC Artificial Intelligence (AI) Subcommittee Charter**

Terms: Voting members serve two-year staggered terms (renewable). Resident/fellow representatives serve one-year terms (renewable).

### **LEADERSHIP DUTIES**

- Chair: Sets agenda, facilitates meetings, and ensures deliverables and reporting to GMEC.
- Vice Chair: Supports Chair and lead assigned workgroups.
- Administrative Lead (CAO/designee): Coordinates minutes, document control, routing approvals, and GMEC reporting.

### **MEETINGS, QUORUM, & VOTING**

- The Subcommittee will meet at least quarterly, with additional meetings scheduled as needed.
- A quorum will consist of 50% of voting members, including at least one GME leader and one clinical informatics representative.
- Minutes will be recorded and submitted to the GMEC for review and inclusion in official GMEC documentation.

### **DELIVERABLES (MINIMUM REQUIRED)**

Initial and ongoing deliverables may include:

- AI Use in GME Policy
- AI literacy curriculum recommendations
- Framework for evaluating AI tools used in training programs
- Guidance on ethical, safe, and equitable AI use
- Review process for AI-related innovations or pilots
- Annual environmental scan of emerging AI technologies relevant to GME

### **RECORDS, CONFIDENTIALTY, & DATA HANDLING**

- Minutes and documents are maintained by the GME Office per records retention policy.
- Discussion of security vulnerabilities, incidents, or vendor contracts may be restricted to closed sessions and handled by institutional policy.
- Materials containing protected information are handled by HIPAA and institutional privacy/security standards.

## **VI. ADDITIONAL INFORMATION: COORDINATION & ESCALATION**



## Policy: GMEC Artificial Intelligence (AI) Subcommittee Charter

The Subcommittee will coordinate with:

- GMEC (primary).
- Quality and Patient Safety Committee (as applicable).
- IT/Information Security and Privacy (tool review and incident response).
- Compliance/Legal (policy review and contractual/regulatory alignment).
- IRB (as applicable for research involving trainees/patients).

Escalation triggers include suspected privacy breach, AI-influenced patient safety event, repeated misuse, or reputational risk.

### REVIEW & REVISION

This charter will be reviewed **annually** by the Subcommittee and submitted to the GMEC for reaffirmation or revision.

**VII. REFERENCES AND RELATED DOCUMENTS:** Not applicable



## Policy

### Artificial Intelligence Use Policy

I. **POLICY STATEMENT:** This policy establishes a governance framework for the **ethical, safe, and effective use of artificial intelligence (AI)** within Eisenhower Health Medical Education programs. It aims to enhance resident education, scholarly activity, and operational efficiency while ensuring **patient safety, data privacy, academic integrity, and regulatory compliance**.

II. **SCOPE AND APPLICABILITY:** This policy governs AI use for educational purposes within Graduate Medical Education. It is designed to complement institutional policies on legal compliance, vendor credentialing, and clinical AI deployment, which fall under separate governance structures. This policy focuses specifically on resident competency development, supervised learning, scholarly activity, and educational best practices.

#### Applicable Persons

- All learners and trainees affiliated with Eisenhower Health.
- Faculty and staff involved in residency education, supervision, or research

#### Applicable Activities

- Education and learning activities
- Clinical training support
- Research and scholarly activity
- Quality improvement and administrative workflows

III. **DEFINITIONS:** Include defined terms that have particular meaning or need for interpretation (Note: If there are no applicable definitions state “Not Applicable”).

A. **Not applicable.**

IV. **POLICY:** In this section include mandated, specified, or prohibited behavior, “what” should be done and when applicable, “why” it should be done (requirements staff must adhere to; regulatory requirements).

#### I. GUIDING PRINCIPLES

**Human Accountability:** AI may assist clinical reasoning or learning but never replaces physician judgment. Residents and faculty remain fully accountable for all decisions and outputs.

**Patient Safety First:** AI tools must not compromise patient safety or quality of care. All AI-generated clinical content must be verified by a supervising physician before use.

**Data Privacy & Security:** Protected Health Information (PHI) must be safeguarded in compliance with HIPAA and institutional policies at all times.

**Transparency & Integrity:** AI use must be disclosed appropriately in scholarly work, educational assessments, and clinical documentation.

**Policy****Artificial Intelligence Use Policy**

**Equity & Bias Awareness:** Users must recognize and actively mitigate AI bias, limitations, and potential for health equity impacts.

**II. PERMITTED AND PROHIBITED USES****A. Permitted Uses****Education & Learning**

- Summarizing medical literature or clinical guidelines (with independent verification)
- Board preparation assistance and self-directed study
- Creating study outlines, teaching materials, or case-based simulations
- Generating practice questions for knowledge self-assessment

**Clinical Support (Non-PHI Only)**

- Differential diagnosis brainstorming using de-identified clinical scenarios
- Reviewing general treatment algorithms or evidence-based guidelines
- Documentation support using institutionally approved HIPAA-compliant tools only

**Research & Quality Improvement**

- Brainstorming research questions and literature review support
- Editing manuscripts or abstracts (disclosure required per Section VI)
- Data analysis of fully de-identified datasets

**B. Prohibited Uses**

- Entering PHI into any non-HIPAA-compliant or non-institutionally approved AI tool
- Using AI to generate final clinical decisions, orders, or diagnoses
- Copy-pasting AI-generated content into the medical record without physician review and verification
- Representing AI-generated output as original work without disclosure
- Using unapproved AI tools for institutional, clinical, or educational work
- Using AI to complete assessments, examinations, or evaluations intended to measure individual competency

**III. PROCEDURE:****1. DATA PROTECTION AND PRIVACY**

- Only institutionally approved AI tools may be used for clinical or operational purposes.
- Public or consumer-facing AI platforms (e.g., ChatGPT, Google Gemini, Claude via personal accounts) may not receive PHI, research data, or proprietary institutional information.
- All users must follow institutional IT security, privacy, and data governance policies.
- Questions regarding whether a specific AI tool is approved should be directed to IT Security or the AI Subcommittee.

**2. SCHOLARLY ACTIVITY AND DISCLOSURE REQUIREMENTS**



Policy

Artificial Intelligence Use Policy

- AI use in research, abstracts, manuscripts, posters, or presentations must be explicitly disclosed. AI tools may not be listed as authors. Residents and faculty must comply with applicable journal disclosure requirements, IRB guidance, and institutional research integrity policies.

Sample Disclosure Statement

“Generative AI tools were used for language editing and/or conceptual brainstorming. All content was reviewed, verified, and approved by the authors, who accept full responsibility for the accuracy and integrity of the work.”

CLINICAL DOCUMENTATION ATTESTATION

For any clinical note in which AI-assisted tools were used for documentation support, the following attestation statement shall be included:

“Artificial intelligence was used solely to support documentation efficiency. The physician retained full responsibility for clinical evaluation, interpretation, and medical decision-making.”

V. ADDITIONAL INFORMATION:

3. HIPAA COMPLIANCE FRAMEWORK FOR AI TOOLS

HIPAA compliance is not an inherent feature of any AI model. Compliance depends on the deployment environment, infrastructure, and contractual safeguards in place. AI tools may be used with PHI only when all of the following conditions are met:

- A Business Associate Agreement (BAA) is executed between Eisenhower Health and the vendor
- Data encryption is implemented in transit and at rest
- Access controls, audit logging, and multi-factor authentication are in place
- Data isolation is maintained with no training or retention of PHI on shared servers
- The tool has been reviewed and approved by IT Security and/or the AI Subcommittee

Practical Guidance

- Never enter PHI into consumer AI tools, regardless of the stated privacy settings
- Use only enterprise AI services with executed BAAs for any clinical documentation, summarization, or workflow automation
- Verify that any vendor is willing and able to sign a BAA before using their platform for PHI
- Report any suspected data exposure or PHI breach immediately per institutional incident reporting procedures

4. MONITORING, COMPLIANCE, AND ENFORCEMENT

Violations of this policy may result in a tiered response proportional to the severity and context of the violation:



**Policy**

**Artificial Intelligence Use Policy**

<b>Tier</b>	<b>Response</b>
<b>Tier 1</b>	Educational counseling and review of policy requirements
<b>Tier 2</b>	Formal remediation plan with documented follow-up
<b>Tier 3</b>	Professionalism review per residency and institutional policies
<b>Tier 4</b>	Disciplinary action, including potential removal of AI tool access

The GMEC AI Subcommittee will review this policy annually, or more frequently as warranted by evolving regulations, technologies, institutional needs, or critical incidents.

**POLICY APPROVAL(S)**

**Graduate Medical Education Committee**

**VI. REFERENCES AND RELATED DOCUMENTS:** Not applicable.