SUBJECT: Annual Institutional Review

1. The DIO will present to the GMEC in December of each year an Annual Institutional Review (AIR) that will review broad performance indicators for the institution for Graduate Medical Education.

2. At the conclusion of the AIR review, the GMEC will identify institutional performance indicators for the AIR for the following year. Performance indicators currently include:

A. Results of the most recent institutional self-study visit to include;
1) The action plan and outcomes to correct citations from the most recent self-study visit.
2) The action plan and outcomes from any findings on the most recent AIR.
3) A review of the most recent CLER visit with the action plan to correct any recommendations from the visit and their outcomes
4) A review of the six areas of CLER (patient safety, quality improvement, transitions of care, supervision, duty hours/fatigue mitigation, professionalism) to formulate an annual plan to promote opportunities for improvement and faculty/resident engagement in CLER activities.
5) A review of all institutional policies and procedures to ensure they are up to date and in substantial compliance with ACGME institutional requirements

B. The results of the annual ACGME resident and core faculty surveys to include:
1) Review institutional aggregate survey results for formulation of an action plan to correct any institutional areas of non-compliance or below average performance measured against national norms.
2) Review the program level results of the resident and core faculty surveys and compare them to the national results for each accredited program

C. Review and report the accreditation status of each ACGME accredited program and the institution, annual program reports, and their most recent self-study visits to include:
1) Validation of successful completion of action plans to remediate deficiencies
2) Review of program data entered into the Accreditation Data System under the Next Accreditation System which will include
   a. A review of program personnel for adequate staffing and turnover rate
   b. Resident and faculty attrition
   c. Board certification take and pass rates
   d. Procedural volume and patient case mix
   e. Faculty and resident scholarly activity
   f. Program compliance with documentation of milestones

3) All action plans resulting from the AIR will be assigned due dates for correcting deficiencies as a standing GMEC agenda item and be documented in the minutes. Any

performance indicator that is found by the GMEC to be out of compliance will be monitored by the GMEC for progress. The frequency of the reporting shall be determined by the DIO based upon the nature of the noncompliant item.

a. Should any item(s) need monitoring, the GMEC may opt to appoint a Subcommittee for, but not limited to, additional document review, development of objectives and/or corrective action plan, citation correction progress review and/or mentoring.

i. Recommendations of the Subcommittee shall report to the full GMEC for approval.

ii. The GMEC may stipulate additional monitoring procedures for action plans resulting from the Subcommittee's review.

4) The DIO, after the AIR is approved by the GMEC will submit an annual executive summary of the AIR to the governing body of the institution.

_____ _____
Randall Culbertson, DO Date
Designated Institutional Official

_____ _____
Carolyn Caldwell Date
Chief Executive Officer

_____ _____
Date
Chairman, Board of Trustees

SUBJECT: Disaster Response Policy

POLICY

Desert Regional Medical Center is committed to providing safe patient care and supporting the well-being of residents, faculty, programs, students, and their families and this is the ultimate goal of all our disaster planning efforts. We recognize the need for disaster preparedness to support graduate medical education programs under any circumstance.

Desert Regional Medical Center shall provide administrative support for GME programs and residents in the event of a disaster or interruption in patient care. This shall include assistance for continuation of resident assignments.

PROCEDURE

I. In the event of a disaster causing significant interruption in patient care the DIO or designee shall convene the Graduate Medical Education Committee to determine if the training programs can reasonably fulfill their obligations to the residents. DRMC through the Office of GME will provide assistance to residents to obtain their training through other suitable venues including transfer to another residency training program.

A. If it is determined that any or all of the programs cannot provide an adequate educational experience then DRMC will to the best of its ability arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of the residents and fellows. If it is determined that DRMC or the program will not be able to re-establish an adequate educational experience within a reasonable amount of time then DRMC will assist the residents to the best of its ability in permanent transfers to other programs/institutions. If more than one program/institution is available for temporary or permanent transfer of a particular resident, the transferee preferences will be considered. DRMC programs will make the keep/transfer decision expeditiously so as to maximize the likelihood that each resident will complete the resident year timely.

B. Within ten days of the ACGME making a declaration of a disaster the DIO (or if not available the designee) will contact the ACGME to discuss due dates regarding program reconfigurations and notifications to residents of transfer decisions.

II. In the case of a Local Extreme Emergent Situation that would cause DRMC to implement its internal disaster plan as outlined in the DRMC Safety Manual Policies and Procedures, Section 5, Emergency Preparedness:

A. ACGME Residency programs at DRMC shall follow the Common Program Requirements and Basic Document for Residency Programs.

B. Residents are, first and foremost, physicians, whether they are acting under normal circumstances or in extreme emergent situations. Residents will be expected to perform according to the expectations of physicians as professionals and leaders in health care delivery, with regard to their degree of competence, their specialty training, and the context of the specific situation.

C. Residents will not be the first-line responders without appropriate supervision given the clinical situation at hand and their level of training and competence.

D. Resident performance in extreme emergent situations should not exceed expectations for their scope of competence as judged by program directors and faculty.

E. Residents will not be expected to perform beyond the limits of self-confidence in their own abilities.

To ensure and facilitate these actions the Graduate Medical Education office shall keep contact information to include e-mail addresses, pager numbers and personal phone number of residents, program directors, residency coordinators, the DIO, staff members of the office of GME and appropriate hospital administrators at the medical center and at least one off site location.

SUBJECT: Duty Hours and Fatigue Mitigation

1. Alertness Management and Fatigue Mitigation Policy

a) Patients should expect to have healthy, alert, responsible and responsive physicians providing their care. It is the expectation of the institution that all residents will have enough time without clinical responsibilities to stay well-rested and will not be fatigued when on duty.

b) While it is the institution's and training programs' responsibility to ensure compliance with duty hours requirements and provide adequate time away from Program responsibilities, it is each individual resident's responsibility to take advantage of time away to get enough exercise and sleep. If a resident appears to be too fatigued to work, he/she will be asked to go home. If/when this occurs, it will be reported to the Program Director who will conduct a review to determine why this occurred and how to prevent it from recurring. Program directors will additionally track program wide trends of duty hour violations based on aggregate individual reports and the annual ACGME resident survey.

c) If, in the normal course of a rotation, any resident feels that he/she is getting too fatigued to safely care for patients or actively engage in learning, he/she should contact the Program Director or Associate Program Director immediately. The plan will be to determine why this is occurring and collaboratively develop a remedial plan of correction, not to administer disciplinary action

d) Each training program will have a process in place to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties which must include a resident or staff back-up system.

e) Faculty and residents are educated on how to recognize the signs of fatigue and sleep deprivation, alertness management and fatigue mitigation processes, and to manage the potential negative effects of fatigue on patient care and learning. All residents and faculty will receive an annual sleep deprivation lecture from the DIO.

f) The institution provides sleep rooms for residents if they are too fatigued to safely return home.

2. Duty Hours Definitions

Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site, travel to and from work, or time engaged in remedial physical fitness training before and after the duty day.

- **Maximum hours per week**: Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
- **Mandatory time free of duty**: Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
- **PGY1 maximum duty period**: Duty periods of PGY-1 residents must not exceed 16 hours in duration.
- **PGY2 and above maximum duty period**: Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital with an additional 4 hours

assigned to transfers of care. No new patients must be managed during this transition period. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. The circumstance by which this occurs varies from RRC to RRC and must be monitored and recorded by the Program Director. Residents are responsible for alerting the Program Director when this occurs.

- **Minimum time off between scheduled duty periods**: PGY-1 residents should have 10 hours, and must have 8 hours, free of duty between scheduled duty periods. Intermediate-level residents (defined differently by each specialty RRC) should have 10 hours free of duty, and must have 8 hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

- **Special circumstances**: Residents in the final years of education (defined differently by each specialty RRC) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. While it is desirable that residents in their final years of education have 8 hours free of duty between scheduled duty periods, there may be (defined differently by each specialty RRC) when these residents must stay on duty to care for their patients or return to the hospital with fewer than 8 hours free of duty. When residents return with fewer than eight hours free of duty, the Program Director must monitor and record these circumstances.

- **Night Float**: Residents must not be scheduled for more than 6 consecutive nights of night float. The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further limited by each specialty RRC.

- **In House Call**: PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

- **Home Call**: Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour 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 duty, when averaged over four weeks. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".

3. Institutional Duty Hour Policy

a) Programs with RRCs that impose a more restrictive duty hour policy than the institutional policy will follow the stricter guidelines.

b) All programs will have a written policy on resident duty hours that will be disseminated to residents and faculty and a process to periodically sample actual resident duty hours and retain a sample of these hours that are reviewed periodically by the Program Director.

c) Each program must include a process for residents to report instances and collect data when residents violate duty hours at the program level.

d) Duty hour violation reporting may be initiated by residents or the program administration

e) The sponsoring institution may institute institution level anonymous resident surveys at periodic levels of specific programs if they score below national benchmarks on the ACGME resident survey. The results of the anonymous duty hour survey will be presented to the Program Director and resident council. The Program Director will present a

remediation plan to the GMEC for any deficiencies and present monthly progress reports verbally to the GMEC which will be documented in the GMEC minutes until such time the duty hour violations are corrected.

4. Resident Initiated Duty Hour Monitoring and Violations

a) Residents should report duty hour concerns to their Program Directors, program administrators and chief residents to try to solve any concerns at the lowest possible level.

b) If systemic issues and scheduling issues are unable to be resolved at the program level, there are several other ways residents can report violations

c) Report the violation to their program's resident council representative or e-mailing the president or vice president of the resident council. This can be brought up by the president or vice president as an anonymous concern from the program at the resident council and GMEC meetings.

d) Report the violation to the DIO who maintains an open door policy for a resident duty violation or grievance and may also e-mail him.

e) Report the violation on the duty hour hotline by calling 843-692-1107 and speaking with the institutional coordinator. If the resident wishes to remain anonymous they may call between 5:00pm and 6:00am and leave a message and the violation and the name of the program. In this case, the DIO and leadership of the resident council will work collaboratively with the program to fully investigate.

f) Report the violation through a web-form on the institution's web site.

g) Report the violation by responding appropriately to the duty hour questions on the anonymous official ACGME survey performed in the January-May time frame each year.

5. Program Initiated Duty Hour Monitoring and Violations

a) Program Directors must establish policies and procedures to measure duty hours in their program. To appropriately measure duty hours, a sampling process must be used that gives the Program Directors an idea of the actual hours worked to ensure no violations are occurring.

b) Programs should keep a written record of these audits, which should be reviewed weekly by the program administration. Program Directors must be proactive to correct violations to ensure they do not occur recurrently.

c) Violations in duty hours must be reported at the monthly GMEC meeting by the DIO with a plan for remediation.

SUBJECT: Accommodation of Disabled Persons

POLICY

Desert Regional Medical Center (DRMC), does not discriminate against qualified individuals with disabilities as defined in the Americans with Disabilities Act (ADA) of 1990 and Fair Employment and Housing Act (FEHS) in job application, procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions and privileges of employment. In accordance with Title I of the ADA and FEHA, DRMC will consider the issue of reasonable accommodation in the workplace in a fair and equitable manner for each qualified individual. As a covered entity under Title II of the Americans with Disabilities Act, DRMC does not discriminate on the basis of disability and, upon request, will provide reasonable accommodation to ensure equal access for all to its programs, services and activities.

PROCEDURE

1. The Interactive process will be used in determining effective reasonable accommodation as outlined in Government Code Section 12940(h) of the FEHA.
2. The Interactive Process will be used any time an employee with a known disability or medical condition requires reasonable accommodation to perform the essential job functions of his/her position.
3. The process requires a meeting with the employee and supervisor or manager to discuss possible reasonable accommodations, during which both parties have an opportunity to exchange and document information.
4. The feasibility of any needed job accommodation, the application of compensation, benefits, training, layoffs, discipline, termination, and all other terms and conditions of employment are administered without discrimination.

SUBJECT: Vendor Interactions

POLICY

The accredited residency programs of Desert Regional Medical Center have specific educational activities residents are required to attend as part of their residency programs. These include lectures, seminars and workshops. For these activities the programs shall follow a procedure similar to the one used by the DRMC Medical Staff for category 1 CME activities, see Attachment A&B. The Program Director or his/her designee will act as the CME committee. The designee must be a member of the active medical staff. The program residency coordinator will act as the CME coordinator. OMEC will review these activities on an annual basis and as needed.

While DRMC does receive financial support for CME from various commercial organizations, it must assure the scientific integrity of its educational activities. The purpose of these guidelines is to help avoid inappropriate commercial influence in the planning, design and implementation of educational activities by commercial companies.

PROCEDURE:

1. Program planning, from need assessment through evaluation, shall be undertaken by the CME Committee acting independently of any commercial source or influence. DRMC is held responsible for the content, quality and scientific integrity of all educational activities it provides. Each required educational activity shall be free of any and all commercial influence.

2. The CME Coordinator will ask for commercial support for activities after having confirmed an activity with faculty identified by the CME Committee or the CME Coordinator.

3. The CME Coordinator or CME Committee shall determine and approve faculty members.

4. Unsolicited faculty suggestions from commercial companies will not be considered

5. The CME Coordinator will send the faculty member the following with the confirmation letter:
   A. Commercial Support Guidelines – with highlighted sections applicable to presenting an unbiased presentation, and reporting requirements relative to:
      1) Generic and Trade Names (all drugs treated the same)
      2) Reporting Scientific Research (to be disclosed to the audience)
      3) Unlabeled Uses of Products (to be disclosed to the audience)
   B. Faculty Disclosure Form
   C. Requests for handout materials in advance for review and copying.

6. If the speaker has violated the guidelines stated in this policy and bias has been determined, the faculty member will be made aware of it in writing. Arrangements will be made for a new and unbiased lecture to be given as soon as possible.

7. The CME Coordinator will send form “Letter of Agreement” to commercial support company representative for review, agreement and signature.

8. Commercial support grants will be paid to the DRMC Education Foundation and the DRMC Education Foundation will write a check for speaker honoraria.

9. Only one commercial support representative will be allowed to be present at the time of the meeting.

10. Commercial representative will not be allowed to display or distribute sales material during the meeting.

11. Acknowledgment of support will appear on the activity advertising.

12. Commercial support companies will be verbally thanked for their support of CME at the meeting.

13. The moderator will disclose any and all financial conflict of interest outlined by the speaker on the Faculty Disclosure Form according to the topic being presented.

Attachment A

DESERT REGIONAL MEDICAL CENTER
COMMERCIAL FREE POLICY

POLICY:

Each activity that is designated category 1 credit shall be free of any and all commercial influence.

PURPOSE:

Outline the process for assuring all Category 1 credit are free of commercial influence.

PROCEDURE:

1. The CME Coordinator shall determine and approve faculty members.

2. Unsolicited faculty suggestions from commercial companies will not be considered

3. The CME Coordinator will send the faculty member the following with the confirmation letter:
   D. CMA Commercial Support Guidelines – with highlighted sections applicable to presenting an unbiased presentation, and reporting requirements relative to:
      4) Generic and Trade Names (all drugs treated the same)
      5) Reporting Scientific Research (to be disclosed to the audience)
      6) Unlabeled Uses of Products (to be disclosed to the audience)
   E. Faculty Disclosure Form
   F. Requests for handout materials in advance for review and copying.

3. A Pharmacy Evaluation Form asking if the presentation was free of bias, and treated the discussion of drugs fair, balanced and accurate will be completed by the Pharmacist in the audience or one designated physician.

4. The CME Committee will review the Pharmacy Evaluation Form.

5. If the speaker has violated the guidelines stated in this policy and bias has been determined, the faculty member will be made aware of it in writing. Arrangements will be made for a new and unbiased lecture to be given as soon as possible to undo the biased information.

Attachment B

DESERT REGIONAL MEDICAL CENTER
COMMERCIAL SUPPORT POLICY

POLICY:

While DRMC does receive financial support for CME from various commercial organizations, it must assure the scientific integrity of its educational activities. The purpose of these guidelines is to help avoid inappropriate commercial influence in the planning, design and implementation of CME activities by commercial companies.

PROCEDURE:

1. Program planning, from need assessment through evaluation, must be undertaken by the CME Committee acting independently of any commercial source or influence. DRMC is held responsible for the content, quality and scientific integrity of all Category 1 CME activities it provides.

2. The CME Coordinator will ask for commercial support for activities after having confirmed an activity with faculty identified by the CME Committee or the CME Coordinator.

3. Faculty will be sent a confirmation letter which will include the educational need identified, objectives written, presentational methods desired and the CMA guidelines on Commercial Support for review. The CME Coordinator will highlight the following three areas in guidelines for compliance:
   G. Generic and Trade Names (all drugs treated the same)
   H. Reporting Scientific Research (to be disclosed to the audience)
   I. Unlabeled Uses of Products (to be disclosed to the audience)

4. The CME Coordinator will send form “Letter of Agreement” to commercial support company representative for review, agreement and signature.

5. Commercial support grants will be paid to the DRMC Education Foundation and the DRMC Education Foundation will write a check for speaker honoraria.

6. Only one commercial support representative will be allowed to be present at the time of the meeting.

7. Commercial representative will not be allowed to display or distribute sales material in or around the meeting area.

8. Acknowledgment of support will appear on the activity advertising.

9. Commercial support companies will be verbally thanked for their support of CME at the meeting.

9. The moderator will disclose any and all financial conflict of interest outlined by the speaker on the Faculty Disclosure Form according to the topic being presented.

DESERT REGIONAL MEDICAL CENTER
Graduate Medical Education Committee

POLICY NO. 1-006
Page 1 of 4

SUBJECT: Resident Grievance

Residents are provided a procedure to initiate grievances to allow for the effective resolution of disputes or controversies: 1) between the resident and coworkers or supervisory personnel; 2) concerning the application of the resident's contract; or, 3) or concerning the policies, rules and regulations of the program and/or Coliseum Medical Center.

The grievance procedure is as follows:

1. G
   Grievances must be submitted in writing to the Program Director, briefly setting forth the complaint(s) giving rise to the grievance. The Program Director shall attempt to resolve the grievance on an informal basis within fifteen (15) business days of its receipt. The Program Director shall propose a resolution in writing and present the resolution to the resident within five (5) business days.

2. I
   If the grievance is not satisfactorily resolved in Step 1, the resident may then submit the grievance in writing to the DIO within five (5) business days of receiving the Program Director's proposed written resolution. The DIO shall respond within fifteen (15) business days of receipt of grievance. The decision of the DIO shall be a final and binding decision on the resident's grievance.

If the resident does not agree with the decision, the grievance will be addressed under the due process policy listed below.

If the grievance pertains to any dispute or controversy between the resident and the policies, rules and regulations of Desert Regional Medical Center, the Program Director shall notify the DIO and Tenet's legal department.

DUE PROCESS PROCEDURE

A resident may appeal a corrective action as follows:

Initiating the Appeal

A. To initiate the appeal process, the resident must submit a written appeal to the GME office within five (5) business days of receipt of the DIO's decision being appealed. The resident's appeal should state the facts on which the appeal is based, the reason(s) the resident believes the DIO's decision was in error, and the remedy requested.
B. The GME office will appoint an *ad hoc* Review Panel to hear the resident's appeal. The Review Panel shall consist of one program director (from a different residency program) acting

as chairperson, and two additional faculty members (from a different residency program).

C. The Review Panel will schedule the appeal hearing and notify the GME Office of the hearing date. Schedules permitting, the appeal hearing should occur within thirty (30) business days from the Review Panel's receipt of the resident's appeal.

D. The GME office will send a Hearing Notice to the resident. The Hearing Notice will contain the names of the Review Panel members, the date, time and location of the appeal hearing, and the deadline to submit evidence. The resident should receive at least ten (10) business days' notice of the hearing date.

Evidence

A. Any evidence the resident wants the Review Panel to consider must be submitted to the Review Panel at least five (5) business days prior to the appeal hearing. Submissions should contain any evidence (including witness statements and written, recorded, or electronic material) believed to be relevant to the appeal. Failure to submit evidence in that time and manner may result in the material not being considered by the Review Panel.

B. The GME office will facilitate the exchange of evidence between the resident and the Program Director and will provide copies of all evidence to the Review Panel.

Appeal Hearing

A. The Review Panel chairperson has wide discretion with respect to conducting the appeal hearing. In general, appeal hearings will proceed according to the following format:

   i. The Program Director may make a presentation to the Review Panel up to twenty (20) minutes.
   ii. The resident may make a presentation to the Review Panel up to twenty (20) minutes.
   iii. The Program Director will have up to ten (10) minutes to respond to the statements made by the resident.
   iv. The resident will have up to ten (10) minutes to respond to the statements made by the program director.
   v. Review Panel members may ask questions of the resident and/or the program director

B. Witnesses other than the Program Director and the resident will not be permitted to participate in the appeal hearing unless called by the Review Panel. In the event the Review Panel elects to hear from additional witnesses, the Program Director and the resident may question those witnesses.

C. The Review Panel and the Program Director shall be assisted during the appeal process and accompanied at the appeal hearing by attorneys from HCA Corporate Legal.

D. The resident may be assisted during the appeal process and accompanied at the appeal hearing by an advisor of the resident's choosing, who may be an attorney at the resident's own expense.

E. Advisors and attorneys may consult with the parties, but shall not actively participate in the appeal hearing.

F. Appeal hearings are confidential. Only participants, advisors or attorneys, and Review Panel members may attend.

Panel Deliberation and Decision

A. Following the appeal hearing, the Review Panel shall deliberate privately.

B. The final decision will be made by a majority vote of the Review Panel members.

C. The Review Panel will prepare a written decision setting forth its conclusions and its reasoning in support of those conclusions.

D. The Review Panel's decision will be sent to the resident, the Program Director and the DIO within ten (10) business days after the hearing.

Burden of Proof

The appealing resident has the burden to demonstrate, by clear and convincing evidence, that the decision issued by the program was arbitrary and capricious. “Clear and convincing evidence” means the evidence presented by the resident is highly and substantially more probable to be true than not. “Arbitrary and capricious” means there was no reasonable basis for the Program’s decision.

Time Limits

Time limits set forth in this procedure must be followed unless extended for good cause at the discretion of the GME OFFICE. A resident who fails to meet the time limits for appealing the Program’s decision may be deemed to have withdrawn the appeal.

SUBJECT: Harassment

I. PREAMBLE

Desert Regional Medical Center (the "Institution") and the Graduate Medical Education Committee (the "GMEC") is committed to providing residents and fellows (the "Housestaff") the opportunity to pursue excellence in their academic and professional endeavors. This can only exist when each member of our community is assured an atmosphere of mutual respect, one in which they are judged solely on criteria related to academic or job performance. The Institution and the GMEC is committed to providing such an environment, free from all forms of unlawful Harassment as defined below, including Harassment based on sex, age, ethnic or national origin, gender, race, color, religion, disability, sexual orientation or any other class protected by federal, state or local laws. The Institution prohibits such harassment whether it occurs on campus, in assignments off campus or at Institution-sponsored functions.

II. SCOPE

This policy applies to the Housestaff who participate in training programs sponsored by the Institution.

III. DEFINITIONS

"Harassment" includes misconduct that undermines the integrity of the employment relationship. It includes communicating, sharing or displaying written or visual material or making verbal comments that are demeaning or derogatory to a person because of race, color, creed, religion, sex, sexual orientation, national origin, age, disability, marital status, citizenship or any other classification protected by federal, state or local law, including material or comments intended as humor. The use of the Institution's facilities to disseminate, duplicate or display such materials is prohibited.

"Sexual Harassment" includes making unwelcome or unwanted sexual advances, requesting sexual favor in exchange for favorable treatment, continued employment, or enrollment in an education program; or, engaging in verbal or physical conduct of a sexual nature which is made a term or condition of employment, participation in an educational program, as a basis for decisions respecting an individual's employment or for academic evaluation, for advancement. Sexual harassment also includes any type of sexually-oriented conduct, including conduct intended to be friendly or humorous, that is unwelcome and has the purpose or effect of unreasonably interfering with an individual's performance at work, in an education program, or by creating an environment that is intimidating, hostile, offensive or coercive to a reasonable person. Sexual Harassment is not limited to male-female interaction but may be male-male or female-female interaction.

IV. POLICY

A. Fundamental to the Institution's and the GMEC's purpose is the free and open exchange of ideas. It is not the Institution's purpose, in promulgating this policy, to inhibit free speech or the free communication of ideas by members of the academic community.

B. Harassment is unlawful and will not be tolerated. The Housestaff found to have engaged in Harassment will be subject to severe disciplinary action, up to and including discharge from the applicable training program.

C. All individuals associated with the Institution, including employees, faculty, Housestaff, trainees and students are responsible for ensuring a Harassment-free environment. Each member of the community is responsible for fostering mutual respect, for being familiar with this policy and for refraining from conduct that violates this policy.

D. The Institution and GMEC prohibits acts of reprisal against anyone involved in filing a good faith complaint of Harassment against the resident. Conversely, the Institution and the GMEC considers intentionally filing false reports of Harassment a violation of this policy. The line between acceptable social conduct and Harassment is not always clear. For that reason, the Institution encourages individuals who feel they are being or may have been harassed to communicate politely, clearly and firmly to the offending party that the conduct is unwelcome, unwanted, offensive, intimidating or embarrassing; to explain how the offensive behavior affects the individual's work or academic performance; and to ask that the conduct stop.

E. If the individual is uncomfortable with making a direct approach to the offending party or has done so, but the perceived harassment has not stopped, the individual may use the *Procedures for Resolution of Claims of Harassment*, which is set forth below. The Institution encourages reporting of incidents of Harassment regardless of the identity of the alleged offender. The Institution and the GMEC is committed to promptly responding to all complaints of Harassment made pursuant to this policy.

V. PROCEDURES FOR RESOLUTION OF CLAIMS OF HARASSMENT

There are several mechanisms for resolving a claim of harassment.

1. Claims of any form of harassment by a member of the medical staff may be submitted as a statement of concern to the Chairman of the Medical Board of the involved hospital to activate an investigation and possible fair hearing procedure in accordance with the hospital's bylaws.

3. Claims of any form of harassment may be reported to the Designated Institutional Official. A prompt investigation shall be carried out. The investigation will be conducted in an expeditious and discrete manner and will include an interview with the individual making the complaint and with any witnesses. The person alleged to have committed Harassment will also be interviewed. If it is determined that the claim has merit, the claim and a report of the investigation will be submitted, as appropriate, for Institutional action. If the alleged harasser is a member of the faculty, the Program Director must be notified. If the alleged harasser is an employee or contractee of the Institution, the Hospital's Human Resources Office must be notified. If the alleged harasser is an employee or contractee of an affiliated hospital or institution, the appropriate officer of that institution must be notified.

VI. CONFIDENTIALITY

The name of the individual making the report of Harassment will be disclosed only to the extent necessary to conduct an investigation; however, absolute confidentiality cannot be guaranteed.

VII. CONTROL

The Designated Institutional Official shall assure conformance with the policy and shall establish such other policies or procedures necessary to effectuate its intent. This includes, but is not limited to, disseminating of this policy during the new Housestaff orientation, training for all supervisory staff on the policy and how to maintain a work environment free of Harassment, and communicating this policy to all non-employed medical staff, vendors, contractors and other business visitors interacting with Institution staff.

The Designated Institutional Official shall notify the legal counsel of Harassment complaints.

SUBJECT: Leaves of Absence

The total of vacation time, conference time, and leaves of absence (Hospital Policy) in excess of six weeks per year must either be made up by sacrificing vacation or conference time in subsequent years or will result in an extension of residency training. Hospital Policy defines the following categories of leaves of absence:

a. General Medical
b. Personal
c. Military Training
d. Active Duty Military
e. Educational
f. Family and Medical

Arrangements for vacation time and conference time (educational meetings) are to be made according to the specific residency program policy. According to the prevailing policy at the time, residents may be expected to make up call nights for vacation and meeting time. All requests for vacations, meetings, and leaves require the prior approval of the Program Director and will be subject to his/her discretion.

An absence due to a minor illness may count toward the three or four weeks allowed for vacations and meetings and are at the discretion of the Program Director. When such an absence occurs, the resident is expected to notify the Program Director or his/her designee. If the resident is scheduled to be on call, he/she will be expected to arrange coverage for the call and to make up the call. The taking of a sick day for legitimate illness will not be questioned, but the Program Director is authorized to request documentation of illness.

A resident must request a leave of absence whenever an absence due to illness will exceed seven calendar days. Such leave of absence may be dependent upon approval of the Program Director and may require certification by the residents personal physician. The first two weeks of such leave will be allowed over and above the four weeks allowed for vacations and meetings. Any time beyond two weeks may result in loss of vacation and/or meeting time in the current year or subsequent years to make up for the training time lost.

At the Program Director's discretion, a brief leave of absence due to serious family illness or death will not be counted.

Specialty boards may have policies regarding minimum length of training necessary for board eligibility when a leave of absence has occurred. Residents are encouraged to discuss this with their Program Director.

If necessary, the DIO will serve as the final arbiter in questions arising from this policy. Residents must view the policy in light of the responsibility they have to their training, to their peers, and to the integrity of the board certification process.

SUBJECT: Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in internal and external moonlighting must be counted towards the 80-hour maximum weekly hour limit.

Residents must not be required to engage in moonlighting, and moonlighting is prohibited unless specifically approved in advance by the Program Director. Such approval must be in writing and must be made a part of the resident's evaluation file. All hours worked must be reported to the program director. Approval may be withdrawn if moonlighting activities are associated with a decline in the resident's performance. The hospital does not provide professional liability coverage for duties assumed outside of the hospital, and residents should obtain written verification of coverage and limits carried by the host institution or employer.

SUBJECT: Non-Compete

Scope
The policy applies to all ACGME-accredited residency and fellowship programs at Desert Regional Medical Center.

Purpose
1. The ACGME specifically prohibits the use of restrictive covenants in trainee agreements.
2. To ensure appropriate institutional oversight as required by the ACGME Institutional Requirements.

Policy Guidelines
Neither the Sponsoring Institution nor any of the sponsoring institution's ACGME-accredited training programs may require residents/fellows to sign a non-competition guarantee or restrictive covenant.

SUBJECT: Physician Impairment

STATEMENT OF POLICY

Desert Regional Medical Center (DRMC) recognizes a fundamental duty and responsibility to assure the health and well-being of its residents. Physician impairment is often first manifested during medical school or residency training and may escape detection or intervention. DRMC leaders have a process to provide education about health issues; the process addresses physical, psychiatric, or emotional illness and facilitates confidential diagnosis, treatment, and rehabilitation of individuals who suffer from a potentially impairing condition. Residents are entitled to the support of an educational environment that is protective and sensitive to confidentiality. Residents will be strongly encouraged to seek help or assistance for any problems with physical, psychiatric, or emotional illness affecting their ability to function as a resident.

PROCEDURE

1. All residents must self-report information about their ability to perform their clinical duties. Each resident is responsible for reporting any change in their abilities that might possibly affect the quality of patient care rendered by them as related to their performance of their clinical duties. Such reports must be made to the P.D. immediately upon the resident becoming aware of the change.
2. Impairment in a resident may be subtle or overt. Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, behavior changes or mood swings, emotional outbursts, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses. In the event that a faculty member, non-physician hospital staff member, patient, other resident, student, or program coordinator notice these warning signs, they will notify the Program Director, the Designated Institutional Official, and/or the appropriate Department Chair.
3. Once notified, the Program Director will meet immediately in a neutral location with the resident, the Designated Institutional Official, and/or the appropriate Department Chair. If the resident acknowledges a problem with physical, psychiatric, or emotional illness, they will be removed from their clinical duties and will be assessed for the impairment. The cost of this assessment will be paid by the GME Office. The resident will be placed on an administrative leave of absence pending further evaluation of their condition. The resident may be reinstated by the Program Director in consultation with the Designated Institutional Official and/or Department Chair based on the results of the evaluation. If a resident requires intervention in the form of inpatient treatment, they will be placed on a leave of absence. The resident may be reinstated by the Program

Director in consultation with the Designated Institutional Official and/or Department Chair based on the results of the evaluation.

a) If the individual's impairment is a disability, whether a reasonable accommodation can be made for the individual's impairment such that, with the reasonable accommodation, the impaired individual would be able to competently and safely perform their clinical duties and the essential duties and responsibilities of the residency program.
b) Whether a reasonable accommodation would create and undue hardship, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care, and, whether the impairment could negatively impact the quality of care or the health or safety of the impaired individual, residents, patients, Hospital employees, physicians or others within the hospital.

4. If a resident refuses to acknowledge a problem with physical, psychiatric, or emotional illness, they will be removed from their clinical duties. If there is a suspected alcohol or substance abuse problem, the resident will be asked to submit to a drug/alcohol urine test in order to rule out these factors. If the resident refuses to submit to this test, they will be immediately suspended from the residency program. The resident may be reinstated by the Program Director in consultation with the Designated Institutional Official and/or Department Chair based on the results of the evaluation.

5. If the resident fails to accept the terms of reinstatement from a leave of absence or from a suspension, or if the resident fails to satisfy the terms of his/her reinstatement or treatment, they will be dismissed from the residency program.

****The Hospital and residency/fellowship program will conduct its investigation and act in accordance with the pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA).****

SUBJECT: Resident and Fellow Recruitment

1) Residents and fellows in accredited programs at our facility are selected based on qualifications that meet or exceed the standards below.

a. Graduate of medical schools in the U.S. and Canada accredited by the Liaison Committee for Medical Education (LCME); OR,
b. Graduate of osteopathic medicine in the U.S. accredited by AOA; OR,
c. Graduate of medical schools outside the U.S. or Canada who have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG); OR,
d. Graduate of medical schools outside the U.S. who have completed a Fifth Pathway program provided by an LCME-accredited medical school.
e. Applicants must be recent (5 or less years) graduates from medical school to be considered competitive. Special exceptions will be considered for
(1) Candidates entering a new residency after completion of a first residency in an ACGME accredited program
(2) Candidates with an MD or DO with a MPH/MS/PhD and extensive prior research experience after completion of an LCME or an AOA accredited medical or osteopathic medical school in the U.S. or Canada, or
(3) Candidates who have served a prolonged period as a general medical officer in the U.S. military.
f. All requisite prior training must be successfully completed prior to beginning any residency or fellowship program.
g. Applicants must have passed USMLE (United States Medical Licensing Examination) Step 1 and have taken both components of Step 2 or the COMLEX (Comprehensive Osteopathic Medical Licensing Examination) Level 1 and have taken both components of Level 2.

2) Programs will select candidates to interview only from among the pool of eligible applicants, evaluating each applicant on the basis of their preparedness, ability, aptitude, academic background (to include clerkship grades, standardized test scores, communication skills, and humanistic qualities such as motivation, honesty, and integrity. For standardized test scores, those candidates who have passed both step 1/step 2 USMLE or level 1/level 2 COMLEX with high scores on the first attempt will be considered more competitive in that category.

3) All GME training programs are required to use the Electronic Residency Application Service (ERAS) to receive and accept applications to the program. All programs at our facility will participate in the National Residency Matching Program (NRMP) as our primary method of recruiting trainees. All applicants that are granted interviews will be interviewed in person during the initial match process unless an exemption is granted by the program director. Telephonic interviews will be acceptable during the Match Week Supplemental Offer and Acceptance Program.

4) The program director evaluating residents or fellows attempting to transfer from other educational programs (prior to completion of training offered in that discipline in that institution) will directly contact the referring program director, chair, and/or other appropriate references to assess the educational qualifications of the resident or fellow prior to making any offer of employment. A final letter of evaluation and recommendation must be obtained from the referring program for all residents or fellows entering our programs after completing any training in another institution.

5) Applicants invited to interview for a resident/fellow position must be informed in writing or by electronic means, of the terms, conditions, and benefits of their appointment to the ACGME-accredited program, as well as all institutional and program policies regarding eligibility and selection for appointment, either in effect at the time of the interview or that will be in effect at the time of their eventual appointment. This includes financial support; vacations; parental, sick, and other leaves of absence; and professional liability, hospitalization, health, disability and other insurance accessible to residents/fellows and their eligible dependents. All terms, conditions, and benefits of the potential appointment are described in the Residency and Fellowship Contract (HCA-109).

6) In compliance with applicable federal and state law we do not discriminate against individuals on the basis of their race, sex, religion, sexual orientation, color, national or ethnic origin, age, disability, or military service, or genetic information in administration of educational policies, programs, or employment.

7) Special Notes for Applicants who are Non-US Citizens

a) Our training program does not sponsor visas. ECFMG is the sole sponsor of J-1 physicians in clinical training programs. Foreign national physicians who seek entry into U.S. programs of graduate medical education or training (Exchange Visitors) must obtain an appropriate visa that permits clinical training activities. One visa commonly used by foreign national physicians is the J-1, a temporary nonimmigrant visa reserved for participants in the Exchange Visitor Program. ECFMG is authorized by the U.S. Department of State to sponsor J-1 Exchange Visitor physicians enrolled in accredited programs of graduate medical education. Applicants who have passed USMLE Step 3 and qualify for H-1 visa sponsorship through ECFMG are eligible to apply as well.

b) Along with the ECFMG certificate needed to apply for the position and a letter of offer for our training program, the applicant must also provide a Statement of Need from the Ministry of Health of the country of nationality or most recent legal permanent residence. This statement must provide written assurance that the country needs specialists in the area in which the Exchange Visitor will receive training and that s/he will return to the country upon completion.
c) Federal Regulations require that Exchange Visitors and dependents obtain health, accident, medical evacuation and repatriation of remains insurance. Insurance must provide the following coverage:

1. medical benefits of at least $50,000 per accident or illness
2. repatriation of remains in the amount of $7,500

3. expenses associated with the medical evacuation of the Exchange Visitor to his/her home country in the amount of $10,000
4. a deductible not to exceed $500 per accident or illness.

ECFMG will provide insurance for the Exchange Visitor and his/her accompanying dependents for medical evacuation and repatriation of remains (numbers 2 and 3 above). The policy will match the prescribed levels stipulated by Federal Regulations and becomes effective on the start date indicated on the DS-2019. A copy of the policy will be sent with the document. It is the responsibility of the Exchange Visitor to obtain the other insurance specified in numbers 1 and 4 above. Please see resident benefits section for health care plan options that would meet these criteria.

SUBJECT: GMEC Special Review Protocol

The GMEC will demonstrate effective oversight of underperforming programs through a Special Review process. The special review process may be triggered by the following events:

1. A program is placed on probation or continued accreditation with warning by the ACGME

2. Underperformance by a program can be identified through a wide range of mechanisms. A program demonstrates a persistent trend or an egregious violation of duty hours, supervision oversight, poor board certification pass rates, program changes, deviations in milestones and competencies, resident attrition, faculty attrition, or service over education issues. A special program review may be proposed by the DIO or governing body and endorsed by a majority vote of the GMEC.

3. A subcommittee of the GMEC will be established to conduct the Special Review. The subcommittee will include the DIO, a peer-selected resident member from the GMEC (Other than from the program under review) and 2 additional GMEC members.

Materials to be used in conducting the Special Review will include but will not be limited to:

a. The most recent Annual Program Evaluation

b. All correspondence from the pertinent ACGME Residency Review Committee:

c. All concerns/citations from the RRC and corrections of those concerns/citations by the program

d. Compliance with established program requirements

e. Board pass rate

f. Annual resident and faculty surveys

g. Procedural volume (where applicable)

h. Evaluations – to include resident, faculty, and program with annual program reviews.

i. Scholarly activity

j. The clinical learning environment to include:

(1) Duty hours
(2) Resident supervision
(3) Patient safety
(4) Quality improvement
(5) Transitions of care
(6) Service vs. Education

4. Interviews - Interviews will be conducted with the program director, faculty, and residents/fellows from each year group selected by peers.

5. Report- The subcommittee will prepare a report of their findings. The report will include all areas of program underperformance identified in the Special Review process. It will also include quality improvement goals and corrective action for the identified areas of underperformance. The report will be forwarded to the GMEC for review and approval.

6. Timelines - Once the report is approved by the GMEC, it will establish timelines for correction of the identified areas of underperformance. The GMEC will then meet with the program director, present the report and timelines for meeting the quality improvement goals and corrections to areas identified as underperforming. The GMEC will monitor completion of the quality goals and corrections by the program director by having him/her present reports as a standing agenda item. The program director reports will become part of the GMEC minutes.

SUBJECT: Resident Compliment Reduction and Closure

1. The Accreditation Council for Graduate Medical Education (ACGME) requires that Coliseum Medical Center, as the Sponsoring Institution of record, have a written policy that addresses a reduction in size or closure of a residency program or closure of the Institution.

2. The senior leadership of the Sponsoring Institution in conjunction with the Department Chairs, Program Director, Designated Institutional Official (DIO) and Graduate Medical Education Committee (GMEC) will make appropriate efforts to avoid the closure of ACGME-accredited programs.

3. The Sponsoring Institution must inform the GMEC, the DIO, and the affected residents within five (5) business days following a decision to reduce the size of or close one or more programs, or when the Sponsoring Institution itself intends to close.

4. In the event a decision is made that a training program must decrease in size:

a) The appropriate Department Chair and Program Director will inform the DIO, GMEC and the residents within five (5) business days of the decision.

b) The DIO and GMEC are responsible for monitoring the complement reduction process.

c) Plans to reduce the complement of residents in the program will be made, where reasonable, by first reducing the number of positions available to incoming residents.

d) If the reduction needs to include residents currently in the training program, the Department Chair, Program Director and DIO will assist affected residents in enrolling in an alternative ACGME-accredited program.

5. In the event a decision is made that a training program must close:

a) The appropriate Department Chair and Program Director will inform the DIO, GMEC and the residents within five (5) business days of the decision.

b) The DIO and GMEC will be responsible for monitoring the closure process.

c) The sponsoring institution will preferentially structure a closure, when reasonable, that allows enrolled residents to complete the program.

d) In the event a program must be closed before one or more residents are able to complete their training, the Department Chair, Program Director and DIO will work closely with the resident(s) to assist them in enrolling in an ACGME-accredited program(s) in which they can continue their education.

6. The Designated Institutional Official (DIO) will notify the ACGME of the residency reduction or closure and arrange to keep in contact with the ACGME and to abide by it policies and procedures pertinent to GME-residency reduction or closure.

SUBJECT: Resident Promotion and Non-Renewal

RESIDENT PROMOTION/RENEWAL AND NON-PROMOTION/NON-RENEWAL AND DISMISSAL

Residents will be promoted based on specific criteria developed by the individual program Clinical Competency Committee. Renewal of contracts will take place by the end of the ninth month of the training year. Criteria for promotion will include, but will not be limited to:

- Evaluations based on the six general competencies of the ACGME
- Achievement of milestones specific to their specialty
- Performance on examinations throughout the academic year.

NON-PROMOTION/NON-RENEWAL/DISMISSAL

In the event of non-promotion, non-renewal of a contract or dismissal from a program, the resident will receive a written notice of intent not to promote, renew, or be dismissed from the program 120 days prior to the end of the contract year. If a resident is on probation or in remediation, the 120 day written notice of intent, will not apply. Any written notice of intent to not promote, renew, or dismiss will include a copy of the residents' right to due process. This copy of the residents' right to due process will have language relating to the above actions when the action is taken during the appointment period: suspension, non-renewal, non-promotion, or dismissal.

SUBJECT: Statement of Commitment to GME

Desert Regional Medical Center (DRMC) is committed to a premier learning environment for all trainees, staff and patients. DRMC will support a strong Graduate Medical Education (GME) system by providing the necessary financial support for administrative, educational, and clinical resources, including personnel, for all of its Accreditation Council for Graduate Medical Education (ACGME) accredited programs. Consistent with the Institutional and Program requirements of the ACGME, each training program will appoint the most qualified applicants, recruit and retain outstanding faculty, and maintain a balance between training, service and research. Training programs will support the professional development and personal growth of each learner.

To achieve the above objectives, DRMC has and will continue to:

• Support a Graduate Medical Education Committee (GMEC) that has policy and oversight responsibilities as required by the Institutional and Program requirements.

• Fund a central administrative Graduate Medical Education department to support GME programs

• Support residency program staffing as specified by training program accreditation requirements.

• Offer educational resources (library, teaching space, resident work stations, equipment, and information systems) to support a quality learning environment in GME programs.

• Ensure that learners have the opportunity to learn and provide supervised safe patient care.

• Ensure that learners are treated fairly and have forums and confidential mechanisms to communicate concerns about supervision, learning environment, and patient safety

• Facilitate and formalize collaborations and affiliations with other teaching hospitals and community facilities needed to support resident training to meet accreditation requirements.

• Provide hospital professional, informational and support services that are adequate to meet the educational goals of each program.

• Provide adequate on-call rooms, food services, and security to ensure the well-being of trainees.

_____ _____

_____ _____
Randall Culbertson, DO Date
Designated Institutional Official

_____ _____
Carolyn Caldwell Date
Chief Executive Officer

_____ _____
Date
Chairman, Board of Trustees

SUBJECT: Transitions of Care

To establish a protocol and standards within Desert Regional Medical Center's GME training programs to ensure the quality and safety of patient care when transfer of responsibility occurs during duty hour shift changes, during transfer of the patient from one level of acuity to another, and during other scheduled or unexpected circumstances.

DEFINITION

A transition of care ("handoff") is defined as the communication of information to support the transfer of care and responsibility for a patient/group of patients from one service and/or team to another. The hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another. Transition of care occurs regularly under the following conditions:

- Change in level of patient care, including inpatient admission from the ambulatory setting, outpatient procedure, or diagnostic area.
- Inpatient admission from the Emergency Department
- Transfer of a patient to or from a critical care unit
- Transfer of a patient from the Post Anesthesia Care Unit (PACU) to an inpatient unit when a different physician will be caring for that patient
- Transfer of care to other healthcare professionals within procedure or diagnostic areas
- Discharge, including discharge to home or another facility such as skilled nursing care
- Change in provider or service change, including resident sign-out, inpatient consultation sign-out, and rotation changes for residents.

POLICY

Individual programs must have a policy addressing transitions of care. Faculty and trainees must be aware of their department policy.

Individual programs should provide instruction to and review of departmental processes with trainees regarding handoff of care.

Individual programs must design schedules and clinical assignments to maximize the learning experience for residents as well as to ensure quality care and patient

safety, and adhere to general institutional policies concerning patient safety and quality of healthcare delivery.
Individual programs should evaluate trainees in their capacity to perform a safe, effective, and accurate handoff of care.

The patient shall not be transferred within the Hospital without the approval of a physician or Chief of Service. The order or priority for patient transfers shall be as follows:

(a) Emergency service to appropriate nursing unit.
(b) From general care unit to intensive care unit.
(c) From intensive care unit to general care unit.
(d) From temporary permanent in an inappropriate service or nursing unit for the patient being transferred.
(e) From obstetric care unit to general care unit.

SUBJECT: Resident Supervision

Purpose:
To ensure that the Desert Regional Medical Center GME programs provide appropriate supervision for all trainees that is consistent with proper patient care, the educational needs of trainees, and the applicable ACGME Review Committee (RC) and Common Program Requirements.

Policy:
There must be sufficient institutional oversight to assure that trainees are appropriately supervised. Appropriate supervision means that a trainee is supervised by the teaching faculty in such a way that the trainees assume progressively increasing responsibility according to their level of education, proven ability, and experience. On-call schedules for teaching faculty must be structured to ensure that supervision is readily available to trainees on duty. The level of responsibility accorded to each trainee must be determined by the program director and the teaching faculty.

Program Responsibility:
It is the responsibility of individual program directors to establish detailed written policies describing trainee supervision at each level for their residency/fellowship programs. The policies must be maintained in the Program Manual.

The requirements for on-site supervision will be established by the program director for each residency/fellowship in accordance with ACGME guidelines and should be monitored through periodic department reviews, with institutional oversight through the GMEC internal review process.

Levels of Supervision

- Direct – the supervising physician is physically present with the trainee and patient
- Indirect:
    - With supervision immediately available the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision
    - With supervision available the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by phone and/or other electronic modalities within 15 minutes of an initial attempt and is available to provide direct supervision within 30 minutes in the event of an emergency.
- Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after the care is delivered

Programs should establish policies that support Effective Supervisor Behaviors. Some examples of preferred behavior are listed below:

Set clear expectations

- When to call
- Situations in which trainees should always call
- How to call – provide accurate pager/phone numbers
- Trainees role in the care of the patient

Create a safe learning environment

- Reassure the trainee that is always appropriate to call if uncertain
- Recognize and address uncertainty in the trainee

Be readily available

- Answer pages and phone calls promptly
- Planned communication (schedule times for calls)

Balance supervision with trainee autonomy. Provide input but don't take over the case.

Be respectful

- Be patient with the trainee regardless of time of day
- Don't yell at or belittle a trainee

Effective Supervisee (Trainee) Behaviors

- Trainees may request the physical presence of an attending at any time and is never to be refused
- Know and follow your programs policies for when you must always contact supervisor
- If you are uncertain…call your supervisor
- If a patient has a change in status…call your supervisor
- Present data to supervisor accurately. If you omitted part of the exam let them know
- Provide feedback to the supervisor regarding what was helpful

Inadequate Supervision

The resident/fellow is protected in a manner that is free from reprisal through established policies regarding their learning and working environment which ensures they can raise concerns and provide feedback without intimidation or retaliation in a confidential manner.

- The first contact for the resident/fellow to report a breakdown in supervision will be the associate program director or program director.
- If he/she is not available, the next contact is the department chair.
- If the department chair cannot be reached, the CMO or DIO is contacted and appropriate supervision is arranged.

If the issue of inadequate supervision is raised, it will be discussed immediately at an ad-hoc GMEC meeting. A trend of inadequate supervision may prompt a special review of the program.

SUBJECT: Graduate Medical Education Committee Charter and Bylaws

1. The Graduate Medical Education Committee (GMEC) of Desert Regional is a committee composed of major stakeholders in medical education at Desert Regional Medical Center (DRMC) that reports directly to the Chief Executive Officer (CEO) who then reports to the Board of Trustees as it is composed of members that are both credentialed members of the DRMC medical staff, clinicians from external rotating sites, and key administrative staff.

2. The GMEC requires a simple majority vote with at least half of the members present to pass or amend policies and procedures. Quorums and voting thresholds related to resident disciplinary processes are discussed in the Resident Due Process Policy.

3. Policies related to resident supervision involving responsibilities of the DRMC medical staff and resident scope of care and responsibility must be dually approved by the Medical Executive Committee (MEC) and the GMEC.

4. The Chairperson of the GMEC is the Designated Institutional Official (DIO) of DRMC. The vice-chair is the Chief Medical Officer. The GMEC will be scheduled to meet monthly, but in no case will it meet less frequently than quarterly. The DIO will provide periodic reports to both the MEC and the Board of Trustees at least semi-annually.

5. Voting membership will consist of the program directors of each ACGME accredited program, the two peer-selected residents, the chief medical officer, the chief nursing officer, two representatives from the hospital administration, the director of quality and patient safety and four members elected by the medical staff from the facility Medical Education Committee. Any members of the medical staff or administration as well as the residency administrators are welcome to attend the meeting in a non-voting capacity.

The current members of the GMEC for academic year 2015-16 include:

- Dr. Randy Culbertson, DIO, GMEC Chair
- Dr. Charles Anderson, Chief Medical Officer, GMEC Vice-Chair
- Carolyn Caldwell, Chief Executive Officer
- Glenn Fischberg, MD, Program Director, Neurology
- Gemma Kim, MD, Program Director, UCR Family Medicine
- Katrina Platt, DO, Program Director, Internal Medicine
- Javed Siddiqi, MD, Program Director, Neurosurgery
- Joel Stillings, MD, Program Director, Emergency Medicine
- Dr. Andrew Fragen (Trauma Surgery, Chief of Staff)
- Dr. Babak Khazaeni (Emergency Medicine)
- Dr. Ralph Steiger (Maternal Fetal Medicine)
- Korey Brunetti (Librarian)
- Glen Moulton (IRB Coordinator)

- Michael Grace (Risk Manager/Patient Safety Officer)
- Catherine Carson (Director of Quality)
- Tushondra Thomas (Director, Clinical Informatics)
- Dora Miller (GME Manager)
- Nastassia Valenzuela (Residency Coordinator, UCR Family Medicine)
- Eli Johnson, DO, PGY-1, Emergency Medicine
- Teresa Khoo, MD, PGY-1, UCR Family Medicine
- Alvin Nguyen, DO, PGY-1, Neurology/Neurosurgery