Graduate Medical Education

Resident

Policy and Procedure Manual

Academic Year 2020-2021

Original Date: June 2018
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Policy Title: Resident Recruitment

PURPOSE

To ensure programs select from among eligible applicants based on their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities including motivation and integrity. Programs will not discriminate with regard to race, color, culture, creed, national origin, religion, sex, age, marital status, sexual orientation, gender identity and/or expression, physical, mental or sensory disability. In order to determine that all candidates making application for openings in the residency programs meet the necessary qualifications, the selection of residents for each program is coordinated with ERAS (Electronic Resident Application System).

DEFINITIONS

ECFMG Number: The identification number assigned by the Educational Commission for Foreign Medical Graduates (ECFMG) to each international medical graduate physician who receives a certification from ECFMG.

Resident: An individual enrolled in an ACGME accredited residency program

Transfer resident: Residents are considered "transfer residents" under several conditions, including: moving from one program to another within the same or between different Sponsoring Institution(s) and within the same or a different specialty; when entering a program requiring a preliminary year at the PGY-2 level even if the resident was simultaneously accepted into the preliminary PGY-1 program and the PGY-2 program as part of the Match (e.g., accepted to both programs right out of medical school).

POLICY

A. Residency Program Eligibility

1. Applicants with one of the following qualifications are eligible for appointment to accredited residency programs at Skagit Regional Health.
    a. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
    b. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
    c. Graduates of medical schools outside the United States or Canada must hold a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment and be eligible for a limited medical license in Washington State. , or

2. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC) accredited or College of Family Physicians of Canada (CFPC)- accredited residency programs located in Canada. Residency programs must receive verification of each applicant's level of competency in the required clinical

field using ACGME or CanMEDS Milestones assessments from the prior training program.

3. A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.

Policy Title: Resident Eligibility and Selection

PURPOSE

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POLICY

Each SRH GME program must develop a program-specific eligibility and selection policy that complies with the requirements outlined in this policy and applicable specialty- specific eligibility requirements as specified by the relevant Review Committee (RC). This must be made available to all interested applicants, (e.g., via the program website).

Application

All SRH GME training programs are required to use the Electronic Residency Application Service (ERAS®).

Residency Program Eligibility

Program directors must comply with the criteria for resident eligibility as defined in the Institutional Requirements [IR IV.A.], the Common Program Requirements [CPR III.A], and the applicable RC requirements of the Accreditation Council for Graduate Medical Education (ACGME). Applicants must meet the following qualifications to be eligible for appointment to an ACGME-accredited SRH Residency program:

1. documented status as a natural born or naturalized citizen of the United States or Canada or valid

Green Card documentation.
2. graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or,
3. graduation from a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA) (AOACOCA); or,
4. graduation from a medical school outside of the United States or Canada, and holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment.

Program directors must also ensure that candidates are eligible for a WA physician provider license, are authorized to work in the United States at the time of appointment[1], and meet the applicable essential abilities requirements of the program.

Passage of Medical Licensing Examinations
Physicians eligible for entry into any SRH GME program must demonstrate appropriate compliance with the SRH GME Passage of Medical Licensing Examinations policy.

Interview
Applicants invited to interview for a resident 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 his or her 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 Position Appointment (RPA), which are available by January 15th of each year and effective for the following academic year. These resources are posted on the SRH GME web page. Applicants who require a disability accommodation for the interview may request an accommodation from the SRH GME Office. In the event that such an accommodation is requested, the SRH GME Office will facilitate an appropriate accommodation consistent with Skagit Regional Health's reasonable accommodation of disabilities policy, if indicated.

Interviews may be in person, standardized virtual interview or combination as determined by program. Video applicants will be scored based on the content of the responses not the appearance of the applicant or the environment in which the applicant completes the interview. (AAMC recommendation)

Selection
Programs must select trainees among eligible applicants on the basis of training program-related criteria such as their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity, as well as professionalism. Programs must not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status.

Matching
All SRH GME training programs are required to participate in the National Residency Matching Program (NRMP) Match.

[1] At the present time, SRH is unable to host J-1 or H-1B visa holders

SRH Program Directors and GME administrators are required to comply with applicable NRMP policies and procedures in the matching process.

Reasonable accommodations
Reasonable accommodations will be made to facilitate employment opportunities for those individuals who are physically or mentally disabled. Such accommodations may include job restructuring, part-time or modified work schedules, work site alterations, acquisition or modification of equipment or devices, and qualified readers or interpreters consistent with Skagit Regional Health's reasonable accommodation of disabilities policy

Program with Osteopathic Recognition

Purpose
To describe how SRH will ensure applicants will have a sufficient background and/or instruction in osteopathic philosophy and techniques in manipulative medicine to prepare them to engage in the curriculum of a residency program with Osteopathic Recognition.

Required Eligibility[2]

1. A desire to learn to incorporate osteopathic philosophy and techniques in patient care.
2. A personal statement explaining their interest in an osteopathically recognized program, or supplemental questions which answer this.
3. At least a 1 day experience shadowing or working with a DO who practices OMT.

Recommended

1. A basic understanding of osteopathic philosophy, principles, techniques, and their applications.
2. Completion of 100 hours (4 weeks) of training in osteopathic philosophy and techniques or manual medicine prior to beginning residency. This includes, but is not limited to: OMT specialty elective rotation, attending AOA convocation or OMT courses, training in physical therapy, occupational therapy, massage therapy, acupuncture, chiropractic, athletic training, somatic therapy, yoga, pilates, feldenkrais, or other manual modality.

[2] Currently Osteopathic Recognition only applies to Family Medicine Program.

Policy Title: Clinical Experience and Education- The Learning and Working Environment

PURPOSE

The goal of Skagit Regional Health (SRH) Graduate Medical Education (GME) Programs is to provide residents with a sound academic and clinical education. This requires the Institution to provide formal written policies and procedures governing resident learning and working environment. Residency education must occur with emphasis on principles of excellence in safety and quality for their current and future patients and excellence in professionalism and commitment to well-being of the entire health care team through faculty modeling.

DEFINITIONS

Clinical and educational work hours: Clinical and educational work hours: All clinical and academic activities related to the program: patient care (inpatient and outpatient); administrative duties relative to patient care; the provision for transfer of patient care; time spent on in-house call; time spent on clinical work done from home; and other scheduled activities, such as conferences. These hours do not include reading, studying, research done from home, and preparation for future cases.

At-home call (pager call): At-home call (pager call): Call taken from outside the assigned site. Clinical work done while on at-home call, including time spent in the hospital and work done at home, such as taking calls or entering notes in an electronic health record (EHR), counts against the 80-hour-per- week limit but does not restart the clock for time off between scheduled in-house clinical and educational work periods. The remaining time, free of clinical work, does not count. At-home call may not be scheduled on a resident's or fellow's one free day per week (averaged over four weeks).

Continuous time on duty: The period that a resident or fellow is in the hospital (or other clinical care setting) continuously, counting the resident's (or fellow's) regular scheduled day, time on call, and the hours a resident (or fellow) remains on duty after the end of the on-call period to transfer the care of patients and for didactic activities.

External moonlighting: Voluntary, compensated, medically-related work performed outside the institution where the resident is in training or at any of its related participating sites.

Fatigue mitigation: Methods and strategies for learning to recognize and manage fatigue to support physician/caregiver well-being and safe patient care (e.g., strategic napping; judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods).

In-House Call: Clinical and educational work hours, beyond the scheduled workday, when residents are required to be immediately available within an assigned site, as needed, for clinical responsibilities. In-house call does not include night float, being on call from home, or regularly scheduled overnight duties.

Internal moonlighting: Voluntary, compensated, medically-related work performed within the site where the resident or fellow is in training or at any of its related participating sites.

Night Float: A rotation or other structured educational experience designed either to eliminate in-house call or to assist other residents/fellows during the night. Residents/fellows assigned to night float are assigned on-site duty during evening/night shifts, are responsible for admitting or cross-covering patients until morning, and do not have daytime assignments. Such a rotation must have an educational focus.

One Day Off: One (1) continuous 24-hour period free from all administrative, clinical and educational activities.

Resident Retreats: Unassigned, non-duty hours during which residents participate in voluntary but coordinated activities intended to promote resident wellness. Resident voluntary retreat hours are not considered as "Clinical and educational work hours" and therefore need not be reported. Mandatory activities determined by Programs are considered part of program curriculum and are to be reported in duty hours and should follow duty hour requirements.

Scheduled duty periods: Assigned duty within the institution encompassing hours which may be within the normal work day, beyond the normal work day, or a combination of both.

Strategic napping: Short sleep periods, taken as a component of fatigue management, which can mitigate the adverse effects of sleep loss.

PROCEDURE

Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

PROGRAM DIRECTOR RESPONSIBILITIES

The program director must implement policies and procedures consistent with relevant program and institutional requirements and this policy, and, to that end, must:

a. distribute these policies and procedures to the residents and faculty;
b. monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with relevant requirements;
c. adjust schedules as necessary to mitigate excessive service demands and/or fatigue;
d. if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue;
e. obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME or any accrediting/approval body information or requests for requests for increases or any change to resident duty hours; and
f. comply with any additional requirements as outlined in specialty specific program requirements.

STANDARDS

Skagit Regional Health has developed the following clinical and educational work hour guidelines applicable to every resident in all SRH GME training programs:

1. Institution

a. Clinical and educational work hours for residents 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.
b. The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
c. Residents should have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents 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.
d. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
e. Residents 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.
f. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. 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 education. Additional patient care responsibilities must not be assigned to a resident during this time.
g. In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
    i. to continue to provide care to a single severely ill or unstable patient;
    ii. humanistic attention to the needs of a patient or family; or,
    iii. to attend unique educational events.

   These additional hours of care or education will be counted toward the 80-hour weekly limit.
h. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. Time spent by residents in internal and external moonlighting must be counted toward the 80-hour maximum weekly limit. PGY-1 residents are not permitted to moonlight.
i. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.
j. Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).
k. Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
l. Residents 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 patient care must be included in the 80-hour maximum weekly limit.
m. Each resident enrolled in a GME training program is required to document his or her daily duty hours online in New Innovations. Residents are required to log their duty hours within 72 hours of completing the logged hours. New Innovations utilizes 4-week rotation blocks to calculate and average duty hours. All approved internal and external moonlighting hours must be logged in New Innovations by the residents within 72 hours of completing the logged moonlighting hours. If a

resident or fellow remains beyond their scheduled period of duty to continue to provide care of a single patient, the resident/fellow must document the reason as part of their duty hours in New Innovations. Duty periods must comply with any other requirements as outlined in specialty specific program requirements. Questions or concerns with the data reported should be brought to the GME Office's attention within 21 days to address any reporting errors in a timely manner.

n. All programs must use New Innovations to monitor and track the duty hours of all trainees. Each Program Director will review duty hours reported for every block rotation or with a frequency sufficient to ensure compliance with relevant requirements. The GMEC will review quarterly Duty Hour reports and resident surveys when available. Programs deemed noncompliant with this policy will be required to submit a corrective plan to GMEC within 60 days of such a request.

2. Programs

All SRH GME programs must:

a. Adhere to the Duty Hour guidelines as stated in this policy and by the ACGME, appropriate specialty-specific Review Committees, and any other applicable entities.(e.g., WA DOH Medical Commission, etc.);
b. Implement policies and procedures for duty hours consistent with the institutional and program
c. requirements for resident duty hours and the working environment, including moonlighting;
d. Distribute the duty hour policies to faculty and residents;
e. Educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients;
f. Ensure the residents and fellows report their duty hours (including assigned clinical activities and moonlighting activities, as directed.
g. Monitor honest and accurate reporting of in-house duty hours by residents and/or fellows;
h. Monitor at-home call;
i. Monitor all moonlighting to assure it does not interfere with the goals and objectives of the program; and
j. Encourage residents to use alertness management and fatigue mitigation strategies in the context of patient care responsibilities.

REPORTING

Residents are encouraged to contact the GME Office anonymously or confidentially to report work hour violations or other concerns to the DIO at the "What's On Your Mind?!" link at https://form.jotform.com/91217244373151.

Policy Title: Transitions of Care

PURPOSE

A responsibility of the Institution that sponsors Graduate Medical Education is to ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Skagit Regional Health (SRH) Graduate Medical Education (GME) programs design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. Programs must ensure that residents are competent in communicating with team members in the hand-over process, and maintain and communicate schedules of attending physicians and residents currently responsible for each patient's care. Each program must ensure continuity of patient care in the event that a resident may be unable to perform their patient care responsibilities dues to excessive fatigue or illness.

DEFINITIONS

Transitions of Care: The relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the health care setting.

Hand-off Communication (Hand-off): A real time, active process of passing patient-specific information from one caregiver to another, generally conducted face-to-face, or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care. Hand-offs should occur at a fixed time and place each day and use a standard verbal or written template.

PROCEDURE

1. Each program will be responsible for developing a standardized approach to hand-offs and a hand-off template. Each program, with the support of the Sponsoring Institution, will facilitate professional development in hand-off methods and practices for core faculty.

2. When possible, residents and faculty will identify a quiet area to give report that is conducive to transferring information with few interruptions.

3. Off going provider will have at hand any supporting documentation or tools used to convey information and immediate access to the patient's record.

4. All communication and transfers of information will be provided in a manner consistent with protecting patient confidentiality.

5. Providers will afford each other the opportunity to ask or answer questions and read or repeat back information as needed. If the contact is not made directly (face-to-face or by telephone), the caregiver must provide documentation of name and contact information (extension, pager, or email address) to provide opportunity for follow up calls or inquiries.

6. The Patient will be informed of any transfer of care or responsibility, when possible. Sample Hand-off Communication Tools include:
    1. SAIF-IR
    2. SBAR

3. I-PASS
4. I-SWITCH
5. 5 P's

The DIO, GMEC, and the Clinical Learning Environment subcommittee will review each department's approach to hand-offs at least annually.

Policy Title: Alertness Management/Fatigue Mitigation

PURPOSE

Skagit Regional Health (SRH) is committed to promoting patient safety and resident wellbeing in a supportive educational environment and ensuring that faculty and residents appear for duty appropriately rested and fit for duty. This policy provides guidance on methodologies available to educate faculty members and residents:

- To recognize the signs of fatigue and sleep deprivation
- Alertness management and fatigue mitigation processes
- Adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

DEFINITIONS

Faculty: The group of individuals (both physician and non-physician) assigned to teach and supervise residents/fellows.

Fatigue mitigation: Methods and strategies for learning to recognize and manage fatigue to support physician/caregiver well-being and safe patient care (e.g., strategic napping; judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods).

Fitness for duty: The condition of being mentally and physically able to effectively perform required clinical responsibilities and promote patient safety (see Fatigue mitigation).

Resident: An individual enrolled in an ACGME-accredited residency program.

Scheduled duty periods: Assigned duty within the institution encompassing hours, which may be within the normal work day, beyond the normal work day, or a combination of both.

PROCEDURE

Each program will provide all faculty members and residents with information and instruction on recognizing the signs of fatigue and sleep deprivation, and information on alertness management, fatigue mitigation processes, and how to adopt these processes to avoid potential negative effects on patient care and learning. This should be accomplished using visual presentations, lectures, white papers or any other educational resources the program may elect to use.

To ensure patient care is not compromised if a resident or faculty member must apply fatigue mitigation techniques while on scheduled duty, each program will create a documented process to ensure continuity of patient care. SRH and its programs will ensure adequate sleep facilities are available to residents and/or safe transportation options for residents requesting assistance due to fatigue because of time spent on duty.

All programs will be monitored for compliance through the SRH GME office review of programs Annual Review meeting minutes or reports, the Internal Review/Special Review process, and the ACGME Annual Survey of Residents.

Policy Title: Supervision of Graduate Medical Education Residents

PURPOSE:

To ensure:

- the provision of safe, effective, and high quality patient care at all times;
- the presence of a clear and uniform structure for resident supervision within all SRH training programs that is consistent with national standards of supervision and graduated responsibility as defined by the Accreditation Council for Graduate Medical Education (ACGME);
- educational needs of all residents are attained in a structured environment that provides appropriate supervision and graded responsibility appropriate to the residents' level of education, competence and experience;
- all training environments promote the development of health care providers who are competent to deliver patient care independently upon completion of their training.

DEFINITIONS

For purposes of this policy, the following definitions are taken from ACGME policy

Clinical Supervision: A required faculty activity involving the oversight and direction of patient care activities that are provided by residents/fellows.

Direct Supervision: The supervising physician is physically present with the resident during the key portions of the patient interactions or the supervising or 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 (VI.A.2.c)

Conditional Independence: Graded, progressive responsibility for patient care with defined oversight.

Faculty: The group of individuals (both physician and non-physician) assigned to teach and supervise residents/fellows

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

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

Program Director: The one physician designated with authority and accountability for the operation of the residency/fellowship program.
Program Year: Refers to the current year of education within a specific program; this designation may or may not correspond to the resident's graduate year level.

Resident: An individual enrolled in an ACGME-accredited residency program.

Participating Site: An organization providing educational experiences or educational assignments/rotations for residents/fellows. Examples of participating sites include: a university; a medical school; a teaching hospital, including its ambulatory clinics and related facilities; a private medical practice or group practice; a nursing home; a school of public health; a health department; a federally qualified health center; a public health agency; an organized health care delivery system; a health maintenance organization (HMO); a medical examiner's office; a consortium; or an educational foundation.

Sponsoring Institution: The organization (or entity) that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements. The Sponsoring Institution has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, a consortium, or an educational foundation).

POLICY:

Roles and Responsibilities:
Resident education is progressively graduated in both experience and responsibility with primary attention to the benefit, and safety of the patient. Development of mature clinical judgment requires that each resident be involved in the decision-making process. The conditional independence of the resident should be determined by each program and individualized to be commensurate with the clinical circumstances and ability of the resident.

In such an environment, each physician participating in the clinical training environment will have specific and defined roles and responsibilities:

- Attending Physicians are responsible for:
  - the assessment, diagnosis, treatment, and outcomes of all patients undergoing care at sites of care functioning under the sponsoring institution;
  - ensuring their role is identified to patients per hospital policy and ACGME requirements;
  - delegating portions of care to residents based on the needs of the patient and the skills of each resident;
  - providing the appropriate level of supervision based upon the nature of a patient's condition, complexity of care, and level of competence of the residents being supervised. (PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.)

- The Program Director is responsible for
  - demonstrating that the appropriate level of supervision is in place for all residents who care for patients;
  - establishing faculty supervision assignments of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility;
  - setting guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions;
  - monitoring resident supervision at all participating sites;
  - communication and collaboration with residents, faculty, clinical and operational

leadership to ensure these guidelines are understood;
- monitoring adherence to these guidelines.

Residents
- are supervised by an attending physician;
- are responsible for being aware of their limitations, roles, and responsibilities within the course of patient clinical care;
- must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence;
- are supervised in a manner consistent with national standards of supervision as defined by the Accreditation Council for Graduate Medical Education;
- are provided progressive authority and responsibility, conditional independence, and, when appropriate, a supervisory role in patient care as assigned by the program director and faculty members.;
- are expected to communicate effectively with attending physicians and other members of the health care team;
- are required to inform patients of their respective role in each patient's care.

Communication:
Communication between residents and the attending physician will occur at the time patient care decisions are being made. Prior to clinical care decisions, the attending physician will facilitate communication regarding care decisions. Examples include, but are not limited to, the following:

- Admission and discharge of a patient;
- Decision making applied to high risk or complex procedures and/or interventions, to include surgeries, use of moderate sedation, and high risk or complex diagnostic procedures;
- An important change in status occurs and/or when a patient is transferred from one service to another and/or from one level of service to another (e.g. Admission of a patient from the clinic, transfer of a patient to an intensive care unit, etc.)
- When a patient's condition is unexpectedly deteriorating, or when a patient is not improving clinically in an expected fashion or time course; and
- When disclosure of a significant adverse event is necessary.

Documentation:
Direction of clinical care and supervision of the residents must be documented in the medical record in accordance with the Bylaws and/or Rules and Regulations of the participating site. In particular, the following events require attending documentation that reflects appropriate supervision and ensures comprehensiveness of the record:

- Patient history and physical examination, and/or patient admission;
- Patient discharge;
- Surgeries and high-risk procedures; and
- Progress notes that cover significant events, complications, patient and family communication, treatments and response to treatment. An attending progress note is particularly important in the event of transfer of responsibility of care.

Consultation: Clinical consultation ranges from verbal advice to interdisciplinary concurrent care. The documentation will reflect the complexity of the clinical question and degree of consultant involvement.

Programs must submit completed Supervision Grids to the Graduate Medical Education Office annually.

The Supervision Grid template is available through the GME Office.

Emergencies:
In an emergency situation to preserve life or prevent serious impairment to health, residents shall be permitted to implement life support services. Notification must be made to the supervising physicians as soon as possible. The responsibilities of the attending physician to the patient and to the residents are not changed by these circumstances.

Policy Title: Evaluations

PURPOSE

To ensure:

- Regular, incremental evaluation of residents, faculty, and the program
- Use of appropriate and sufficient formative assessment tools for evaluation
- Communication sufficient to support development of trainees' knowledge, skills and competencies leading to their ability to practice independently.
- Each trainee upon completion is provided with a summative evaluation attesting his/her ability to practice independently within the discipline of training.

DEFINITIONS

• To be derived from the ACGME Glossary of Terms[3]

Summative evaluation: See Background and Intent associated with Common Program Requirement V.A1.

Formative Evaluation: See Background and Intent associated with Common Program Requirement V.A1.

Clinical Competency Committee (CCC): A required body comprising three or more members of the active teaching faculty that is advisory to the program director and reviews the progress of all residents or fellows in the program

Program Evaluation Committee (PEC): Group appointed by the program director to conduct program review as needed and the Annual Program Evaluation. See Common Program Requirements under V.C.

POLICY

Roles and Responsibilities:

Resident education constitutes a progressive learning experience occurring within a complex environment of patient care. Development of mature clinical judgment and acquisition of procedural skills in a safe and efficient manner within this environment depends upon continual assessment and feedback involving all elements of the system (e.g. residents, faculty, and program).

Resident Evaluation:

Each GME program will establish a Clinical Competency Committee. Members will be appointed by the Program Director. At a minimum the Clinical Competency Committee must be composed of three

[3] Available online at https://www.acgme.org/Portals/0/PDFs/ab_ACGMEglossary.pdf

members of the program faculty. Any additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings.
There must be a written description of the responsibilities of the Clinical Competency Committee. The Clinical Competency Committee shall:

- Review all resident evaluations at least semi-annually;
- Prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to
- ACGME (as applicable); and
- Advise the Program Director regarding resident progress, including promotion, remediation, and dismissal.

Formative Evaluation

The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

The program must:

- Provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones (as applicable);
- Use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
- Document progressive resident performance improvement appropriate to educational level; and
- Provide each resident with documented semiannual evaluation of performance with feedback.

The evaluations of resident performance must be accessible for review by the resident. Programs are encouraged to create, complete, and maintain all evaluations in New Innovations. Required evaluations must be maintained in New Innovations.

Summative Evaluation

The specialty-specific Milestones must be used as one of the tools (as applicable) to ensure residents are able to practice core professional activities without supervision upon completion of the program. The Program Director must provide a summative evaluation for each resident upon completion of the program.

This evaluation must:

- Become a part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy;
- Document the resident's performance during the final period of education; and,
- Verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

Faculty Evaluation:

At least annually, the program must evaluate faculty performance as it relates to the educational program. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

This evaluation must include at least annual written confidential evaluation by the residents.

Program Evaluation and Improvement:

Each GME program will establish a Program Evaluation Committee. Members will be appointed by the Program Director. At a minimum the Program Evaluation Committee must be composed of at least two program faculty members and should include at least one resident.

There must be a written description of the responsibilities of the Program Evaluation Committee. The

Program Evaluation Committee should participate actively in:

- Planning, developing, implementing, and evaluating educational activities of the program;
- Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
- Addressing areas of noncompliance with ACGME standards (or other standards as might be applicable); and.
- Reviewing the program annually using evaluations of faculty, residents, and others.

The program, through the Program Evaluation Committee, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. The program must monitor and track each of the following areas:

- Resident performance;
- Faculty development;
- Graduate performance, including performance of program graduates on the certification examination;
- Program quality; and,
- Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
- 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.
- Progress on the previous year's action plan(s).

The Program Evaluation Committee must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above, as well as delineate how they will be measured and monitored. The Action Plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

Policy Title: Promotion of Residents

PURPOSE

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

PROCEDURE

1. The Program Director will obtain from the Clinical Competency Committee, the faculty, and other pertinent sources and/or relevant committees, information on the performance of each resident.

2. 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, experience, demonstrated ability, clinical performance, and professionalism). The Program Director will also take into account the appropriate program and institutional guidelines set by the Residency Review Committee (RRC), specialty board guidelines, institutional resources, and the relative merit of the individual compared to other residents.

3. Prior to considering promotion of said resident, the Program Director may offer a resident additional time in any given Post Graduate Year. The added time would allow the resident to achieve the required level of proficiency for promotion. A resident accepting this condition must be given a written summary of deficiencies, a delineation of the remediation program and the criteria for advancement.

4. If the resident is not promoted, he/she will receive as much written notice of the intent not to promote and/or reappoint as circumstances permit. A decision not to promote a resident is subject to the Due Process and Appeal procedures set forth in Skagit Regional Health GME polices. A resident may choose to implement the Due Process procedure upon written notice of intent not to promote to next level of training.

Policy Title: Resident Moonlighting

PURPOSE
To establish the procedures for all Skagit Regional Health (SRH) Graduate Medical Education (GME) training programs to follow for residents desiring to perform moonlighting activities.

SCOPE:
This policy applies to Residents and Chief Residents participating in Skagit Regional Health (SRH) Residency training programs.

BACKGROUND:
Moonlighting is an optional activity. Neither SRH nor any of its training programs require moonlighting. Rather, such activities are generally discouraged because training programs are a full time endeavor that should be the Trainee's highest priority at all times. The Accreditation Council for Graduate Medical Education (ACGME) has generally discouraged Moonlighting for the following reasons:

- Moonlighting competes with the opportunity to achieve the full measure of the educational objectives of the residency; and
- The added time burden takes away from study and reduces opportunities to rest and the ability for a more balanced lifestyle.

Nevertheless, SRH does recognize that moonlighting, when managed appropriately, may provide an opportunity for Trainees to augment their professional skill development. In addition, economic factors may sometimes lead some Trainees to pursue moonlighting. However, in no instance will a Trainee be required to engage in such activity.

Trainees who choose to Moonlight must ensure that Moonlighting does not interfere with their ability to achieve the goals and objectives of their training program. Trainees in ACGME-accredited training programs are responsible for complying with the Institutional Duty Hours Policy, which requires that all moonlighting hours count towards total duty hours. Accordingly, Program Directors and the Office of Graduate Medical Education (GME) may approve Moonlighting activities only if these activities will not in any way interfere with the Trainee's program responsibilities and the Trainee's ability to comply with the Duty Hours Policy and this Policy.

DEFINITIONS:

ACGME: Accreditation Council for Graduate Medical Education.

Duty Hours: Includes all clinical and academic activities related to the training program, such as patient care (in-patient and out-patient), administrative duties related to patient care, transfer of patient care (including any medical record charting completed remotely), the provision for transfer of patient care, time spent in-house during call activities, scheduled didactic activities such as conferences and journal club, scheduled research activities, and other program activities such as participating in committees and in interviewing residency candidates. Duty hours also includes all hours engaged in any Moonlighting activities. Duty Hours do not include reading and preparation time spent away from the duty site.

Clinical and educational work hours: All clinical and academic activities related to the program: patient care (inpatient and outpatient); administrative duties relative to patient care; the provision for transfer of patient care; time spent on in-house call; time spent on clinical work done from home; and other scheduled activities, such as conferences. These hours do not include reading, studying, research done from home, and preparation for future cases.

External Moonlighting: Voluntary, compensated, medically-related work performed outside the site where the resident or fellow is in training and any of its related participating sites.

Internal Moonlighting: Voluntary, compensated, medically-related work performed within the site where the resident or fellow is in training or at any of its related participating sites

Moonlighting: Voluntary, compensated, medically-related work performed beyond a resident's or fellow's clinical experience and education hours and additional to the work required for successful completion of the program.

Professional Fee Billing: Billing for a physician's clinical services to patients under the Medicare Physician Fee Schedule.

Trainee: Residents, Chief Residents and Fellows participating in Approved Training Programs and Senior Fellows and Senior Fellow Trainees who are participating in non- accredited training programs and who do not hold a concurrent acting instructor or other faculty title.

POLICY:

SRH prohibits a Trainee from engaging in any Moonlighting activity unless approved in writing by the Trainee's Program Director and the GME Office **PRIOR** to engaging in such activity. Either the Program Director or the GME Office has the discretion to deny or terminate Moonlighting activities for any reason, including interference with educational objectives, patient care responsibilities and/or Duty Hour compliance.

A. Site

- Internal moonlighting at a site within the SRH system is NOT permitted.
- External moonlighting at a site that is not within the SRH system is permitted with the approval of the Program Director and the SRH GME Office.

B. Moonlighting Request Process

It is the responsibility of the Trainee to initiate the following Moonlighting Request process.

1. Prior to the commencement of any Moonlighting activity, a trainee wishing to Moonlight must submit a completed and signed Request for Approval of Moonlighting Activities to his/her Program Director for approval. This Request for Approval may be obtained from the Program Director, or the GME Office.

2. The Program Director has the discretion to decide whether or not the proposed Moonlighting activity is compatible with the training requirements of the training program. The Program Director may permit, prohibit, limit or revoke permission to moonlight as s/he deems appropriate. Factors to be considered include PGY level, academic standing, total Duty Hours,

interference with trainee's ability to achieve the goals and objectives of his/her Approved Training Program, and ability to complete regular duties. PGY-1 residents are not permitted to moonlight.

3. The Program Director must indicate his/her approval of a trainee's request by completing the appropriate section of the Request for Approval form. If approved, the Program Director then sends the Request form to the GME Office for review and a determination. The trainee shall not Moonlight without written approval from both the Program Director and the GME Office. If the Program Director denies the request, no Moonlighting shall occur. The Program Director's decision to deny a Moonlighting request is final and not subject to review.

TRAINEE REQUIREMENTS AND RESPONSIBILITIES

A. General – The trainee must be in good standing within his or her Residency Program and have an unrestricted license to practice medicine or osteopathic medicine in the state in which he or she intends to moonlight.

B. Work Hours (Duty Hours)– Work hours limits as described in the SRH GME Clinical/Educational Work Hours Policy. Trainees must comply with the Clinical/Educational Work Hours Policy.

C. Professional Liability Coverage –External moonlighting activities are not covered by SRH Residents' professional liability program. A trainee must either purchase sufficient malpractice insurance to cover his or her moonlighting activities or obtain written assurance from the site or hiring entity that it will provide malpractice insurance and workers' compensation coverage to the trainee.

D. Medical Licensure Requirements – Under Washington State Law (RCW 18.71.095(3)), a limited license ". . . shall permit the resident physician to practice medicine only in conjunction with his or her duties as a resident/fellow physician and shall not authorize the physician to engage in any other form of practice." Approval of moonlighting activities by the SRH Graduate Medical Education Program does not constitute the Institution's endorsement that the trainee has the appropriate license. It is the trainee's responsibility to ensure that he or she is appropriately licensed before engaging in any Moonlighting activities.

E. DEA Licensure Requirements –Drug Enforcement Administration (DEA) licenses obtained through the SRH Graduate Medical Education Program are restricted to activities performed by the individual (a) within the scope of their SRH GME duties as part of the trainee's Residency Program, including activities at all affiliated training sites. Trainees who engage in moonlighting activities at any site outside of SRH sites (External Moonlighting) must communicate with the DEA that they have an active full medical license.

PERIOD OF APPROVAL

Approval of a Request for Approval is valid for the then current academic year only. The Trainee must submit a new Request for Approval each academic year (generally July 1 – June 30).

WITHDRAWAL OF APPROVAL

The Program Director and or GME Office may withdraw approval at any time if the Trainee is not in compliance with the conditions of approval or if it appears that the Moonlighting activities are interfering

with the Trainee's performance in the Approved Training Program.

PROFESSIONAL FEE BILLING

Professional Fee Billing for services performed by trainees in inpatient, outpatient and emergency department services is permitted at sites that are not part of the SRH system.

Attachment A: Resident Disclosure and Request for Approval of Moonlighting Activities

Section I: Disclosure of Proposed Moonlighting

1. Resident Name: _____
2. Residency Program: ☐ Family Medicine ☐ Internal Medicine
3. Training Year: ☐ PGY-2 ☐ PGY-3
4. Specific description of the activity:
   _____
   _____
5. Name of institution/organization: _____
   _____
6. Name and e-mail of the Medical Director/Supervisor where the services will be provided:
   _____
7. Dates of moonlighting activities: Start: _____/_____/_____ End: _____/_____/_____
8. Average number of moonlighting hours worked per day: _____
9. Maximum length of shift: _____ hours
10. Amount of time off (number of hours) between end of moonlighting shift and the beginning of the scheduled accredited program shift: _____

ATTESTATION: The information provided above is true, complete, and accurate to the best of my knowledge.

_____	_____	_____
RESIDENT NAME (PRINTED)	RESIDENT SIGNATURE	DATE

---------- FOR GME OFFICE USE ONLY ----------

☐ Approved	☐ Approved
☐ Not approved	☐ Not approved

_____	_____	_____	_____
PROGRAM DIRECTOR	DATE	DIO	DATE

Policy Title: Passage of Medical Licensing Examinations

PURPOSE:

To ensure that residents and fellows complete the necessary steps required for licensure by the Washington Medical Commission. It is beneficial to complete the US Medical Licensing Exam (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) within the first year of postgraduate training.

DEFINITIONS:

Program: A structured educational experience in graduate medical education designed to conform to the Program Requirements of a particular specialty/subspecialty, the satisfactory completion of which may result in eligibility for board certification.

Residency program: A structured educational activity comprising a series of clinical and/or other learning experiences in graduate medical education, designed to prepare physicians to enter the unsupervised practice of medicine in a primary specialty. There are two types of residency programs: (a) residency programs available for physician admission immediately upon graduation from medical school as described in the Institutional Requirements; and (b) residency programs available for physician admission after completion of prerequisite clinical training as described in the relevant specialty-specific Program Requirements.

Program Director: The one physician designated with authority and accountability for the operation of the residency/fellowship program.

Program year: Refers to the current year of education (of an individual resident or fellow) within a specific program; this designation may or may not correspond to the resident's or fellow's post-graduate year.

Resident: An individual enrolled in an ACGME-accredited residency program.

Residency: A program accredited to provide a structured educational experience designed to conform to the Program Requirements of a particular specialty.

PROCEDURE:

Program Directors must ensure all residents comply with this policy. Therefore, a plan for effective communication of this policy to trainees must be developed and implemented.

1. **Program Acceptance:** Prior to acceptance into a residency program at Skagit Regional Health, the Program Director should make certain the applicants have passed either the USMLE Step 1 (within the number of attempts allowed by the TMB) and has taken USMLE Step 2 Clinical Knowledge (CK) and Clinical Skills examinations (CS) OR the COMLEX- USA level 1 and 2-CE and 2-PE.

2. **Examination Requirements:**

a. Prior to commencing training in a SRH program, matched applicants must provide proof of passing USMLE Step 2 CK and Step 2 CS OR the COMLEX- USA level 2-CE and 2-PE.

b. All residents will be encouraged to sit for the USMLE Step 3 examination OR the COMLEX- USA level three (3) early in the PGY1 year and certainly by January 1 of PGY2 year. All residents are required to show proof of passage of Step 3 or Level 3 by March 1 of the PGY2 year.

c. Any trainee entering an ACGME-accredited program at the PGY 3 level must demonstrate completion of USMLE step 3 OR the COMLEX- USA level 3 prior to matriculating on the program.

3. **Failure to Complete USMLE Step 3 OR the COMLEX- USA level 3:** Residents who do not complete the USMLE Steps (or its equivalent) in accordance with the above requirements will not be allowed to commence training or advance to the next level and are subject to corrective action.

4. **Graduation Requirement:** Passage of all medical licensing examinations required for licensure in the state of Washington is a requirement for graduation from SRH's ACGME-accredited graduate medical education programs.

5. **Exceptions:** Exceptions to this policy due to extenuating circumstances may be made at the discretion of the Program Director with approval of the Designated Institutional Official (DIO).

6. **Right to Appeal:** A decision not to promote a resident is subject to the Due Process and Appeal procedures set forth in SRH GME polices. A resident may choose to implement the Grievance and Due Process procedure upon written notice of intent not to promote to next level of training.

Policy Title: Academic Improvement and Corrective Action

PURPOSE

To establish the procedures for all Skagit Regional Health (SRH) Graduate Medical Education (GME) training programs to follow if a resident fails to meet academic expectations and/or engages in misconduct.

SCOPE

This procedure applies to all GME training programs at SRH and all residents training in those programs. For purposes of this procedure, a "resident" means any physician in any GME program at Skagit Regional Health, including interns and residents. For purposes of this policy and procedure, Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements will apply to all residents receiving training at SRH.

DEFINITIONS

Academic Deficiency: the resident is not meeting an objective assessment of competence in one or more of the ACGME Core Competencies (patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice). Examples of academic deficiencies include but are not limited to:

- Issues involving knowledge, skills, job performance or scholarship;
- Failure to timely achieve acceptable exam scores (USMLE, in-training exam, etc.);
- Tardiness or absenteeism; and
- Unprofessional conduct.

Misconduct: the resident's conduct or behavior violates workplace rules or policies, applicable law, or widely accepted societal norms. Examples of misconduct include but are not limited to:

- Unethical conduct, such as dishonesty or falsification of records;
- Illegal conduct (regardless of criminal charges or criminal conviction);
- Sexual misconduct or sexual harassment;
- Workplace violence;
- Job abandonment; and,
- Violation of SRH GME or SRH system-wide policies and/or procedures.

Structured Feedback: giving a resident documented assessment of his/her competence in one or more of the ACGME Core Competencies for the purpose of helping the trainee understand aspects of his/her performance in order to reflect on, and where necessary, improve learning and practice.

Performance Improvement Plan (PIP): a plan of remediation designed to improve a resident's proficiency in one or more ACGME Core Competencies. A PIP is not Corrective Action or formal disciplinary action, but rather an educational tool to correct areas of unsatisfactory academic performance by a resident. Therefore a resident may not appeal a PIP pursuant to the General Grievances and Due Process for Corrective Actions Policy. The issuance of a PIP does not trigger a report to any outside agencies, but may be reported should an outside agency specifically inquire whether a resident ever received a PIP.

Corrective Action: formal disciplinary action issued to a resident as the result of unsatisfactory academic performance and/or misconduct. The program is not required to issue a resident a PIP as a prerequisite to Corrective Action. Serious academic deficiencies and/or misconduct may warrant Corrective Action up to and including dismissal, regardless of whether a resident ever received a PIP. A Corrective Action may include one or more of the following measures:

- **Probation** - formal notification to the resident that there are identified areas of unsatisfactory performance that will require remediation and/or improvement or the resident will not be permitted to continue in program.
- **Repetition of Rotation** - due to identified areas of unsatisfactory performance, the resident must repeat a rotation and perform at an acceptable level in order to advance to the next level of training.
- **Non-promotion to the Next PGY Level** - due to identified areas of unsatisfactory performance, the resident will not be promoted to the next level of training unless or until the resident's performance improves to the level required.
- **Extension of the Defined Training Period** – due to identified areas of unsatisfactory performance, the resident will not complete the program on time and the defined training period will be extended to allow the resident an opportunity to perform at the level required.
- **Suspension** – the resident is temporarily not permitted to perform any job duties due to unsatisfactory performance.
- **Dismissal** – the resident is permanently separated from the program.

A Corrective Action may trigger a report to outside agencies (e.g., licensing or accreditation boards) and is appealable pursuant to the General Grievances and Due Process for Corrective Actions Policy.

PROCEDURES

Providing Structured Feedback

When a program determines a resident has an academic or performance deficiency, the program may elect to first provide structured feedback to the resident concerning the deficiency. Structured feedback should include discussion with the resident of the specific (or global) deficiencies and strategies for improvement. Structured feedback should be documented in the resident's file. If the program determines that structured feedback has not produced the necessary improvement, or the deficiency is significant enough to warrant more formal action, the program may elect to issue a PIP or Corrective Action. If deficiency has been resolved the structured feedback can be expunged from residents file at the program directors discretion.

Issuing a Performance Improvement Plan (PIP)

A PIP must be in the form of a letter from the program director to the resident and must include:

i. formal notice to the resident of the specific academic deficiencies;
ii. the remedial action or improvement that is required;
iii. a plan of remediation to cure the deficiencies;
iv. a defined period of time (e.g., 60 days) with a start and end date.

The PIP must be signed by the program director (or appropriate designee), delivered to the resident in person, and co-signed by the resident.

A copy of the signed PIP must be forwarded to the SRH GME Office and placed in the resident's file. At

the end of the PIP period, the program director must provide the resident with written notice as to whether the resident has or has not satisfactorily cured the deficiency. A copy of this written notice must be forwarded to the SRH GME Office and placed in the resident's file.

If the program director determines that the PIP is not producing the necessary improvement or the resident has failed to satisfactorily cure the deficiency by the end of the PIP period, the resident may be issued an updated or new PIP or Corrective Action.

A PIP is academic in nature and is not appealable pursuant to the General Grievances and Due Process for Corrective Action Policy.

Issuing Corrective Action

When a program director has determined that Corrective Action is warranted, the program director should first consult the SRH GME Office. A Corrective Action cannot be issued to a resident until it has been reviewed and approved by the DIO and SRH Director for Risk and Compliance.

A Corrective Action must be in the form of a letter from the program director to the resident and must include:

i. the specific Corrective Action measure(s) to be taken;
ii. a description of the academic deficiencies and/or incidents of misconduct that are the basis for the Corrective Action;
iii. the specific remedial action or improvement that is required (unless the Corrective Action is dismissal);
iv. a defined period of time (e.g., 60 days) with a start and end date (if applicable);
v. notice of the right to appeal, the deadline to initiate an appeal, and that failure to timely appeal constitutes the resident's waiver of all appeal rights.

The Corrective Action should be signed by the program director, delivered to the resident in person, and co-signed by the resident. A copy of the signed Corrective Action must be forwarded to the SRH GME Office placed in the resident's file.

If the Corrective Action was suspension or dismissal and the resident timely submits an appeal, the program director may remove the resident from participation in the program pending final resolution of the appeal.

RESPONSIBILITIES

Clinical Competency Committee or Clinical Education Committee - advise the program director about resident performance and progress and make recommendations to the program director regarding promotion, remediation, and dismissal decisions.

Designated Institutional Official – review and approve all PIPs and Corrective Actions before they are issued to the resident; provide guidance to the program director regarding this procedure and the proper handling of academic improvement and corrective action issues involving residents.

Program Director - make decisions regarding resident performance; ensure structured feedback, PIPs and Corrective Actions are given in accordance with this procedure and in consultation with the DIO and the Vice President for Legal Affairs.

SRH Graduate Medical Education Office - facilitate the issuance of PIPs and Corrective Action in accordance with this procedure and maintain appropriate documentation.

SRH Director of Risk and Compliance - review and approve all PIPs and Corrective Actions before they are issued to the resident; provide legal guidance to the DIO, the GME Office and the program director regarding this procedure and the proper handling of academic improvement and corrective action issues involving residents.

Policy Title: Grievance and Due Process for Graduate Medical Education Trainees

PURPOSE

The purpose of this policy is to assure that Residents receive procedural due process in matters of discipline and promotion. This procedure is to be followed in all instances in which a Resident is disciplined or not offered promotion to the next GME level. The Program Director is primarily responsible for decisions on discipline and non-promotion of the Resident. The GMEC assures the Resident of due process in these procedures.

SCOPE

This policy and procedure apply to all Graduate Medical Education (GME) training programs at Skagit Regional Health (SRH) and all residents training in those programs. For purposes of this policy and procedure, a "resident" means any physician in any GME program at SRH, including interns and residents.

POLICY

All GME programs at SRH will promote fair, reasonable, efficient and equitable resolutions for general grievances that may arise in the course of residency training. Residents who receive Corrective Action pursuant to the Academic Improvement and Corrective Action Policy will be permitted to appeal in accordance with the due process procedure outlined herein.

This policy and procedure do not apply to complaints related to sex discrimination, including sexual misconduct, harassment, or violence. This policy and procedure also do not apply to complaints related to discrimination on the basis of race, color, national origin, religion, age, protected veteran status, citizenship status, disability, sexual orientation, gender identity, or gender expression.

GENERAL CONSIDERATIONS

The Program Director shall not consider anonymous reports, but need not reveal the identity of any person reporting information about possibly actionable events.

The Program Director shall review all reports alleging rule violations or deficiencies in clinical performance, meet promptly with the Resident to discuss any reports which the Program Director believes to have substance, and place a written account of the meeting, including pertinent discussion, problems identified, and plans for remediation in the Resident's file.

The following sanctions are available in the discipline of Residents:

A. Informal resolution, which may or may not be documented in the Resident's file.
B. Oral reprimand, a notice of which must be placed in the Resident's file.
C. Written reprimand, a copy of which must be placed in the Resident's file.
D. Probation, with the length of time specified along with any other sanctions as specified.
E. Suspension, with the length of time specified. This may be with or without pay.
F. Non-renewal of contract.
G. Dismissal.
H. A combination of sanctions may be used.
I. Suspensions and/or terminations may begin immediately if the Program Director or DIO believes immediate action is needed to protect the quality of patient care or stable operations of SRH. Sanctions (D.) through (G.) may be appealed by the resident.
J. Sanctions that are appealed do not go into effect until the appeal process is completed except for those
K. Immediate suspensions/terminations as noted above.
L. Residents may respond in writing to sanctions (B.) through (G.), which will be entered into the Resident's file.

PROCEDURE FOR BRINGING GENERAL GRIEVANCES

A general grievance may be brought regarding any matter affecting the terms and conditions of a resident's training, except for academic or job performance, Corrective Action, or discrimination. Residents may pursue general grievances as follows:

A. The resident should first attempt to resolve the grievance informally by consulting with the chief resident, senior fellow, appropriate faculty, or the program director.
B. If the resident is unable to resolve the grievance informally, the resident may submit the grievance in writing to the Designated Institutional Official (DIO). The DIO will issue a written decision to the resident regarding the grievance within fourteen (14) business days. The decision of the DIO is final and binding.

DUE PROCESS PROCEDURE FOR APPEALING APPEALABLE SANCTIONS Initiating an Appeal

A resident who has received one of the appealable sanctions and who wishes to appeal it must file a written notice of appeal with the DIO within thirty (30) calendar days of receiving the sanction. Failure to file within thirty (30) days forever bars an appeal by the Resident.

Each appeal must be in writing and must specify:

A. The sanction being appealed;
B. The reasons for appeal;
C. Any new information the resident wishes to be considered; and
D. Any alternate sanctions the resident might accept.

On receipt of an appeal, the DIO shall send copies of the appeal to the involved Program Director and shall name an ad hoc subcommittee to hear the appeal. The DIO shall appoint a secretary for the subcommittee.

Appeal Hearing Process and Possible Actions
The DIO shall request the record of the meeting at which the sanction was given and other supporting

data from the Program Director.

The DIO shall notify the resident in writing of receipt of the appeal and of the membership of the subcommittee.

The subcommittee shall consist of the DIO and three other members of the GMEC, a least two of whom are from departments other than the Resident's.

For an Intern, these two members must be from departments through which the Intern has not rotated or not directly involved in the alleged offenses.

Within ten (10) days of its formation, the subcommittee shall meet to hear the appeal. The DIO shall notify the resident of the subcommittee time, date and place as soon as the hearing is scheduled but not without notice of less than 5 calendar days.

The resident may designate another resident or a member of the Medical/Dental staff as his/her representative before the subcommittee.

The hearing proceedings will be closed.

The hearing will consist of a presentation by the involved Program Director and a presentation by the resident or his/her representative.

The resident and/or his/her representative may introduce further written evidence with the permission of a majority of the subcommittee.

The subcommittee members have the right to question both presenting parties.

The subcommittee meets in executive session to deliberate and decide its final recommendation.

A majority of the members of the subcommittee must support a recommendation in order for it to be enacted.

The subcommittee is limited to making the following recommendations:

A. Upholding the sanction;
B. Imposing a sanction of lesser severity; or
C. Imposing no sanction.

Post Appeal Hearing Process and Possible Actions

The subcommittee's report will be presented to the GMEC at its next regular meeting. The report will be in writing and give the subcommittee's recommendation and the reasons for it. The GMEC will vote on whether to accept the report.

If the report is not accepted, the DIO will within ten (10) days, convene a special meeting of the GMEC for a de novo appeal hearing, which will be conducted in the same manner as in the initial appeal hearing above.

The Program Director whose decision is being appealed may not participate in the GMEC's deliberations or votes.

If the report is accepted, it will be referred to the CEO of SRH for final action.

The involved Program Director and the Resident shall be informed in writing of any reports filed or actions taken in the appeal process. The Program Director will file a copy of all reports and notifications of action in the Resident's personnel file.

Miscellaneous

A. A decision not to certify a Resident as eligible for a specialty certification exam is not a sanction covered by this procedure
B. A copy of this Policy shall be given to each Resident at the start of postgraduate training at SRH.
C. Notice of sanction, appeal, or committee action may be given by personal service or by first class mail.
D. Time is of the essence in all proceedings.

Policy Title: Resident Wellbeing

PURPOSE

Skagit Regional Health is committed to providing residents with a high quality academic and clinical education, which must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Clinical and educational work assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients. Physicians and all members of the health care team share responsibility to address well-being in self and others as an aspects of resident competence and professionalism.

DEFINITIONS

Work compression: An increase in the amount of work to be completed without a corresponding increase in the amount of time provided to complete that work.

POLICY

As the Sponsoring Institution, Skagit Regional Health will work collaboratively within its system and with hospital affiliates and program to ensure a healthy and safe work environment for residents. These include: access to food 24 hours a day; call rooms that are safe, quiet, and private; security and safety measures including parking facilities, on-call quarters, lactation accommodations hospital and institutional grounds, and 24 hours on-site security. We will provide services that help to assure that residents do not perform work extraneous to achieving educational goals and objectives. These include but are not limited to patient support services, such as peripheral IV access placement, phlebotomy, laboratory/pathology/radiology services, and transport services.

Skagit Regional Health in partnership with the programs will gather and utilize safety data and address any safety concerns of residents and faculty members. Which could include but not limited to workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events. (VI.C.1.c)

This includes attention to scheduling, work intensity, and work compression that impacts resident and/or faculty well-being. Effort to enhance the meaning that each resident finds in the experience of being a physician including protecting time with patients and promoting progressive autonomy and flexibility.

Programs in partnership with SRH will educate residents and faculty in identification of the symptoms of burnout, depressions, and substance abuse, including means to assist those who experience these conditions and to be trained in recognizing those symptoms in themselves and how to seek appropriate care. Residents and Faculty are encouraged to review http://www.acgme.org/Whate-We-

Do/Initiatives/Physician-Well-Being

Residents must be given the opportunity to attend medical, mental health. And dental care appointments, including those scheduled during their working hours. VI.C

Programs must have policies and procedures in place to ensure coverage of patient care when residents need time away. These policies must be implemented without fear of negative consequences.

Residents have access to confidential and affordable mental health assessment and treatment through EAP 24 hours a day 7 days a week.

Residents and faculty members must 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 (VI.C.1) Programs will provide residents and faculty access to appropriate tools for self-screening (VI.C.1.e)

Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (CPR VI.B)

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interest of the patient may be served by transitioning that patient's care to another qualified and rested provider. (CPR VI.B)

Diversity, Equity, and Inclusion (DEI)

Program must create and nurture a safe work environment for all. Programs, in partnership with Sponsoring Institutions 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 (CPR VI.B

Programs will provide educate on diversity, equity, and inclusion for residents and faculty.

Policy Title: Social Media

PURPOSE

The purpose of this policy is to address the proper use of various forms of social media by residents Skagit Regional Health (SRH) Graduate Medical Education (GME) Programs support the use of Social Media by its community members as a way to facilitate communication.

GUIDELINES

1. All material published on the web should be considered public and permanent. Nothing should be posted that would not be appropriate in a public forum, and all content should be respectful and professional

2. Residents should expect no privacy when using institutional or hospital computers.
   a. Internet use must not interfere with the timely completion of educational and clinical duties.
   b. Personal blogging or posting of updates should not be done during work hours or with institutional computers.

3. The individual is responsible for the content of his/her own blogs/posts, including any legal liability incurred (i.e. HIPAA).
   a. Do not discuss any sensitive, proprietary, confidential, private health information or financial information about the institution (including but not limited to all sites within the SRH system and/or non-SRH clinical training sites).
   b. Do not post anything that would do harm to SRH, its personnel, patients, or any patients treated by SRH faculty, staff or learners at any of the affiliated hospital partners.
   c. If you might be perceived as an agent of Skagit Regional Health or an affiliated site or institution, make it clear in your postings that you are not representing the position of the Institution or any affiliate. If you use any SRH or affiliate trademark or logo, add a disclaimer that the posting may not necessarily reflect the views and positions of that institution.

4. The tone and content of all electronic conversations must remain honest, respectful and professional. Language that is illegal, threatening, infringing of intellectual property rights, invasive of privacy, profane, libelous, harassing, abusive, hateful or otherwise injurious to any person or entity is prohibited.

5. Relationships such as doctor-patient, faculty-student, and supervisor-subordinate merit close scrutiny in the Social Media world. Use good ethical judgment when posting and follow all Skagit Regional Health policies and all applicable laws/regulations such as, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

6. Physicians and those who interact with patients should follow the guidelines promulgated by the American Medical Association (http://www.ama-assn.org/ama/pub/meeting/professionalism-social-media.shtml), which specifically states, "If they interact with patients on the internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just as they would in any other context."

7. All residents and faculty must be familiar with and comply with the SRH Policy entitled “Employee Use of Social Media” which may be accessed in Lucidoc via the SRH intranet.

CORRECTIVE ACTION

In the event of a violation of this Policy, Skagit Regional Health will take whatever corrective action is necessary to protect the integrity of the institution itself and its research and clinical projects and enterprises. In addition, it may at its discretion impose penalties upon the violator. The penalties for such violations may range from reprimand, suspension, to termination, and may depend upon the severity of the violation and what can be known about the intentions of the violator.

Policy Title: Paid Time Off Utilization

PURPOSE:

To clarify the types and amounts of leave time generally available to graduate medical education trainees.

DEFINITIONS:

Paid Time Off (PTO): Any days away from work for which the trainee receives payment from their employer

Approved Leave: Leave taken within the guidelines outlined below

Sick Leave: PTO used for absences due to sickness, injury, confinement due to pregnancy, and/or the sickness or injury of an immediate family member when the employee is needed to care for and assist the ill immediate family member. The terms sickness or injury, for purposes of using sick leave are not limited to their commonly understood meanings, but also include absences required for medical, dental, optical, or mental health examination or treatment; or absences for physical therapy and laboratory work or tests as ordered by a licensed practitioner.

Vacation Leave: PTO scheduled in advance according to the protocol of the individual program, to be used at the trainee's discretion

Discretionary Time Away: Time away that may be approved at the discretion of the Program Director for specific personal or professional reasons

POLICY:

The resident must report absence from duty for reason of illness to 1) the Director of the program in which the resident is enrolled, and 2) the supervisor of the service to which the resident is assigned. A telephone number where the resident may be contacted must be provided in case the director or supervisor needs to contact the resident. Failure to do so can result in disciplinary actions.

a. Paid Time Off:

1. The paid time off ("PTO") plan provides residents 20 days (160 hours) total per annum at 100% prorated paid stipend. Any time over 20 days must be made up which means a resident's end date may be extended. This could delay the start of post-graduation employment, fellowship training, and affect eligibility for Board certification exam(s).
    1.a 15 days of PTO is defined as time away for vacations.
    1.b 5 days will be scheduled late in the year at the Program Director's discretion and considered banked time. The 5 days of banked time may be used for sick time, interviews, bereavement, medical appointments, or personal wellness day during the year.
2. PTO is not cumulative from year to year. Unused PTO will not be paid out at the end of the academic year.
3. Absence for marriage or any other personal life events must be covered by paid time off with the

approval of the Program Director.
4. Prior to vacation all documentation must be completed.
5. All time away is subject to the Program Director's approval and will be scheduled by April 1st of the preceding academic year. Vacation changes will be considered but must be submitted in writing no less than 3 months in advance and are subject to approval by the program director. Residents are not allowed to schedule vacation block 1 of their PGY 1.

b. Release Time for Examinations:

1. All residents taking the USMLE Step III or COMLEX Level III examination and Board Certification will be released from all duties on that day(s).
2. SRH accepts responsibility for the coverage of the resident physician while taking USMLE Step III or COMLEXIII, in-service training exams, and Board Certification exam.

c. Leave of Absence:

1. The Program Director or designee for any appropriate reason may grant a resident an unpaid leave of absence.
2. The granting of such leave is discretionary with the appointing power, except for military leave and some provisions of maternity/paternity leave.
3. Unpaid leave of absences are usually granted for such circumstances as: special educational needs, recovery from an illness or injury, assisting another public jurisdiction, maternity/paternity leave. "Personal reasons" is not an acceptable reason by itself. (See SRH Family Medical Leave Policy)
4. All absences must be reported to the resident's immediate supervisor and to the Program Director or designee. Anticipated absences must have the prior approval of the GME office.
5. ACGME accredited programs will provide residents with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's eligibility to participate in examinations by the relevant certifying board(s).
6. Leave of Absence must be reported to the Program Director.

d. Effect of Absence on Certification of Training:

1. The resident's department or ACGME, and the applicable program specialty requirements have defined the length of training that a resident must serve in order to satisfy the minimum requirements for the specialty and to qualify to sit for the certifying examination of the specialty board.
2. The department shall make its training requirements known to residents upon application to the program and again at the time of acceptance into the program.
3. Aside from regularly scheduled PTO time, the resident may be required to "make up" all other absences from scheduled work hours if one or more periods of absence results in the resident falling below the minimum requirements for certification of completion of training. This may cause an extension of the residency program.

f. Family Medical Leave and the Family and Medical Leave Act of 1993:

1. Family Medical Leave is intended to allow employees to balance their work and the needs of family life by taking reasonable leave for reasons such as: medical conditions, the birth or adoption of a child, or the care of a spouse or parent who has a serious health condition.
2. The Family Medical Leave Act (FMLA) provides up to twelve (12) weeks of unpaid, job-protected leave to "eligible employees" for certain family and medical reasons. An employer is required to give an employee FMLA if the employee has worked at least one (1) year and 1,250 hours over the previous 12 months. FMLA is unpaid leave. However, a resident may

elect to use PTO time in accordance with management and the Office of Human Resources approval.

g. Maternity/Paternity Leave:

1. Pregnancy and childbirth is considered a medical disability for leave purposes.
2. A pregnant employee may work as long as she wishes provided her physician certifies she is physically and medically capable of performing all of the duties of the position without risk to herself, the unborn child, or posing a liability to the clinic or hospital.
3. The department may require medical certification allowing the employee to continue work.
4. Request for leave of absence for reasons associated with pregnancy must be submitted in writing to the supervisor with a certification from the physician giving the dates her temporary disability will begin and end. Based on the certification submitted, the employee may be granted sick leave benefits (up to the available benefit levels).

h. Industrial Injury Leave (Worker's Compensation):

1. An employee should report an industrial injury/illness to his/her supervisor within 24-hours.
2. Failure to report an injury/illness may result in delayed medical services and possible loss of benefits.

Washington State paid Family and Medical Leave

Time granted for a leave of absence is unpaid leave unless resident elects to use their accrued PTO or the leave is covered through Washington State paid family or medical leave. https://paidleave.wa.gov

Bereavement Leave

Procedure

1. In the event of the death of a resident immediate family member, Skagit Regional Health will provide paid time off for up to five (5) days.
2. These days may be taken consecutively or/and intermittently.
3. Upon notification of death in the family, the resident must contact his/her program director to request bereavement time.
4. The employee may request additional time off without pay for bereavement leave if PTO hours are not available.

Immediate Family: Defined as spouse, domestic partner, child, parent, brother, sister, daughter-in-law, grandparent, grandchild, stepparent, stepchild, stepbrother, stepsister, or the in-law equivalent of parent, grandparent, brother or sister.

Effect of Leave Time on Eligibility for Board Certification and duration of program
Residents should be aware that graduation from residency and Board certification eligibility depends on the completion of a specified amount of training. See the GME policy entitled Effects of Leaves of Absence Policy.

Policy Title: Effects of Leaves of Absence

PURPOSE

This policy provides residents with information regarding the effects of leaves of absence on completion of residency programs and on eligibility for certification by the relevant certifying board(s).

PROCEDURE

Residents should be aware that graduation from residency and Board certification depends on the completion of a specified amount of training. Each Skagit Regional Health (SRH) Graduate Medical Education (GME) program must provide information regarding the specific training requirements for the resident's particular program.

Extended absences from the program may require additional time and training. In general, cumulative annual leave exceeding that allowed by Paid Time Off (PTO) may result in an extension of the resident's training. The program must provide the resident with written notice in the event their training will be extended because of a leave of absence.

Certifying Boards vary in their requirements regarding the effect of leaves of absence taken—for any reason—during residents' training on their eligibility and timing for board certification. Residents and fellows should access the specific relevant information from their certifying boards, available from the American Board of Medical Specialties (ABMS) website.

Policy Title: Prohibition of Restrictive Covenants in Trainee Agreements

POLICY: Neither Skagit Regional Health nor any of its Graduate Medical Education programs may require Residents to sign a non-competition guarantee (restrictive covenant).

Policy Title: Special Review Process

PURPOSE:

To ensure effective oversight of underperforming Graduate Medical Education programs by the Sponsoring Institution via the Designated Institutional Official and the Graduate Medical Education Committee. Specifically, this policy will (1) establish criteria for identifying underperformance and (2) address the procedure to be utilized when a residency program undergoes a Special Review.

Criteria for Identifying Underperformance:
Underperformance by a program can be identified through a wide range of mechanisms. These may include, but are not limited to:

- Deviations from expected results in standard performance indicators:
    - Program Attrition
    - Program Changes
    - Scholarly Activity
    - Board Pass Rate
    - Clinical Experience
    - Resident or Faculty Survey
    - Milestones
    - Competencies

- Communications about or complaints against a program indicating potential egregious or substantive noncompliance with the ACGME Common, specialty/subspecialty-specific Program, and/or Institutional Requirements; or noncompliance with institutional policy;

- A program's inability to demonstrate success in any of the following focus areas:
    - Integration of residents into institution's Patient Safety Programs;
    - Integration of residents into institution's Quality Improvement Programs and efforts to reduce Disparities in Health Care Delivery;
    - Establishment and implementation of Supervision policies;
    - Transitions in Care;
    - Duty hours policy and/or fatigue management and mitigation; and
    - Education and monitoring of Professionalism

- Self-report by a Program Director or Department Chair.

PROCEDURE:

Designation: When a residency/fellowship program is deemed to have met the established criteria for designation as an underperforming program, the DIO/Chair of the GMEC shall schedule a Special Review. Special Reviews shall occur within 60 days of a program's designation as 'underperforming.'

Special Review Panel: Each Special Review shall be conducted by a panel including at least one member of the GMEC who shall serve as Chair of the panel, one additional faculty member from within the SRH GME Program, and one resident. 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.

Preparation for the Special Review: The Chair of the Special Review panel, in consultation with the DIO/GMEC and/or other persons as appropriate, shall identify the specific concerns that are to be reviewed as part of the Special review process. Concerns may range from those that broadly encompass the entire operation of the program to single, specific areas of interest. Based on identified concerns, the program being reviewed may be asked to submit documentation prior to the actual Special Review that will help the panel gain clarity in its understanding of the identified concerns.

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

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

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

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

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

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

Policy Title: Reduction in Program Size or Program / Institutional Closure

PURPOSE

To provide guidance in the event that a decision is reached by Skagit Regional Health (SRH) as the Sponsoring Institution (SI) to reduce the size of or close one or more ACGME-accredited residency program(s).

PROCEDURE

1. In the event that a decision is reached to reduce the size of or close one or more ACGME-accredited programs, the Designated Institutional Official will be notified in writing as soon as possible.

2. Upon receiving such written notice, DIO will immediately notify affected program director(s) who will provide written notice of the Sponsoring Institution's decision as soon as possible.

3. The program director and DIO will jointly notify the appropriate accrediting board (e.g. ACGME RRC) and participating training sites when the SI intends to reduce the size of or close one or more ACGME-accredited programs.

4. The SI and affected program director(s) will work collaboratively to ensure that current residents in the program(s) are able to complete their education within the SRH program or assist trainees wishing to transfer into another ACGME-accredited program in which they may continue their education.

5. The SI and affected program director(s) will consider such issues as transfer of funding and board-specific requirements of trainees, and will make every attempt to phase out the program over a period of time to allow all residents/fellows currently in the program to complete their training. In all cases, SRH and the program(s) will fulfill the terms of appointment (e.g., stipend, benefits) as described in the Resident Position Appointment/Fellowship Position Appointment for the duration of the current academic year, if applicable.

6. The GMEC and DIO shall oversee all processes relating to reductions and closures of individual GME programs, at the SI and major participating sites.

Policy Title: Disasters

PURPOSE

The GMEC establishes this policy to protect the safety, well-being, and educational experience of our trainees in the event of a disaster or interruption in patient care.

DEFINITIONS

Disaster: An event or set of events causing significant alteration to the residency experience at one or more residency programs. When warranted, the ACGME Executive Director, with consultation of the ACGME Executive Committee and the Chair of the Institutional Review Committee, will make a **declaration of a disaster**.

Extreme Emergent Situation: A local event (such as a hospital-declared disaster for an epidemic) that affect resident education or the work environment but does not rise to the level of an ACGME-declared disaster as defined in the ACGME Policies and Procedures.

PROCESS

The following principles will guide specific planning:

1. Residents are, first and foremost, physicians, whether they are acting under normal circumstances or in extreme emergent situations. Residents must be expected to perform according to society's expectations of physicians as professionals and leaders in health care delivery, taking into account their degree of competence, their specialty training, and the context of the specific situation. Many residents at an advanced level of training may even be fully licensed, and, therefore, they may be able to provide patient care independent of supervision.

2. Residents are trainees. Residents should not be first-line responders without appropriate supervision given the clinical situation at hand and their level of training and competence. If a resident is working under a training certificate, s/he must work under supervision. Resident performance in extreme emergent situations should not exceed expectations for the scope of competence as judged by program directors and other supervisors. Residents should not be expected to perform beyond the limits of self-confidence in their own abilities. In addition, a resident must not be expected to perform in any situations outside of the scope of his/her individual license. Expectations for performance under extreme circumstances must be qualified by the scope of licensure. Decisions regarding a resident's involvement in local extreme emergent situations must take into account the following aspects of his/her multiple roles as a student, a physician, and an institutional employee:

- the nature of the health care and clinical work that a resident will be expected to deliver;
- the resident's level of post-graduate education specifically regarding specialty preparedness;
- resident safety, considering their level of post-graduate training, associated professional judgment capacity, and the nature of the disaster at hand;
- board certification eligibility during or after a prolonged extreme emergent situation; reasonable expectations for duration of engagement in the extreme emergent situation; and, e. self-limitations according to the resident's maturity to act under significant stress or even duress.

Educational Experience: If an adequate educational experience cannot be provided for each resident/fellow the sponsoring institution will:

1. Arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows.
2. Cooperate in and facilitate permanent transfers to other programs/institutions. Programs/institutions will make the keep/transfer decision expeditiously so as to maximize the likelihood that each resident will timely complete the resident year.
3. Inform each transferred resident of the minimum duration of his/her temporary transfer, and continue to keep each resident informed of the minimum duration. If and when a program decides that a temporary transfer will continue to and/or through the end of a residency year, it must so inform each such transferred resident.

Financial support: The Designated Institutional Official (DIO) will collaborate with leadership of appropriate funding institutions to identify ongoing arrangements for salary and benefits for displaced residents.

Communications: At the Institutional Level:
The program directors' (PDs) first point of contact for answers to questions regarding a local extreme emergent situation is the GME Office/DIO. The GME Office will provide guidance and information.

The DIO will contact the Executive Director, Institutional Review Committee (ED-IRC) via telephone only if an extreme emergent situation causes serious, extended disruption to resident assignments, educational infrastructure or clinical operations that might affect the Sponsoring Institution's or any of its programs' ability to conduct resident education in substantial compliance with ACGME Institutional, Common, and specialty-specific Program Requirements. On behalf of the Sponsoring Institution, the DIO will provide information to the ED-IRC regarding the extreme emergent situation and the status of the educational environment for its accredited programs resulting from the emergency.

Given the complexity of some events, the ED-IRC may request that the DIO submit a written description of the disruptions at the Institution and details regarding activities the Institution has undertaken in response. Additional updates to this information may be requested based on the duration of the event.

The DIO will receive electronic confirmation of this communication with the ED-IRC which will include copies to all EDs of Residency Review Committees (RRCs).

Upon receipt of this confirmation by the DIO, PDs may contact their respective EDs-RRCs if necessary to discuss any specialty-specific concerns regarding interruptions to resident education or effect on educational environment.

PDs will copy the DIO on communications (electronic and telephonic) with EDs-RRCs regarding any specialty-specific issues.

The DIO will notify the ED-IRC when the institutional extreme emergent situation has been resolved.

Communications: At the Resident Level:
Residents and Program Directors will contact each other regarding specific assignments. Residents may call or email the appropriate Review Committee Executive Director with information and/or requests for information.

Policy Title: Vendors

PURPOSE

Appropriate ethical behavior requires adherence to well-defined policies to guide interactions of Skagit Regional Health (SRH) faculty, trainees, and staff with those who provide goods and services necessary for us to carry out our professional duties. Furthermore, it is important for our relationships with our patients, students, and the public that we be free of conflicts of interest or perceptions of such conflicts. These policies are intended to instruct interactions of all members of the SRH community with employees of companies that promote and sell biomedical, scientific, or pharmaceutical products or services.

PROCEDURE

Personal Gifts:
Personal gifts of significant value (more than $50/year) must not be accepted from those who are promoting products for sale.

While the practice of free distribution of token promotional gratuities from suppliers to individuals is widespread and has been accepted for years, there is no good reason for a professional to participate in a company's promotional activities. Such activities may not influence behavior, but they create a perception of a biased relationship. We strongly discourage such practices.

Gifts include items of any sort and include meals, services, and entertainment that are not provided as part of appropriately sanctioned educational activities (e.g., scientific or educational meetings; see below).

Unsolicited gifts received by mail or courier should be donated to an appropriate agency, institution, or needy (unrelated) individual.

Individuals must consciously and actively divorce clinical care decisions from any perceived or actual benefits expected from any company.

Free medication samples may be accepted only for distribution to patients and should not be used by physicians or their staff for themselves or their family members.

Conferences/Meetings:
Only speakers, panel members, or moderators may accept compensation for attending a meeting, for any associated costs, or for subsidies to compensate for their time. "Audience" participants cannot accept payment or other incentives for attendance.

Individuals may accept modest meals or attend social events that are held as part of a conference or meeting.

Site Access:
Vendors may make an appointment to meet with faculty or staff in private offices or laboratories on a per-visit basis or as a standing appointment.

Vendors may not promote products in public areas, inpatient or outpatient care units, clinics, etc.

Vendors are specifically prohibited from directly contacting residents for the purpose of promoting professional products or for distributing materials of any type. This policy specifically prohibits the provision of free beverages or meals, tickets to entertainment and sporting events, or other types of social functions.

Vendors who desire to provide educational material to residents must contact the SRH GME Office. The Designated Institutional Official will review all material for the accuracy and appropriateness of the educational content and will then make decisions about the proper forum for making the information available to the trainees.

Provision of Scholarships and Other Educational Funds to Students and Trainees: Industry support of students and trainees through funding mechanisms such as scholarships, reimbursement of travel expenses, or other non-research funding in support of scholarship or training should be free of any actual or perceived conflict of interest, must be specifically for the purpose of education, and must comply with all of the following provisions:

- the department, center, program, or division selects the student or trainee.
- the funds are provided to the department, center, program, or division and not directly to student or trainee.
- the department, center, program, or division has determined that the funded conference or program has educational merit.
- the recipient is not subject to any implicit or explicit expectation of providing something in return for the support, i.e., a “quid pro quo.”

This provision does not apply to national or regional merit-based awards, which should be considered on a case-by-case basis.

Industry Support for Educational and Professional Programs on the Campus:
All educational events sponsored by industry on the campus must be fully compliant with ACCME guidelines, regardless of whether formal CME credit is awarded and approved by SRH Continuing Medical Education.

Educational events sponsored by industry on the campus should comply with the following provisions:

- Gifts of any type are not distributed to attendees or participants before, during, or after the meeting or lecture.
- Funds to pay for the specific educational activity are provided to the department, institution, program, or division and not to an individual faculty member.
- Meals or other types of food directly funded by vendors are prohibited.

Guidelines for Delivering Industry-Sponsored Lectures or Participating in Legitimate Conferences and Meetings off the SRH Campus:
Faculty should only participate in meetings sponsored directly by industry or by intermediate educational companies subsidized by industry if the activity meets all ACCME guidelines.

Faculty should not facilitate the participation of trainees in industry sponsored events that fail to comply with these standards.

All faculty and residents must be familiar with and comply with the provisions of the SRH policy entitled “Vendor Management” available in Lucidoc via the SRH Intranet.

Educational GME Funds for Residents and Graduate Celebrations

PURPOSE

To provide residents and programs reimbursement procedures for allowable expenses when resident utilizes educational funds and graduates are not able to attend SRH graduation celebration

ANNUAL BENEFIT

Benefits are outlined in individual resident appointment agreements and are determined by length of contract and program year.

REQUIREMENT FOR REIMBURSEMENT

Resident requests approval to purchase educational materials. *refer to generally approved items below or consult with your program director.*

Resident submits CEAR and proof of payment to residency coordinator for processing.

Acceptable proof of payments

- A copy of the front and back of the cancelled check (a copy of the front of a check is not proof of payment).
- A copy of the on-line payment receipt that includes actual date of payment.
- Lodging receipts need to reflect detailed daily charges rather than just a summary charge for the stay).
- Credit card statement detail with a copy of the invoice showing what the payment was for will suffice.

No expense older than 30 days, from the date the expense was paid (as verified per the date of the receipt) will be reimbursed.

For travel to workshops any person accompanying the resident must travel at their personal expense.

Expenses incurred prior to a resident's date of hire or after a graduation date are not eligible for reimbursement. Exceptions are made for Board Review and Board Testing Fee that are scheduled and paid prior to resident graduation date.

Categories of creditable continuing medical education activities (WAC 246-919-450):

a. Category I Continuing medical education activities with accredited sponsorship;
b. Category II Continuing medical education activities with non-accredited sponsorship
c. Category III Teaching of physicians or other allied health professionals (maximum of eighty hours);
d. Category IV Books, papers, publications, exhibits (maximum of eighty hours);
e. Category V Self-directed activities: Self-assessment, self-instruction, specialty board examination preparation, quality of care and/or utilization review (maximum of eighty hours)

Devices are not allowable expenses
Reference Skagit Regional Health CME/Professional Fees Policy

Graduate Celebrations

Graduates not able to attend a formal graduation celebration due to a force majeure event at the successful completion of their program will be awarded $125 monetary award, paid via payroll and subject to appropriate taxes withheld to celebrate completion of their program.

External Rotations

PURPOSE

To give residents guidelines for away rotations.

Definitions

Mandatory Away Rotations: Mandatory away rotations are core rotations within a program that is not available at Skagit Regional Health

Elective Away Rotations: Elective away rotations are rotations that a Program Director has approved and justified for a resident to supplement their training.

Policy

Mandatory away rotations: Rotation greater than 1 hour travel away from Mount Vernon will be offered SRH arranged housing. Housing for mandatory rotations will be within 1 hour travel time of rotation site. (I.B.5)

Mileage from a resident's home to housing or work site and home will be reimbursed per IRS SRH approved rate. Mileage from housing to site and home will not be paid. Residents who would like mileage reimbursement need to submit: Date of travel, mileage from – to their coordinator or GME. Mileage will be submitted through KRONOS by GME on the Friday prior to Payroll Thursday. Coordinators will verify schedules with dates travel.

Elective Away Rotations: Must be approved by Program Director, GME, Preceptor and Participating site. No housing or mileage will be reimbursed for elective away rotations.

Professional Appearance

PURPOSE

To provide guidance and expectation to Skagit Regional Health residents regarding professional appearance. A professional image communicates to patients and visitors that they will receive professional and compassionate care at SRH. It is important that residents understand appearance standards that are appropriate within our industry and project competence and credibility to patients, colleagues, and visitors. (taken from SRH professional appearance policy)

Policy

Skagit Regional Health Scrubs

Residents will be provided scrubs that will be laundered and are acceptable in the following areas and circumstances:

Operating Room
Family Birth Center
All other In Patient areas
When a resident's clothes has become soiled or concern of contamination

- When not in the OR and not performing a procedure, it is expected that all residents wear their white coat over their scrubs.
- Scrubs are to be worn only while at work/ in the hospital and are not to be worn home or taken home
- Scrubs are not to be worn in the outpatient clinics

Skagit Regional Health Logo Jackets

Residents will be provided 1 Skagit Regional Health logo jacket that will be home laundered.

Skagit Regional Health White Coats

Residents will be provided 3 white coats that will be laundered through Skagit Regional Health laundry services. Residents are to send their white coats to the laundry at least weekly. Special bins will be located in each locker room.

Programs, individual preceptors and departments may specify their expectations and requirements for their specific areas and rotations.

General Guidelines

Out Patient areas:

White Coat preferred with professional attire underneath (not scrubs) excluding program defined rotations or circumstances.

In Patient areas:

White coat with professional attire or scrubs underneath. SRH Logo Jackets can be worn under white coats.

Conferences and Events:

SRH Logo Wear ok with casual/ professional attire