THE MEDICAL CENTER AT BOWLING GREEN

RESIDENT POLICIES AND PROCEDURES MANUAL

A member of The Appalachian Osteopathic Postgraduate Training Institute Consortium (A-OPTIC)
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I. INTRODUCTION

The Medical Center is committed to its osteopathic residency programs and their success. We affirm that we will provide an excellent education for residents who come through the program. The residency program budget provides funding for program development and progression to include staffing, faculty development, resident salaries and educational benefits.

The Medical Center is committed to providing the funding and resources necessary to ensure the Osteopathic Internal Medicine Residency Program is a premier training program. As a member of the Appalachian Osteopathic Postdoctoral Training Institution Consortium (A-OPTIC), The Medical Center agrees to comply with the American Osteopathic Association (AOA) postdoctoral training requirements to include all elements of a competency based experience and program, faculty, and trainee outcome assessment.

The information contained in this manual is presented for the benefit of the residents of The Medical Center. The intent of this manual is to provide and to direct the resident to necessary information concerning the expectations, policies, procedures and practices of The Medical Center. The Medical Center reserves the right to revise, withdraw, suspend or discontinue its policies, procedures and practices at any time. This manual is not intended to and does not enlarge or create any additional rights of employment. It does, however, set forth and direct the resident to many matters that the resident is obligated to obey or observe.

In no way should this manual be considered as the only, or final, source of information regarding the policies, procedures and practices of The Medical Center. Residents are to refer to specific CHC employment policies, nursing policies, The Medical Center Medical Staff Bylaws and Rules and Regulations and separate Medical Staff Policies and Procedures for issues concerning employment or patient care, and are encouraged to contact the Graduate Medical Education Office for additional information or clarification on any such matters.

1.1. Description of Training Environment

Hospital Facilities

Bowling Green - Warren County Community Hospital d/b/a The Medical Center was originally founded as a city hospital in 1926. Prior to the dedication ceremony that August, a reporter with the Park City Daily News remarked that “in every detail the hospital will compare favorably with million dollar institutions. . . in being equipped to accommodate over one hundred patients. . . they can meet any demands that may be made locally.”

Nearly ninety years later, The Medical Center stands as the leading health care system in south central Kentucky. The Medical Center is a 337-bed, not-for-profit hospital located in Bowling Green, Kentucky with a medical staff comprised of 300+ physicians representing 45 different specialties. The Medical Center is a full service, regional referral center. Services include, but are not limited to, the following: General medical/surgical care, critical care, orthopedics, medical/radiation oncology, obstetrics, neonatology/perinatology, mental health, neurosciences, cardiothoracic surgery, bariatrics, hospitalist medicine, vascular surgery, and emergency medicine.

The Medical Center is accredited by The Joint Commission, including Disease Specific accreditation as a Primary Stroke Center (PSC). In addition, The Medical Center is an accredited Chest Pain Center with PCI (Cycle II) through the Society of Chest Pain Centers and operates a fully accredited Cancer Center through the American College of Surgeons.

The Medical Center’s service area is generally recognized as the 10-county Barren River Area Development District (BRADD). BRADD counties include: Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson, and Warren. This area represents a population of approximately 290,000 people.

The Medical Center admits more than 18,500 patients per year with an Average Daily Census (ADC) of 235 patients. Our Emergency Department cares for nearly 48,000 patients annually with an admission rate of 18-19%. The Medical Center’s surgical services functions with 17 operating rooms and generates a volume of approximately 13,500 cases per year, including almost 400 heart cases annually. The Medical Center maintains Warren County’s only obstetrical program, delivering more than 2,300 babies per year. Our hospital is the leader in cardiac care throughout south central Kentucky, operating a 3,600 volume Cath Lab with 9 interventional cardiologists and 3 electrophysiologists on staff.

Our health system employs 35 physicians representing the following specialties: Hospitalists, ENT, OB/GYN, Vascular, Cardiothoracic, Infectious Disease, Family Practice, Internal Medicine, Adult Psychiatry, Child/Adolescent Psychiatry, and Neurosurgery.
The Bowling Green – Warren County community is a progressive, vibrant community located in south central Kentucky. Bowling Green is the 3rd largest city in Kentucky (population 58,000) and features a large corporate base including Houchens Industries, Fruit of the Loom, and General Motors (Corvette). Bowling Green is also home to the Southern Kentucky Performing Arts Center as well as the Bowling Green Hot Rods (Triple A Baseball). Bowling Green is noted to have experienced the largest private sector job growth in Kentucky during the period 2001 through 2010.

Continuity of Care Facilities

The Medical Center will provide a clinic to ensure that each resident receives an adequate continuity of care experience with an appropriate panel size. The Medical Center will utilize the Commonwealth Health Free Clinic located at 740 East Tenth Street in Bowling Green, Kentucky, approximately 1 mile from The Medical Center’s hospital campus.

1.2. Changes in Policy

This manual supersedes all previous residency manuals and memos. While every effort is made to keep the contents of this document current, The Medical Center at Bowling Green at its option, may modify, delete, suspend or discontinue portions of this manual at any time without prior notice. It is the resident physician’s responsibility to obtain the most current version of this manual. A current copy of this manual is available in the Medical Center Medical Education Department and on The Medical Center website under the Graduate Medical Education tab. Any changes in this manual shall apply to existing as well as to future residents.
II. INSTITUTIONAL GME POLICIES AND PROCEDURES

2.1. Resident Recruitment, Eligibility, and Selection Policy

Each residency program shall select from eligible applicants. The Medical Center is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, age, national origin, disability, or any other applicable legally protected status. Recruitment and selection of residents is the responsibility of each program.

All medical trainees must meet the minimum selection criteria as described by the American Osteopathic Association (AOA) for the specialty.

All programs offering positions at the PGY-1 level must participate in the National Matching Service (NMS) and Electronic Residency Application Service (ERAS). In selecting residents for positions other than the PGY-1 level, programs may forego use of the NMS. All applicants must apply using ERAS.

In selecting residents for PGY-1 positions, the residency application process is as follows:

a. Interested osteopathic medical school students must apply through the National Match Service (NMS) via ERAS;
b. Applicants are considered for interview upon receipt of information requested on the NMS and available on ERAS, and with the following requirements:
   1. Graduate of a Commission on Osteopathic College Accreditation (COCA) accredited College of Osteopathic Medicine
   2. Three letters of professional reference;
   3. Letter from your medical school Dean stating you are a student in good standing;
   4. Successful completion of COMLEX-USA Level 1 and COMLEX-USA Level 2 CE & PE
   5. No minimum score
   6. Official medical school transcripts must be provided
c. The Graduate Medical Education Department or designee will contact applicants to arrange an appointment for an interview. The following are provided to each applicant: (1) Hotel and (2) Lunch during the day of interview
d. Interviews are scheduled between October 1 and mid-January of each year. Specific dates are set annually.
e. A max of 4 interviewees per day.
f. Resident applicants are interviewed by the Program Director, Director of Medical Education, Hospital Administrative Staff and the Program Coordinators;
g. Applicants are discussed at either the December or January Medical Education Committee meeting and either accepted or denied and a rank order list is generated;
h. The Medical Center completes the National Intern Registration Match within the appropriate timeframe, usually in January;
i. Results of the Match are returned, usually in February. Resident contracts are mailed out within the time allotted by the American Osteopathic Association (AOA)/NMS Match regulations.

2.2. Resident Contract

The Medical Center shall provide trainees with a fully executed annually renewable contract within ten (10) working days after receipt of the match results. The contract must be completed as outlined in the Match rules, and returned within thirty (30) days.

The resident contract shall outline the terms and conditions of their appointment and shall include or make reference to the following items:

a. Intern/resident/fellow responsibilities
b. Duration of appointment (annual)
c. Financial support
d. Conditions under which living quarters, meals, laundry are provided
e. Conditions for reappointment and promotion
f. Mutual release clause
g. Grievance and due process procedures
h. Professional liability insurance
i. Liability coverage for claims filed after program completion
j. Insurance benefits
k. Leave of absence policy
l. Sick leave policy
m. Policy on effects of leaves on satisfying criteria for program completion
n. Duty hour’s policies and procedures
o. Policy on moonlighting
p. Policy on other professional activities outside the program
q. Counseling, medical, psychological support services
r. Policy on physician impairment and substance abuse
s. Policy on sexual harassment
t. Policy closure of hospital/training programs or reduction in approved Resident positions

All residents new to The Medical Center are issued a conditional offer of employment. The offer is contingent upon the successful completion of an employee background check and pre-placement health assessment.

Contract requirements must be met in full. Violation of the contract by the trainee may result in the loss of credit for time served in the program. A trainee who breaches his or her contractual commitment prior to the start of training shall not serve in an AOA-approved program for a period of twelve (12) months following the date of the breach. A trainee who breaches the trainee contract during his/her training shall not serve in an AOA-approved internship or residency until the beginning of the following training year (effective July 1st).

All contracts are for one year and may be renewed at the discretion of the institution, upon continued evidence of satisfactory performance. A written statement of benefits will be attached to the contract when provided to the trainee. The fully executed contract shall be maintained in the individual trainee file.

2.3. Resident Promotion / Contract Renewal

Advancement to the next year of a residency program shall be based on evidence of satisfactory performance in the core competencies including demonstrated ability to assume graded and increasing responsibility for patient care. Satisfactory performance shall be determined based on the semi-annual reviews of each resident. Determination of promotion is the responsibility of the GMEC using data from evaluation instruments and the Program Director.

The following are prerequisites for promotion of the resident to the following year of training:

1. Complete all rotations with a passing grade as per rotation schedule.
2. Copies of all activity (didactic) summaries, case logs, monthly and concurrent summaries, evaluations, time logs are completed and turned in to the appropriate Program Director and/or the Graduate Medical Education Office.
3. Evaluations demonstrate an acceptable performance for residents at his/her academic level for advancement.
4. Successful completion of the COMLEX Step III exam prior to the start of the OGME II is strongly suggested. No contract for OGME III will be offered without proof of satisfactorily passing of the COMLEX Step III exam.
5. Evaluations demonstrate no disciplinary or professional behavioral problems.
6. Complies with didactic program per program requirements.
7. Resident is not under any formal disciplinary action which would prohibit advancement.
2.4. **Non-Renewal of Contract**

If at any time a Program Director determines that a resident is not meeting the standards of the program, he/she may recommend non-renewal of the resident’s contract.

The Program Director must submit the recommendation for non-renewal in writing to the Director of Medical Education and will include the basis on which the action is being taken. If the Director of Medical Education determines that there is sufficient reason not to renew the contract, he/she will notify the Program Director, who will so inform the resident in writing.

Programs shall provide their residents a written notice of intent not to renew a resident’s contract no later than four (4) months prior to the end of the resident’s current contract. If the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the contract or if a formal disciplinary action is enacted against the resident, the Program Director must ensure that the resident is provided with as much written notice of the intent not to renew as circumstances reasonably allow prior to the end of the contract.

Resident receiving notice of non-renewal of contract may implement his/her right to due process through the Resident Appeal Procedures, as presented in this manual.

2.5. **Program or Institutional Closure and Reduction Policy**

The Medical Center will immediately notify the AOA, its Osteopathic Postdoctoral Training Institution (OPTI) and its trainees of a program closure or any pending or anticipated reduction in positions impacting trainees prior to program completion. The institution will make every effort to allow residents already in the program to complete their education. If any trainees are displaced by the closure of a program or a reduction in the number of residents, the institution will make every effort to assist the residents in identifying a program in which they can continue their education. Severance pay shall be provided for two months if the Medical Center Residency Program closes or reduction decisions prevent residents from program completion in that or another geographically proximate program arranged by the Medical Center Residency Program and/or the OPTI.

2.6. **Non-competition Guarantee or Restrictive Covenants**

The Medical Center does not require any resident to sign a non-competition guarantee or restrictive covenant.

2.7. **Visa Policies & Procedures for Foreign/US Medical School Graduates**

The Medical Center will comply with the immigration laws of the United States, and all residents must obtain and maintain an immigration status that permits employment by the Hospital in a clinical capacity if applicable prior to the time their employment begins. The resident is responsible to acquire and maintain their own visa and provide evidence of same to the program. All offers of employment are contingent on verification of the candidate’s right to work in the United States. During the orientation process, every new associate will be asked to provide original documents verifying his or her right to work and, as required by federal law, to sign Federal Form I-9, and the Employment Eligibility Verification Form.

2.8. **Resident Transfers Policy**

The Graduate Medical Education Office must be notified prior to initiating the acceptance of a transferring resident. The transferring resident must sign an “Authorization of Release of Information” form before information is exchanged between institutions/programs.

Before accepting a resident who has prior GME training, the Program Director must obtain written or electronic verification of previous educational experience and a summative competency-based performance evaluation of the transferring resident including an assessment of competence in the following areas:

1. Osteopathic Philosophy, Principles and Manipulative Treatment
2. Medical Knowledge and Its Application Into Osteopathic Medical Practice
3. Osteopathic Patient Care
4. Interpersonal and Communication Skills in Osteopathic Medical Practice
5. Professionalism in Osteopathic Medical Practice
6. Osteopathic Medical Practice-Based Learning and Improvement
7. Systems-Based Osteopathic Medical Practice

The GMEC recommends that Program Directors make personal contact with the Program Director or other individual able to evaluate the resident’s performance.
III. EMPLOYMENT POLICIES

3.1. Equal Employment Opportunity/Diversity

CHC is an Equal Opportunity Employer, and the administration of its employment policies and practices will not discriminate against its employees or applicants for employment because of race, color, creed, sex, age, religion, national origin, disability, or any other factor protected by law except to the extent that the forgoing lawfully constitutes a bona fide occupational qualification.

It is the intent and desire of CHC that equal opportunity be provided, in employment, training, promotion, transfer, compensation, benefits, and all other privileges, terms and conditions of employment.

If employees believe that an employment or personnel decision regarding any issue described above was not made in accordance with the principle of equal employment opportunity and non-discrimination, they are encouraged to notify a supervisor or the Human Resources Department. Any issue brought to the attention of a management official or the Human Resources Department which may involve possible violation of this policy will be investigated by the Human Resources Department.

3.2. Employee Background Check

A comprehensive background check will occur for all new residents. The background verification may include but not be limited to the following; education and work history, criminal conviction history, professional licensure status, driver’s record and Medicare/Medicaid sanctions as a component of the selection process.

Employment will be conditional dependent on the results of this screening. Documentation related to the background check will become part of the resident’s program file. This information is maintained with strictest confidentiality.

3.3. Pre-Placement Health Assessment

Residents to whom a contract has been offered are required to complete the CHC Pre-Placement Health Assessment prior to their residency start date. Employment will be conditional dependent on the results of this screening. Residents may be required to submit to periodic medical tests when warranted by the hospital during employment.

The Pre-Placement Health Assessment includes but is not limited to the following components:

1. Health history documented on Pre-Placement Health Assessment form. This includes history of illnesses, diseases, injuries, medications, and any conditions, which are currently being treated.

2. Immunization history, to include review for completeness and status of immunity to, but not limited to the following: seasonal influenza, measles, mumps, rubella, tetanus/diphtheria, polio, varicella, and hepatitis B.

3. Evaluative Laboratory Tests:

   (1) Rubella titer and/or Rubeola IGG and/or Mumps IGG for those without documentation of immunization or immunity.

   (2) Individuals with negative titers to Rubella, Rubeola or mumps will have MMR administered according to CDC guidelines.

   (3) Varicella zoster IGG if no documentation of varicella zoster immunization or immunity. Employees with negative titers to varicella will have varicella vaccine administered according to CDC guidelines.

   (4) Hepatitis B titer if history of vaccine immunization in the past, but no documentation of a positive Hep B titer.

   (5) Interferon Gamma Release Assay (IGRA) testing may be used for Tuberculosis (TB) screening (in place of two-step TB skin test) if possible.

4. Two-step Mantoux (PPD) Tuberculin Skin Test - unless documented history of positive PPD or IGRA testing. For those with documented history of positive PPD a chest x-ray (unless individual is pregnant).

5. Pre-placement drug test, as specified in the Substance Abuse policy.

6. Pre-placement physical.
7. Pre-placement urinalysis.

Employee Health Services will schedule all appointments associated with Pre-Placement Health Assessments once resident contracts are executed. Documentation related to the pre-placement health assessment will become part of the resident’s program file. This information is maintained with strictest confidentiality. The resident will be informed of the results of the assessment.

3.4. TB Skin Testing

All residents are required to complete a TB skin test (PPD – Mantoux) each year on or prior to the date the TB skin test was completed the previous year. Employee Health Services will coordinate the TB skin testing and notification procedures.

3.5. Influenza Vaccine

Residents will be provided the flu vaccine on an annual basis. Residents must consent or decline the flu vaccine on an annual basis and will receive education on influenza virus and vaccine. In the event that a resident declines the flu vaccine, he/she must provide a declination statement identifying the reason for declining the vaccine.

3.6. Fragrance-Controlled Environment

CHC has adopted a Fragrance Free Environment policy in recognition that exposure to strong scents and fragrances can cause discomfort and directly impact the health of sensitive individuals. Residents working at any CHC clinical setting are not to wear perfumes, colognes, after shave products, or scented body sprays. Residents are to wear unscented lotions, powders, hair products and other personal products.

Residents who report to work out of compliance with this policy will be asked to remove the scent. Repeated incidences of non-compliance will be addressed by the resident’s Program Director.

3.7. Harassment Policy

CHC is committed to maintaining a work environment that is free from discrimination where employees at all levels of the organization are able to devote their full attention and best efforts to the job. Harassment, either intentional or unintentional, has no place in the work environment. Accordingly, CHC does not authorize and will not tolerate any form of harassment of or by any employee, physician, vendor or patient based on race, sex, religion, color, national origin, age, disability, or any other factor protected by law. The term “harassment” for all purposes includes, but is not limited to, offensive language, jokes, or other verbal, graphic or physical conduct relating to an employee’s race, sex, religion, color, national origin, age, disability, or other factor protected by law which would make the reasonable person experiencing such harassment uncomfortable in the work environment or which could interfere with the person’s job performance.

3.8. Sexual Harassment Policy

Sexual harassment includes: (a) physical assaults or physical conduct that is sexual in nature; (b) unwelcome sexual advances or comments or requests for sex or sexual activities concerning one's employment or advancement, regardless of whether they are accompanied by promises or threats; (c) sexual displays or publications such as calendars, cartoons or graffiti; (d) other verbal or physical conduct of a sexual nature which has the purpose or effect of interfering with an individual's work performance, or creating an intimidating, hostile, or offensive work environment; and (e) retaliation for complaints of harassment. CHC regards all such conduct as creating a hostile and offensive work environment in violation of this policy, regardless of whether submission to such conduct is made either explicitly or implicitly a term or condition of employment. Examples of sexual harassment include sexual propositions, sexual innuendo, sexually suggestive comments, sexually-oriented “kidding”, “teasing” or “practical jokes,” jokes about gender-specific traits, foul or obscene language or gestures, displays of foul or obscene printed or visual material, and physical contact, such as patting, pinching, or brushing against another's body; or reading or otherwise publicizing in the work environment materials that are sexually suggestive or revealing.
3.9. Expectations of Conduct

CHC is committed to promoting an exceptional work environment both supported and inspired by a system of values articulated in the corporation mission and values statements. CHC employees, contract personnel, students/interns, volunteer and Allied Health Professionals are expected to perform their job duties and conduct themselves in a manner that is consistent with CHC’s mission and values statements. Conduct or performance, which is not consistent with CHC’s mission and values, may result in performance counseling or other corrective action, and may result in separation of association with CHC.

Associates of CHC are responsible for conducting themselves in a manner that promotes respectful and courteous interactions, open and effective communication, and collaboration towards the attainment of common goals. Associates include CHC employees, volunteers, contract or affiliated personnel and medical staff.

Conduct Which Fails to Meet Expectations

The following conduct, which fails to meet the expectations of conduct for CHC employees and associates, will normally result in counseling for performance improvement. Performance counseling and corrective action are intended to provide employees and associates the opportunity to correct inappropriate behaviors and understand how they can meet the relevant expectations of conduct. However, repeated violations or patterns of inability or unwillingness to meet conduct expectations may result in separation of employment or termination of association with CHC. Nevertheless, CHC reserves the right to impose whatever corrective action, including separation from employment or termination of association it deems appropriate to the circumstances.

1. Discourteous treatment of patients, visitors, fellow employees, or other customers.
2. Violation, disregard, for CHC policies contained in the CHC Employee Handbook to include but not be limited to the following:
   • Attendance Policy
   • Distribution of Written Material and Solicitation Policy
   • Dress Code Policy
   • Fragrance Controlled Environment Policy
   • Personal Phone Calls, Personal Cell Phones, Personal Cameras, and Other Personal Electronic Devices Policy
   • Social Media and Network Policy
   • Tobacco Free Campus Policy
   • Workplace Harassment Policy
   • HIPAA Policies
   • CHC Code of Conduct
3. Inability or failure to maintain work standards.
4. Violation or disregard of any rules of safety.
5. Failure to wear gloves and/or altering gloves at any time when working with or exposed to body fluids.
6. Disregard for CHC property.
7. Violation, disregard or neglect of duty of a department policy or procedure.
8. Leaving assigned duty without notice or authorization.
9. Rowdiness or excessive noise while on the premises.
10. Use of the Employee’s title or CHC name to support political appointees or candidates for office.
11. Participation on premises in games/activities involving chance, with exchange of money or items of monetary value (Exception: CHC approved raffles).

Serious Failure to Meet Conduct Expectations

The following conduct represents a very serious failure to meet conduct expectations, and may result in immediate separation from employment or termination of association with CHC. Separation from employment or termination of association is not limited to the conduct shown below, as there may be other offenses for which CHC deems such action to be warranted.

1. Violation of the standards and guidelines of the CHC HIPAA policies by employees is a serious offense and constitutes cause for corrective action up to and including separation from employment. For other Associates, violation of the standards and guidelines described in the HIPAA policies is also a serious offense, and will result in appropriate corrective action up to and including dismissal. Additionally violations of a severe nature may result in notification to law enforcement officials as well as regulatory, accreditation and/or licensure organizations. Civil and criminal penalties may apply.
2. Unauthorized possession or removal of property belonging to CHC, a patient, a visitor or another Employee.
3. Destruction or abuse of CHC property and equipment.
4. Disclosure of confidential information, violation of patients’ right to privacy, or other material violation of the Confidentiality Policy.
5. Inability and/or unwillingness to properly record information, or material misrepresentation of information on employment records (including application), clocking transactions/time cards, patient charts or records and other official documents.
6. Concealing or misrepresenting material fact to supervisor or management or other associate.
7. Unauthorized possession of firearms, explosives, or weapons.
8. Abusive and/or foul language; language or behavior that conveys threat to personal safety; verbal or physical harassment.
9. Assault of another on premises.
10. Fighting on premises.
11. Sleeping while on duty.
12. Performing non-authorized activities during scheduled work time to include but not limited to such activities as reading personal books and other materials, doing homework, playing games, etc.
13. Disregard for or unnecessarily endangering the health and/or safety of a patient, guest, employee or medical staff.
14. Prohibited conduct as outlined in the Substance Abuse Policy, subject to provisions outlined in that policy; to include withholding of consent and failure to complete or document completion of rehabilitation as specified in the policy.
15. Conviction of any misdemeanor or felony that prohibits continued employment in the assigned position.
16. Inability or unwillingness to properly account for cash or other items of value.
17. Direct refusal to do work assigned; abandonment of assigned workstation and/or of patient.
18. Serious violations of the Workplace Harassment Policy.
19. Serious violation or disregard of the Code of Conduct Policy.
20. Serious violation or disregard to the Personal Phone Calls, Personal Cell Phones, Personal Cameras and Other Personal Electronic Devices Policy.
21. Serious violation or disregard to the Social Media and Network Policy.

3.10. Corporate Compliance

Corporate Compliance is a broad initiative at CHC, affecting every employee. We want to state publicly that we will follow all federal and state laws that govern the operation of our business. Additionally, we expect that our employees will make themselves familiar with the Corporation’s policies and procedures relating to ethical behavior in the workplace and to the performance of assigned duties.

Since action follows words, we have implemented a training and support program. Questions and concerns regarding compliance issues should be directed to the Director - Corporate Compliance at extension 1535. There is a compliance hotline telephone number, 1-800-826-6762, for reporting compliance concerns anonymously.

3.11. Change of Personal Data

It is the responsibility of each resident to report any changes in name, address, phone number, or email address to the Graduate Medical Education Office and to the Human Resources Department. Efficient distribution of W-2 forms, benefits information, and other important hospital mailings is dependent upon the data an associate has provided and timely submission of reimbursement items as well as end-of-year tax information.

3.12. Safety

The Medical Center strives to provide its associates, patients, and visitors with a safe and healthy environment. Should conditions or hazards be identified that pose an immediate threat to life, health or safety, the situation must be immediately and appropriately addressed and reported to the Safety Officer at extension 1654.
3.13.  CHC Information Security Policy

All residents must comply with the CHC Information Security Policy. Information security practices help us achieve our organization’s mission of caring for people and improving the quality of life in the communities we serve. The security, privacy, and integrity of information related to our patients, employees, and business partners is very important to us and we have to continue to do our best to protect this information. Securing our information helps us prevent breaches and penalties due to violation of the Health Insurance Portability and Accountability Act (HIPAA) and other applicable laws.

All healthcare providers, hospitals, nursing homes, clinics, pharmacies, and medical equipment dealers, and their Business Associates are covered entities and must comply with HIPAA. Our organization is mandated by the federal government to comply with HIPAA.

CHC confidential information includes: (1) electronic protected health information (EPHI) such as all medical record information, patient demographics; (2) personally identifiable information (PII) such as patient name, social security number, driver’s license number, and credit or debit card information; and (3) financial and proprietary information that should only be accessed by authorized personnel.

CHC Information and Technology assets include a wide range of information sources that our organization uses to access, process, and store information. Examples include desktop computers and laptops, personal digital devices (smart phones), fax and copy machines, data storage devices, printers and scanners, computer hard drives, telephones, emails, Data Network, and Biomedical Engineering equipment.

The CHC Information Security Policy is located in the S drive: S:\CHC Policies and Procedures\Compliance & HIPAA\Information Security\CHC Information Security Policy

The key responsibilities of CHC users are listed in Section 3.3 of the policy. For any questions or any further explanations about this policy contact the CHC Information Security Officer at ext. 5186.


The personal appearance of CHC employees and associates is important to the impression that our patients, their families and visitors and other CHC customers have about each of us and of CHC. CHC employees and associates will dress with taste and discretion and will present a clean, sanitary and well-groomed professional appearance which inspires confidence and trust and prevents the exposure of potentially resistant and serious infections.

Each resident must dress in a way that conveys a professional image to patients, visitors, and other staff members. Although different modes of dress are appropriate to different training specialties, each resident must maintain high standards of personal appearance and hygiene regardless of where he/she works.

Each resident will wear the official medical center identification badge. ID badges must be worn at all times while on duty and worn so that the photograph, name and job title is visible at all times. ID badge holders and lanyards worn by CHC employee and associates working in a clinical setting must be plastic or metal. I.D. badge lanyards and holders made of cloth or a cloth-like material are not permitted. ID badges must be worn so that the badge is above the individual’s waistline. Employees and associates cannot wear or use another individual’s ID badge.
IV. RESIDENT DISCIPLINARY ACTION AND GRIEVANCE PROCEDURES

4.1. Introduction

At any time during the Residency Training Program, the Residency Program Director, or Director of Medical Education may determine that the resident is not meeting the standards of the program or the profession. Most concerns should be managed initially with feedback including informal verbal counseling by the program director and faculty. Failure of the resident to appropriately remediate after such intervention or concerns that should not be addressed with informal verbal counseling alone must be managed with additional intervention. In those situations, one of the actions listed below (Written Reprimand/Remedial Program, Non-Promotion, Probation, Suspension, Dismissal or Non-renewal) is taken, depending on the nature and/or severity of the deficiency, actions, or conduct. In determining which level of intervention is appropriate, the program director should take into account the resident’s overall performance, including previous evaluations, results of any informal counseling, etc.

4.2. Written Reprimand/Remedial Program

Program Directors are encouraged to use a written reprimand as a preliminary measure to resolve minor instances of unsatisfactory performance or misconduct. A written reprimand may be issued by the Program Director for reasons that may include, but are not limited to:

1. A resident’s unsatisfactory performance or conduct is too serious to be dealt with by informal verbal counseling; and/or
2. A resident’s unsatisfactory performance or conduct continues and does not improve in response to verbal counseling.

Written reprimands must provide an explanation of the unsatisfactory performance or conduct with the expectation of improvement outlined and include a time frame in which the resident must meet these expectations. The time frame should not be greater than three months. Review of the written reprimand by the Director of Medical Education is required.

The Program Director or designee will review the reprimand with the resident which both must sign. A copy of the reprimand will be placed in the resident’s file. During or at the end of the reprimand period, the resident will meet with the Program Director or designee to determine whether the unsatisfactory performance or conduct has been corrected or whether further corrective action will be taken. If the resident fails to achieve and/or sustain improvement or a repetition of conduct occurs, then the Program Director may take additional action including Probation, Non-Promotion, Suspension, Non-Renewal of Appointment, or, Dismissal/Termination after consulting with the Director of Medical Education.

4.3. Formal Disciplinary Actions (Probation, Non-Promotion, Suspension, Non-Renewal of Appointment, Dismissal/Termination)

Formal disciplinary action may be taken for any appropriate reason, including but not limited to any of the following:

1. Failure to satisfy the academic or clinical requirements or standards of the training program expected for the level of training;
2. Any inadequacy or conduct which adversely bears on the individual’s performance, such as attitude, conduct, interpersonal or communication skills, or other misconduct;
3. Violations of professional responsibility, policies and procedures, state or federal law or any other applicable rules and regulations.

Probation

If a resident’s academic or clinical performance, attitude, behavior, or interpersonal or communication skills puts him/her in jeopardy of not successfully completing the requirements of the training program or other deficiencies exist with are not corrected by informal verbal counseling or written reprimand and remediation, or are of as serious nature such that informal verbal counseling or written reprimand and remediation are not appropriate, the resident shall be placed on Probation.

Probation should be used when the underlying deficiency requires a substantial change in resident oversight. Probation may include, but is not limited to, special requirements or alterations in scheduling a resident’s responsibilities, a reduction or limitation in clinical
responsibilities or enhanced supervision of the resident’s activities. This temporary modification of the resident’s participation in or responsibilities with the training program are designed to facilitate the resident’s accomplishment of program requirements. The resident will be informed in writing by the Program Director that he/she is being placed on Probation. Written notification should include explanation of the deficiencies, performance or conduct in competency-based language giving rise to the probation, remediation requirements, method of ongoing evaluation, a faculty advisor/supervisor for the probationary period, and the anticipated length of probation.

The length and conditions of the Probation must be determined by the Program Director after consultation with the Director of Medical Education. Probationary periods must be time-limited. All rotations during the probationary period must be within the sponsoring institution. Failure to meet the terms of probation may result in non-renewal of the resident’s contract or immediate dismissal from the training program.

If a resident is on probation, and the end of the resident’s probation period is within four months of the end of the contract year, the fact that the resident is on probation will serve notice that the resident contract may not be renewed or he/she may be dismissed from the program if the probation is not remediated successfully.

Residents may appeal being placed on probation using the Resident Appeal Procedures (Article 4.4).

**Non-Promotion of a Resident**

If a resident has not met the program standards sufficiently in his or her current training level, the program may make a decision not to promote a resident to the next level of training in lieu of dismissal from the program. Decisions regarding non-promotion of a resident must be determined by the Program Director after consultation with the Director of Medical Education. An official period of probation may or may not be indicated.

The resident should be notified of this decision in writing as soon as circumstances reasonably allow, and in most cases four months prior to the end of the contract year. Exceptions to this timeframe would include performance issues that arise within the final four months of the contract year. If a resident has received a written reprimand or is on probation, and the end of the resident’s remediation period is within four months of the end of the contract year, the fact that the resident is remediating will serve as notice that the resident may not be promoted.

The notice of non-promotion should outline the remediation steps to be accomplished prior to the resident’s advancement to the next level and provide an estimation of the amount of remediation time anticipated. As determined by the applicable accrediting body, the total training time in the program may be lengthened by the duration of remediation. The resident will be paid at his or her present level until he/she is advanced to the next level. If the resident does not successfully complete the remediation plan, the process regarding resident dismissal/termination will apply.

Residents may appeal non-promotions using the Resident Appeal Procedures (Article 4.4).

**Suspension**

In urgent circumstances, a resident may be administratively suspended from all or part of assigned responsibilities by his/her Program Director after consultation with the Director of Medical Education. Cause for suspension include but are not limited to failure to meet general or specific academic standards, failure to provide patient care in a manner consistent with expectations, potential impairment of the resident, potential misconduct by the resident, or failure to work in a collegial manner with other providers. A resident may also be suspended pending an investigation of an allegation of any of the above concerns.

A resident must be notified verbally and in writing as to the reason for the suspension. The program shall maintain documentation that the resident has received written notification and a copy of the notification must be sent to the Graduate Medical Education Office. Unless otherwise directed by the program director, a resident suspended from clinical services may not participate in other program activities. Suspension is generally with pay. Suspensions must be time-limited but can be renewed if appropriate. A suspension may be coupled with or followed by other disciplinary actions or conclude in the resident being reinstated.

**Automatic Suspension** – A suspension of a resident shall be imposed automatically if action by the Kentucky Board of Medical Licensure results in revocation or suspension of the resident’s license or temporary certificate. Such automatic suspension shall become effective immediately upon notice of action by the Kentucky Board of Medical Licensure. During the suspension, the resident will be on unpaid leave status and, in order to continue health benefits, will need to pay the premium directly since in the absence of a paycheck, deduction of that premium is not possible. If the license or temporary certificate is reinstated, the resident
Residents may appeal being placed on suspension using the Resident Appeal Procedures (Article 4.4).

Non-Renewal of Appointment

While residents are generally granted a renewal contract annually, Program Directors may determine that continuation in the program is not warranted because of deficiencies in academic progress or for other reasons. A prior period of probation or suspension is not required. A decision regarding reappointment must be reached by the Program Director no later than March 1 (unless the resident is on suspension or probation) of the year of the current appointment (for residents on a July 1 – June 30 contract year; no later than four months prior to the end of the current appointment).

The notice of non-renewal of contract must be approved by the Director of Medical Education. The notification will be made in writing to the resident with a copy to the resident’s program file. If the reason(s) for the non-renewal occur(s) within the four months prior to the end of the resident’s current contract, every effort will be made to ensure the program provides the resident with as much written notice of the intent not to renew as circumstances reasonably allow.

The resident may be offered the opportunity to conclude the remainder of the contract year or resign from the program. For those who continue, at his/her appointed level of training through the end of the contract period full credit for the year may be given to the resident at the discretion of the Program Director and guidelines of the accrediting body. If deficiencies in professional competence arise during continued training under a non-renewal status, the resident may be terminated or suspended immediately after consultation with the Director of Medical Education.

A decision of non-renewal of appointment may be appealed using the Resident Appeal Procedures (Article 4.4).

Dismissal/Termination

A resident may be dismissed from a program because of failure to remediate deficiencies during a probationary period; suspension or revocation of the resident’s license; conduct constituting criminal activity; gross and serious violation of expected standards of patient care; failure to abide by the Expectations of Conduct and/or other application regulations of The Medical Center, and or other facilities to which the resident may rotate or other responsibilities as specified by the program; or gross and serious failure to work in a collegial manner with other providers.

The decision to dismiss/terminate a resident from his/her program, must involve both the Program Director and the Director of Medical Education. Dismissal may, depending upon the situation, be immediate or follow a period of suspension and/or probation. Insofar as is possible, a resident should be notified in person and in writing about the dismissal decision. The notification must include the reason for the dismissal decision, the date of the dismissal, and method for appeal. Credit for training may be given in the event of any satisfactory performance prior to dismissal, per accrediting body guidelines.

A resident receiving notice of dismissal/termination may implement his/her right to due process through the Resident Appeal Procedures (Article 4.4).

4.4. Resident Appeal Procedures

A. Whenever an appealable formal disciplinary action (Probation, Non-Promotion, Suspension, Non-renewal of Appointment, and/or Dismissal/Termination) is imposed on a resident, the Program Director or Director of Medical Education shall provide written notification to the resident, either in person or by certified mail of the formal disciplinary action. Such notice shall contain a specific statement of the grounds for such action and shall refer to the resident’s right of appeal as set forth below.

B. To appeal a formal disciplinary action, the resident must submit, within ten (10) calendar days after receiving such notice, a written request either in person or by certified mail to the Director of Medical Education for a hearing before an Appeals Committee. No electronic requests will be accepted.
C. Upon receipt of a written request for a hearing, the Director of Medical Education shall appoint an Appeals Committee consisting of seven individuals, five of whom will have a vote. The Director of Medical Education will Chair the Committee. The voting members will include:

1. A resident member of the Graduate Medical Education Committee or a Chief Resident;
2. Two residency Program Directors and/or faculty members;
3. An Executive Vice President; and
4. A Medical Staff Member from a different Clinical Department than that of the resident requesting the Appeal Hearing and that of the two Program Directors serving on the Committee.

The non-voting members will be:
1. The Director of Medical Education; and
2. A resident, from another program if available, at a similar level of training as the resident who filed the appeal. The non-voting resident member may participate in all aspects of the deliberations prior to the vote.

D. The Director of Medical Education will appoint the Program Coordinator to serve as Secretary, who will keep minutes of the meeting. The Director of Medical Education, or his/her designee, will determine the date, time, and place of the meeting.

E. No later than ten (10) business days after receipt of the resident's request for a hearing, the Director of Medical Education or his/her designee, shall notify the resident by certified mail of the date, time, and place of the hearing.

F. The hearing shall be held no fewer than thirty (30) and no more than forty-five (45) business days after receipt of the resident’s request for a hearing. A hearing for a resident who is under suspension shall be held as soon as the arrangements may reasonably be made, but not later than thirty (30) calendar days from the date of receipt of the request for a hearing, unless extended by mutual consent.

G. From the date upon which the Director of Medical Education receives the resident's request for a hearing until the date of the hearing, the residency Program Director or Director of Medical Education, or his/her designee shall permit the resident, upon his/her request, to examine and duplicate any written materials that relate in any way to the suspension, termination, or corrective action. No later than ten (10) business days prior to the scheduled hearing date, the parties shall provide each other with a list of witnesses that each intends to call at the hearing. A maximum of 3 witnesses each may be called by the resident and by the Program Director to appear in person. An unlimited number of witnesses, however, may submit written testimonials for review by the Appeals Committee.

H. Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately.

I. None of the parties to the appeal shall be aided or represented at this hearing by an attorney.

J. At the hearing, both the residency Program Director and the resident may make opening statements. The residency Program Director shall then present his/her case supporting the formal disciplinary action. The resident shall then present his/her case opposing the formal disciplinary action. Both the residency Program Director or Director of Medical Education and the resident may make closing arguments.

K. At the hearing, both the residency Program Director and the resident may present written evidence, examine witnesses, and cross-examine witnesses. The Rules of Evidence that govern proceedings in a court of law shall not apply.

L. Within five (5) business days after the hearing, the Director of Medical Education, the Committee Chair, shall prepare and send to both the residency Program Director and the resident, by certified mail, a written decision which shall affirm, modify or reverse the resident's formal disciplinary action. This decision shall be by a majority vote of the Committee's members and shall be based solely upon the written and oral evidence presented by the residency Program Director and the resident at the hearing. The Director of Medical Education shall receive a copy of the written decision.

M. The decision of the Committee shall be final and binding upon both the residency Program Director and the resident.

N. A resident under formal disciplinary action, and who has instituted an appeal as provided herein, may resume clinical practice only if recommended in writing by the Appeals Committee.
4.5. Informal Dispute Resolution Process

Purpose
The Medical Center is committed to maintaining an open and fair method of resolving resident concerns and answering questions. To this end, all residents are encouraged to informally raise any questions or concerns they have about the terms or conditions of their employment. If informal methods are not satisfactory, the Informal Dispute Resolution Process makes a three-step process available to residents who have an issue.

Prohibition Against Retaliation
The Medical Center is committed to preventing any retaliation against persons who raise legitimate questions about the terms and conditions of their employment in good faith. Administrative staff at all levels are expected to take the time to answer questions, and work toward the resolution of workplace concerns.

Policy
All residents are encouraged to raise questions or concerns about their employment contract, academic programs and policies, departmental work rules, and unsafe or unhealthy work environments.

Residents should discuss these issues with their Supervising Attending Physician, Program Director whenever possible, and if possible, the Supervising Attending Physician should work with the resident to resolve the concerns. If the concerns cannot be resolved to the resident’s satisfaction by the resident’s Supervising Attending Physician or Program Director, this procedure provides for additional prompt review by the Director of Medical Education.

A resident may use the process outlined in this policy and procedure to raise concerns regarding written reprimands. A resident may not use the process outlined in this Informal Dispute Resolution Process, when formal disciplinary actions (Probation, Non-Promotion, Suspension, Non-Renewal of Appointment, and Dismissal/Termination) are initiated against the resident.

The procedures set forth in The Medical Center policies prohibiting employment discrimination should be used to make complaints about unlawful employment discrimination or harassment. This grievance policy is not intended to limit any rights residents may have under Federal or State laws prohibiting discrimination.

Procedure
The Resident Informal Dispute Resolution Process consists of the following:

Step 1: The resident is expected to start seeking answers to a question or resolving a concern by an informal discussion with his or her Supervising Attending Physician and/or Program Director whenever possible.

Step 2: If the question or concern cannot be resolved informally, the resident may file a request for an Informal Dispute Resolution Process and again discuss the question or concern with his or her Supervising Attending Physician within 7 calendar days of the first informal discussion. The resident should use the Resident Informal Dispute Resolution Process Form to file a request for a review under this process. The Supervising Attending Physician is expected to review the request and get back to the resident with a written answer or response within 14 calendar days.

It is recognized that in some cases a concern may involve a resident’s Supervising Attending Physician and the resident may be reluctant to discuss the situation with that person. If this is the case, a resident may request information or raise a concern with the Program Director by using the Resident Informal Dispute Resolution Form.

Step 3: If the resident is not satisfied with the response provided by the Supervising Attending Physician or Program Director or the Supervising Attending Physician or Program Director fails to provide an answer within 14 calendar days, the resident may forward his or her concern using the attached form to the Director of Medical Education. The resident must submit the resident Informal Dispute Resolution Form, along with the original grievance and the response thereto, to the Director of Medical Education within 7 calendar days from the date of the resident receipt of the Supervising Attending
Physician and/or Program Director’s response. It is the responsibility of the Director of Medical Education or designee to investigate the resident’s question or concern, discuss it with the resident, and provide a written response to the resident within 14 calendar days, which will be the final decision and resolution of the resident’s concern.

4.6. Complaints Filed with the AOA

A complainant may seek informal consultation, or may file a formal complaint, with the AOA Division of Postdoctoral Training regarding a program or institution concerning a violation of AOA approved standards.

The procedure for filing an official complaint begins with informal consultation. Each complainant must initially attempt to resolve any differences or problems with the specific program, base institution or OPTI through direct dealings. A complaint to the AOA should only be made after these attempts at resolution have been unsuccessful or where a trainee is concerned about retribution.

A formal complaint shall meet the following criteria:

(a) The complainant shall present information concerning an alleged violation of AOA-approved standards. The information shall be accurate and well documented with documentation where possible.
(b) The complainant shall document efforts to resolve the problem through appropriate program, base institution, or OPTI channels. Where such measures are not possible, the complainant shall state reasons.
(c) The complainant shall include information about any other actions initiated to resolve the problems.
(d) The complaint shall be presented in writing to the AOA Division of Postdoctoral Training and signed by the complainant. The complainant’s identity shall be held in confidence at all times.
V. RESIDENT IMPAIRMENT POLICY AND PROCEDURE

5.1. Impairment Policy Statement

The Medical Center committed to providing patients with quality care. The delivery of quality care can be compromised if a Resident is suffering from an impairment. Impairment may result from a physical or mental condition. When a resident is experiencing performance-related problems or engaging in suspicious behavior, impairment of suspected, the institution shall have the right to require the resident to undergo further evaluation.

5.2. Reporting Requirements and Investigation Procedure

1. It is the responsibility of the Medical Staff and of all residents who suspect that another resident may be impaired to report suspicious behavior to his/her attending physician and/or Program Director. Suspicious behavior is defined as any instance in which a resident, faculty member, hospital employee, patient or patient’s family, or other person suspects that a resident is impaired during the exercise of his/her professional duties. These incidents may include, but are not limited to perceived problems with judgment, behavior, speech, emotional outbursts, depression, alcohol odor or other evidence of impairment. The attending physician must immediately contact the Program Director and/or Director of Medical Education.

2. Upon receiving such a report, the Program Director and/or Director of Medical Education should immediately meet with the resident to ascertain if there is cause for concern.

3. The Program Director and Director of Medical Education shall make a reasonable effort to investigate and determine whether the suspicion is reasonable. If it is determined that the report has no foundation and that there are no performance concerns with respect to the resident, no further action will be taken. Documentation of this assessment should be recorded by the Program Director and placed in the resident’s file.

4. If the investigation produces evidence of possible impairment, the Director of Medical Education Program Director shall meet personally with the resident under investigation and shall inform the resident of the results of the review and discuss with the resident appropriate options for resolving the matter.

5. The Director of Medical Education, in his/her sole discretions, may:
   a) Refer the resident to the Kentucky Physician Health Foundation for evaluation, treatment, and ongoing after-care including regular meetings and compliance monitoring; and/or
   b) Require the resident to undertake a rehabilitation program as a condition of continued appointment; and/or
   c) Impose restrictions on appointment; and/or
   d) Immediately suspend the resident’s appointment until acceptance and completion of appropriate rehabilitation.

6. All notes, memoranda, reports, or other documents relative to the investigation shall be kept confidential by the Director of Medical Education and may not be disseminated except as required by statute, regulation, or order from a court of competent jurisdiction, or as may be required in any peer review proceeding instituted by the Medical Staff or the Board. All individuals involved in the investigation shall be subject to this confidentiality requirement.

5.3. Rehabilitation and Reinstatement

1. If rehabilitation is warranted, The Medical Center and Graduate Medical Education Department Leadership shall assist the resident in locating a suitable program. If the resident is suspended, reinstatement will not occur until the resident has successfully completed the rehabilitation program to the satisfaction of the Director of Medical Education.

2. Reinstatement shall be conditioned on the receipt and review by the Director of Medical Education of a report or other credible documentary evidence from the rehabilitation program which shall include (a) whether the resident is
3. The impaired resident shall be required to consent to the release of all necessary information from the rehabilitation program and from any and all primary care of specialty physicians who have provided care to the resident physician. Following successful completion of the rehabilitation program and all after-care programs, if any, the Director of Medical Education may unconditionally reinstate the resident physician or may impose such conditions as the Director of Medical Education deems necessary in his/her sole discretion, including but not limited to the following:

   a) The requirement that one or more resident physicians agree to assume responsibility for the care of the impaired resident’s patients, in the event that he or she is unable to care for them.
   b) Periodic reports from the impaired resident’s primary care or specialty physicians or after-care program providers.
   c) Monitoring by The Medical Center and Graduate Medical Education Department Leadership
   d) Submission to periodic substance abuse screening.

5.4. Kentucky Physicians Health Foundation

The Kentucky Physicians Health Foundation will provide assistance to professionals licensed by the Kentucky Board of Medical Licensure impacted by addictive disease and mental or emotional illness. The Foundation assists by providing confirmation of impairment issues, intervention, assessment, and directing acute and after-care treatment including regular meetings and compliance monitoring. In addition, the Foundation serves as an advocate for the recovering physician with the Kentucky Board of Medical Licensure and other appropriate agencies.

5.5. Refusal to Cooperate

If a resident who requires further treatment as determined by the Kentucky Physicians Health Foundation refuses to enroll or remain enrolled with the Foundation, the Director of Medical Education will be obligated to report the resident to the Kentucky Board of Medical Licensure. In addition, the resident may be suspended or terminated from the training program. The resident shall have the right to appeal the suspension and/or termination pursuant to the appeal procedures set forth in the Resident Appeal Procedures Section of this manual.
VI. GRADUATE MEDICAL EDUCATION POLICY AND PROCEDURES

6.1. General Guidelines

Residents will comply with all applicable state and federal statutes and regulations relating to provision of care to patients, all applicable standards of care, and all then current requirements of the Program’s policies and procedures manual and handbook. Residents will comply with all other then current policies, procedures, rules and regulations of Hospital.

All residents are expected to become familiar with The Medical Center rules and standards of conduct and are expected to follow these rules and standards faithfully. In addition all residents are expected to review and follow the Medical Staff Bylaws, Rules and Regulations of the Medical Staff, and all Medical Staff Policies and Procedures.

6.2. Trainee Duty Hours Policy

The Medical Center strives to meet institutional and program requirements of the American Osteopathic Association (AOA) to ensure that the learning objectives of its residency programs are not compromised by excessive reliance on Residents to fulfill service obligations.

Duty hours are defined as all clinical and academic activities related to the residency program including but not limited to: patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time done away from the training site.

1. Trainees shall not be assigned to work physically on duty in excess of 80 hours per week averaged over a 4-week period, inclusive of in-house night call and any allowed moonlighting. No exceptions to this policy shall be permitted.
2. The trainee shall not work in excess of 24 consecutive hours.
   a. Allowances for already initiated clinical care, transfer of care, educational debriefing and formal didactic activities may occur, but shall not exceed 4 additional hours and must be reported by the resident in writing with rationale to the DME/program director and reviewed by the MEC for monitoring individual residents and program. These allowances are not permitted for OGME-1 trainees.
   b. Trainees shall not assume responsibility for a new patient or any new clinical activity after working 24 hours.
3. The trainee shall have 48-hour periods off on alternate weeks, or at least one 24-hour period off each week and shall have no call responsibility during that time.
4. Upon conclusion of a 20-24 hour duty shift, trainees shall have a minimum of 12 hours off before being required to be one duty or on call again.
   a. Upon completing a duty period of at least 12 but less than 20 hours, a minimum period of 10 hours off must be provided.
5. All off-duty time must be totally free from clinical, on call and educational activity.
6. Rotations in which a trainee is assigned to Emergency Department duty shall ensure that trainees work no longer than 12 hours shifts with no more than 30 additional minutes allowed for transfer of care and shall be required to report in writing to the DME/program director for review by the MEC, only any time exceeding the 30 additional minutes, for monitoring individual trainees and program.
7. In cases where a trainee is engaged in patient responsibility which cannot be interrupted at the duty hour limits, additional coverage shall be assigned as soon as possible by the attending staff to relieve the trainee involved. Patient care responsibility is not precluded by the duty hours policy.
8. The trainee shall not be assigned to in-hospital call more often than every third night averaged over any consecutive four-week period. Home call is not subject to this policy, however it must satisfy the requirement for time off. Any time spent returning to the hospital must be included in the 80 hour maximum limit.
9. Comfortable sleep facilities will be provided to trainees too fatigued at shift conclusion to safely drive if requested.

Monitoring of Duty Hours

The Graduate Medical Education Office requires residents to log daily activities into New Innovations. Weekly resident hourly reports are run each Monday morning so all hourly logging activities should be completed prior to 7am each Monday morning. Hours above 80 are reported to the Director of Medical Education who will investigate each occurrence. Any week that is close to an 80 hour violation is to be reported by the resident immediately to the DME for immediate action.

Evidence of review of resident duty hours by the Graduate Medical Education Committee (GMEC) will occur at least quarterly.
The GMEC is committed to assuring that residents are able to report concerns regarding duty hours without retribution. Residents may report issues by:

1. Scheduling an appointment with the Program Coordinator.
2. Scheduling an appointment with the Director of Medical Education.
3. Contacting the resident representative of the Graduate Medical Education Committee who will supply a report to the GMEC.

### 6.3. Moonlighting

Moonlighting is defined as any professional clinical activity performed outside of an official residency/fellowship program. Moonlighting may only be conducted following written permission of the Program Director and DME and must not interfere with the resident’s didactic or clinical performance. A written request will be filed in the institution’s trainee file. If moonlighting is permitted for residents, hours shall be inclusive of the 80 hour per week maximum work limit and must be reported accurately and monitored by the GMEC. Failure to report and receive approval by the program may be grounds for terminating a resident’s contract.

1. It is understood that residents shall devote themselves conscientiously to the performance of his/her full-time professional efforts as defined by hospital policies, Graduate Medical Education Department policies/procedures and program specific requirements. Required program obligations take precedence over all moonlighting activities. Residents shall not engage in moonlighting activities unless:
   
   a. The resident completes the moonlighting request form. This form provides written notice of the nature, duration and affiliation of moonlighting activities. Completion and approval of the moonlighting request form by the resident’s Program Director and the Graduate Medical Education office must be received prior to engaging in any moonlighting activities; and
   
   b. The resident must have a Permanent Medical License to practice and agrees that moonlighting activities performed do not adversely reflect on the hospital’s reputation or functions; and
   
   c. The resident must be a United States citizen or have a permanent Visa. Individuals who have either a J-1 or H-1B Visa are not allowed by the ECFMG and Immigration and Naturalization Service to participate in any moonlighting activities; and
   
   d. The Resident must provide his/her Program Director and the Director of Medical Education proof of Professional Liability Insurance from the facility where moonlighting is being performed. This insurance must fully indemnify The Medical Center against any claim, damage, expense, or liability resulting from engaging in moonlighting activities; and
   
   e. It is further understood that engaging in moonlighting activities; the resident will not be covered by The Medical Center’s Professional Liability Insurance. Permission to engage in moonlighting activities is not to be construed as constituting acceptance or ratification by the Hospital of responsibility for the Resident’s conduct while engaging in such moonlighting activities.

2. PGY-1 trainees shall be prohibited from moonlighting.

3. Residents must remain in good academic standing at their training institution to be eligible for moonlighting privileges.

4. It is understood that residents performing moonlighting activities, in addition to their Hospital position, that creates a conflict of interest; or are performed during the same working hours, or results in impaired efficiency, absenteeism, tardiness; or performing such work for another employer without prior authorization will subject the resident involved to disciplinary action up to and including discharge.

5. Individual programs may have additional requirements. Residents need to consult with their individual Program Director for these additional requirements.
6.4.  On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when residents are required to be immediately available in the assigned institution.

1. All resident classes (PGY 1, 2, 3) must participate in call. While PGY 1’s are expected to take more call than senior residents, all residents within a class level (PGY) should take approximately the same number of call nights as the others in their respective class. No class or resident is exempt from call duties.

2. There must be an in-house senior resident (senior resident that has been evaluated by their PD as being able and ready to supervise the interns and medical students) at all times. This senior resident’s duty is to oversee all of the interns and medical students. The senior resident is in charge of the in-patient team which is under the authority of the in-patient attending.

3. The Chief Residents develop and administer all call schedules. Chief Residents must approve any change in resident call assignments.

4. Once the Chief Resident posts the call schedule, it is final. Any assigned call or shift becomes the assigned resident’s personal/professional obligation to fulfill it completely. If a resident wants to switch an assigned call, it is the resident’s responsibility to obtain alternative resident to cover and to notify his/her Chief Resident.

5. A resident may occasionally request to switch call assignments with another resident; however, the switch must be equal meaning that the other resident is of the resident level of training as you in order to switch, and it must be approved by the Chief Resident, Program Director and DME before the scheduled shift occurs. A switch must not create a violation of the Duty Hours Policy for the accepting resident.

6. Any missed scheduled shift/rotation will be referred to the Program Director and/or DME for review and possible disciplinary action. The resident missing the originally assigned shift will be assigned additional future call to make up for the missed shift(s).

7. It is recognized that emergencies can occur, but these should be extremely rare. When an emergency occurs that prevents a resident from working his/her assigned shift, the resident must contact the Chief Resident and Program Coordinator of their program. If these individuals are not available, the Program Director may be contacted. In addition, the resident must notify his/her attending physician as a professional courtesy prior to the scheduled shift.

8. Chief Residents must maintain an on-going emergency call list of residents to cover any unexpected emergency shift or call. The Chief will contact the next resident on the Emergency Call list and arrange coverage. Preference will be made by the Chief Resident to provide a makeup call coverage for the resident that works the emergency replacement shift or call.

6.5.  Unscheduled Absence

Absence from work for two (2) consecutive days without notifying your Program Director or the Graduate Medical Education Office will be considered a voluntary resignation. If your attending physician is taking time off, you are still considered on duty. You must notify the Graduate Medical Education Office of your attending physician’s absence and your availability for didactics and other activities of the program.

6.6.  Subpoenas, Claims, & Other Requests

Residents may periodically receive requests for information regarding a legal claim, or potential claim, involving a patient and the Hospital. Whenever a Resident receives such a request he/she should immediately contact the Department of Medical Education who will notify Risk Management. The resident is not to provide any written or verbal response to such a request without authorization. This will ensure compliance with the Hospital's procedures for release of information only to authorized persons. Residents may not witness wills, advanced directives, or other legal documents for patients. Requests for such assistance should be referred to the Case Manager or the Nursing Supervisor/Administrative Director in charge.

6.7.  Disputes between Residents & Medical Supervisors

The Medical Center adheres to the AMA Council of Ethical and Judicial Affairs, Ethical Opinion 9.055, which states, in part, “Residents should refuse to participate in patient care ordered by their superiors in cases in which the orders reflect serious errors in clinical or ethical judgment, or physical impairment, that could result in a threat of imminent harm to the patient or to others.”
In such a circumstance, the Resident may refuse to provide the care ordered by the supervisor, provided the omission will not threaten the patient’s immediate welfare. Residents should communicate their concerns, immediately, to the physician issuing the orders, and to the Program Director and Director of Medical Education. Residents who raise such a complaint will not be subject to retaliatory or punitive actions, if the complaint was made in good faith, in the interest of patient care.

The Director of Medical Education may take such action as he deems reasonable, in his sole discretion, to investigate and resolve the situation, subject to the rights and obligations of the parties as set forth in The Medical Center and Medical Staff Policies and Procedures.

6.8. Emergency Medical Treatment and Labor Act (EMTALA)

EMTALA is the federal “anti-dumping” law enacted by Congress in 1986 to assure that patients who come to hospitals for treatment of an emergency medical condition are not turned away or transferred to another facility, based on their ability to pay. It applies to any individual who is not a patient who presents to The Medical Center’s Emergency Department or property requesting or being deemed to need an examination or treatment for a medical condition, including active labor.

To be in compliance with EMTALA physicians must provide an appropriate medical screening examination to determine the presence or absence of an emergency medical condition. If an emergency medical condition is found, the individual’s medical condition must be stabilized within the capabilities of the staff and facilities available at the hospital, prior to discharge or transfer. Obstetric patients with contractions are considered unstable until delivery of baby and placenta. An unstable patient cannot be transferred unless the patient (or a person acting on his or her behalf) requests the transfer or the transferring physician certifies in writing that the medical benefits of the transfer outweigh the risks, and is in the best medical interest of the patient.

Physicians and hospitals found to be in violation of EMTALA may be sanctioned up to $50,000 per violation. For more information regarding EMTALA, please refer to The Medical Center Physicians’ Guide to EMTALA.

6.9. Revocation of Off-Duty Hours

In the case of delinquent medical records, or other incomplete work, the resident may be assigned extra call by the Program Director or Director of Medical Education pending the completion of work

6.10. Policy & Procedures

Residents are held responsible for reviewing and will be expected to conform to all hospital and residency program policies and procedures. All policies and procedures are located on the hospital’s internal website. Select policies and procedures will be reviewed during orientation.

The Director of Medical Education and Residency program directors will review and update manuals on an as needed basis. Updates to program manuals and policy and procedures changes will be communicated to residents via e-mail. Program Directors will ensure that a copy of the Residency Program Manual will be on file in the Graduate Medical Education Department.

Each resident will sign an acknowledgment attesting that they have reviewed the Resident Policies and Procedures Manual and their residency program manual. This acknowledgement will be maintained in each resident’s personnel file located in the Department of Medical Education.

6.11. Reporting of Patient Care Issues

Incident reports are completed for any happening out of the ordinary which results in a potential for or actual injury to a patient, visitor, or employee. Incident reports are also completed for damage to facility property or equipment. Employees, volunteers, and Medical Staff Members have an affirmative duty to report occurrences.

Residents should immediately notify their attending physician, Program Director, the Director of Medical Education, and/or the Graduate Medical Education Office of any incidents.
All incidents will be investigated as soon as possible by the Risk Management Department, the Department of Medical Education, and the Director of the Area in which the incident occurred.

6.12. Letters and Training Certificates of Completion

Upon satisfactory completion of post-graduate year 1, the institution shall issue a letter of completion to each trainee in the appropriate specialty, for licensing purposes, and with a copy to the OPTI.

Upon completion of a residency training program at The Medical Center, the institution and OPTI shall jointly award the resident a training completion certificate. The trainee completion certificate shall confirm the successful fulfillment of the program requirements and will include: the name of the base institution, the name of the OPTI, trainee name, program type, completion date of the program, signature of the program director, and signature of the DME.

The Hospital is justified in holding such a certificate back only if the Resident fails to complete the internship, residency, or fellowship program, including all required paperwork; or if the Resident’s performance has been such as to indicate that the Resident is not yet adequately prepared for the practice of osteopathic medicine. Under no circumstances will the hospital arbitrarily refuse to issue such a certificate for relatively minor reasons. In the event of illness necessitating the Resident’s withdrawal from training, the hospital may properly issue a certificate to include the period of training completed or arrange for additional training at a later date to complete the training.

6.13. Chain of Communication

When necessary the Director of Medical Education presides over all areas concerning Medical Education and is the final step in the resident chain of command. When issues/problems occur, the resident should contact his/her:

1. Chief Resident (if available)
2. Attending Physician
3. Residency Program Director
4. Director of Medical Education
VII. RESIDENT RESPONSIBILITIES

7.1. Resident Membership in AOA

All residents are required to be members of the AOA. The AOA does charge a fee for membership for residents. It is the resident’s responsibility to assume payment for keeping his/her AOA membership current. The resident must supply the Graduate Medical Education Department with a copy of their current AOA membership card. Failure to maintain membership will result in loss of credit for training.

7.2. Licensure

All trainees shall obtain the appropriate licensure from the Kentucky Board of Medical Licensure. It is the responsibility of the resident to obtain the appropriate licensure. An individual pursuing a residency in the State of Kentucky must be licensed by the Kentucky Board of Medical Licensure. Physicians in their first year of post graduate training (PGY1) are exempt from licensure pursuant to KRS 311.560, section 2(c). After completion of one year of training, a physician is required to obtain an Institutional Practice Limited License or a Residency Training License to practice in Kentucky.

An Institutional Practice Limited License (IP) is issued to a physician entering an accredited residency training program in Kentucky. This license limits medical practice to the parameters of a training program. This license is issued on an academic calendar year, July 1 to June 30, and renewable annually while in training. An applicant must have completed one year of accredited postgraduate training and Parts 1 and 2 of the USMLE or COMLEX. Please refer to 311.571.

A Residency Training License (R) is issued to a physician entering residency training in Kentucky. This license allows a physician to practice within the parameters of the training program, as well as moonlight at locations designated by the Program Director. This license allows a physician to apply for a DEA license. This license is issued on an academic year, July 1 to June 30, and is renewable annually while in training. An applicant must have completed one year of an accredited postgraduate training and all parts of the USMLE or COMLEX. Please refer to 311.571.

It is Kentucky Board of Medical Licensure policy that a physician who has completed two or more years of accredited training and passed all components of a Board approved licensing examination must apply for a Regular license.

A Regular License is issued to a physician who meets statutory and regulatory requirements for licensure. All graduates must complete two years of accredited postgraduate training. Successful completion of a Board approved licensing examination is also required for licensure. Please refer to 311.571, 201 KAR 9:021 and 201 KAR 9:031.

Permanent licensure can be initiated by contacting the Kentucky Board of Medicine (502-429-7150 ext. 222/223.) The Graduate Medical Education Office must be kept informed of any change in licensure status.

7.3. Drug Enforcement Agency (DEA) Numbers

Residents will be assigned a DEA number through The Medical Center which serves as authorization to write prescriptions while in training at the institution. This number can only be used in association with formal training program activities. The DEA cannot be used for unofficial and nonaffiliated purposes, including personal moonlighting. When a resident completes training at The Medical Center, the DEA number is no longer valid.

To obtain a permanent DEA number, contact the Drug Enforcement Administration in Washington D.C., at (202) 633-1000.

Prescribing Controlled Substances over the Telephone:

Under no circumstances should residents prescribe controlled substances over the telephone for any patient, unless the resident personally knows the patient as a result of providing medical treatment to him/her as part of the resident's training program. In addition, prior to prescribing any controlled substance over the telephone, the resident should first review the patient's medical record to verify any pharmacies, patients, or other individual's request for the prescription also use the guidelines for prescribing controlled drugs from House Bill 1. The appropriate response to a telephone request for controlled substances from anyone claiming to be the patient of a Medical Center attending physician is as follows:

1. Take the patient’s name, phone number, and attending physician’s name;
2. Call the attending physician with the information and let the attending physician instruct you on how to respond to the request.

The resident must keep a record of any and all patient calls, and see that these notes are placed in the patient’s medical record.

7.4. **Advanced Life Support Certifications (ACLS)**

All residents must be ACLS certified prior to arrival. The certification must be American Heart Association accredited. All residents must maintain his/her Advanced Cardiac Life Support (ACLS) certification throughout their residency program.

7.5. **Resident Attendance at Didactics**

Resident attendance at all didactic sessions is required. The Medical Center Residency Program maintains records of resident attendance at all didactic sessions. A minimum mean of 80% attendance to all didactic sessions is required. Residents must sign in for each didactic session. If a resident must be absent or arrives late, the resident may e-mail his/her program coordinator to explain the absence or tardiness. Absences may be excused, but may not always be, based on a review by the Program Coordinator and Program Director based on the circumstance of the absence. Excused absences are not counted against the resident’s attendance. Attendance is tracked by the residency program coordinator and placed in each quarterly resident evaluation. If a resident falls below the 80% attendance, the resident will be made aware of the deficiency by the program coordinator. If the resident fails to bring their attendance up to the 80% during the next quarter, he/she will be referred to the Graduate Medical Education Committee for possible disciplinary action.

7.6. **Resident Responsibility for Requests for Consults**

Residents requesting an inpatient or outpatient consultation should call the consulting physician, in addition to entering an electronic order for the inpatient consultation. A consultation order must include the specialty or specific physician, reason for the consult and whether the consultation is emergent or non-emergent. If the consult is non-emergent, the call may be made by the ordering resident at 7:00 a.m. the following morning. Nurse or ward/unit clerks are not be asked to make the call to the consultant, unless the resident cannot leave a critically ill patient.

7.7. **Medical Records**

Resident physicians will be held to the same level of responsibility as members of the Medical Staff in regard to medical record chart completion and documentation (Reference: Article X - Medical Records). Residents should be familiar with the Health Information Management (HIM) Suspension Procedure Policy. Any resident suspended for documentation deficiencies has until midnight on the day following suspension to complete the deficiencies. Failure to complete deficiencies by this time will result in the resident’s suspension without pay until the deficiencies are completed. Deficiencies that remain present each subsequent midnight result in continued suspension without pay for the following day regardless of the time of deficiency completion during that 24 hour period. Suspensions are deemed resolved through the Graduate Medical Education Office after notification of record completion by the HIM Department. Removal of suspensions occurs only during normal business hours that excludes nights and weekends. Repeated or prolonged deficiencies may result in additional disciplinary action as outlined in Article IV – Resident Disciplinary Action and Grievance Procedures.

7.8. **Specialty College Requirements**

Residents shall meet all specialty college requirements, including annual reports, in-service examinations, research requirements, etc. Program directors will review the results of the annual in-service examination with each resident. Documentation of the exam review will be placed in the resident’s program file.
7.9.  AOA Clinical Assessment Program (CAP)

All residents are expected to take part in the AOA’s online Clinical Assessment Program (CAP). Residents will choose one of the available AOA CAP disease state modules and enter the required number of their panel patients into the CAP program. It is expected that residents will do at least one module each year. Additional modules are encouraged.

7.10.  Resident Participation on Hospital Committees and in Continuous Quality Improvement

Residents are assigned to various Hospital Committees each year during their residency. The committee assignments are for one year duration. Residents may be assigned to new committees to gain more experience in hospital policy management.

Continuous quality improvement is required for all aspects of patient care at The Medical Center and is a central component of all physicians’ professional activities. In addition, it is required for all physicians to maintain their board certification. All first year residents and some senior residents will be assigned to one or more Continuous Quality Improvement projects. Second and Third year residents will be assigned to membership on one or more Hospital Committees. Residents on either a Continuous Quality Improvement project or hospital committee are expected to attend all Committee meetings unless they have urgent patient care. Residents are expected to be able to regularly report their Continuous Quality Improvement Project and/or Committee activities to the resident groups as a whole.
VIII. RESIDENT BENEFITS

8.1. Salary

| PGY 1 | $49,500 |
| PGY 2 | $51,000 |
| PGY 3 | $52,500 |

8.2. Payroll

Payroll Deductions

Some deductions from employee earnings are required by law. These are the employee’s Social Security Tax or F.I.C.A. (CHC contributes a matching amount), occupational tax, Kentucky State income tax, federal income tax, and any other applicable taxes. Employees may arrange to change his/her income withholding by specified amounts through completion of the appropriate forms in the Human Resources Department.

Employees may want to have other deductions made from their check such as other Commonwealth Health Corporation approved benefit programs. If employees are not sure if a payroll deduction can be made, contact the Human Resources Department.

Pay Periods and Pay Days

There are 26 pay periods in a year. Employees are paid every other Friday. All CHC payroll checks will be deposited into each employee's individual account. Employees have the option of using an existing account or opening a checking or transfer account.

Upon employment, employees should inform the Human Resources Department of his/her account number to ensure prompt deposit of his/her check.

Employees access to current and historical pay stub information through myHRaccess.

8.3. Paid Time Off (PTO)

All AOA-approved programs must offer a minimum of 10 business days (Monday through Friday) per contract year of vacation time and provide a maximum of 20 business days (Monday through Friday) per contract year of vacation, professional, sick, or other leave as granted by the DME, unless such leave is designated by federal, state, or union regulations. In such cases, federal, state and/or union regulations shall supersede these policies for each contract year of training.

The Medical Center provides residents with 20 days paid time off per contract year. No more than 20 business days per contract year of leave shall be granted for any purpose without extending the program.

The DME/program director has the authority to extend the trainee contract for a period of up to 3 months for leave, illness or remediation purposes without requesting approval for overlap of trainee numbers from the specialty college and/or PTRC. Any overlap in excess of 3 months shall require advance approval and be reported to the AOA Divisions of Postdoctoral Training, specialty college(s) and OPTI.

Before utilization of PTO, residents must obtain and complete the form entitled “Resident PTO Request” from the Department of Medical Education. The resident is to submit the completed form to his/her Program Director for approval. The form should then be forwarded to the Department of Medical Education for approval/disapproval by the Director of Medical Education.

In order for PTO to be approved, any and all duties or scheduled call times must be covered. If you are scheduled for a call shift during the time you would like to take PTO, you will be responsible for finding someone to switch call shifts with you. Remember that any call switch is not allowed until after it has been approved by the PD/DME.
The Medical Education Office will notify the resident of the status of the request.

Except in the case of emergencies, requests for PTO must be made two weeks prior to the date(s) desired or within 24 hours of returning from a sick day(s). Every effort will be made to accommodate last minute requests for job/residency interviews. You may not take more than one week vacation at a time.

8.4. Family and Medical Leave of Absence (FMLA)

Residents are eligible for Family and Medical Leave of Absence (FMLA) under hospital policy. Residents may be eligible for FMLA once they have worked at least one (1) year and have performed at least 1,250 hours of service in the previous twelve month period immediately preceding the date a requested leave is to commence. Residents may take up to twelve (12) weeks of paid/unpaid leave in a rolling twelve (12) month period for any or all of the following reasons:

a) Leave taken for the birth of a child or the placement of a child with the employee for adoption or foster care;
b) Leave taken to care for a spouse, parent or child with a serious health condition;
c) Leave taken due to an employee’s own serious health condition.

Military Family Leave

a) Injured Service Member Leave: A special FMLA leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period.
b) Qualifying Exigency Leave: Eligible employees with a covered military member serving in the National Guard and Reserves and the Regular Armed Forces may use their FMLA entitlement for “any qualifying exigency” arising out of the fact that a covered military member (spouse, child or parent) is called to covered active duty status is support of a contingency operation and requires deployment to a foreign country.
c) Parental Care Leave Qualifying Exigency Leave: Eligible employees may take leave to care for a military member’s parent who is incapable of self-care when the care is necessitated by the member’s covered active duty.

For additional information concerning FMLA benefits, contact the Graduate Medical Education Office or the Human Resources Department.

8.5. Bereavement Leave

Paid bereavement leave up to three (3) days may be granted for scheduled work absences related to the death of an immediate family member. Immediate family member is defined as parent (including stepparent), sister, brother, spouse, child (including stepchild), mother-in-law, father-in-law, daughter-in-law, son-in-law, grandparent, grandchild and great grandparent.

Residents must immediately notify their Program Director and the Graduate Medical Education Office of the need for bereavement/funeral leave.

Additional time off, whether paid or unpaid, must be arranged through your Program Director and the Director of Medical Education is based on the ability of your department to staff adequately during your absence.

8.6. Jury Duty

If you receive a notice that you are to report for jury duty, notify your Program Director and the Department of Medical Education immediately so coverage can be arranged for you. The Medical Center will pay you your regular salary for the length of time connected with either the selection process or jury duty. Upon returning to work, written proof of your jury duty must be submitted to your Program Director and the Department of Medical Education in order to be reimbursed.
8.7. Medical Plan

Residents may choose from a selection of medical plan options. This allows you the flexibility to select the benefits that best meet your individual/family needs. As a medical plan participant, you are automatically enrolled to receive prescription benefits. The specifics of the health insurance benefit programs are subject to change. For this reason, benefit overviews are available by contacting The Human Resources Department at (270) 745-1540.

On termination of your contract with The Medical Center, you may arrange for continued coverage under the Consolidated Omnibus Budgeted Reconciliation Act, which guarantees an associate the right to uninterrupted coverage by his/her employer’s medical insurance for up to 18 months after termination. Regular coverage ends on the last day of the month in which employment ends. If you elect to continue coverage, you must pay the entire cost. Information on COBRA is available through the Human Resources Department.

8.8. Dental and Vision Plans

Dental coverage is available for purchase for you and your dependents. This plan utilizes the Health Resources, Inc. (HRI) Dental Network. Coverage begins the first day of the month following the 60-day waiting period. On-Line enrollment must be completed within 31 days in a benefit eligible status. Plan premiums are a deducted on a pre-ta basis. For enrollment questions contact the Human Resources Department at (270) 745-1540.

Vision coverage is available for purchase for you and your dependents through Human Vision. Coverage begins the first day of the month following the 60-day waiting period. On-Line enrollment must be completed within 31 days in a benefit eligible status. Plan premiums are a deducted on a pre-ta basis. For enrollment questions contact the Human Resources Department at (270) 745-1540.

8.9. Life Insurance

The hospital provides at no charge two times your base annual salary rounded to the next highest multiple of $1,000 in life insurance up to a maximum of $600,000. This includes an Accidental Death and Dismemberment Benefit at no charge.

Additional voluntary term life insurance protection up to $150,000 for you and your eligible dependents is available. Proof of insurability is not required when initially eligible for the benefit. An Accidental Death and Dismemberment Benefit is included. Coverage amounts are available in increments of $10,000 to $150,000. Dependent coverage for your spouse and children is also available.

Coverage begins the first day of the month following the 60-day waiting period. On-Line enrollment must be completed within 31 days in a benefit eligible status and must be approved by the insurance company. Coverage is paid in full by you and varies from person to person. The monthly cost per $1,000 is based upon age as of the date your benefit goes into effect.

For more information, contact the Human Resources Department at (270) 745-1540.

8.10. Long Term Disability

You may receive a portion of your salary for total disability. There is a 180 day elimination period. The plan pays up to 60% of your salary up to a maximum monthly benefit of $15,000. The taxation of the LTD premium is 100% employee paid on an after-tax basis. Therefore the benefit, when received, will not be taxable income. Coverage begins after 30 days employment in an eligible status. The premium is paid by CHC.

8.11. Flexible Spending Accounts

This plan has two primary parts: (1) Pre-tax deductions for Child/Dependent Care Expenses and (2) Pre-tax deductions for Health Care Expenses. Deductions begin the first day of the month following the 60-day waiting period. On-Line enrollment must be completed within 31 days in a benefit eligible status. You are able to designate the amount of money that you wish to have placed in the flexible spending account up to the legal limit. Note: IRS rules require that any money left in your account at the end of the plan year be forfeited.
8.12. **Retirement Savings Plan (RSP)**

Offered is a defined contribution plan in which you may contribute a percentage of your annual compensation on a pretax basis up to the IRS annual maximum contribution amount. CHC will match on a pretax basis up to 50 percent of the first six percent of your contributions. There is also an annual CHC Service Based Contribution made by CHC based on your years of service. You are vested in the CHC portion after 3 years of service. You will automatically be enrolled at a 3 percent contribution effective the first of the month after 90 days of service in an eligible status. You may change your contribution rate to a percentage of your annual compensation ranging from one percent to 100 percent up to the IRS maximum contribution amount. For questions, contact the Human Resources Department at (270) 745-1540.

8.13. **Employee Health Services**

Employee Health Services provides CHC employees the ability to see a Nurse Practitioner at no cost for limited acute-type conditions.

8.14. **Employee Assistance Program**

You and your dependents may receive confidential professional help with personal problems. The employee assistance program is available immediately upon employment. There is no cost to you for the first six sessions of each incident.

8.15. **Relocation Expense Reimbursement**

The Medical Center will reimburse incoming residents up to $1,000 for relocation/moving expenses.

8.16. **Malpractice Insurance**

Residents acting within the scope of his/her residency training program are provided coverage under the CHC Self-Insured Trust. Residents participating in activities outside the scope of their residency training program will not be covered under the hospital’s malpractice coverage. Activities outside the scope of residency training are strictly prohibited unless prior approval is obtained from the Program Director and the Director of Medical Education. Participation in activities outside the residency training program without the expressed written consent of the Program Director and Director of Medical Education are grounds for immediate dismissal.

8.17. **Medical Education Stipend**

On an annual basis, The Medical Center allocates each resident $1,500 to assist with the funding of expenses directly related to or required by their residency program during the course of their training. The monies may be used to purchase books, authorized DVDs, professional journals, professional association memberships, medical equipment (necessary for the residency program), hand-held tablets, review courses, and educational conferences (authorized by resident’s Program Director).

1. The annual allotment to each resident will cover the time period of the academic year or contract year and cannot be carried over. If a resident contract is extended due to a leave of absence, no additional monies will be allocated.
2. All expenses must be submitted on the designated reimbursement form to the Medical Education Department. The expenses must be preauthorized by the Program Director or DME. The form can be obtained by contacting the Medical Education Office.
3. All expenses incurred during the academic or contract year must be submitted to the Medical Education Department within 30 calendar days following the end of the academic or contract year, whichever occurs later. Any request received after the 30 calendar days will be denied.
4. All expenditures must be itemized. All original itemized receipts must be submitted.
5. The expense reimbursement form must be completed, dated, and signed by the resident, and where applicable, co-signed by the Program Director. Incomplete, inaccurate or illegible forms will not be accepted. The forms must be submitted to the Medical Education Department.
6. Reimbursed amounts that meet CHC’s Employee Business Expense Reimbursement Policy and IRS guidelines will be offset against the $1,500 allocation each academic/contract year.

7. IRS guidelines state that a computer is not allowed as an educational expense.

8. Hand-held tablets may be reimbursed. All requests must be accompanied by a letter from the Program Director stating specifically what educational needs will be met by the use of the device. Reimbursement will be limited to $500 towards the purchase of the device only and is limited to one device per resident for the duration of training at The Medical Center. Reimbursement requests from first-year residents that are not continuing on to a Medical Center residency program will be reviewed on a case-by-case basis.

9. Reimbursement for fees, items, devices, services, equipment, exams, licenses, etc. not directly related to your program is not allowed. The following is a list of items that are considered non-reimbursable (not to be considered all-inclusive):
   a) Laptop and/or desktop computers
   b) Post residency/fellowship licensing fees
   c) Extended warranties, carrying cases, accessories
   d) Apparel or shoes
   e) Mileage reimbursement for travel to/from local rotations

10. Reimbursement for personal expenses not directly related to the reimbursable educational course/item is not allowed. Any expenses incurred before or after the conference dates will not be reimbursed.

11. All expenses incurred by an accompanying spouse/child(ren)/significant other will not be reimbursed.

12. Travel by personal automobile to a conference will be reimbursed based on the prevailing IRS standard mileage rate. Verification of conference attendance, showing location and dates must be submitted for mileage reimbursement.

13. Rental car reimbursement is allowed only if a car is needed to travel from separate lodging to the conference site and local transportation costs prove to be less economical than a rental car. Expenses for a rental car beyond a standard size car will be not reimbursed.

14. Hotel expenses must accompany verification of conference/seminar attendance, showing location and dates. The itemized hotel bill, showing a zero-balance must be submitted for reimbursement.

15. Reimbursement for all meals while traveling is a maximum of $50.00 per day. An itemized receipt of the meal and proof of payment must be submitted.

16. Reimbursement for alcoholic beverages is not allowed.

17. Airfare expenses must accompany verification of conference attendance, showing location and dates. Business class or First Class airfare will not be reimbursed.

18. If a contract is canceled, the resident will not be eligible for reimbursement after the contract termination date. The resident may still submit for expense reimbursement up to the annual $1,500 amount for educational expenses incurred prior to the contract termination date. Any requests received after the 30 calendar days will be denied.

8.18. Resident Professional Exam Costs

The Residency Program will pay for (not from your CME funds) the resident to take the COMLEX III exam either the OGME 1 or 2 year. Residents must have passed the COMLEX III exam prior to OGME 3 contracts being offered. One paid day off to take the exam is provided. No other exam associated costs will be covered by the program.

One additional paid day to take your Board Certification exam near the end of your OGME 3 will also be provided. The resident is responsible for the overall cost of the Board Examination. (This paid day is included in PTO hours)

8.19. Additional Benefits

**Lab Coats and Uniforms:** The Medical Center will furnish each resident with two white lab coats per year. It is recommended white coats be laundered daily in a bleach containing wash. It is also recommended white coats be hung outside of the patient area before doing an examination or providing patient care. It is the responsibility of the resident to see that they have clean, professional coats at all times. Residents requiring scrubs must consult their individual training departments for instructions on obtaining them.

**Meals:** Meals are provided to Resident Physicians free of charge in the Cafeteria, Physician’s Lounge, and in the Resident’s Lounge while on duty at the hospital. Food is not provided for resident family members; it is not to be taken home; and should only be the amount for a healthy single meal. A limited selection of sandwiches, snacks, salads and beverages are available during evening hours and weekends in the Physician’s Lounge and Resident Lounge.

Residents are responsible for their own meals while at other institutions.
The Medical Center at Bowling Green offers many on-site conveniences. They include:

The Medical Center Cafeteria

Monday through Friday
Breakfast 6:30 a.m. to 10:00 a.m.
Lunch 11:00 a.m. to 3:30 p.m.
Dinner 4:30 p.m. to 7:00 p.m.

Saturday and Sunday
Breakfast 6:30 a.m. to 10:00 a.m.
Lunch 11:00 a.m. to 2:00 p.m.

Subway
Monday through Friday Hours: 7:00 a.m. to 10:00 p.m.
Saturday Hours: 8:00 a.m. to 10:00 p.m.
Sunday: Hours: 9:00 a.m. to 10:00 p.m.

Vending Machines
Vending machines are available and open 24 hours per day throughout the facility. Items available for purchases are snacks, and beverages.

Parking: Parking is available free of charge to all residents. Residents will park in a designated lot.

Holidays: Holidays are granted and scheduled at the discretion of the Medical Education Department. The hospital recognizes the following holidays: New Year’s Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day.
IX. EVALUATIONS

All components of a trainee’s program must be evaluated. This evaluation must be related to the educational objectives of the program and shall include clinical experiences, intellectual abilities and skills, attitudes and interpersonal relationships and progress in core competency achievement.

All components of the resident’s program will be evaluated and meet the guidelines set forth by the AOA. The evaluation instrument utilized will be the form developed by New Innovations. This evaluation instrument encompasses the seven (7) Core Competencies. It will be sent out on a monthly basis at the completion of your rotations. The faculty will be expected to return the form within 10 days following completion of each rotation.

9.1. Evaluation of Trainees

1. At the completion of each rotation the appropriate faculty member shall evaluate the trainee. The evaluation shall be signed by the assigned faculty member and the trainee; reviewed by the Program Director and DME, and maintained on file in the Graduate Medical Education office. Evaluations must be returned to the Graduate Medical Education office within 10 days following the completion of the rotation end date.

2. The DME and the Graduate Medical Education Committee shall verify the satisfactory performance of every intern on a quarterly basis and all other trainees semiannually to ensure that educational objectives are being met.

3. The Program Director shall review trainee performance at least quarterly with each intern and semiannually with each resident unless required more frequently by the specialty affiliate. This must be documented in writing with performance assessment, recommendations, and acknowledgement by signature of trainee.

4. Prior to early termination of a contract, the institution shall provide the trainee with appropriate written warning and counseling. The assigned faculty member is responsible for documenting deficiencies and attempting to resolve concerns with the trainees, including potential remediation for deficiencies.

5. In cases of early termination of a contract, the DME/program director shall provide the trainee with documentation regarding which rotations, if any, were completed satisfactorily. In cases of early termination or unsatisfactory completion of a contract, the AOA Postdoctoral Division and/or specialty college and OPTI must be promptly notified and the terminated contract submitted to AOA.

6. If the trainee transfers into another training program of the same specialty, the receiving Program Director as the authority to determine which, if any, satisfactorily completed rotations from previous AOA-approved program(s) will be accepted. Additionally, the transfer shall be in accordance with the respective specialty college’s basic standards and approval.

7. At the completion of each residency training year, the Program Director must complete the AOA Program Director’s Annual Evaluation Report (CCCP Part 3) to be attached to any specialty-specific reports unless the specialty specific form has been approved by COPT in lieu of the AOA form. Copies must be maintained in the resident’s file.

8. At the completion of each residency training program, the Program Director must complete the AOA Program Complete Summary – Final Resident Assessment (CCCP Part 3) unless the specialty specific form has been approved by COPT in lieu of the AOA form. Copies must be maintained in the resident’s file and forwarded to the OPTI.

9.2. Evaluation of Training Programs and Faculty

While the training program contains an important patient service component, it must be primarily an educational experience. This educational mission must not be compromised by an excessive reliance on trainees to fulfill institutional service obligations. To monitor this educational process, provision should be made for various levels of program evaluation. The results of these evaluations should be used to continually improve the program.

1. At the completion of each rotation, each trainee shall evaluate the educational experience and the faculty. These evaluations shall be reviewed by the Program Director and maintained on file by the Program Director/DME. Evidence of evaluations and their review must be available during on-site review. Evaluations must be returned to the Graduate Medical Education office within 10 days following the end of the rotation.

2. The Program Director shall review each rotation evaluation monthly. The program director shall determine the amount of work being required of the trainees to ensure that they are not overburdened with routine responsibilities and that they have the
opportunity to observe a sufficient variety of cases and to achieve all educational goals and objectives. These evaluations shall be reviewed with the appropriate individuals or departments.

3. The Graduate Medical Education Committee shall evaluate the intern training program quarterly. When necessary, the committee shall approve affiliations within the scope of AOA policies and procedures and evaluations must be available during program on-site review.

9.3. Resident Credentialing for Procedures

Competency in performing clinical procedures is an important part of our program curricula. Program curriculum is listed in each respective program’s curriculum chapter. Competency is defined by the resident performing five (5) procedures with a faculty attestation to the resident’s procedural competency recorded in New Innovations for each procedure. The attesting faculty must be privileged by The Medical Center in the procedure. (Please consult The Medical Center’s internal shared drive folder titled Physician Information for a list of privileged procedures by Medical Staff member.)

Note: A senior resident who has performed at least 10 (ten) of any one procedure may attest to the trainee’s procedure, as long as their attending physician is aware of the senior resident’s oversight of the other resident. The attending physician remains responsible for the procedure being done, and must signoff in New Innovations.

A pocket card is provided to the resident to record procedures, dates, attending, etc., at the time of the procedure. It is provided to each resident by the resident coordinators. The information on these cards must then be entered into the New Innovations Procedure log page. New Innovations will automatically contact the attending for approval and comment.

A list of residents with their individual privileged procedures will be accessible through the New Innovations website.
X. MEDICAL RECORDS

1. All Records: All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. (CMS 482.24 (c)(1) A-0450).

2. Physician Orders: All orders for treatment shall be documented. A licensed nurse, licensed pharmacist, certified or registered respiratory therapist, licensed physical therapist, registered dietician or certified radiology technician may accept a verbal or telephone order. Orders given over the telephone shall be signed by the person to whom dictated with the name of the physician indicated. A physician must sign such orders as soon as possible. CMS requires that all records be completed within 30 days.

A. Standing Orders and Protocols
   1. Standing orders and protocols shall be signed, dated, and timed by the ordering physician or another practitioner responsible for the patient’s care as soon as possible. CMS requires that all records be completed within thirty (30) days of the patient’s discharge or registration either electronically or handwritten with date and time.
   2. Standing orders and protocols shall be reviewed by the hospital’s nursing and pharmacy leadership and other clinical staff (i.e. individual physician and/or specialty area of practice) every two years for the following:
      a. For appropriateness and accuracy.
      b. For consistency with nationally recognized and evidence-based guidelines.
      c. Continued usefulness and safety.
         (CMS 482.24; TJC – MM.04.01.01)

B. Verbal & Telephone Orders
   1. A verbal order for a medication shall be given only to a licensed practical or registered nurse, paramedic, or pharmacist and shall be signed by a member of the medical staff or other ordering practitioner as soon as possible after the order was given; or if the patient was discharged prior to the order being authenticated, within thirty (30) days of the patient’s discharge.
   2. Verbal orders shall be signed by a physician as soon as possible or within thirty (30) days of the patient’s discharge either electronically or handwritten with date and time.
   3. Verbal orders are to be used infrequently and never for convenience of the physicians.
      (CMS 482.24 (c)(1)iii) A-0457)  (902 KAR 20:016)

3. Complete Record: The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, imaging, and other; provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress note, follow-up, restraint documentation, a narrative discharge summary and autopsy when available. In the event of an incomplete medical record due to unforeseen and unavoidable circumstances, a note of explanation is kept on file.

4. History & Physicals:

   A. All records must contain the following as appropriate; a medical history & physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, and/or prior to surgery or a procedure requiring anesthesia services, including all inpatient, outpatient, or same-day surgeries or procedures. Advanced Practice Registered Nurse and Physician Assistants, as permitted by the State scope of practice laws, may conduct a history & physical examination which shall be signed by the physician. (CMS 428.24(c) (2)(i)(B) A-0461 & TJC MS.03.01.01).

      1. Contents of a complete H&P (ambulatory, operative/invasive* procedures performed in the operating suite):
         - Chief Complaint
         - Present Illness
         - Current Medications
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- Past Medical History
- Social History
- Family History
- Review of Systems
- Physical Exam
- Impression
- Plan of Care

2. Contents of a brief H&P (ambulatory, operative/invasive* procedures not performed in the operating suite):
- Preoperative Diagnosis
- Significant past medical history
- Allergies
- Pertinent Physical Examination to include heart/lungs
- Plan for Anesthesia
- Treatment and Progress

*An invasive procedure is a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy. (TJC MS.03.01.01)

B. Updated History & Physical Requirements:
If a complete history and physical (see #1 above) has been recorded in the physician’s office, or the patient has been readmitted for the same or similar problem within thirty (30) days prior to the patient’s admission or registration, a legible copy of the H&P may be used in the patient’s medical record. A reassessment by the examining physician must be noted, authenticated, dated, and timed within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services of the admission. The exam must be conducted by a practitioner that is credentialed and privileged. Reassessment includes the H&P Review/Update stamp indicating:
- H&P has been reviewed
- Patient has been examined
- No change in condition
- Change in condition (See H&P/Progress Notes)
- Date
- Time
- Physician Signature

Other than in the case of a patient emergency, if a transcribed history and physical examination, or a handwritten H&P form is not present on the chart before an operation or invasive procedure, the procedure shall be delayed or rescheduled unless the physician performing the procedure has stated in writing that such delay would be detrimental to the patient. An H&P must be completed within 24 hours of procedure and/or admission. (CMS 428.24(c)(2)(i)(B) A-0461 & TJC PC.01.02.03, MS.03.01.01 & RC.02.01.03).

C. Outpatient Behavioral Health History and Physicals:
A complete history and physical examination for patients in the outpatient Psychiatric Partial Hospitalization Program shall be written or dictated within 48 hours of admission to the Program. A documented history and physical within 60 days prior to admission is acceptable.

D. Dental Surgery:
All dental surgery patients must have a history and physical completed by a physician with the dental portion completed by the dentist, which shall include a detailed description of the physical findings of the oral cavity prior to surgery.
Advanced Practice Registered Nurse and physician assistants, as permitted by the state scope of practice laws, may conduct the history & physical examination which shall be signed by a physician. An H&P performed within thirty (30) days prior to the procedure may be used providing a reassessment by the dentist is documented. Reassessment includes the H&P Review/Update stamp indicating: H&P has been reviewed, patient has been examined, no change in condition, change in condition (See H&P/Progress Notes), date, time and physician signature. If patient requires inpatient admission for a medical problem or a surgical problem outside the scope of the dentist, dentist shall request a consult with appropriate physician.

E. Oral Maxillofacial Surgery:
Oral Maxillofacial surgeons who are privileged may perform their own history and physical. An H&P performed within thirty (30) days prior to the procedure may be used providing a reassessment by the dentist is documented. Reassessment includes the H&P Review/Update stamp indicating: H&P has been reviewed, patient has been examined, no change in condition, change in condition (See H&P/Progress Notes), date, time and physician signature. (CMS 482.24(c)(2)(i)(A))

F. Prenatal Record:
The prenatal record (including the history and physical) is acceptable for obstetrical patients, but must be updated within 24 hours of admission and meet all reassessment requirements stated in #4.B. (TJC MS.03.01.01)

G. Substitute for H&P:
Consultation reports may be substituted for the history and physical if completed within 24 hours of admission and all components and requirements of a history and physical (as listed in #4.A.1) are included.

5. Consultations:
   A. A consultation order must include the specialty of specific physician, reason for the consultation and whether the consultation is emergent or non-emergent.
      1. Emergent – Consultations deemed Emergent by the requesting physician require direct communication between the requesting physician and the physician being asked to provide the consultation.
      2. Non-Emergent – Consultations deemed Non-Emergent must be performed within twenty-four hours of the request. The ordering physician must provide information on the reason for the consultation request at the time the order is given. Ordering physician will be contacted for the clarification of orders not containing the appropriate information. (MEC Memo to Medical Staff dated 06/15/05).
   B. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient must be documented in the medical record. This information must be promptly completed in order to be available to the physician or other care providers to use in making assessments of the patient’s condition, to justify treatment or continued hospitalization, to support or revise the patient’s diagnosis, to support or revise the plan of care, to describe the patient’s progress and to describe the patient’s response to medications, treatment and service. (CMS 482.24 A-0464 (c)(2)(iii)).

6. Property:
   All records are the property of the hospital and shall not be taken away without subpoena, court order or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending physician.

7. Access to Medical Records:
   Access to all medical records of all patients shall be afforded to Staff physicians in good standing for Institutional Review Board approved study and research, and shall be compliant with maintaining the privacy of personal information concerning the individual patients. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

8. Informed Consent:
   An invasive procedure shall be performed only after informed consent of the patient or his/her legal representative is obtained, except in emergencies. (TJC RI.01.03.01) & CMS A-0466 482.24 (c)(2)(v)

9. Operative Report:
   An operative procedure report is written or dictated upon completion of the procedure and before the patient is transferred to the next level of care. The operative procedure report includes:
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- The name of the licensed independent practitioner who performed the procedure and the assistants
- The name of the procedure performed
- A description of the procedure
- Findings of the procedure
- Any estimated blood loss
- Any specimen removed
- The post-operative diagnosis

When a full operative procedure report cannot be entered immediately into the medical record, a brief operative note or progress note is entered before the patient is transferred to the next level of care. The brief operative note includes the name of the primary surgeon and assistants, procedure performed and a description of each procedure finding, estimated blood loss, specimen removed, and post-operative diagnosis. (TJC RC.02.01.03)

10. Discharge Summary: A discharge summary is to be completed as soon as possible. CMS requires that all records be completed within 30 days of discharge. A discharge summary shall include the following elements:

- The reason for hospitalization
- The procedures performed
- The care, treatment, and services provided
- The patient’s condition and disposition at discharge
- Information provided to the patient and family
- Provisions for follow-up care

(CMS A-0468 482.24(c)(2)(vii) & Report on Medicare Compliance: Volume 22, Number 8, February 25, 2013)

11. Suspension: All medical records must contain a final diagnosis. All medical records must be complete within 30 days of discharge or outpatient care. The Health Information Management Team, with the approval of the Medical Executive Committee, shall take such measures as necessary to insure compliance with this policy. All physicians shall be advised of the suspension process. (CMS A-0468 482.24(c)(2)(viii) & HIM Suspension Procedure Policy dated 05/29/12)

12. Progress Notes: Progress notes shall be documented daily by either the attending physician or another practitioner involved in the care of the patient. Pertinent progress notes shall be recorded at the time of observations, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient’s clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results in tests and treatment.

13. Cancer Staging: Physicians must document in the medical record the use of cancer staging in treatment planning. They may use the provided American Joint Committee on Cancer (AJCC) Cancer Staging form or dictate the clinical (prior to definitive surgery) elements of the AJCC method (T,N,M and stage group) in the admitting history and physical or the operative note. If staging is not provided in the operative period, the staging form can be used or dictated in the medical record, but must include treatment and/or referral planned for the patient and all AJCC elements (T, N, M and stage group). (Commission on Cancer Standard 1.6)
XI. INSTITUTIONAL RESOURCES

11.1. Program Administration

Program Director

An osteopathic program director shall be appointed for each approved OGME program with approval by the specialty college. Adequate institutional support including financial, in-kind, staff, and other resources will be provided to program directors to meet program standards. The program director shall only serve as the director of one OGME program in the same specialty. However, the program director may serve as joint program director in both a base specialty residency and a fellowship program, with specialty college approval. The GMEC must approve a change in Program Director.

Program directors shall meet the specific qualifications and shall have specific responsibilities as outlined in the AOA Basic Documents for Postdoctoral Training and specialty/subspecialty program requirements otherwise approved by the applicable accrediting body.

The program director of each residency will report to and be responsible to the Director of Medical Education for all aspects of his/her residency program.

Teaching Faculty

Teaching faculty shall be selected from among the institution’s professional staff based on qualifications, commitment, and desire to function as a teacher, trainer, and clinical supervisor. Faculty must be qualified by training and experience to perform this role and shall be proficient in their areas of practice. Faculty must be willing and able to provide instruction to trainees at the bedside and in ambulatory settings and coordinate in-patient care schedules. Faculty shall provide instruction to residents in clinical and classroom settings. The teaching faculty shall consist of individuals qualified to teach the bio-psycho-social behavioral component such as psychiatrists or other physicians with related skills, clinical psychologists, and bio-ethicists. In addition, faculty must participate in periodic faculty development activities. Faculty must be educated in recognizing early fatigue and sleep deprivation and to alter schedules and counsel residents as necessary, while maintaining continuity of patient care.

11.2. Risk Management Program

It shall be the policy of Commonwealth Health Corporation to develop, implement, support, monitor and evaluate a comprehensive, corporate-wide risk management program aimed at: (1) eliminating or reducing the risk of loss or injury to the facility, its patients, clients, employees and visitors, and (2) eliminating or reducing the risk of liability losses due to such injuries.

The purpose of the risk management plan for Commonwealth Health Corporation (CHC) is to provide for the safe delivery of health care and other business operations while decreasing potential financial losses to the corporation. Risk management is the process of making and carrying out decisions that will minimize the adverse effects of accidental losses on the organization. The risk management process will be carried out in the following ways:

a. Identifying exposures to accidental loss that may interfere with the corporation’s basic objectives;
b. Examining feasible risk management techniques for dealing with exposures to loss;
c. Selecting the appropriate risk management technique(s);
d. Implementing the chosen risk management technique(s); and
e. Monitoring the results of the chosen technique(s) to ensure that the risk management program remains effective.

This plan is also developed to facilitate compliance with the requirements of various federal, state and voluntary licensing and regulatory agencies.

The following goals are established for the Risk Management Program:

1. To minimize or eliminate potential exposures to accidental losses, thereby improving the quality of patient care and other business operations.
2. To decrease the frequency and severity of preventable injuries to patients, clients, staff and visitors.
3. To identify and classify exposures to accidental loss.
4. To measure frequency and severity of exposures to accidental loss.
5. To develop and implement methods to eliminate or minimize preventable losses.
6. To identify risks which are not reasonably preventable.
7. To develop and implement methods to minimize the frequency and severity of losses which are not reasonably preventable.
8. To provide risk financing for those losses to the organization that cannot be prevented.
9. To develop and implement appropriate educational and training programs regarding risk management and the prevention of losses.
10. To maintain current data on the investigation and management of exposures and losses, as well as the expenditures associated with losses.

### 11.3. Patient Care and Safety Information

The Medical Center strives to maintain a safe environment for patients, visitors, and our staff. Such policy and procedures can be found on The Medical Center’s Internal Website. Should conditions or hazards be identified that pose immediate threat to life or safety, the incident must be immediately and appropriately addressed and reported to the Corporate Safety Officer.

### 11.4. Emergency Codes

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<th>Code</th>
<th>Description</th>
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<td>Code Red</td>
<td>Fire</td>
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<td>Code Blue *</td>
<td>Medical Emergency</td>
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<td>Code Yellow</td>
<td>Internal/External Disaster</td>
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<td>Code Pink</td>
<td>Infant Abduction</td>
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<td>Code Orange</td>
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<td>Code Silver</td>
<td>Active Shooter</td>
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<td>Code Black</td>
<td>Bomb Threat</td>
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<td>Code White</td>
<td>Missing Patient</td>
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<td>Severe Weather</td>
<td>Severe Weather</td>
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XII. RESIDENT RESOURCES

12.1. Conference Rooms and/or Didactic Areas

The Medical Center has multiple conference rooms and didactic areas that will serve resident needs throughout the course of their program. The facility has a 110 seat capacity Auditorium on the first floor with fully integrated and functional Information Technology services. This space is anticipated to serve as the base site for grand rounds, Continuing Medical Education (CME) luncheons and evening programs, and various guest lectures, conferences, and seminars. The Medical Conference Room located just down the hall from the Auditorium hosts regular meetings including Tumor Conference, Sleep Medicine Journal Club, and Brain & Spine Conference to name a few. Two additional classrooms are located on the first floor of facility. In addition, The Medical Center features two classrooms on the third and fourth floor of the facility’s D Tower. To accommodate events on a larger scale, The Medical Center offers a 200 seat capacity meeting room in the Health Science Complex located on the hospital’s campus which can be divided into two, 100-seat rooms when necessary. This space also features fully integrated IT/AV set up and regularly hosts guest speakers on a variety of health related topics.

12.2. Library Resources

A limited library is available adjacent to The Medical Center’s Physician Lounge located on the first floor of the hospital. Computers are available to the residents in the Continuity Care Clinic and the resident lounge for literature search, procedure documentation and special projects.

The Medical Center provides access to knowledge-based information resources and reference materials adequate to support medical education activities, and readily available to faculty and trainees at all times, including after hours and on weekends. Library resources and services are reviewed annually by the GMEC.

Library resources include materials relevant to specialty or sub-specialty specific areas relevant to AOA-approved programs, and materials relevant to osteopathic principles and practice, and osteopathic manipulative treatment.

The residency program can also access additional library resources through the ESKIND Biomedical Library at Vanderbilt University Hospital. These links provide additional electronic access to journals and professional publications as well as access to extensive research data.

In addition to onsite resources, Residents are given access to the Kentucky College of Osteopathic Medicine (KYCOM) electronic library during residency.

12.3. Additional Educational Resources

Additional educational resources include:

- Desktop computers with free internet access
- Printer and Copier for preparation of presentations, etc.
- AV equipment including digital projectors, video players, and videoconferencing.

12.4. Call Room

Call rooms are available at The Medical Center for the use of all residents while on call. Residents are expected to remain on premises for call. The Medical Center seeks to provide a comfortable call room space to accommodate on call assignments. All furnishings and equipment provided in the call room is for use by all assigned residents and remains the property of The Medical Center.
12.5. Email and Internet Access

Residents shall be provided an email account. Residents shall use The Medical Center’s email account as their primary work-related address, check it daily, and respond appropriately in a timely manner.
XIII. INSTITUTIONAL OVERSIGHT

13.1. Graduate Medical Education Committee (GMEC)

The GMEC is a standing committee and shall work to maintain and improve the quality of its residency training programs. The GMEC shall establish, implement, and oversee formal written criteria and processes for the administrative and academic aspects of its residency programs. The GMEC is responsible for the continued accreditation of its residency training programs. The GMEC reports to the governing body of the entity in whose name the accreditation is registered. The GMEC shall meet at least ten (10) times annually. Emergency meetings of the GMEC may be called by the DME or a majority of its Members. A quorum shall be considered in existence if 25% of the GMEC members are present. Meetings may be conducted through e-mail, teleconference, or videoconference.

Composition

All Members of the GMEC are voting Members unless stipulated otherwise. Membership on the GMEC shall include:

- The Director of Graduate Medical Education who shall be chairperson
- Program Director of each residency program
- Peer-nominated trainee representatives
- Representatives from major affiliate institutions that host training, if applicable
- Administrative members may include:
  - Chief Executive Officer
  - Executive Vice Presidents
- A-OPTIC Representative (non-voting)
- Program Coordinator(s) (non-voting)

GMEC Functions and Responsibilities

General

- Organize and oversee all GME programs.
- The GMEC shall establish a written policy to monitor duty hours and moonlighting compliance.
- The GMEC shall ensure that each of its residency programs comply with all AOA and respective Specialty College requirements.
- The GMEC shall establish and oversee an administrative system to oversee all residency programs.
- The GMEC shall communicate with The Medical Center’s Board of Directors concerning its residency programs at least annually.
- The Committee shall, in cooperation with the DME, develop a curriculum and methods to evaluate the educational experience of the interns and residents during training.
- The GMEC shall evaluate the effectiveness of the various aspects of GME and report opportunities for improvement to the base institution Board of Directors annually.
- The GMEC shall establish institutional policies applicable to all residency programs regarding the accreditation, quality of education, and the work environment for the residents in each program.
- The GMEC shall review and revise this GME policy manual approximately at least every three years.
- The GMEC shall ensure the submission of requested documentation to the OPTI.
- The GMEC shall oversee the development of program descriptions for each residency program in accord with the AOA Basic Documents for Postdoctoral Training.
- The GMEC shall make recommendations on the appropriate funding for resident positions, including benefits and support services.
- The GMEC shall review all AOA and OPTI correspondence and ensure that appropriate and timely responses are given.
- The GMEC shall assist in the development of, review, and approval of all corrective action plans or other responses to deficiencies cited on AOA/Specialty College accreditation inspections in accord with the AOA Basic Documents for Postdoctoral Training and A-OPTIC Policies and Procedures. All Corrective Action Plans and Substantive Changes must be endorsed by the OPTI CAO.
• The GMEC shall oversee all substantive changes to an existing program as defined by the AOA Basic Documents for Postdoctoral Training
• The GMEC shall develop policies and procedures for and conduct Internal Reviews of residency programs in accord with the AOA Basic Documents for Postdoctoral Training
• The GMEC shall ensure the scheduling of a site visit from OPTI at least annually for each of its residency programs
• The GMEC shall ensure participation in related OPTI activities
• The GMEC shall review and approve a Resident Handbook for each residency program; each program-specific handbook shall be updated as needed and at least every three (3) years

Curriculum
• The GMEC shall ensure the development of an Institutional Core Competency Plan (ICCP) that meets the requirements of the AOA Basic Documents for Postdoctoral Training by the Director of Medical Education (DME). The GMEC shall review and approve the ICCP after its development. The GMEC shall direct faculty, staff, and program directors to assist the DME as needed.
• The GMEC shall ensure the submission Core Competency Annual Reports to the AOA and A-OPTIC annually.
• Annually, the GMEC shall use data gathered with objective evaluations, trainee evaluations, to evaluate the following curricular items, including, but not limited to:
  o Each residency program’s goals and objectives
  o The appropriate integration of osteopathic principles and practice (OPP) into all teaching services
  o The educational effectiveness of each clinical rotation
  o The educational effectiveness of didactic programming
  o In-service Examination Scores
  o Licensing Board Pass Rates
  o Evaluations of the program by graduates in years 1, 3, and 5.
• The GMEC shall ensure that there are adequate educational experiences for residents and that, when necessary, appropriate affiliation agreements and other documents are in place, current, and reflect Specialty College and AOA requirements.
• The GMEC shall ensure that educational experiences are objective-based and in accord with curriculum requirements and resident needs.
• The GMEC shall ensure the appropriate integration of osteopathic principles and practice (OP&P) into all educational programming.
• The GMEC shall ensure that the library and educational resources of the program are current, useful, and meet the provisions of the AOA Basic Documents for Postdoctoral Training.

Faculty
• The GMEC shall develop faculty and administrative job descriptions and evaluation procedures and instruments.
• The GMEC shall evaluate the effectiveness of the program faculty as a group and individually.
• The GMEC shall implement a program of faculty development based on various data points, including, but not limited to:
  o Resident evaluations
  o In-service examinations
  o Specialty Board testing outcomes
  o Curriculum evaluations
  o Scholarly activity needs for accreditation and to develop and maintain a healthy atmosphere of scholarly curiosity in all programs.
  o OPTI conducted evaluations
  o Internal Review
• The GMEC shall ensure that supervision of residents is in accord with best practices for education and patient care and all relevant accreditation standards.
• The GMEC shall review and approve the supervision policies for each of its residency programs.
• The GMEC shall ensure the availability of qualified mentorship in Osteopathic Principles and Practice (OP&P).
• The GMEC shall ensure that faculty meet or exceed accreditation requirements for faculty scholarly activity.
The GMEC shall ensure that all applicable standards, procedures, and policies governing research are met.
The GMEC shall ensure the establishment of a policy and timeline for residents to follow in meeting Specialty College standards relating to Research and/or Scholarly Activity for each residency program.
The GMEC shall ensure the provision of research curriculum that meets the needs of residents in an evidence-based curriculum and the Specialty College requirements.
The GMEC shall ensure the availability of qualified research mentors for each trainee.

Trainee Selection
- The GMEC shall set and evaluate the standards and process for admission to the program in accordance with the AOA Basic Documents for Postdoctoral Training.
- The GMEC shall review and process requests for transfer into and out of ALL programs and ensure compliance with Basic Documents for Postdoctoral Training.

Trainee Evaluation
- The GMEC shall ensure that faculty submit evaluations of trainees in a timeframe that allows the information to be useful in the overall evaluation of the trainee and program.
- The GMEC shall oversee the process of trainee evaluation, ensuring compliance with AOA Basic Documents for Postdoctoral Training and applicable Specialty College Standards.
- The GMEC shall review and approve all completed evaluations of trainees.
- The GMEC shall review and approve all resident remediation efforts.
- The GMEC shall develop institutional guidelines and policies for the evaluation, promotion, and dismissal of residents. These guidelines and policies shall define:
  - Criteria for satisfactory educational progress and promotion within a residency program.
  - Procedures for evaluation of resident progress in meeting educational objectives.
  - Procedures for addressing resident complaints and grievances relevant to the GME programs. These policies and procedures must satisfy the requirements of fair procedures as defined by the AOA Basic Documents for Postdoctoral Training.
- The GMEC shall review and approve all instruments used for evaluating trainees.

Trainee Welfare and the Balance between Service and Education
- The GMEC shall ensure that residents are in compliance with all applicable rules governing work hours.
- The GMEC shall establish a written policy to monitor duty hours and moonlighting compliance; reports of work hours concerns shall be sent to A-OPTIC.
- The GMEC shall ensure an environment of learning in which issues can be raised and resolved without fear of intimidation or retaliation. This includes:
  - Provision of an organizational system for communication and exchange of information on all issues pertaining to residents and their educational programs.
  - Procedures to address concerns of individual residents in a confidential and protected manner; anonymity, where it is possible, appropriate, and beneficial, will be ensured.
  - Establishment and implementation of fair institutional policies and procedures for academic or other disciplinary actions taken against residents.
  - The GMEC shall review and approve on-call policies for each residency program.

TIVRA and OPPORTUNITIES
- The GMEC shall ensure that its programs comply with the requirements of Trainee Information, Verification and Registration Audit (TIVRA).
- The GMEC shall ensure that its programs update AOA Opportunities program data between March 1 and June 30 annually.
13.2. Director of Medical Education

Position Description:

The Director of Medical Education (DME) is directly responsible for the overall program administration of all Residency Programs within the Institution. The DME is responsible for assuring the development of high quality post graduate education programs providing high quality residency training.

The DME is responsible for assuring the development of a high quality curriculum as well as assuring the highest quality clinical experiences for the residents. Assuring the development of post-graduate programs is a major priority. The DME will also serve as an advisor to students and residents regarding their career choices. The DME will participate in the clinical training of the residents.

The DME must be qualified to manage and direct PDs and residents in a graduate medical education program within the residency training requirements of the American Osteopathic Association and all applicable laws and regulations.

Responsibilities:

1. Provide oversight, administration, and accountability for The Medical Center’s American Osteopathic Association (AOA) approved programs;
2. Maintain good standing with the AOA;
3. Maintain good standing with the AODME;
4. Coordination of all AOA training programs at The Medical Center and away rotations as required to fulfill programmatic requirements;
5. Ensure compliance with the *AOA Basic Documents* and AOA-approved specialty standards for OGME programs;
6. Organize and implement high quality OGME programs at The Medical Center;
7. Supervise all aspects of OGME programs at The Medical Center including participation in appointment and supervision of Residency Program Directors;
8. Serve as the Intern Program Director, unless an Intern Program Director is separately designated;
9. Ensure the completion of all evaluations, quarterly meetings, and requirements of the internship and residency programs;
10. Manage all applicable affiliation agreements, documents, and correspondence related to AOA programs;
11. Manage the Internal Review process with the Medical Education Committee (MEC);
12. Prepare the Core Competency Plan;
13. Prepare and present an annual report on the “state of AOA educational programs at The Medical Center” to the Medical Staff and Board of Directors, with a copy to the OPTI. Copies of annual reports shall be available for on-site reviews. The annual report will review the activities of the Medical Education Committee and programs with attention to:
   ii. The supervision, responsibilities, and evaluation of interns, residents, and fellows;
   iii. Compliance with the duty hour standards at The Medical Center and at affiliated institutions;
   iv. The Medical Center’s internal review activities;
   v. Outcomes of safety initiatives, patient care quality improvement, and inter-professional teams where trainees are core members;
   vi. Progress on the Core Competencies and identified goals for the program(s) for the new year.
14. Participate in process where resources, including budgetary resources, are allocated for program support;
15. Annually attend an AODME and/or AOA OME conference for educational faculty development.

13.3. Policy and Procedure Modification

All policies may be modified or amended at any time. Updated versions of this manual will be posted to The Medical Center Graduate Medical Education website and Program Directors notified when an update has been posted. Updated policies become effective upon posting.

Residents are required to remain current on all policies and procedures as they occur for the hospital and their residency program.
Approved by the GMEC:
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Revisions approved by GMEC:
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