HOUSE STAFF MANUAL

UNIVERSITY OF ILLINOIS COLLEGE
OF MEDICINE AT PEORIA

RESIDENCY AND FELLOWSHIP PROGRAMS
BASED AT
OSF SAINT FRANCIS MEDICAL CENTER

Academic Year
2017 – 2018
HOUSE STAFF MANUAL

UNIVERSITY OF ILLINOIS COLLEGE
OF MEDICINE AT PEORIA

RESIDENCY AND FELLOWSHIP PROGRAMS
BASED AT
OSF SAINT FRANCIS MEDICAL CENTER

A Component of the Resident Agreement

Academic Year 2017 – 2018

Approved by:

The University of Illinois College of Medicine at Peoria
Graduate Medical Education Committee

Terrance Brady, M.D., Chairman
June 23, 2017
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I. GENERAL INFORMATION

A. INTRODUCTION

1. The University of Illinois College of Medicine at Peoria

The University of Illinois College of Medicine has been a nationally recognized leader for over 100 years in its three-fold commitment to providing excellence in teaching, research, and patient care. Today the College of Medicine offers both undergraduate and graduate medical education programs at Peoria, Champaign-Urbana, Chicago, and Rockford. The faculty at the University of Illinois College of Medicine at Peoria (UICOMP) includes a core of full-time physicians and basic scientists plus over 800 hospital and office-based physicians in the region. Residents are an integral part of the University of Illinois academic community. UICOMP is committed to providing graduate medical education (GME) as the sponsoring institution of all ACGME accredited programs that facilitates residents’ professional, ethical, and personal development. UICOMP and its GME programs support safe, appropriate and quality patient care through curricula, evaluation, and resident supervision.

2. OSF Saint Francis Medical Center

Since its inception in 1877, OSF Saint Francis Medical Center (OSF SFMC) has developed into a large complex medical center with modern facilities, state of the art equipment, and a dedicated staff to meet the health care needs of central Illinois.

Two values have been nurtured for over a century at OSF SFMC:

a. “In the spirit of Christ and the example of Francis of Assisi, the Mission of OSF HealthCare is to serve persons with the greatest care and love in a community that celebrates the Gift of Life.”

b. A commitment to teaching.

OSF SFMC House Staff (house Staff) is composed of all postgraduate physician trainees participating in UICOMP sponsored Residency Programs, which are based at OSF SFMC. Residents are made full partners in this tradition of compassion and commitment to teaching.

3. Definition of Term: Training Level (TL)

The training level defines the year of postgraduate training to which the resident has progressed within a specific residency program. Training levels are not cumulative from one specialty to another. The exception to this rule is when a preliminary postgraduate year is a requirement of the residency program. The steps on the graduated salary scale are organized according to these training levels.

B. PURPOSE OF THE MANUAL

The OSF SFMC House Staff Manual (Manual) sets forth specific rules and regulations concerning activities and responsibilities of full-time House Staff. The Manual is a component of the Resident Agreement. It provides an expanded definition of the commitments of UICOMP, OSF SFMC, and the residents. The House Staff is expected to comply with the institution’s general policies and rules as specified in this document.
C. **POSTGRUATE MEDICAL EDUCATION PROGRAMS SPONSORED BY THE UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA**

<table>
<thead>
<tr>
<th>Program</th>
<th>(years)</th>
<th>(number)</th>
<th>Length</th>
<th>Resident #</th>
<th>ACGME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Imaging Fellowship¹</td>
<td></td>
<td>1</td>
<td>2</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td></td>
<td></td>
<td>3</td>
<td>9</td>
<td>Accreditation</td>
</tr>
<tr>
<td>Fellowship¹</td>
<td></td>
<td></td>
<td>4</td>
<td>32</td>
<td>Accreditation</td>
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<tr>
<td>Combined Medicine-Pediatrics¹</td>
<td>4</td>
<td></td>
<td>5</td>
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<td>Full Accreditation</td>
</tr>
<tr>
<td>Diagnostic Radiology¹</td>
<td></td>
<td></td>
<td>3</td>
<td>36</td>
<td>Full Accreditation</td>
</tr>
<tr>
<td>Emergency Medicine¹</td>
<td>3</td>
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<td>1</td>
<td>30</td>
<td>Full Accreditation</td>
</tr>
<tr>
<td>Family Practice¹</td>
<td>3</td>
<td></td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenterology Fellowship¹</td>
<td>3</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Internal Medicine-C¹</td>
<td></td>
<td></td>
<td>1</td>
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<tr>
<td>Internal Medicine-P¹</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
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</tr>
<tr>
<td>Neurological Surgery³</td>
<td>3</td>
<td></td>
<td>6</td>
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<tr>
<td>Neuroradiology Fellowship¹</td>
<td>1-2</td>
<td></td>
<td>4</td>
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<td>N/A</td>
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<tr>
<td>Obstetrics/Gynecology³</td>
<td>4</td>
<td></td>
<td>12</td>
<td></td>
<td>Accredited with Warning</td>
</tr>
<tr>
<td>Pediatrics-C¹</td>
<td>3</td>
<td></td>
<td>30</td>
<td></td>
<td>Full Accreditation</td>
</tr>
<tr>
<td>Psychiatry²</td>
<td>4</td>
<td></td>
<td>16</td>
<td></td>
<td>Full Accreditation</td>
</tr>
<tr>
<td>Simulation Fellowship</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary/Critical Fellowship</td>
<td>3</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery-C¹</td>
<td>5</td>
<td></td>
<td>18</td>
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<td></td>
</tr>
<tr>
<td>Vascular/Interventional</td>
<td>1</td>
<td></td>
<td>1</td>
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<td>Continued Accreditation</td>
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<tr>
<td>Radiology Fellowship¹</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Vascular Neurology/Stroke</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td>Accreditation Withdrawn</td>
</tr>
<tr>
<td>Fellowship¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine Obstetrics</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fellowship²</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Based at OSF SFMC
² Based at UnityPoint/Methodist Medical Center
³ Based at OSF SFMC with certain rotations performed at Unity Point Health Methodist
C, Categorical
P, Preliminary
N/A, Programs for which the ACGME has no accreditation process
## D. UICOMP DEPARTMENT CHAIR/HEAD ROSTER

<table>
<thead>
<tr>
<th>Department</th>
<th>Chair/Head</th>
<th>Other Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Biology and Pharmacology &amp; Pharmacology</td>
<td>Marcelo Bento de Mello Soares, Ph.D. (Chair)</td>
<td>Professor &amp; Head of Cancer Biology</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Allan C. Campbell, M.D. (Chair)</td>
<td>Clinical Professor of Dermatology</td>
</tr>
<tr>
<td>Education</td>
<td>Meenakshy Aiyer, M.D. (Chair)</td>
<td>Associate Dean of Academic Affairs</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>Timothy Schaefer, M.D. (Chair)</td>
<td>Clinical Associate Professor of Emergency Medicine</td>
</tr>
<tr>
<td>Family and Community Medicine</td>
<td>Tom Golemon, M.D.</td>
<td>Thomas &amp; Ellen Foster Endowed Chair Professor of Clinical Family Practice</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Teresa Lynch, M.D. (Interim Chair)</td>
<td>Clinical Associate Professor of Medicine</td>
</tr>
<tr>
<td>Neurology</td>
<td>Jorge C. Kattah, M.D. (Head)</td>
<td>Professor of Neurology</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Jeff Klopfenstein, M.D. (Head)</td>
<td>Associate Professor of Neurosurgery</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>Steven Thompson, M.D. (Interim Chair)</td>
<td>Assistant Professor of Clinical Obstetrics/Gynecology</td>
</tr>
<tr>
<td>Pathology</td>
<td>Pushpa Joseph, M.D. (Interim Chair)</td>
<td>Professor of Pathology</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Pedro de Alarcon, M.D. (Chair)</td>
<td>William H. Albers Professor of Pediatrics</td>
</tr>
<tr>
<td>Psychiatry and Behavioral Medicine</td>
<td>Ryan Finkenbine, M.D. (Chair)</td>
<td>Professor of Clinical Psychiatry</td>
</tr>
<tr>
<td>Radiology</td>
<td>Sean Meagher, M.D. (Chair)</td>
<td>Clinical Assistant Professor of Radiology</td>
</tr>
<tr>
<td>Surgery</td>
<td>J. Stephen Marshall, M.D. (Interim Chair)</td>
<td>Professor of Surgery</td>
</tr>
</tbody>
</table>
### E. OSF SFMC DEPARTMENT CHAIR ROSTER WITH UICOMP APPOINTMENTS

<table>
<thead>
<tr>
<th>Department</th>
<th>Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>Chris Collison, M.D.</td>
</tr>
<tr>
<td>Cardiovascular Medicine</td>
<td>Dale Mueller, M.D. Clinical Associate Professor of Surgery</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Mark Gaudio, M.D. Clinical Assistant Professor of Emergency Medicine</td>
</tr>
<tr>
<td>Family Practice</td>
<td>Greg Link, D.O. Clinical Assistant Professor of Family Practice</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Teresa Lynch, M.D. (Chair) Clinical Associate Professor of Medicine</td>
</tr>
<tr>
<td>Neurology</td>
<td>Jorge, Kattah, M.D. Professor of Neurology</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Todd McCall, M.D. Assistant Professor of Neurosurgery</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>Stephen Thompson, M.D. Assistant Professor of Clinical Obstetrics &amp; Gynecology</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>Jeffrey W. Akeson, M.D. Clinical Assistant Professor of Surgery Clinical Assistant Professor of Pediatrics</td>
</tr>
<tr>
<td>Pathology</td>
<td>James Seibert, M.D.</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Kay Saving, M.D. Professor of Pediatrics</td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation</td>
<td>Jeffery Stedwill, M.D. Clinical Assistant Professor of Medicine</td>
</tr>
<tr>
<td>Psychiatry and Behavioral Medicine</td>
<td>Abraham Frenkel, M.D. Clinical Assistant Professor of Psychiatry</td>
</tr>
<tr>
<td>Radiology</td>
<td>Jeffrey DeSanto, M.D. Clinical Assistant Professor of Radiology Clinical Assistant Professor of Neurology</td>
</tr>
<tr>
<td>Surgery</td>
<td>Richard Anderson, M.D. Associate Professor of Clinical Surgery</td>
</tr>
<tr>
<td>Transplantation</td>
<td>Timothy O’Connor, M.D. Visiting Clinical Associate Professor of Medicine</td>
</tr>
</tbody>
</table>
## F. UICOMP RESIDENCY/FELLOWSHIP PROGRAM DIRECTORS

<table>
<thead>
<tr>
<th>Fellowship</th>
<th>Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Imaging Fellowship</td>
<td>Jessica Guingrich, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Radiology</td>
</tr>
<tr>
<td>Cardiovascular Disease Fellowship</td>
<td>Sudhir Mungee, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Associate Professor of Medicine</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>Terrance M. Brady, M.D.</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Radiology</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Surgery</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>John Hafner, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Associate Professor of Emergency</td>
</tr>
<tr>
<td></td>
<td>Medicine</td>
</tr>
<tr>
<td></td>
<td>Clinical Associate Professor of Family &amp; Community Medicine</td>
</tr>
<tr>
<td>Family Practice</td>
<td>Kelvin Wynn, M.D.</td>
</tr>
<tr>
<td></td>
<td>Associate Professor of Clinical Family Practice</td>
</tr>
<tr>
<td>Gastroenterology Fellowship</td>
<td>Sonu Dhillion, M.D.</td>
</tr>
<tr>
<td></td>
<td>Visiting Clinical Associate Professor of Medicine</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Steven Tsoraides, M.D.</td>
</tr>
<tr>
<td></td>
<td>Assistant Professor of Clinical Surgery</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Teresa Lynch, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Associate Professor of Medicine</td>
</tr>
<tr>
<td>Medicine-Pediatrics</td>
<td>Francis McBee Orzulak, M.D.</td>
</tr>
<tr>
<td></td>
<td>Associate Professor of Clinical Medicine &amp; Director, Academic Program</td>
</tr>
<tr>
<td>Neurology</td>
<td>Greg Blume, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Neurology</td>
</tr>
<tr>
<td>Neuroradiology Fellowship</td>
<td>Jeffrey DeSanto, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Radiology</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Neurology</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Julian Lin, M.D.</td>
</tr>
<tr>
<td></td>
<td>Associate Professor of Clinical Neurosurgery</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>Rebecca Byler-Dann, M.D.</td>
</tr>
<tr>
<td></td>
<td>Assistant Professor of Clinical OB/Gyn</td>
</tr>
</tbody>
</table>
Assistant Professor of Clinical Surgery
Pediatrics
Bhavana Kandikattu, M.D.
Assistant Professor of Clinical Pediatrics

Psychiatry & Behavioral Medicine
Ryan Finkenbine, M.D.
Professor of Clinical Psychiatry

Simulation Fellowship
Nur-Ain Nadir, M.D.
Assistant Professor of Emergency Medicine

Pulmonary Fellowship
Subramanyam Chittivelu, M.D.
Clinical Professor of Medicine

Vascular/Interventional Radiology Fellowship
Kenneth Moresco, M.D.
Clinical Assistant Professor of Radiology

Family Medicine Obstetrics Fellowship
Rahmat Na’Allah, M.D.
Clinical Assoc. Prof. of Fam.Med.

G. PROGRAM DIRECTOR RESPONSIBILITIES

1. Each residency program has a single Program Director with authority and accountability for the operation of that program. The Designated Institutional Official (DIO) and the Graduate Medical Education Committee (GMEC) of the University of Illinois College of Medicine at Peoria (UICOMP) must approve a change in Program Director. After approval, the Program Director must submit this change to the ACGME via the Web Accreditation Data System (ADS).

2. The Program Director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

3. Qualifications of the Program Director must include:

   a. Requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

   b. Current certification in the specialty by the relevant American Board of Medical Specialties (ABMS) or specialty qualifications that are acceptable to the Review Committee; and,

   c. Current medical licensure and appropriate medical staff appointment.

4. The Program Director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The Program Director must:

   a. Oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

   b. Approve a local director at each participating site who is accountable for resident education;

   c. Approve the selection of program faculty as appropriate;
d. Evaluate program faculty and approve the continued participation of program faculty based on evaluation;

e. Monitor resident supervision at all participating sites;

f. Prepare and submit all information required and requested by the ACGME, including but not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete;

g. Provide each resident with documented semiannual evaluation of performance with feedback;

h. Ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

i. Provide verification of residency education for all residents, including those who leave the program prior to completion;

j. Implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

1) Distribute these policies and procedures to the residents and faculty;

2) Determine the types of procedures to track, the minimum number of procedures needed, and define competency/proficient for their own residents/fellows. The list must be updated monthly and sent to the GME office where compliance can be tracked. The GME office will then send the list to the hospital representative responsible for posting it to the hospital websites.

3) Develop procedures to monitor his/her resident duty hours. Monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

   a) Provide a monthly written report to the GME office that identifies any significant, recurring exceptions to the duty hour requirements. Such reports will include the description of an action plan to bring the program into compliance with the ACGME Requirements.

4) Adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

5) If applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

k. Monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

l. **Transitions of Care**

The sponsoring institution must facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care; and, ensure that participating
sites engage residents/fellows in standardized transitions of care consistent with the setting and type of patient care.

Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. Programs, in partnership with their Sponsoring Institutions must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Programs must ensure that residents are competent in communicating with team members in the hand-over process. Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. Each program must ensure continuity of patient care, consistent with the program’s policy and procedures referenced in C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness.

The following elements should be considered in resident hand-offs.
   1) The hand-off should occur in a quiet place removed from clinical areas.
   2) The hand-off should take place at a previously designated time each day.
   3) A senior resident or ideally faculty member should be present.
   4) Hand-off should be orally communicated but available in written form as well.

m. Clinical Responsibilities

   The clinical responsibilities for each resident must be based on TL-Level, patient safety, resident ability, severity and complexity of patient illness/condition and available support services.

n. Team Building

   The ACGME requires that residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. [Each Review Committee will define the elements that must be present in each specialty.]

o. Fatigue Mitigation

   Responsibilities of the Program Director and Attending Physician:

   Educate all faculty and residents to recognize the signs of fatigue and sleep deprivation. (see section II.H.5.i)

   Additional Responsibilities of the Program Director/Chairman:

   If the removed resident’s absence impacts other residents, this should be accounted for immediately and resolved where required. The resident’s schedule, patient care responsibilities, and personal problems/stressors will be discussed. When necessary, the rotation will be reviewed for potential changes. If the problem is recurrent or not resolved in a timely manner, the resident may be removed from patient care responsibilities indefinitely. A medical evaluation may be requested or required as the situations warrant.

p. Comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
q. Be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

r. Obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting to the ACGME information or requests for the following:

1) All applications for ACGME accreditation of new programs;
2) Changes in resident complement;
3) Major changes in program structure or length of training;
4) Progress reports requested by the Review Committee;
5) Proposed adverse actions;
6) Requests for increases or any change to resident duty hours;
7) Voluntary withdrawals for ACGME-accredited programs;
8) Requests for appeal of an adverse action;
9) Appeal presentations to a board of Appeal or the ACGME; and,

s. Obtain DIO review and co-signature on all correspondence or documents submitted to the ACGME that addresses:

1) Program citations, and/or
2) Requests for changes in the program that would have significant impact, including financial, on the program or institution.

t. Submit the Annual Program Evaluation Committee Summary to the GMEC.

u. Provide updates requested by the GMEC as identified in the Annual Institutional Review of Programs report.

H. FACULTY

At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

Faculty Must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents; and administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.
The physician faculty must have current certification in the specialty by the American Board of that specialty, or possess qualifications judged acceptable to the Review Committee. They must possess current medical licensure and appropriate medical staff appointment.

The non-physician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

The faculty must establish and maintain an environment of inquiry and scholarship, and regularly participate in organized clinical discussions, rounds, journal club, and conferences.

Some members of the faculty should also demonstrate scholarship by one or more of the following:

- peer-reviewed funding;
- publication of original research or review articles in peer reviewed journals, or chapter in textbooks;
- publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or
- participation in national committees or educational organizations.

Faculty should encourage and support residents in scholarly activities.

I. ASSOCIATE DEAN FOR GRADUATE MEDICAL EDUCATION

The Associate Dean for Graduate Medical Education (GME) is the Designated Institutional Official (DIO) at UICOMP. The DIO, in collaboration with the Graduate Medical Education Committee (GMEC), has authority and responsibility for the oversight and administration of each of the Sponsoring Institution’s ACGME-accredited programs, as well as for ensuring compliance with the ACGME Institutional, Common, and specialty/subspecialty-specific Program Requirements; and Governing Body: The entity which maintains authority over the Sponsoring Institution and each of its ACGME-accredited programs. The DIO’s office is charged with maintaining the Institution’s ACGME Accreditation; maintaining the Institution’s Residency Programs’ ACGME Accreditation; improving the Institution’s Educational Program; developing and supporting Residency Program Directors; managing the Institution’s GME Budget and supporting data for Medicare Reimbursement; advocating for resources; managing the Institution’s GME Operations; representing the Institution’s GME Enterprise; overseeing the well-being of the Institution’s residents; and providing guidance on legal matters. The GME Office is also responsible for providing oversight of the licensing process and liaison with the State of Illinois Department of Professional Regulations for matters concerning licensure. Finally, the DIO is responsible for compliance of all institutionally sponsored residency programs with the National Residency Matching (NRMP) requirements.

J. HOUSE STAFF PRESIDENT

1. The House Staff President is elected by the House Staff by secret ballot each spring and receives additional compensation for the increased workload related to House Staff activities.

2. The role of the House Staff President is to:

   a. Serve as an ex-officio, voting member of the GMEC Committee;
   b. Preside over meetings for the entire House Staff;
c. Preside over meetings with Chief Residents from all specialties;

d. Organize hospital-wide activities for the House Staff;

e. Serve as an Ombudsman for residents

3. The House Staff President should be contacted directly concerning problems between these persons or areas:
   a. Resident – Resident;
   b. Resident – Attending;
   c. Resident – Teaching Faculty; and
   d. Resident – Administration

K. HOUSE STAFF VICE PRESIDENT

1. The House Staff Vice President is also elected by the House Staff each spring.

2. The Vice President receives additional compensation for the increased workload related to House Staff activities.

3. He/she assists the House Staff President in all of the above-listed tasks.

4. He/she serves as an ex-officio member of the GMEC, voting only in the absence of the House Staff President.

5. He/she manages the Portal which serves as an electronic means of communication for residents only.

L. CHIEF RESIDENT

1. Each specialty program has one or more designated Chief Residents.

2. The role of the Chief Resident varies somewhat from Program to Program, but in general this person conducts regular meetings for the residents in his/her Program and serves as a liaison between the residents and the Program Director.

3. The Chief Resident(s) should be contacted directly concerning minor complaints regarding the specific Residency Program.

M. UICOMP GME ADMINISTRATIVE COUNCIL

1. Membership. UICOMP has a GME Administrative Council which consists of one administrative representative designated by the CEO of OSF SFMC and one administrative representative appointed by the CEO of UPHM, the Regional Dean of UICOMP or his/her designee, the Chair of the Graduate Medical Education Committee (GMEC) and the Associate Dean for GME (DIO) who shall serve as Chairperson.
2. Functions. The Administrative Council shall be responsible for:

a. The establishment and administration of financial policies for GME, including, but not limited to:

1) Funding of Required Away Rotations

2) Inter-institutional financial agreements between participating hospitals for resident activities including cost-sharing and distribution of Medicare and Illinois Higher Education Board of Education Grant Funds

3) The establishment of the annual GME budgets, effective July 1 of each year, which shall include provisions for the payment of all direct expenses for GME.

   a) The establishment of uniform stipend ranges and comparable fringe benefits for all UICOMP residents.

   b) Setting the Agenda for the Graduate Medical Education Committee (GMEC) Monthly Meetings.

3. Accountability. Actions of the Administrative Council

   a. Will be reported to the GMEC at the monthly meeting by the UICOMP Associate Dean of GME (DIO) or his/her designee.

   b. May be used to document institutional commitment and support for GME during ACGME accreditation reviews.

N. GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)

1. Charge to the Committee: The Graduate Medical Education Committee (GMEC) is appointed by the Regional Dean of the University of Illinois College of Medicine at Peoria (UICOMP) for oversight and to coordinate all of its residencies and fellowships. The purpose and duties of the Committee relate directly to the current Institutional Requirements for Accredited Residencies published by the Accreditation Council for Graduate Medical Education (ACGME) in July 2017. In addition, with approval of the Regional Dean, the Committee may, from time to time, add to its scope of responsibilities, as it deems necessary.

2. Membership and Voting: All departments with residency or fellowship programs will have at least two voting members, each with one vote. These members will be the department chair/head and the program/fellowship director, except in departments where the same person fills both roles. In the latter case, another member of the department (usually the associate Program Director) is appointed to ensure adequate representation from each program at meetings of the GMEC. All programs will have an alternate who will be permitted voting privileges and count towards the quorum in the absence of the chairman or Program Director. Additional voting members include the DIO, House Staff President from OSF SFMC, one of the two Chief Residents from UPHM, Qi/PS Officer, and other faculty as determined by the Regional Dean. Non-voting members include the House Staff Vice President from OSF SFMC, one of the Chief Residents from UPHM, the Regional Dean, the Associate Dean for Academic Affairs, the Director of Medical Affairs at OSF SFMC, and the Director of Medical Affairs from UPHM. All actions of the Committee are based on simple majority. The GMEC Chairman votes
only in case of a tie. A majority of those present at any scheduled meeting will constitute a quorum.

3. GMEC Responsibilities: The GMEC meets at least quarterly and maintains minutes that document the execution of all required GMEC functions and responsibilities, establishes and implements policies and procedures regarding the quality of education and the work environment for the residents in all programs. These policies and procedures include:

a. Stipends and position allocation: Annual review and recommendations to the Sponsoring Institution regarding resident stipends, benefits, and funding for resident positions.

b. Appointment of subcommittees that address required GMEC responsibilities. Note such subcommittee’s must include a peer-selected resident/fellow.

c. Communication with Program Directors: The GMEC:

   1) Ensures that communication mechanisms exist between the GMEC and all Program Directors within the institution.

   2) Ensures that Program Directors maintain effective communication mechanisms with the site directors at each participating institution for their respective programs to maintain proper oversight at all clinical sites.

d. Resident duty hours: The GMEC:

   1) Develops and implement written policies and procedures regarding resident duty hours to ensure compliance with the Institutional, Common, and specialty/subspecialty-specific Program Requirements.

   2) Considers for approval requests from Program Directors prior to submission to a Review Committee for exceptions in the weekly limit on duty hours up to 10 percent or up to a maximum of 88 hours in compliance with ACGME policies and procedures for duty hour exceptions.

e. Oversight of the GME Learning and working environment within the Sponsoring Institution’s ACGME accredited programs and its participating sites.

f. Oversight of the quality of educational experiences in each ACGME accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty/subspecialty-specific Program Requirements.

g. Oversight of the ACGME accredited programs’ annual evaluation and improvement activities.

h. Oversight of resident supervision: Monitor programs’ supervision of residents which ensures that supervision is consistent with:

   1) Provision of safe and effective patient care;

   2) The educational needs of residents;
3) Progressive responsibility appropriate to residents' level of education, competence, and experience; and,

4) Other applicable Common and specialty/subspecialty-specific Program Requirements.

i. Communication with Medical Staff: Communication between leadership of the medical staff regarding the safety and quality of patient care that includes:

1) The annual report to the Organized Medical Staff (OMS);

2) Description of resident participation in patient safety and quality of care education; and,

3) The accreditation status of programs and any citations regarding patient care issues.

j. Curriculum and evaluation: Assurance that each program provides a curriculum and an evaluation system that enables residents to demonstrate achievement of the ACGME general competencies as defined in the Common and specialty/subspecialty-specific Program Requirements.

k. Resident status: Selection, evaluation, promotion, transfer, discipline, and/or dismissal of residents in compliance with the Institutional and Common Program Requirements.

l. Oversight of program accreditation: Review of all ACGME program accreditation letters of notification and monitoring of action plans for correction of citations and areas of noncompliance.

m. Management of institutional accreditation: Review of the Sponsoring Institution’s ACGME letter of notification from the Institutional Review Committee (IRC) and monitoring of action plans for correction of citations and areas of noncompliance.

n. Oversight of the Sponsoring Institutions accreditation through an Institutional Review (AIR). (See attachment #1)

o. Oversight of program changes: Review of the following for approval, prior to submission to the ACGME by Program Directors:

1) All applications for ACGME accreditation of new programs;

2) Changes in resident complement;

3) Major changes in each of its ACGME accredited program structure or duration of training;

4) Additions and deletions of each of its ACGME Accredited programs participating sites;

5) Appointments of new Program Directors;

6) Progress reports requested by any Review Committee;

7) Responses to Clinical Learning Environment Review (CLER) reports;

8) Requests for exceptions of resident duty hours;
9) Voluntary withdrawal of program accreditation;

10) Requests for an appeal of an adverse action by the RRC; and,

11) Appeal presentations to a Board of Appeal or the ACGME Appeals Panel.

p. Oversight of reductions and closures: Oversight of all processes related to reductions and/or closures of:

1) Individual programs;

2) Major participating institutions; and,

3) Sponsoring Institution

q. Vendor interactions: Provision of the institutional policy that addresses interactions between vendor representatives/corporations and residents/GME programs.

r. Oversight of Reports from Institutional Review of Programs Committee.

s. Summary of Items for GMEC Notification and Approval. (see Table 1)
Table 1. Summary of Items for GMEC Notification and Approval

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<tr>
<th>TOPIC</th>
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<td>Program Directors</td>
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<td>Program-Specific Progress Reports</td>
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<td>Institutional Review of Program Report</td>
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<td>Changes in Resident Compliment</td>
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<td>Major change in Program structure</td>
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4. **GMEC Committee Roster**

   **Cardiovascular Disease Fellowship:**
   Sudhir Mungee, M.D. Program Director

   **Combined Medicine Pediatrics:**
   Francis McBee Orzulak, M.D. Program Director
   Gregory Nulty, M.D. Associate Program Director
   Matt Mischler, M.D. Assoc. Prog. Director, Alternate

   **Emergency Medicine:**
   John Hafner, M.D. Program Director
   Tim Schaefer, M.D. Department Chair
Greg Tudor, M.D._ASSOC. PD, Alternate
Sarah Krzyzaniak, M.D._ASSOC. PD, Alternate

**Family Medicine:**
Kelvin Wynn, M.D. Program Director
Tom Golemon, M.D. Department Chair
Jeff Leman, M.D. Assoc. PD, Alternate

**Gastroenterology Fellowship:**
Sonu Dhillion, M.D. Program Director
Michael Cashman, M.D. Assoc. PD, Alternate

**General Surgery:**
Steve Tsoraides, M.D. Program Director
Stephen Marshall, M.D. Department Interim Chair
Thomas Rossi, M.D. Associate Program Director, Alternate

**Internal Medicine:**
Teresa Lynch, M.D. Program Director & Interim Dept. Chair
Sidney Palmer-Hill, M.D. Assoc. PD, Alternate
Vamsi Emani, M.D. Assist. PD, Alternate

**Neurology:**
Gregory Blume, M.D. Program Director
Jorge Kattah, M.D. Department Head

**Neuroradiology Fellowship:**
Jeff DeSanto, M.D. Program Director

**Neurosurgery:**
Jeff Klopfenstein, M.D. Department Chair
Julian Lin, M.D. Program Director
Patrick Tracy, M.D. Alternate

**OB/Gyn:**
Rebecca Byler-Dann, M.D. Program Director
Stephen Thompson, M.D. Department Chair

**Pediatrics:**
Bhavana Kandikattu, M.D. Program Director
Pedro de Alarcon, M.D. Department Chair
Jawad Javed, M.D. Associate PD, Alternate
Michele Beekman, M.D. Assistant PD, Alternate
Amy Christison, M.D. Assistant PD, Alternate
Barry Gray, M.D. Alternate

**Psychiatry:**
Ryan Finkenbine, M.D. Program Director/Department Chair
Jean Clore, Ph.D. Associate PD, Alternate

**Pulmonary/Critical Care Fellowship:**
Subramanyam Chittivelu, M.D. Program Director
II. INSTITUTIONAL RESPONSIBILITIES

A. COLLABORATIVE NATURE OF GRADUATE MEDICAL EDUCATION

A major affiliation agreement between the OSF HealthCare System and the University of Illinois College of Medicine at Peoria establishes that all graduate medical education programs at OSF will be operated in collaboration with UICOMP. In this collaboration UICOMP, through the DIO/GMEC, is exclusively responsible for the educational aspects of the residency programs (i.e., is the Sponsoring Institution), and OSF SFMC is responsible for employing the residents and for providing a learning environment in which residents participate in patient care under the supervision of UICOMP faculty (i.e., is a major participating institution). In order to continue their
employment by OSF SFMC and their enrollment in a residency program, residents must remain in good standing with both institutions.

B. UICOMP RESPONSIBILITIES AS A SPONSORING INSTITUTION

1. UICOMP retains responsibilities for the quality of GME, including resident educational experiences occurring at other sites. UICOMP assures that each program has established program letters of agreements (PLAs) for all off-site rotations (i.e., required rotations of one or more months at institutions or facilities which are not affiliated with OSF) as mandated by the ACGME.

2. UICOMP is aware that it must be in substantial compliance with the ACGME Institutional Requirements and must ensure that its ACGME-accredited programs are in substantial compliance with the Institutional, Common and specialty-specific Program Requirements, and the ACGME Policies and Procedures.

3. UICOMP, together with its education partner OSF, is committed to providing Graduate Medical Education (GME) that facilitates resident’s professional, ethical, and personal development. UICOMP and OSF, through curricula, evaluation, and resident supervision support safe, appropriate, learning and working environment that facilitate Patient Safety & Health Care Quality.

4. UICOMP, together with its educational partner OSF, ensures that the DIO and the GME Program Directors have sufficient financial support and protected time to carry out their respective educational and administrative leadership responsibilities.

5. UICOMP, together with its educational partner OSF, ensures that faculty and residents have ready access to adequate resources for resident education, communication resources and technological support as defined in the specialty program requirements.

6. UICOMP, together with its educational partner OSF, ensures that residents will have ready access to specialty/subspecialty-specific and other appropriate reference material in print or electronic format and that electronic medical literature databases with search capabilities are available at its facilities.

7. UICOMP, together with its educational partner OSF ensures that:

   • the program director(s) has sufficient financial support and protected time to effectively carry out his/her educational, administrative, and leadership responsibilities, as described in the Institutional, Common and specialty/subspecialty-specific Program Requirements;

   • the program receives adequate support for core faculty members to ensure both effective supervision and quality resident/fellow education;

   • the program director and core faculty members engage in professional development applicable to their responsibilities as educational leaders;

   • the program coordinator has sufficient support and time to effectively carry out his/her responsibilities; and
resources, including space, technology, and supplies, are available to provide effective support for each of its ACGME-accredited programs.

- Transitions of Care: Refer to I.G.I

C. ACCREDITATION FOR PATIENT CARE IN MAJOR PARTICIPATING INSTITUTIONS THAT ARE HOSPITALS

1. OSF SFMC and other major participating Institutions that are hospital affiliates of the University of Illinois College of Medicine at Peoria (UICOMP) must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JAHCO); accredited by another entity with reasonably equivalent standards as determined by the Institutional Review Committee (IRC); or recognized by another entity with reasonably equivalent standards as determined by the IRC.

2. When a major participating Institution of UICOMP that is a hospital is not so accredited or recognized, UICOMP must provide an explanation satisfactory to the IRC of why neither has been granted or sought.

3. Should OSF SFMC or other major participating Institution of UICOMP that is a hospital lose accreditation or recognition, UICOMP will notify and provide a plan of response to the IRC within 30 days of such loss. It is understood that, based on the particular circumstances, the IRC may request the ACGME to invoke its “Procedure for Alleged Egregious or Catastrophic Events” policy.

D. ELIGIBILITY AND SELECTION OF RESIDENTS

The University of Illinois College of Medicine at Peoria (UICOM-P) must have written policies and procedures for resident/fellow recruitment and appointment and must monitor programs for compliance.

A. Residents

1. In selecting residents:
   a. UICOMP must ensure that its ACGME-accredited programs select from among eligible applicants on the basis of residency program–related criteria such as preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity, without regard to sex, race, age, religion, color, national origin, or veteran status.

   b. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada.
c. Residency programs must receive verification of each applicant’s level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program.

A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the TL-1 level and, at the discretion of the program director at the ACGME-accredited program and with the approval of the ACGME may be advanced to the TL-2 level based on ACGME Milestone assessments at the ACMG-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b (ACGME Common Program Requirements) for residency programs that require completion of a prerequisite residency program prior to admission. Review Committees will grant no other exceptions to these eligibility requirements for residency education.

d. In the case of an applicant with a disability, a determination will also be made as to whether “reasonable accommodation” would enable the individual to participate in all learning activities established in the program curriculum as essential to achieving the program’s general competency objectives as well as the ability to achieve attendance in the training program as required by the specialty or subspecialty board.

e. In selecting among qualified applicants, UICOM-P and all of its programs will participate in an organized matching program, such as the NRMP or AOA Matching Program.

f. Each program will ensure that an applicant invited to interview for a resident/fellow position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual employment. Information that is provided must include: financial support, vacations; parental, sick and other leaves of absence; and professional liability, hospitalization, health, disabilities and other insurance accessible to residents/fellows and their eligible dependents.

2. To be eligible for appointment as a resident, U.S. or Canadian graduate candidates must:

a. Be graduates from institutions in the U.S. or Canada whose programs are accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association.

b. Complete the approved residency application form providing all required information. (By ERAS for residency match or paper for transfers)
c. Provide the following documents with the application:

1) Dean's letter (residency program applicants); Program Director's letter (fellowship program applicants or transfers)

2) Medical school transcript

3) Three letters of professional reference

d. Appear for a personal interview with the Program Director or his/her designee and at least one additional faculty member and one resident, with each interviewer submitting a written critique of the candidate.

e. Provide official documentation of all standardized examinations that have been taken, including dates & scores for each sitting (e.g., USMLE, FLEX, COMLEX).

f. Meet requirements as set forth in the current Illinois Medical Practice Act for appropriate licensure.

g. For candidates who have previously been in one or more residency program, or those wishing to transfer from another program, documentation, as detailed in the UICOM-P Resident Transfer Policy will be required in addition to the provision of three letters of professional reference related to residency program performance.

3. To be eligible for appointment as a resident, from a medical school outside of the United States or Canada, the candidate must:

a. Meet one of the following additional qualifications:

1. Show proof of eligibility to enter an ACGME accredited residency by providing a current Educational Commission for Foreign Medical Graduates (ECFMG) Certificate prior to appointment.

2. Hold a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty/subspecialty program;

3. Have graduated from a medical school outside the United States and completed a Fifth Pathway** program provided by an LCME-accredited medical school.

b. Show that he/she holds a current and appropriate visa to enroll in a residency program, if a foreign national, or agree to obtain an appropriate visa prior to employment.

c. Provide official documentation of all standardized examinations that have been taken, including dates and scores or pass/fail results for each sitting (ECFMG, FMGEMS, FLEX, USMLE).
d. Provide official documentation of their score on both parts of the ECFMG and FMGEMS.

e. Demonstrate the ability to communicate in English by written and oral means.

f. Complete the approved residency application form, providing all required information.

g. Provide the following documents with the application:

1) Dean's letter (residency program applicants); Program Director’s letter (fellowship program applicants)

2) Medical school transcript

3) Medical school diploma or Fifth Pathway Certificate, if appropriate

4) Three letters of professional reference

5) Short biographical sketch

6) Certified translations of all documents that are not in English

h. For first year positions, make application to the program according to the guidelines of the NRMP or AOA Matching Program.

i. Appear for a personal interview with the Program Director or his/her designee with at least one additional faculty member and one resident, with each interviewer submitting a written critique of the candidate.

j. Meet requirements as set forth in the current Illinois Medical Practice Act for appropriate licensure.

4. For candidates who have previously been in one or more residency program, or those wishing to transfer from another program, documentation, as detailed in the UICOM-P Resident Transfer Policy will be required in addition to the provision of provide three letters of professional reference related to residency program performance.

5. In the case of an applicant with a disability, a determination will also be made as to whether “reasonable accommodation” would enable the individual to participate in all learning activities established in the program curriculum as essential to achieving the program’s general competency objectives as well as the ability to achieve attendance in the training program as required by the specialty or subspecialty board.

6. The Program Director is authorized to select any applicant after the match without GMEC approval. Names of residents who meet the criteria should be announced at the next GMEC meeting. The Program Director is accountable to the GMEC for the residents he/she selects.
A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following condition: (1) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical; (2) have studied at a medical school outside the United States and Canada but listed in the World Health Organization Director of Medical Schools; (3) have completed all the formal requirements of the foreign medical school except internship and/or social service; (4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 & 2 of the United States Medical Licensing Examination (USLME).

Eligibility Requirements – Fellowship Programs

1. All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada.

   a. Fellowship programs must receive verification of each entering fellow’s level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.

   b. Fellow Eligibility Exception

      A Review Committee may grant the following exception to the fellowship eligibility requirements:

      An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed but who does meet all of the following additional qualifications and conditions.

      1. Assessment by the program director and fellowship selection committee of the applicant’s suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and

      2. Review and approval of the applicant’s exceptional qualifications by the GMEC or a subcommittee of the GMEC; and

      3. Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and,

      4. For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and
5. Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant’s Milestones evaluation conducted at the conclusion of the residency program.

   a. If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the Competency Committee and the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training.

**An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program. [Each Review Committee will decide whether the exception specified above will be permitted.]

E. RESIDENT COMPLEMENT

- The number of residency positions that may be offered by each residency program is determined by the Joint Oversight Committee of Academic Programs (JOCAP), which consists of senior administrators from OSF SFMC and, OSF ministry and from UICOMP (including, the Regional Dean, Associate Dean for GME [DIO], the Associate Dean for Academic Affairs, and one or more senior faculty members (appointed by the Regional Dean).

- The number of residency positions cannot exceed the complement assigned by the relevant review committee.

- The program’s educational resources must be adequate to support the number of residents appointed to the program. The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements.

F. FINANCIAL SUPPORT FOR RESIDENTS

OSF SFMC will provide all residents with appropriate financial support and benefits to ensure that he/she is able to fulfill the responsibilities of their ACGME-accredited program.
G. BENEFITS and CONDITIONS OF APPOINTMENT

Candidates for programs (i.e. applicants who are invited for an interview) are given the web address for the current House Staff Manual and a hard copy of the Resident Agreement which detail the terms, conditions, and benefits of their appointment including duration of appointment; financial support; vacations, parental/sick and other leaves of absence; professional liability; hospitalization, health, disability, and other insurance provided for the residents and their families; the conditions under which call rooms, meals, laundry services or their equivalents are provided; resident responsibility; and conditions for reappointment. Candidates who are selected for residency positions under UICOMP sponsorship will be sent a Resident Agreement (contract) and the link to the current House Staff Manual. (see Benefits section IV. in this manual for additional information regarding benefits provided for house staff.)

H. AGREEMENT OF APPOINTMENT

1. UICOMP/OSF SFMC provides all residents with a written agreement of appointment/contract outlining the terms and conditions of appointment.

2. The Resident Agreement requires approval of the GMEC, the Program Director and the OSF HealthCare System.

3. UICOMP/OSF SFMC monitors programs with regard to implementation of terms and conditions of appointment by Program Directors. Compliance is, in part, documented by review of the ACGME Resident Survey and during the meeting with residents when the Annual Review of the particular program is conducted.

4. The first year postgraduate Resident Agreement is issued in accordance with NRMP guidelines.

5. The Resident Agreement contains or provides reference to the following institutional policies:
   a. Residents’ Responsibilities (see Resident Responsibilities, section III.)
   b. Duration of Appointment
   c. Financial Support
   d. Conditions for Reappointment:
      1) Signing a Resident Agreement does not guarantee issuance of a Resident Agreement for the next training period. However, residents who are deemed to be meeting the responsibilities described herein and in the specialty-specific manual will be offered consecutive agreements that will allow them to complete their residency program. Residents whose contracts are not being renewed will receive at least four months written notice of the decision not to reappoint them, except when a resident is terminated for exhibiting egregious behavior or when the primary reason for non-continuance occurs within the four months prior to the end of the resident’s contract. In these circumstances, residents will receive as much written notice, prior to the end of their contract, as circumstances allow.
      2) Residents who receive a written notice of the intent not to renew their contract or of intent to renew their agreement but not promote them to the next level of training may
appeal this decision by following the UIC grievance procedure. Note: Residents may not utilize the OSF SFMC grievance procedure to appeal a contract non-renewal.

e. Grievance Procedures and Due Process

UICOMP/OSF SFMC provides residents with fair, reasonable, and readily available written institutional policies and procedures for grievance and due process. These policies minimize conflict of interest by adjudicating parties in addressing:

1) Academic or other disciplinary actions taken against residents that could result in dismissal, non-renewal of a resident’s agreement, non-promotion of a resident to the next level of training, or other actions that could significantly threaten a resident’s intended career development and,

2) Adjudication of resident complaints and grievances related to the work environment or issues related to the program or faculty.

f. Professional Liability Insurance

1) UICOMP/OSF SFMC provides residents with professional liability coverage and with a summary of pertinent information regarding this coverage (described in Benefits, section IV.A.6.d.).

2) Liability coverage includes legal defense and protection against awards from claims reported or filed after the completion of the program(s) if the alleged acts or omissions of the residents are within the scope of the program(s) (described in Benefits, section IV.A.6.d.).

g. Health and Disability Insurance

UICOMP/OSF SFMC provides hospital and health insurance benefits for the residents and their families (see Benefits). Coverage for such benefits begins on the first recognized day of their respective programs, consistent with OSF policy for employees. UICOMP/OSF provides Long-Term and Short-Term Disability plans to all residents for disabilities resulting from activities that are part of the educational program (described in Benefits, section IV.A.9.b. and c.). If the first day of health insurance eligibility is not the first day that residents/fellows are required to report, then the resident/fellow will be given advanced access by the hospital to information regarding interim coverage so that they can purchase coverage if desired. This information will be included with the HR welcome packet.

h. Leaves of Absence

1) UICOMP/OSF SFMC has institutional policies on residents’ vacation and other leaves of absence as detailed in the Benefits section of this manual. These include parental and sick-related leaves of absence (see Benefits, section IV.A.4.b.).

2) UICOMP/OSF SFMC ensures that each program provides residents with:

   a) Access to Program Requirements concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program and;
b) Access to information relating to eligibility for certification by the relevant certifying board.

i. Duty Hours (see section II.J.)

1) Program Director’s Responsibilities in Relation to Duty Hours

a) Residency and fellowship Program Directors will ensure that their programs are in compliance with ACGME, RRC, and Program duty hour’s requirements.

b) Residency and Fellowship Program Directors must develop procedures to monitor the duty hours of his/her residents and fellows. Such procedures must be approved by the GMEC.

c) Residency and Fellowship Program Directors will provide a monthly, written report to the GME Office that identifies any significant, recurring exceptions to the all duty hour requirements. Such report will include the description of a plan to bring the program into compliance with ACGME requirements, violations, and the number of residents committing such violations. This report will include an action plan to bring the program into compliance with ACGME requirements.

2) Institutional (DIO/GMEC) Oversight in Relation to Duty Hours

a) The Associate Dean for Graduate Medical Education will use the ACGME anonymous survey documents for residents to report their compliance or noncompliance with the duty hours requirements.

b) The residents in each program can request to meet with the Associate Dean for Graduate Medical Education and/or one of the house staff officers for a confidential discussion of duty hours issues and other issues of concern to the residents. Follow up on their concerns will be undertaken and written feedback provided to the residents.

c) Based on the findings of the ACGME Resident Survey Summary the DIO will call a meeting with the Chair, Program Director and/or residents to discuss duty hours and work to resolve any issues.

d) The results of the resident surveys and interview, as it pertains to the duty hours requirements, will be reported by the Associate Dean to the GMEC.

f) The GMEC will require the program director to correct any areas of noncompliance with the duty hours requirements, and to report progress made in correcting those violations at each subsequent meeting of the GMEC until the program is in full or substantial compliance with the requirements.

3) Resident Responsibilities in Relation to Duty Hours

a) Residents are expected to comply with the ACGME, RRC, and program duty hour’s requirements.

b) Residents will inform their Program Director when circumstances prevent them from being in compliance with ACGME, RRC, and program duty hours requirements.
c) Residents who choose to do so may report infractions of duty hour's requirements to the house Staff President or Vice President, one of the MMCI Chief Residents, or the Associate Dean for Graduate Medical Education (671-8450).

j. Moonlighting

1) UICOMP/OSF SFMC has a written policy that addresses employment outside the residency, or moonlighting. This policy states that:

a) Residents are not required to engage in moonlighting.

b) TL-1 level residents are not permitted to moonlight.

c) Residents must notify the Program Director of his/her intention to moonlight prior to engaging in this activity.

d) A prospective, written statement of permission is required from the Program Director that will be included in the resident’s file should a resident elect to engage in moonlighting.

e) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. The resident’s performance will be monitored for the effect of these activities and adverse effects on resident performance may lead to withdrawal of permission.

f) Professional liability insurance coverage provided by OSF SFMC/ UPHM does not extend to any activity performed outside of residency program approved activities.

g) Temporary licensure does not cover the practice of medicine outside of educational venues approved by the residency-training program.

h) Residents may not use the OSF SFMC/ UPHM (institutional) DEA number when writing prescriptions outside of their duties as a resident.

i) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) even during vacation time must be counted toward the 80-hour Maximum Limit.

k. Counseling Services

UICOMP/OSF SFMC will facilitate resident access to confidential counseling, and medical and psychological support services (see Resident Health Policies, section III.J.3-4. and Benefits, IV.A.7.).

l. Physician Impairment

UICOMP/OSF has written policies which address physician impairment, including that due to drug abuse (see Resident Health Policies, III.J.3-4.).

m. Harassment
UICOMP/OSF SFMC is committed to creating and maintaining an environment in which students, faculty and administrative academic staff can work together in an atmosphere free of all forms of harassment, exploitation or intimidation, on any basis prohibited by law including harassment based on sex (see Complaints, III.I.2.). Intimidation of residents may lead to removal from the teaching faculty.

n. Accommodation for Disabilities

UICOMP/OSF SFMC have written policies regarding accommodation which applies to residents and resident candidates with disabilities (see Policy Manual).

o. The resident should contact the Program Director directly concerning:

1) Resident Agreements;
2) Documentation required by the Resident Agreement;
3) Licensure, Federal Drug Enforcement Administration Registration, Illinois Controlled Substances Registration;
4) Parking cards and name badges;
5) Certificate of training;
6) Resident health policies and benefits; (see section III.J.);
7) Program transfer; (see section III.L.);
8) Service assignments, responsibilities, problems, complaints;
9) Faculty appointments with UICOMP;
10) Absences – vacations, meetings, illness, etc.;
11) Evaluations;
12) Employment outside the residency program;
13) Desired program transfer; and
14) Resignation (see section II.M.8.).

p. Closures and Reductions

UICOMP/OSF SFMC has a written policy for residency program closure or reductions (see Policy Manual). It states:

1) a decision made by the University of Illinois College of Medicine at Peoria (UICOMP) and its educational partner, OSF SFMC, to close or reduce the size of a residency program will be accomplished by attrition, i.e., by reducing the number of new residents accepted into the program. UICOMP/OSF SFMC will continue to support the residency
program until all current residents have completed the program. *NB: A residency candidate that has been offered a position, and has signed a resident agreement [i.e., contract for employment as a resident], is considered to be a current resident.*

2) The DIO, GMEC and relevant residents will be informed about any decision on the part of UICOMP/OSF SFMC to close or reduce the size of a program as soon as practicable after the decision has been finalized. Those residents who wish to transfer to another program will be assisted by the Program Director and DIO to identify an alternative program in which they can continue their education.

q. Restrictive Covenants

Neither UICOMP/OSF SFMC nor its program may require residents to sign a non-competition guarantee (see Policy Manual).

I. RESIDENT PARTICIPATION IN EDUCATION AND PROFESSIONAL ACTIVITIES

1. UICOMP ensures that each program provides effective educational experiences for residents that lead to measureable achievement of educational outcomes in the ACGME competencies as outlined in the Common and specialty/subspecialty-specific Program Requirements.

2. UICOMP ensures that residents:

a. Participate in committees and councils whose actions affect their education and/or patient care. A resident from each specialty program is required to participate in the Annual Program Review. A Resident, who has completed core residency program in his/her specialty and is eligible for specialty board certification may be a member of the program’s Clinical Competency Committee. The House Staff President and one of the UPHM Chief Residents are *ex officio*, voting members of the GMEC. The Internal Medicine SOAR Resident sits on the Professional Staff Quality Improvement Committee of OSF SFMC and the House Staff President sits on the Equal Employment Opportunity and Affirmative Action Committees of UICOMP.

b. Residents sit on the Resident Safety Council, AIAMC National Initiative VI, Resident Council, Laboratory Committee, Needle Stick Committee, Pharmacy and Therapeutics Committee and Children’s Hospital Quality Safety Council at OSF SFMC. Two UICOMP residents sit on the Patient Safety Committee, which is charged with maintaining a safety curriculum for our house staff. Internal Medicine residents are engaged in a six sigma project designed to improve patient hand-offs. At Methodist, residents sit on the Bioethics Committee and CPR Committee.

J. THE LEARNING AND WORKING ENVIRONMENT

UICOMP, together with its education partner OSF, ensures that residency education occurs in the context of a learning and working environment that emphasizes the following principles:

1. Excellence in the safety and quality of care rendered to patients by residents today
2. Excellence in the safety and quality of care rendered to patients by today’s residents in their future practice

3. Excellence in professionalism through faculty modeling of:
   a. The effacement of self-interest in a humanistic environment that supports the professional development of physicians
   b. The joy in curiosity, problem-solving, intellectual rigor, and discovery

4. Commitment to the well-being of the residents, faculty members, students, and all members of the health care team

A. Patient Safety, Quality Improvement, Supervision and Accountability

1. Patient Safety and Quality Improvement: All physicians share responsibility for promoting patient safety and enhancing quality of patient care. UICOMP/OSF SFMC will prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care. Residents must demonstrate the ability to analyze the care they provide, understand their role within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures. It is necessary for residents and faculty members to consistently work in a well-organized manner with other health care professionals to achieve organizational patient safety goals.

A) Patient Safety

a. Culture of Safety: A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. UICOMP/OSF SFMC has formal mechanisms to access the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas of improvement.
   a. The program, its faculty, residents and fellows must actively participate in patient safety systems and contribute to a culture of safety.
   b. The program must have a structure that promotes safe, interprofessional, team-based care.

b. Education on Patient Safety: Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques.

c. Patient Safety Events: Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanism for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.
a. Residents, fellows, faculty members, and other clinical staff members must: know their responsibilities in reporting patient safety events at the clinical site; know how to report patient safety events, including near misses, at the clinical site; and be provided with summary information of our institution’s patient safety reports.

b. Resident must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.

d. Resident Education and Experience in Disclosure of Adverse Events: Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

   a. All residents must receive training in how to disclose adverse events to patients and families.

   b. Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.

B) Quality Improvement

1. Education in Quality Improvement: A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals. Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.

2. Quality Metrics: Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts. Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.

3. Engagement in Quality Improvement Activities: Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care. Residents must have the opportunity to participate in inter-professional quality improvement activities. This should include activities aimed at reducing health care disparities.

2. Supervision and Accountability:
   UICOMP and its educational partners have guidelines for the supervision of residents (see Policy on Resident Supervision, Attachments 4 and 5).

   A. Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. UICOMP/OSF SFMC, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.
Supervision in the setting of graduate medical education provides safe and
effective care to patients; ensures each resident’s development of the skills,
knowledge, and attitudes required to enter the unsupervised
practice of medicine; and establishes a foundation for continued professional
growth.

1. Each patient must have an identifiable and appropriately-
credentialed and privileged attending physician (or licensed
independent practitioner as specified by the applicable Review
Committee) who is responsible and accountable for the patient’s
care.
   a. This information must be available to residents, faculty
      members, other members of the health care team, and
      patients.
   b. Residents and faculty members must inform each patient
      of their respective roles in the patient’s care when
      providing direct patient care.

B. Supervision may be exercised through a variety of methods. For many aspects
of patient care, the supervising physician may be a more advanced resident or
fellow. Other portions of care provided by the resident can be adequately
supervised by the immediate availability of the supervising faculty member,
fellow, or senior resident physician, either on site, or by means of telephonic
and/or electronic modalities. Some activities require the physical presence of the
supervising faculty member. In some circumstances, supervision may include
post-hoc review of resident-delivered care with feedback.
   a. The program must demonstrate that the appropriate level of supervision
in place for all residents is based on each resident’s level of training and
ability, as well as patient complexity and acuity. Supervision must be
exercised through a variety of methods, appropriate to the situation. [The
Review Committee may specify which activities require different levels of
supervision.]

C. Levels of Supervision:
   To promote oversight of resident supervision while providing for graded authority
and responsibility, the program must use the following classification of
supervision:
   1. Direct Supervision – the supervising physician is physically present with the
      resident and patient.
   2. Indirect Supervision:
      – with Direct Supervision immediately available – the supervising physician is
      physically within the hospital or other site of patient care, and is immediately
      available to provide Direct Supervision.
      – with Direct Supervision available – the supervising physician is not
      physically present within the hospital or other site of patient care, but is
      immediately available by means of telephonic and/or electronic modalities,
      and is available to provide Direct Supervision.
3. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

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

E. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).
   a. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.
   b. Initially, TL-1 residents must be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which TL-1 residents progress to be supervised indirectly with direct supervision available.]

F. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.

B. Professionalism

1. Programs, in partnership with UICOMP/OSF SFMC, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.

2. The learning objectives of the program must:
   a. be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events;
   b. be accomplished without excessive reliance on residents to fulfill non-physician obligations;
   c. ensure manageable patient care responsibilities.

3. The Program Director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility

4. Residents and faculty members must demonstrate an understanding of their personal role in the:
   a. provision of patient- and family-centered care;
   b. safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;
c. assurance of their fitness for work, including:
   1. management of their time before, during, and after clinical
      assignments; and,
   2. recognition of impairment, including from illness, fatigue, and
      substance use, in themselves, their peers, and other members of the
      health care team.

d. commitment to lifelong learning;

e. the monitoring of their patient care performance improvement
   indicators; and,

f. accurate reporting of clinical and educational work hours, patient
   outcomes, and clinical experience data.

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

6. Programs must provide a professional, respectful, and civil
environment that is free from mistreatment, abuse, or coercion of
students, residents, faculty, and staff. Programs, in partnership with
UICOMP/OSF SFMC, should have a process for education of
residents and faculty regarding unprofessional behavior and a
confidential process for reporting, investigating, and addressing such
concerns.

C. Well-Being
   In the current health care environment, residents and faculty members are at increased risk for
burnout and depression. Psychological, emotional, and physical well-being are critical in the
development of the competent, caring, and resilient physician. Self-care is an important component
of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects
of residency training. Programs, in partnership with UICOMP/OSF SFMC, have the same
responsibility to address well-being as they do evaluate other aspects of resident competence.

1. The responsibility must include:
   a. efforts to enhance the meaning that the resident finds in the experience of
      being a physician, including protecting time with patients, minimizing non-
      physician obligations, providing administrative support, promoting
      progressive autonomy and flexibility, and enhancing professional
      relationships;
   b. attention to scheduling, work intensity, and work compression that
      impacts resident well-being;
   c. evaluating workplace safety data and addressing the safety of residents
      and faculty members;
   d. policies and programs that encourage optimal resident and faculty
      member well-being; and,
1. Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.
   e. attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with UICOMP/OSF SFMC, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with UICOMP/OSF SFMC must:
      1. encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence;
      2. provide access to appropriate tools for self-screening; and,
      3. provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work.

   In the event that a resident is unable to begin or finish a shift, he/she will report the situation to the Chief Resident. The Chief Resident will then contact the resident on “standby” (or “jeopardy”) who will then assume the infirmed resident’s shift. If the Chief Resident is unavailable, the attending or senior on service should be contacted. If neither can be reached, the Program Director must be called. If the situation involves a resident who is on duty, the infirmed resident may either go to one of the assigned call rooms or home depending upon his/her physical condition. Transportation to and from the training site will be made available to the resident through the Nursing Supervisor on call.

D. Fatigue Mitigation
   1. Programs must:
      a. educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
      b. educate all faculty members and residents in alertness management and fatigue mitigation processes; and,
      c. encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.
d. UICOMP/OSF SFMC has made available the Sleep, Alertness and Fatigue Education in Residency (SAFER) module, in response to this required education. Whether is it accomplished by the use of the SAFER module or some other method, education on fatigue must be documented and verification provided to GMEC by the program director every academic year.

2. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in C.2 (above), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue.

3. The Program, in partnership with UICOMP/OSF SFMC, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.
   - **OSF Residents**: may ask for a travel voucher for a taxi from the night supervisor or a social worker during the day.
   - **UPHM Residents**: may be provided transportation to and from the hospital via the patient delivery system; if not available a taxi voucher will be provided.

E. **Clinical Responsibilities, Teamwork, and Transitions of Care**

1. **Clinical Responsibilities**: The clinical responsibilities of each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. [Optimal clinical workload may be further specified by each Review Committee]

2. **Teamwork**: Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in that specialty and larger health system. [Each Review Committee will define the elements that must be present in each specialty.]

3. **Transitions of Care**:
   a. Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.
   b. Programs, in partnership with UICOMP/OSF SFMC, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
   c. Programs must ensure that residents are competent in communicating with team members in the hand-over process.
   d. Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.
   e. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in C.2 (above), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.
   f. The following elements should be considered in resident hand-offs:
      1. The hand-off should occur in a quiet place removed from clinical areas.
      2. The hand-off should take place at a previously designated time each day.
      3. A senior or ideally a faculty member should be present.
      4. Hand-off should be orally communicated but available in written form as well.
F. **Clinical Experience and Education**

Programs, in partnership with UICOMP/OSF SFMC, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

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

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

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

4. **Clinical and Educational Work Hour Exceptions**
   In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
   a. to continue to provide care to a single severely ill or unstable patient;
   b. humanistic attention to the needs of patient or family; or,
   c. to attend unique educational events.
      These additional hours of care or education will be counted toward the 80-hour weekly limit. A review committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

5. **Moonlighting**
   a. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident’s fitness for work nor compromise patient safety.
b. Time spent by residents in internal and external moonlighting must be counted toward the 80-hour maximum weekly limit.
c. TL-1 residents are not permitted to moonlight.

6. In-House Night Float
   Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

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

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

K. RESIDENT AIDS IN THE WORK ENVIRONMENT

1. UICOMP provides an educational and work environment in which residents may raise concerns and provide feedback to resolve issues without fear of intimidation or retaliation and in a confidential manner as appropriate (see Complaints, III.I.). Mechanisms which facilitate achievement of an appropriate work environment for the resident include:
   a. Meetings of the House Staff President with the representatives from each specialty program (i.e., the resident council) to discuss any issue(s) of importance to his/her respective program two times per year.
   b. Email service accessible only to our house staff where residents can communicate with each other and/or the house staff officers and express any concerns they might have in a confidential and protected manner.
   c. Biweekly meetings between the House Staff President and Vice-President, the DIO, and OSF SFMC Director of Medical and Academic Affairs to discuss any resident-related issues that are brought to the attention of house staff officers.
   d. An annual meeting of the House Staff President with all residents which serves as an open forum where resident concerns may be expressed.

2. UICOMP’s educational partner, OSF SFMC, provides services and has developed a health care delivery system to minimize residents’ work that is extraneous to the GME programs’ educational goals and objectives and ensure that residents/fellows educational experience
is not compromised by excessive reliance on them to fulfill non-physician service obligations. These services include:

a. Patient support services: Peripheral intravenous access placement, phlebotomy, laboratory, pathology and radiology services and patient transport services provided in a manner appropriate to and consistent with educational objectives and to support high quality and safe patient care.

b. Laboratory/pathology/radiology services: Laboratory, pathology, and radiology services in place to support timely and quality patient care.

c. Electronic Medical records: An electronic medical records system available at all sites that documents the course of each patient’s illness and care available at all times and adequate to support high quality and safe patient care, residents’ education, quality assurance activities, and provide a resource for scholarly activity.

d. Patient Safety: access to systems for reporting errors, adverse events, unsafe conditions, and near misses in a protected manner that is free from reprisal via the Verge system. Opportunities to contribute to root cause analysis or other similar risk-reduction processes.

e. Quality Improvement: access to data to improve systems of care, reduce healthcare disparities, and improve patient outcomes. Residents can participate in the Resident Safety Council and have an opportunity to work with the six sigma team to participate in quality improvement activities.

3. UICOMP and its educational partner, OSF SFMC, ensures a healthy and safe work environment that provides for:

a. Food services: The OSF SFMC cafeteria is open 24 hours/day. Residents are permitted free food at all times while on duty, independent of call status. For details, see Benefits, section IV.A.10.

b. Call rooms: Residents on call are provided with adequate and appropriate sleeping quarters that are safe, quiet, private, and within reasonable proximity to in-house patients to support education and safe patient care.

c. Security/safety: Appropriate security and personal safety measures are provided to residents at all locations including, but not limited to, parking facilities, on-call quarters, hospital and institutional grounds, and related facilities.

L. EVALUATION

1. Resident Evaluation
   The program director must appoint the Clinical Competency Committee
   a. At a minimum the Clinical Competency Committee must be composed of three members of the program faculty.
i. The program director may appoint additional members of the Clinical competency Committee.
   a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program’s residents in patient care and other health care settings.
   b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee.

b. There must be a written description of the responsibilities of the Clinical Competency Committee.
   i. The Clinical Competency Committee should:
      a) Review all resident evaluations semi-annually;
      b) Prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and
      c) Advise the program director regarding resident progress, including promotion, remediation, and dismissal.

2. Formative Evaluation
   a. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.
   b. The program must:
      i. Provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones;
      ii. Use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
      iii. Document progressive resident performance improvement appropriate to educational level; and
      iv. Provide each resident with documented semiannual evaluation of performance with feedback.
   c. The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

3. Summative Evaluation
   a. The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program.
   b. The program director must provide a summative evaluation for each resident upon completion of the program. The evaluation must:
      i. Become part of the resident’s permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy;
      ii. Document the resident’s performance during the final period of education; and
      iii. Verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

4. Faculty Evaluation
   i. At least annually, the program must evaluate faculty performance as it relates to the educational program.
   ii. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
   iii. This evaluation must include at least annual written confidential evaluations by the residents.
5. Program Evaluation and Improvement

i. The program director must appoint the Program Evaluation Committee (PEC). The Program Evaluation Committee:
   a) Must be composed of at least two program faculty members and should include at least one resident;
   b) Must have a written description of its responsibilities; and should participate actively in:
      i. Planning, developing, implementing, and evaluating educational activities of the program;
      ii. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
      iii. Addressing areas of non-compliance with ACGME standards; and
      iv. Reviewing the program annually using evaluations of faculty, residents, and others, as specified below.

ii. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE).

The program must monitor and track each of the following areas:
   a) Resident performance;
   b) Faculty development;
   c) Graduate performance, including performance of program graduates on the certification examination
   d) Program quality; and
      i. Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
      ii. The program must use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program.
   e) Progress on the previous year’s action plan(s).

iii. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in 4.b., as well as delineate how they will be measured and monitored
   a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
   b) A copy of the Annual Program Evaluation must be submitted to the GMEC.

M. Advancement

The Program Director has the ultimate responsibility for the recommendation of resident advancement. The Clinical Competence or Education Committee is advisory to the Program Director.

The GMEC must approve all advancement recommendations.
a. Mechanism:
   i. The Program Director presents his/her advancement recommendations to the February GMEC meeting after receiving the advice of his/her Clinical Competence or Education Committee.
   
   ii. The material on which the recommendation is based is made available to the GMEC through the Program Director.
   
   iii. Approval by the GMEC instructs the Program Director to complete the Resident Agreement process and to forward the Agreements to the OSF Administrator.
   
   iv. For residents not serving on a traditional academic year schedule (i.e., July through June), the date of the GMEC review will be four months prior to the expiration of their current agreement date.
   
   v. For residents on probation or to be dismissed, see Resident Discipline and Grievance Procedures, section V.

b. All states require passage of a licensing exam(s) before a license to practice medicine will be issued. At UICOMP, residents must pass all parts of the USMLE or COMLEX exam as a requirement for graduation from his/her program. It is mandated that residents complete taking all parts of the licensing exam before the end of his/her second year of residency for those in 3 year programs and before the end of his/her third year of residency for those in programs of 4 years or more.

N. OTHER INSTITUTIONAL POLICIES OF IMPORTANCE TO RESIDENTS

1. Disaster Policy
   UICOMP/OSF SFMC has developed a policy to define the process and procedures for graduate medical education programs in the event of a disaster (see Policy Manual).

2. Relationships with Industry Policy
   UICOMP/OSF SFMC has guidelines for resident and faculty to manage interactions between the healthcare industry and its faculty, residents and students (see Relationships with Industry – Attachment 6).

3. Resident Deposition Policy
   This policy provides guidelines for residents to follow when presented with a request for a deposition and is applicable to depositions regarding patients for which the resident has provided care as part of his/her training program (see Policy Manual and Resident Responsibilities, section III.O.).

4. Licensure
   a. Prior to the start of each postgraduate training year (PGY), all residents must have either a Temporary Certificate or Permanent License in order to see patients. The State of Illinois requires:
TL-1: Temporary Certificate* OR Permanent Illinois License (for those who have previously completed 24 or more months of training in an accredited U.S. residency program and have satisfied the examination requirements).

TL-2: Temporary Certificate* OR Permanent Illinois License (for those who have previously completed 24 or more months of training in an accredited U.S. residency program and have satisfied the examination requirements).

TL-3: Temporary Certificate* OR Permanent Illinois License (for those who have previously completed 24 or more months of training in an accredited U.S. residency program and have satisfied the examination requirements).

TL-4: Extended Temporary Certificate OR Permanent Illinois License**

TL-5: Extended Temporary Certificate OR Permanent Illinois License**

TL-6: Extended Temporary Certificate OR Permanent Illinois License**

*It is illegal to practice medicine outside of the residency-training program with a temporary certificate.

**Individual Program Directors may require permanent licensure of all residents at TL-4 level and above.

Temporary Certificates and Permanent Licenses are issued by:
State of Illinois Department of Professional Regulation
320 W. Washington, 3rd Floor
Springfield, IL 62786

b. Application forms for Illinois temporary and permanent licensure and Illinois Controlled Substance License are available in the Program Director’s office. It is the resident’s responsibility to submit the completed applications, and to provide the licensure fee, and all supporting documents directly to the Program Director’s Office at least 90 days prior to the effective date of the Resident Agreement. All original documents will be sent to the GME Office for processing. Copies will be kept by the Program Director, GME Office, and resident.

c. Prior to beginning a residency program at TL levels 1, 2, and 3, the resident must have on file in the Program Director’s office, the original of his/her temporary license. Fully executed temporary licenses are issued by the Illinois Department of Professional Regulation (IDPR) and mailed directly to the GME Office. The original will be retained in the Program Director’s office with copies given to the resident and GME Office.

d. It has become standard policy for pharmacies and third party payers to use a physician’s federal DEA number as a physician identifier on all prescriptions, not just those written for controlled substances. To assist these pharmacies and third party payers, OSF SFMC issues a Hospital-Assigned DEA Number to each resident for use until a Federal DEA number is obtained. Use of the hospital DEA number with the three digit resident identifier, shall therefore serve as:

i. A physician identifier, and
ii. Shall permit the resident to prescribe Class II, III, IV, and V Controlled Substances to be filled in a retail setting when used within the context of his/her residency training. The Hospital Assigned DEA number is not for personal or family use and may not be used in any non-residency-related activity. Note: there may be programmatic restrictions to this policy for 1st year residents. Please see the program specific manuals.

e. Prior to beginning a residency program at training levels 4 and above, the resident must submit and have on file in the Program Director’s office a copy of his/her completed application for permanent licensure, or the permanent medical license, or an extended temporary certificate.

When applying for a permanent license, the resident should also complete an application for his/her Illinois Controlled Substance License and submit both applications directly to the Illinois Department of Professional Regulation.

Both the permanent medical license and Controlled Substance License are issued by the Illinois Department of Professional Regulation directly to the resident, who must then provide copies of both licenses to the Program Director’s office and GME Office.

f. Following receipt of the permanent medical license and Illinois Controlled Substance License, the resident must contact the United States Department of Justice, Drug Enforcement Administration, P.O. Box 28083, Central Station, Washington, D.C., 20005, to obtain a DEA-224 application in order to obtain a federal DEA license. The resident must provide copies of the DEA certification to the Program Director’s Office and GME Office on receipt of such certification.

g. Fulfillment of licensure requirements (as outlined above) is a prerequisite to issuance of an Agreement.

h. The resident is responsible for following the State of Illinois Medical Practice Act and Rules at all times. This document is on file in the GME Office.

5. Documentation

a. The resident is required to submit copies of the following documents to the Program Director’s office for inclusion in his/her permanent file.

i. Medical School Diploma

ii. Completed, dated application for temporary Illinois licensure

iii. Completed, dated documentation for extended temporary licensure (if submitted)

iv. Completed, dated application for permanent Illinois licensure

v. Permanent Illinois license (if obtained)

vi. Illinois Controlled Substance Certificate

vii. DEA Certificate (if obtained)

viii. National Board scores, USMLE (if applicable)
ix. FLEX scores (if applicable)

x. ECFMG or FMGEMS Certificate (if applicable)

xi. Visa (if applicable)

xii. Certified translation of all documents not written in English

b. All residents are strongly encouraged to maintain their own personal files at home including all of the above items. No documents or correspondence regarding licensure should ever be mailed to state or federal agencies without first making a copy. Further, it is recommended that documents be mailed “Return Receipt Requested” so that proof of receipt by that agency can be produced when necessary.

6. Appearance and Conduct (see OSF Policy #115 on Personal Appearance, Attachment 2)

a. The appearance and conduct of the resident will at all times reflect the dignity and standards of the medical profession as well as those of UICOMP and OSF SFMC.

i. Each resident will provide quality health care to the best of his/her abilities.

ii. Residents will provide quality health care in a manner that is not demeaning to any patient.

iii. The resident should always remain cognizant of the vulnerability of a patient in the physician-patient relationship and not take advantage of the patient for personal or sexual gain, or attempt to impose change in the patient’s religious beliefs.

iv. Violations of appearance and conduct are considered infractions of professionalism.

b. Uniform Coats and Scrub Suits

i. The House Staff uniform is a blue pinstriped laboratory coat with a UICOMP insignia. The resident is expected to wear clean professional clothing with a well-kept House Staff uniform (see OSF Policy #115 for details).

ii. Fresh OSF scrub suits are to be worn in Labor and Delivery, Surgical Suites and Recover, the Neonatal Intensive Care Unit, and for Special Procedures Rooms for infection control purposes of maintaining a clean environment. If they are worn outside these areas, residents are to wear a laboratory coat over them. Scrub suits must be changed for re-entry if the resident goes outside the hospital campus.

iii. Scrub suits are not to be worn for routine hospital rounds, routine duties (including post-call duties), or when seeing patients in the ambulatory clinic offices, such as the Ambulatory Internal Medicine Center (AIM), Pediatric Ambulatory Center (PAC), or Specialty Clinics. However, residents scheduled in the Operating Room, or on Trauma, Medical Intensive Care Unit, Night Float, or Emergency Medicine Services may wear scrub suits for hospital duties.

iv. House Staff Physicians on-call may wear scrub suits with a laboratory coat during the hours of call because of the added comfort and convenience of the attire. However,
scrub suits must be changed when entering a designated clean environment as noted above.

v. Scrub suits are not to be worn outside the hospital.

vi. Residents receive two sets of scrub suits at orientation, which may be exchanged if they become soiled or damaged. However, additional scrub suits are not to be taken home.

7. Resident Resignation

a. Residents may resign from their employment and withdraw from the residency-training program by sending a letter of resignation to his/her Program Director. Although a minimum of two week’s notice is required, residents are encouraged to work with their Program Director to identify a mutually agreeable termination date. The resident’s termination of employment by OSF SFMC, and enrollment in the UICOMP-sponsored residency program will occur concurrently. The Program Director will draft a statement of the circumstances surrounding the resignation, and a copy of this letter and the resident’s letter of resignation, will be maintained in the resident’s permanent file in the residency program office and the OSF SFMC Department of Human Resources.

b. A resident may elect not to continue his/her employment as a resident by not signing a renewal Resident Agreement when it is offered. Those who elect this option will be allowed to continue as residents, without prejudice, under the terms of their current agreement.

8. Physician Impairment Training/Alertness Management and Fatigue Mitigation and Substance Abuse (fatigue and substance abuse) (see section II.H.5.l.)

9. Institutional Review of Programs Policy (Complete Review Policy to follow)

UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA

Office of Graduate Medical Education

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<td>Institutional Review of Programs</td>
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PURPOSE:

The ACGME requires that all institutions which sponsor ACGME accredited GME programs have an organized process for review of its residency programs. This process is an important component of the Graduate Medical Education Committee’s (GMEC’s) oversight responsibility of its residency program(s) and is the charge of the Institutional Review of Programs Committee (IRPC) at UICOMP. The IRPC is a subcommittee of the GMEC which assists the residency director(s) in preparing for the Review Committee
(RC) site survey, by assessing the program’s compliance with the ACGME Institutional, Common, and specialty-specific Program Requirements effective July 1, 2015.

**POLICY:**

It is the GMEC’s responsibility to demonstrate oversight of all ACGME accredited programs and identify any underperforming programs. The IRPC will review each ACGME accredited program with the objective of identifying quality improvement goals and areas of concern and suggesting corrective actions that may enhance program performance. The IRPC presents its findings and recommendations to the GMEC. Should a program be identified as underperforming, a Special Review will be initiated (see below).

**PROCEDURE:**

A. **Timing**

The Institutional Review of Programs Committee will review each residency program approximately every 18 months. When the review process is initiated, it is documented in the GMEC or Administrative Council minutes. In the event that the ACGME schedules a self-study visit earlier than originally anticipated, a review of the program will be conducted by the IRPC in advance of the site visit.

For programs that have no residents enrolled at the time of the IPRC review, a modified review will be conducted to ensure that the program has maintained adequate faculty and staff resources, clinical volume and other necessary curricular elements required to be in substantial compliance with the Institutional, Common and Specialty-Specific program requirements. The review will be completed within the second 6 months of the resident’s first year in the program.

B. **Committee Composition**

The GMEC/DIO will appoint a Institutional Review of Programs Committee (IRPC), which will include, at minimum:

1. Chair of the Review Committee appointed by the DIO.
2. A faculty member from a program other than that which is under review.
3. A senior resident from a program other than that which is under review.
4. The Associate Dean for Graduate Medical Education.
5. An administrative assistant to serve as support staff to the process.

C. **Review Content**

The Institutional Review of Programs Committee will review current and historic program documents, and interview program faculty and residents, to assess:

1. The residency program’s compliance with ACGME Institutional, Common and specialty/subspecialty-specific Program Requirements pertaining to the program;
2. The program’s educational objectives;
3. The effectiveness of the program in achieving these educational objectives;
4. The adequacy of educational and financial resources provided to support the program;

5. The effectiveness of the program in addressing areas of noncompliance and/or concern in previous ACGME accreditation letters and in the previous reviews conducted;

6. Whether the program has defined, in accordance with the relevant Programmatic Requirements, the specific knowledge, skills, and attitudes required and provides educational experiences for the residents to demonstrate competency in the following areas: patient care skills, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning, and systems-based practice.

7. The appropriateness of the milestone evaluation tools used by the program to ensure that the residents demonstrate competence in each of the six areas listed in C.3.f. above;

8. The effectiveness of the program in using appropriate milestone evaluation tools and dependable outcome measures to evaluate each of the six general competencies listed above;

9. The effectiveness of the program in implementing a process that links educational outcomes with program improvement;

10. Annual program improvement efforts in resident performance using aggregated resident data; faculty development; graduate performance including performance of program graduates on the certification exam, and program quality.

Program quality includes:

- Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually AND
- The program must use the results of residents’ assessments of the program together with other program evaluation results to improve the program.
- If deficiencies are found, the program should prepare a written plan of action to document initiatives to track improve performance in those areas.
- The action plan should be reviewed and approved by the teaching faculty and documented in the Clinical Competency Committee meeting minutes.
- The program must document formal systematic evaluation of the curriculum at least annually.

11. Verification of compliance with resident duty hour requirements, and of the program’s use of an ongoing and effective monitoring system;

12. Other issues or concerns, which may properly come before the Review Committee

D. Data Sources

As soon as the membership of the Review Committee is organized, the appointed support staff person begins assembling the materials and data to be evaluated by the committee. Copies of all data are made available to all committee members no later than two weeks prior to the scheduled review date.

IRPC Document Review List:
ACGME – Annual Data submitted using WebAds plus program specific data:

1. Program Director Verification Checklist
2. Program Directors Narrative
3. Copies of current Program Requirements, including specialty Milestones
4. Yearly accreditation notifications, LON (with comments for any areas of concern)
   a) Program clarification response if needed
5. ACGME-RRC accreditation letter
   a) Include last PIF, if applicable
   b) Last ACGME-RRC accreditation letter including citations
   c) Programmatic response/progress with citations
   d) Any other ACGME correspondence applicable
6. Previous Internal Review Report with areas identified in need of improvement
   a) Program’s response/progress in these areas
7. Program attrition:
   a) Program Director change history
   b) Program Faculty roster (number of core faculty) and attrition rate
   c) Resident attrition rate
   d) Program change requests to the ACGME (change in compliment)
8. Scholarly Activity:
   a) Residents over the past 12 months
   b) Faculty over the past 12 months
9. Resident/Faculty conference attendance (see Narrative)
10. Percentage of residents involved in PS/PI projects-CLER focus areas
    a) PI/PS projects that residents are involved in
    b) If residents serve on hospital committees is attendance quantified
11. Compliance with Duty Hours – CLER focus area (as assessed by last year’s data)
    a) From monthly program data collection, Resident ACGME Survey and town hall meeting
    with residents
12. Compliance with Supervision – CLER focus area
    a) From resident ACGME survey and town hall meeting with residents
13. Specialty board pass rates by program graduates
14. Clinical experience (case logs, procedural competency listing)
15. ACGME Resident and Faculty Survey Results (with comments for areas under 70%)
    a) Comparison of programmatic results with both national and institutional results
    b) Areas identified in survey(s) that are problematic and need action plans and follow-up by
    the GMEC
16. Compliance with Transitions in Care – CLER focus area (see Narrative)
17. Match results:
    a) Percentage of incoming residents that were ranked in top 50% (GME will supply)
18. Resident perception of service to education
    a) From resident ACGME survey and town hall meeting with residents
19. Resident Milestone Progress reports (currently submitted annually)
20. Cross utilization milestones for interns
21. Preparation of Residents for the six focus areas of CLER (see Narrative)

Annual Program Evaluation:

1. Composition of Program Evaluation Committee (PEC)
2. Description of PEC responsibilities
   a) Planning, developing and evaluating activities of the program
   b) Reviewing and making recommendations for revisions of curriculum
   c) Addressing areas of non-compliance with ACGME standards
   d) Reviewing program annually (APE) using evaluations from all relevant stakeholders
3. Previous (2013) and most recent (2014) Annual Program Evaluations
   a) Includes anonymous program evaluations by Residents
   b) Includes program evaluation by Faculty
   c) Provide an Executive Summary/Highlight of the Annual Program Evaluation
4. Annual Program Directors report from the PEC sent to the GMEC (beginning in 2015 Academic year)
5. Evaluations: Provide sample
   a) Faculty Evaluation by Residents
   b) Resident Evaluation by Faculty

Clinical Competency Committee (CCC) for Milestones evaluation and reporting:

1. Composition of the Clinical Competency Committee (CCC)
2. Description of CCC responsibilities
   a) Prepare and report Milestone evaluations semi-annually to ACGME
   b) Advise Program Director re: resident progress, including promotion, remediation and recommendation for dismissal
3. Process of CCC
   a) Review all resident evaluations (must be at least semi-annually) from multiple sources
   b) Results of Annual In-Training Exam reports (data by global standards and national comparison)
   c) Determine Milestone assessment level of each resident
   d) Sample of latest CCC reports/minutes
4. Milestone evaluations
   a) Sample of tool
   b) Results of Milestone assessments of residents
   c) Feedback, if any from ACGME re: Milestone process/results

E. Protocol for Reviews

    Reviews will involve the following sequence of activities:

1. Assembly and collation of relevant program materials by the GME Office, which will also coordinate the scheduling of the meetings.
2. Committee Chair(s) and the Associate Dean for Graduate Medical Education meet with program director, associate program director(s) and program coordinator.
3. Committee meets with peer selected residents (at least one from each training level) and any other residents that wish to attend the meeting.
4. Committee meets with program's core and volunteer faculty members (excluding the program director, associate program director(s) and the department chair/head).
5. Committee meets to review all information obtained in the review and make its assessment of the program. The Chair prepares a draft summary report. Committee reviews draft and makes recommendations to Committee Chair.
6. The final written report is then prepared by the Committee Chair, then sent to the Program Director and Associate Director(s) and all Committee members.
7. The Chair of the Committee presents the final report to the GMEC.
F. Documentation and Reporting of Reviews

1. A written report will be presented to the GMEC by the IRPC chair or designee within three months of completion of the review. The template of the review is shown below.

UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA
INSTITUTIONAL REVIEW OF PROGRAMS REPORT
FOR GRADUATE MEDICAL EDUCATION

Program Name:
Current Accreditation Status and Effective Date:
Self-Study Date:
Date of Last WebAds Submission:
Date of Institutional Review:

IRPC:

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<td>Marc Squillante, D.O.</td>
<td>Chair</td>
<td>GME/Emergency Medicine</td>
</tr>
<tr>
<td>Gerald Wickham, Ed.D</td>
<td>Co-Chair</td>
<td>GME/UGME</td>
</tr>
<tr>
<td>Thomas J. Santoro, M.D.</td>
<td>DIO, Associate Dean</td>
<td>Graduate Medical Education</td>
</tr>
<tr>
<td>Lisa Collins</td>
<td>Administrative Assistant</td>
<td>Graduate Medical Education</td>
</tr>
<tr>
<td>Michelle Shearhod</td>
<td>Committee Coordinator</td>
<td>Graduate Medical Education</td>
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<td>Faculty Member</td>
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<td>Resident Representative</td>
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MATERIALS

ACGME –Annual Data submitted using WebAds plus program specific data:
1. Program Director Verification Checklist (see attached)
2. Program Directors Narrative (see attached)
3. Copies of current Program Requirements, including specialty Milestones
4. Yearly accreditation notifications, LON (with comments for any areas of concern)
   a) Program clarification response if needed
5. ACGME-RRC accreditation letter
   a) Include last PIF, if applicable
   b) Last ACGME-RRC accreditation letter including citations
   c) Programmatic response/progress with citations
   d) Any other ACGME correspondence applicable
6. Previous Internal Review Report with areas identified in need of improvement
   a) Program’s response/progress in these areas
7. Program attrition:
   a) Program Director change history
   b) Program Faculty roster (number of core faculty) and attrition rate
   c) Resident attrition rate
   d) Program change requests to the ACGME (change in compliment)
8. Scholarly Activity:
a) Residents over the past 12 months
b) Faculty over the past 12 months

9. Resident/Faculty conference attendance (see Narrative)

10. Percentage of residents involved in PS/PI projects - CLER focus areas
    a) PI/PS projects that residents are involved in
    b) If residents serve on hospital committees is attendance quantified

11. Compliance with Duty Hours – CLER focus area (as assessed by last year’s data)
    a) From monthly program data collection, Resident ACGME Survey and town hall meeting with residents

12. Compliance with Supervision – CLER focus area
    a) From resident ACGME survey and town hall meeting with residents

13. Specialty board pass rates by program graduates

14. Clinical experience (case logs, procedural competency listing)

15. ACGME Resident and Faculty Survey Results (with comments for areas under 70%)
    a) Comparison of programmatic results with both national and institutional results
    b) Areas identified in survey(s) that are problematic and need action plans and follow-up by the GMEC

16. Compliance with Transitions in Care – CLER focus area (see Narrative)

17. Match results:
    a) Percentage of incoming residents that were ranked in top 50% (GME will supply)

18. Resident perception of service to education
    a) From resident ACGME survey and town hall meeting with residents

19. Resident Milestone Progress reports (currently submitted annually)

20. Cross utilization milestones for interns

21. Preparation of Residents for the six focus areas of CLER (see Narrative)

**Annual Program Evaluation:**

1. Composition of Program Evaluation Committee (PEC)

2. Description of PEC responsibilities
   a) Planning, developing and evaluating activities of the program
   b) Reviewing and making recommendations for revisions of curriculum
   c) Addressing areas of non-compliance with ACGME standards
   d) Reviewing program annually (APE) using evaluations from all relevant stakeholders

3. Previous (2013) and most recent (2014) Annual Program Evaluations
   a) Includes anonymous program evaluations by Residents
   b) Includes program evaluation by Faculty
   c) Provide an Executive Summary/Highlight of the Annual Program Evaluation

4. Annual Program Directors report from the PEC sent to the GMEC (beginning in 2015 Academic year)

5. Evaluations: Provide sample
   a) Faculty Evaluation by Residents
   b) Resident Evaluation by Faculty

**Clinical Competency Committee (CCC) for Milestones evaluation and reporting:**

1. Composition of the Clinical Competency Committee (CCC)

2. Description of CCC responsibilities
   a) Prepare and report Milestone evaluations semi-annually to ACGME
   b) Advise Program Director re: resident progress, including promotion, remediation and recommendation for dismissal

3. Process of CCC
a) Review all resident evaluations (must be at least semi-annually) from multiple sources
b) Results of Annual In-Training Exam reports (data by global standards and national comparison)
c) Determine Milestone assessment level of each resident
d) Sample of latest CCC reports/minutes

4. Milestone evaluations
   a) Sample of tool
   b) Results of Milestone assessments of residents
   c) Feedback, if any from ACGME re: Milestone process/results

PROCESS

The materials listed above are collected and distributed to members of The Institutional Review of Programs Committee (IRPC) for review. The Committee consists of a chair, co-chair, faculty member, resident, the DIO and an administrator within the GME department. The faculty member and resident are selected from a program not being reviewed. The co-chair and/or chair will recuse him/her from the review if a program in which he/she serves as a faculty member is undergoing review. In this case, the DIO will take the place of the recused committee member. After reviewing the materials, separate meetings will take place with the Program Director and Program Coordinator; Core Faculty; and Residents. The chair will then draft a report of his/her

PROGRAM INFORMATION

1. Program description (including number of residents, Associate Program Directors, total faculty, key faculty, participating institutions)
2. Annual Program Evaluation (APE)
   a) Composition of PEC
   b) Description of responsibilities
      1) Planning, developing and evaluating educational activities of the program
      2) Reviewing and making recommendations for revisions of curriculum
      3) Addressing areas of non-compliance with ACGME standards
      4) Reviewing program annually (APE) using evaluations from all relevant stakeholders
   c) Summary of recommendations from last PEC meeting to improve performance (from Narrative)
   d) Measures proposed for how performance improvement was/will be measured (from Narrative)
   e) Impact of APE recommendations on program quality (from Narrative)
   f) Annual Program Director report from the PEC sent to the GMEC (beginning in 2015 Academic year)
3. Clinical Competency Committee (CCC) for Milestone evaluation and reporting
   a) Composition of CCC
   b) Description of responsibilities
      1) Prepare and report Milestone evaluations semi-annually to ACGME
      2) Advise PD re: resident progress, including promotion, remediation and dismissal
   c) Process
      1) Review all resident evaluations (must be at least semi-annually) from multiple sources
      2) Results of Annual In-Training Exam reports (data by global standards and national comparison)
      3) Determine milestone level of each resident
   d) Results of Milestone assessments of residents
   e) Feedback, if any from ACGME re: Milestone process/results
4. Annual Data Survey submitted using wedADS plus program-specific data of relevance
   a) Program Director Verification Checklist
b) Program attrition
   1) Program director change history
   2) Program faculty roster (number of core faculty) and attrition rate
   3) Resident attrition rate
   4) Program change requests to the ACGME (change in compliment)

c) Scholarly activity
   1) Residents over the past 12 months
   2) Faculty over the past 12 months

d) Board pass rate (5 year rolling average)

e) Clinical experience (Case logs, Procedural Listing)

f) Faculty and Resident ACGME Survey results (with comments for areas under 70%)
   1) Comparison of programmatic results with both national and institutional results
   2) Areas identified in survey(s) that are problematic and need action plans and follow-up by GMEC

g) Last ACGME/RRC accreditation letter including citations
   1) Programmatic response/progress to citations

h) Most recent ACGME LON (accreditation status)
   1) Programs clarification response if needed

i) Areas identified in need of improvement in last Internal Review
   1) Program’s response/progress in this area

j) Resident/faculty conference attendance
   1) Percentage of residents that are non-compliant with ACGME requirements

k) Preparation of Residents for the six focus areas of CLER (from Narrative)

l) Percentage of residents involved in PS/PI projects-Clear Focus areas
   1) PI/PS projects that residents are involved in
   2) If residents serve on hospital committees is attendance quantified

m) Compliance with Duty hour-CLER focus area
   1) From monthly program data collection, Resident ACGME Survey and town hall meeting with residents

n) Compliance with Supervision-CLER focus area
   1) From resident ACGME survey and town hall meeting with residents

o) Compliance with Transitions in Care-CLER focus area
   1) Are hand-offs done face-to-face, at set time with a senior or attending present?
   2) Is a standardized method (e.g. IPASS) used?

p) Match results
   1) Percentage of incoming residents that were ranked in top 50% (GME will supply)

q) Resident perception of service to education
   1) Resident survey and town hall meeting

FINDINGS (list below, or use attachments referenced below as needed)

After review of the material provided, interview of the individuals listed above, and discussion of the findings in comparison to the ACGME and RC standards, the IRPC has found:

IRPC Response to Program Director’s Narrative Assessment of Program’s Plans/Preparations for CLER and Milestones:

PROGRAM STRENGTHS:
AREAS NEEDING IMPROVEMENT:

IRPC RECOMMENDED ACTIONS:

**Actions required** by the institution and/or program to achieve accreditation compliance and achieve established educational objectives:

**Actions recommended** for enhancing or strengthening the quality of the program:

SIGNATURE: ___________________________ DATE: ___________________________

IRPC Chair

DATE REVIEW PRESENTED TO UICOMP GMEC:

GMEC ACTION TAKEN ON REPORT:

DATE THAT THE DIO/GMEC WILL MONITOR PROGRAM’S ACTIONS IN RESPONSE TO THE RECOMMENDATIONS OF THE GMEC IN THE PROGRAMS REVIEW: ___________________________

2. When the findings of the review are presented to the GMEC the Program Director or designee is expected to be in attendance. The Program Director may address any perceived errors of fact in the report at that time.

3. Any areas of noncompliance are identified, and appropriate action is recommended.

4. Recognizing that the residents are major stakeholders in the review process who need to understand the means by which the quality of their education is assured by the Sponsoring Institution, Chief Resident(s) will be invited to attend the GMEC meeting at which the report of the review of their residency program is presented. The Chief Resident(s) will receive a copy of the report, which they are expected to discuss with the other residents in their program. Chief Resident(s) will also be invited to attend those GMEC meetings at which their Program Directors are scheduled to give updates on deficiencies previously identified in the Review.

5. A copy of the report of the review will be incorporated in the minutes of the GMEC meeting(s) in which the IRPC report and program director progress report(s) were presented. Reports will be maintained by the Associate Dean for Graduate Medical Education and the respective program director.

G. **Correction of Deficiencies Identified in Reviews**

Program directors are expected to take timely action to correct deficiencies identified in reviews. A three-six month progress report is required of the program, indicating how the program is addressing each of the actions recommended by the GMEC. The progress report may be requested sooner if deemed appropriate by the GMEC. The GMEC may request an additional progress report (at a time interval specified by the GMEC), or may recommend a Special Review for further intervention to assure program compliance.

H. **Special Review:**
Programs assessed as being in substantial non-compliance with one or more of the Common or Program-Specific ACGME requirements, or programs that have failed to correct deficiencies identified by the IRPC in a timely manner will be deemed “underperforming.” The GMEC must demonstrate effective oversight of underperforming programs with a Special Review. The Special Review process results in a report that:

1. Clearly identifies the area(s) in which the program is in substantial non-compliance
2. Describes the quality improvement goal(s)
3. Articulates the corrective actions
4. Provides a realistic assessment of the time required for the program to achieve compliance
5. Creates a process for GMEC monitoring of outcomes

Process for Special Review:

For programs subjected to a Special Review, the Program Director will meet with the DIO and the Chair of the IRPC. As stated above, the area(s) in which the program is in substantial non-compliance will be clearly identified. An action plan intended to render the program compliant, and a timeline required to achieve compliance will be agreed upon. Updates by the Program Director related to the program’s progress in achieving compliance will be given to the GMEC in a timely fashion, but no later than every 6 months.

10. **General In-House Call Policies:** Residents assigned in-house calls OSF-SFMC

   1) On call hours for residents are determined by the Program Director of the department or by the section to which the resident is assigned, individually or conjointly and will be consistent with Institutional and ACGME guidelines (see Duty Hours, section II.H.5.i).

   2) Services assignment, Emergency Room, and In-House Call schedules will be determined departmentally and will be consistent with Institutional and ACGME guidelines.

   3) Any resident signing-over call responsibility to another resident must follow these guidelines:
      
      1) Obtain prior approval of the substitute resident.
      
      2) The substitute resident must fulfill all on-call responsibilities.
      
      3) Changes in the call schedule must have prior approval and appropriate notice shall be given to all involved parties:
         
         a) Emergency Room
         
         b) Operators
         
         c) Nursing Units
         
         d) Program Director’s Office, and
         
         e) Other involved parties

11. **Information on Board Eligibility**
Residents will be provided access to specific, current information, by program, related to eligibility for board exam.

III. RESIDENT’S RESPONSIBILITIES

A. GENERAL RESPONSIBILITIES

1) To initiate and follow a personal program of self-study and professional growth.

2) To participate in safe, effective, and compassionate patient care under supervision commensurate with his/her level of advancement and responsibility. Note: A resident is permitted to order restraint or conduct face-to-face evaluations of patients in restraint or seclusion if the Program Director has certified (i) that the resident has been provided with relevant education and training for these functions, and (ii) that the Program Director considers the resident competent to perform these activities.

3) To participate fully in the educational activities of his/her program and, as required, assume responsibility for teaching and supervising other residents and medical students. Residents must complete Ethics I and II, Residents as Teachers I and II and the Online Patient Safety Modules in order to graduate.

4) To participate in institutional programs and activities involving the Medical Staff of OSF SFMC and to adhere to established practices, procedures and policies of the medical staff as currently written or amended.

5) To participate, when invited, in medical staff committees, especially those that relate to patient care review and apply cost containment measures in the provision of patient care.

6) To conform to OSF SFMC policies, procedures and regulations that are applicable to the resident and that are not inconsistent with the Resident Agreement, including the House Staff Manual, which is a component of the Resident Agreement. NB: OSF SFMC follows the Ethical and Religious Directives for Catholic Health Facilities.

B. PROFESSIONALISM

1) To conduct oneself in a professional manner in dealing with Program Director, Coordinator, Faculty, other residents, Medical Staff, medical students, OSF SFMC and UPHM employees, patients, visitors, and supervisors, whether on or off duty.

Any lapse in professionalism (e.g., untimely dictation of medical records, failure to meet core lecture series attendance requirements) may be treated by a Program Director in the following ways:

a. Educational Intervention: Resident receives a warning, issued by the Program Director. Resident’s cafeteria privileges may be revoked for a length of time specified by the Program Director.
b. Administrative Suspension:

Is NOT a formal disciplinary action, and will NOT be reported to licensing and credentialing agencies, but will be documented in their portfolios/training files. During the period of administrative suspension, the resident may be removed from their clinical duties at the discretion of the Program Director. During the period of administrative suspension, the resident’s cafeteria privileges may be revoked and the resident may be required to take vacation time at the discretion of the Program Director. If a resident chooses not to take vacation time, or has no vacation time available, the suspension status is considered time off without pay. The resident will be removed from their clinical duties for the duration of the suspension.

c. Suspension: If a resident is placed on suspension:

Program Director will document this lapse of professionalism in the resident’s permanent file. (see Resident Discipline and Grievance Procedures, and UICOMP (GMEC) Disciplinary Process, section V.). This is a formal disciplinary action which will be reported to licensing and credentialing agencies. This information may be included in letters of recommendation.

2) To comply with OSF SFMC Standards of Professional Relationships (see Attachment 3).

3) To comply with the Institutional Requirements as they relate to duty hours (also see Duty Hours, section II.H.5.i. and Resident Education and Work Environment, section II.J.):

a. Residents are expected to comply with the ACGME, Review Committee (RRC), Institutional and Program duty hour's requirements.

b. Residents will inform their Program Director when circumstances present them from being in compliance with ACGME, RRC, and program duty hour requirements.

c. Residents who choose to do so may report infractions of duty hour’s requirements to the Chief Resident, or the Associate Dean for Graduate Medical Education (671-8450).

4) To comply with the ACGME requirements for recognizing fatigue

Other residents who notice a colleague’s fatigue have the professional responsibility to notify the supervising attending, Chief Resident, or Residency Director without fear of reprisal. A resident who feels fatigued has the professional responsibility to notify the supervising attending, Chief Resident, or Residency Director without fear of reprisal.

C. TEACHING

Residents are expected to participate in the student learning experience as provided throughout required and elective rotations. The LCME requires that all teaching sponsored by the College of Medicine be provided by faculty instructors. Therefore, all residents must have a faculty appointment to teach at the College of Medicine.

D. PAGING SYSTEM

1) Each resident is issued an individual pager unit. Audio paging will be used in the case of no response or in case of an emergency.
2) Resident availability through the pager unit is determined by the resident’s current assignments.

3) The resident is financially responsible for the functional integrity of the unit.

4) For repair or replacement of pager units, call Jane Schwindenhammer, Telecommunications at 655-4058.

E. ON-CALL SCHEDULE

1) A resident will not be scheduled for in-house call more often than every third night, when averaged over a month (see Duty Hours, section II.H.5.i).

2) The Program Director or his/her designee will assign residents to in-house call for the department.

F. BLUE ALERTS

1) OSF SFMC has a well-organized team approach to Blue Alerts, monitored by the SFMC Blue Alert Committee. Any concerns about Blue Alerts should be taken to the Program Director who will then take them to the Blue Alert Committee.

2) Advanced Cardiac Life Support Certification is required for all residents. Scheduling priority for the course will be given to those responsible for running Blue Alerts.

3) All Internal Medicine on-call residents are required to respond to Blue Alerts, regardless of the location of the alert.

4) At night and on weekends, all residents in the house should respond to Blue Alerts.

5) Individual residents will respond to Blue Alerts involving their assigned patients, in accordance with departmental policies.

6) The resident in charge of running adult Blue Alerts will be the resident assigned to in-house Internal Medicine calls.

7) For Pediatric Blue Alerts, the Senior Pediatric resident is in charge of the code.

8) Other support personnel (e.g., respiratory therapy, pharmacy, nursing, and anesthesia) will respond in accordance with the instructions provided in the Blue Alert Manual.

9) The resident in charge will be responsible for directing resuscitation of the patient and for organizing or dismissing available personnel.

G. RESIDENT’S PERMANENT FILE

1. All records concerning each resident’s participation in the Graduate Medical Education Program at OSF SFMC will be retained as follows:
a. The permanent file will be retained in the Program Director’s Office.

b. An additional file containing more limited information will be maintained in the GME Office.

2. The permanent file will be considered the resident’s official file and all letters of reference with respect to each resident written by the Program Director on behalf of the institution will be based on the material in, and become a part of his/her permanent file.

3. The resident may review the contents of his/her permanent file by giving the office in which the file is kept reasonable time to produce the file for review and by agreeing to review the file in the presence of the Program Director or his/her designee.

4. The permanent file shall include, but not be limited to, the following:

   a. Application for Graduate Medical Education to OSF SFMC;

   b. OSF SFMC’s Human Resources Department employment application;

   c. Resident Agreements;

   d. Resident Performance Rating Scale evaluation forms;

   e. All correspondence including official faculty or administrative actions, actions of committees, or other correspondence relating to the resident;

   f. Licensure documentation; and

   g. All disciplinary records.

5. Both the permanent file and the duplicate file fall within the Illinois Employee Access to Personnel Records Act. Review and release of all information will be in accordance with the Act.

H. HEALTH INFORMATION SERVICES (MEDICAL RECORDS)

1. Resident Identification

   When a resident dictates or writes a History & Physical, Discharge Summary, or an Operative Report in a Medical Record, he/she shall identify himself/herself by name and status (see Hospital Rules & Regulations, 72-6).

   Medical Records – It is the responsibility of each resident to maintain all medical records at MMC, Proctor, and SFMC up to date and to complete such records by requesting that records be pulled for completion.

2. Delinquent Records

   a. It is the resident’s duty to check their EPIC in-basket daily and complete their outstanding records. The resident is expected to inform the Health Information Services Department before he/she leaves for outside rotations, conferences, or vacations. (309-655-2418)

   b. It is the responsibility of the resident to communicate with the attending or supervising physician to clearly understand the resident expectations for clinical documentation on each
patient record, including but not limited to history and physical, consultations, progress notes, procedure notes, and discharge summary.

c. In order to facilitate continuity of care and patient transitions between settings, Discharge Summary Reports are expected to be completed in all cases within 5 (five) days of discharge date. Discharge summary reports completed later than 5 days post discharge will be considered untimely. Residents should complete the oldest records first.

d. A summary report of all physicians’ delinquent records is produced weekly. It is the resident’s responsibility to check his/her email or mailbox for this notice and to respond by resolving outstanding records within one week.

e. Weekly, Health Information Services will send to residency Program Directors resident-specific data when a resident in their program is on notice for delinquent records, including the number of delinquent charts, the latency of completion, and the tasks that require completion (e.g., the number of charts needing signatures/dictations).

f. If the resident is cited for multiple weeks for having a dictation burden of greater or equal to ten charts each time, disciplinary action may be taken. As well, disciplinary action may also be taken for discharge summary reports repeatedly exceeding the timeliness expectations of within 5 days of discharge.

g. Disciplinary action may include any of the following not necessarily in sequential order:

1) Educational Intervention: Resident receives a warning, issued by the Program Director to complete delinquent records. Resident’s cafeteria privileges may be revoked for a length of time specified by the Program Director.

2) Administrative Suspension:

   a) This is NOT a formal disciplinary action, and will NOT be reported to licensing and credentialing agencies, but will be documented in their portfolios/training files.

   b) During the period of administrative suspension, the resident may be removed from their clinical duties at the discretion of the Program Director.

   c) During the period of administrative suspension, the resident’s cafeteria privileges may be revoked and the resident may be required use the time suspended as vacation.

   d) If a resident chooses not to take vacation time, or has no vacation time available, the suspension status is considered time off without pay. The resident will be removed from their clinical duties for the duration of the suspension.

3) Suspension: If a resident is placed on suspension:

   a) Program Director will document this lapse of professionalism in the resident’s permanent file. (see Resident Discipline and Grievance Procedures, and UICOMP (GMEC) Disciplinary Process, section V.). This IS a formal disciplinary action which will be reported to licensing and credentialing agencies. This information may be included in letters of recommendation.
b) If a resident chooses not to take vacation time, or has no vacation time available, the suspension status is considered time off without pay. The resident will be removed from their clinical duties for the duration of the suspension.

c) During this period, the resident will maintain health coverage but no other benefits including cafeteria privileges.

d) Depending upon the educational requirements of the rotation and length of suspension, credit toward resident program fulfillment may be lost. In some cases, this may delay eligibility to sit for Board certification.

4) In extenuating circumstances, residents may appeal to their Program Director for a waiver of disciplinary action due to delinquent medical records. The residency Program Director will document the circumstances for the resident’s permanent file.

5) A resident with incomplete medical records who is suspended is not entitled to the right of review provided under the Resident Agreement. (see Resident Discipline and Grievance Procedures, section V.).

6) Residents are not permitted to violate the Institution’s duty hour rules in order to dictate charts.

I. EMPLOYMENT OUTSIDE THE RESIDENCY PROGRAM

The Institutional policy on moonlighting is detailed in section II.H.5.j. of this manual and in the Policy Manual.

J. COMPLAINTS

1. General

Residents who believe that they have been treated inappropriately or unfairly in the course of the performance of their duties as residents should bring such situations to the attention of their leadership, as described below. The leadership’s first response to resident’s complaints will be to try to resolve them informally, through discussion with the parties involved.

2. Complaints Involving Discrimination or Sexual Harassment

Special procedures have been developed to respond to residents’ complaints involving discrimination or sexual harassment. Discrimination occurs when a resident is exposed to bias based on race, color, sex, religion, national origin, age, handicap, or status as a disabled veteran or veteran of the Vietnam era or Gulf War. Sexual Harassment occurs when a resident is exposed to an unwanted sexual gesture, physical contact, or statement, which a reasonable person would find offensive, humiliating, or an interference with his/her required tasks or career opportunities.

a. Complaints involving discrimination or sexual harassment by individuals employed by UICOMP or by UICOMP faculty (salaried and non-salaried) should be directed to one of the following designated intake officers:

Lynn Keeton, Director of Human Resources, UICOMP (671-8519).
b. Complaints involving discrimination or sexual harassment by non-faculty physicians at OSF SFMC, and non-physician OSF SFMC employees, visitors, patients, and agents should be directed to one of the following persons:

Robert Sparrow, M.D., Chief Medical Officer, OSF SFMC (655-2244)

Director of Employee Relations, OSF SFMC (655-2128)

Bob Anderson, Executive President and COO, OSF SFMC (655-7796)

c. Complaints involving discrimination or sexual harassment by non-faculty physicians at UPHM and UPHM employees (non-physician), visitors, patients, and agents should be directed to one of the following persons:

Kathy Jaegle, Director of Human Resource Services, UPHM (672-5572)

Phil Scherer, Director of IIAR, Proctor, (691-0155)

d. Residents who have been accused of, or think they may be accused of discrimination or sexual harassment are entitled to a fair and impartial process. Residents in such circumstances are encouraged to consult one of the individuals listed immediately above in subsections a., b., and c.

3. All Other Complaints

All complaints not involving discrimination or sexual harassment should normally be directed to the Chief Resident and/or the Program Director for informal resolution. The resident, at any time, may, however, direct his/her complaints to any of the following persons:

President or Vice President of the House Staff

Department Chair/Head

Thomas J. Santoro, M.D., Associate Dean for Graduate Medical Education, UICOMP (671-8450)

Robert Sparrow, M.D., Chief Medical Officer, OSF SFMC (655-2244)

4. Grievances

When informal efforts to resolve a complaint fail to produce results that satisfy the resident making the complaint, the resident may initiate a written complaint (grievance), which describes the alleged infraction and also the desired outcome or resolution. The procedures for responding to residents’ grievances will depend upon the employment/faculty status of the individual whose actions are being grieved.

a. Grievances concerning the actions of individuals employed by UICOMP and UICOMP faculty (salaried and non-salaried) may be pursued using the UIC Grievance Procedures (see section V).

Grievances concerning the actions of non-faculty physicians at OSF SFMC, and OSF SFMC employees (non-physician), visitors, patients, and agents may be pursued using the OSF SFMC grievance procedures, which are available from the offices of Robert Sparrow, M.D.,
b. Grievances concerning the actions of non-faculty physicians at UPHM and UPHM employees (non-physician), visitors, patients, and agents may be pursued using the UPHM grievance procedures, which are available from the program director.

K. RESIDENT HEALTH POLICIES

House Staff members are subject to Employee Health Policies as applied to all OSF employees. A copy of the policy is available at all nursing units.

1. Health Assessment

   All new residents are required to have an initial Health Assessment performed through the Center for Occupational Health to complete the Resident Agreement.

2. Personal Illness

   a. In the event of any personal illness necessitating absence from duties, the resident’s Program Director must be notified.

   b. It is the primary responsibility of the resident to notify his/her assigned service and other commitments of his/her absence during illness so that necessary alternative arrangements can be made.

   c. As is the policy for all OSF SFMC employees, the resident must receive clearance by the Center for Occupational Health before returning to work in the following situations:

      1) Minor illness where three or more consecutive working days are missed;

      2) Hospitalization for any length of time;

      3) Prolonged illness of three weeks or longer; and,

      4) Having undergone outpatient surgery.

3. Resident Impairment

   UICOMP has established a Resident Health Committee that is responsible for dealing with impaired residents. The Committee’s charter composition and operating procedures are detailed below:
The purpose of the UICOMP Graduate Medical Education (GME) Resident Health Committee (RHC) is to assure patient safety through appropriate recommendations to support an impaired resident. The RHC serves as a resource to ACGME-accredited training programs in the management of impaired residents. Impairment includes any physical or mental illness that interferes with a resident’s ability to function appropriately in their role as a trainee and to provide safe patient care. The RHC does not directly address academic performance or disciplinary needs except as a product of a physical or mental impairment.

Education

The GME Office will provide educational materials to programs about recognition of resident impairment and the signs of impairment.

Training Program Directors (PD) will distribute information about the RHC to residents, faculty, staff, and other parties that interface with trainees. Program Directors will ensure that all residents in their program are aware of the self-referral provisions in the RHC procedures.

Self-Referral

Residents are required to notify his/her PD, Department Chair, or the GME Office directly, if he/she experiences any physical or mental problem that may impact his/her capacity to function appropriately as a trainee and to provide safe patient care. Problems might include alcohol or drug use or intoxication, including with prescription or Adverted drugs; an active mental illness, such as depression; or a physical illness, such as a serious head injury.

The PD, Chair, and GME Designated Institutional Official (DIO) must inform the other parties that a resident has self-referred.

The DIO, with the input of the resident’s referral information, the PD, and the Chair shall determine if the report involves a possible impairment that may negatively affect the resident’s capacity to complete duties or provide safe patient care. If the DIO judges in the affirmative, then the DIO shall refer the resident to the RHC, shall notify the PD, and shall make a record of the matter. If judged in the negative, the DIO shall refer the resident to his/her PD who may proceed with other resident assistance and the DIO shall not make a record.

Referral by Others

Faculty, staff, and other parties that interface with trainees shall immediately report any observed behavior that establishes a reasonable belief that a resident is impaired. Examples of observed behaviors to be reported include: evidence of intoxication, alcohol on the breath, threatening or boisterous behavior, improper disposal or misappropriation of drugs, or the appearance of suspect physical problems. The individual who observed the behavior shall notify the Administrator-On-Call (AOC) or his/her immediate supervisor. The notification may be verbal. The notification shall include a description of the observed behavior, when it was observed, and in what context. Neither the reporting individual nor the resident of concern shall be anonymous.

The party first notified shall forthwith notify the PD or Department Chair, either of whom may gather additional information to determine if the matter warrants additional action. After assessment by the PD or Chair (or both), the matter may be addressed at the level of the department or if the matter involves possible impairment that may negatively affect the resident’s capacity to complete duties or provide safe patient care shall be referred to the DIO.

Matters that are referred to the DIO shall be subsequently referred to the RHC, the PD notified (if not already), and the DIO shall make a record of the matter.
If the matter is of an emergent or urgent nature, the PD, Chair, or DIO may immediately refer the resident for drug testing and/or may temporarily suspend the resident from clinical activities.

[drug test process, resident declines]

In the event a resident is temporarily suspended from clinical activity, the immediate supervisor shall be notified. The supervisor shall, with the assistance of the PD, arrange for coverage of the resident's patient care services.

**Resident Health Committee Procedures**

The RHC serves as a committee of the GME Office and reports its recommendation to the Program Director and DIO.

The RHC shall include no fewer than 5 and no more than 9 members, inclusive of the RHC Chair. All members shall have voting privileges. The membership shall include at least 2 PDs, two residents in good standing and an attending physician who practices as, and is an employee of OSF SFMC. The remainder of the members may be faculty or staff from any department with an ACGME-accredited training program. All members are appointed by the DIO. Appointments are made annually or to replace a member who steps down and may be renewed.

The RHC Chair accepts responsibility for the management of committee work. These tasks include calling a committee to meet, establishing a quorum, inviting guests, calling for a vote, signing the record of the meeting, and signing final recommendations, among others.

A quorum is established by the presence of four members. Members may not request proxy substitutions from other members or non-members.

A recording secretary from the GME Office shall be present at formal meetings to keep minutes, provide information gathered from external sources, tally votes, and assist in administration of non-meeting activities (such as scheduling and announcing meetings, receiving drug test reports or medical records from outside agencies, and transcribing committee recommendations). The secretary shall not have voting privileges.

No audio or video recording of meetings shall occur. Distributed documents must be returned to the recording secretary at the conclusion of each meeting. The proper maintenance and storage of personal notes are the responsibility of individual members.

The deliberations and work product of the RHC shall be kept confidential to the extent necessary within the scope of privilege with residents to the GME Office, departments, and training programs, and under the peer review privilege, except as limited by regulation, ethical obligation, Medical Staff Manuals, and/or imminent danger to others. Individuals within the scope usually include the DIO, Chair, PD, and sometimes supervisors or Chief Residents. The RHC shall meet on an as needed basis to establish educational programs, attend to recent referrals, and to follow open cases. Ad hoc meetings shall be called to attend to interim case referrals. If the agenda includes a new case referral, the resident referred shall be informed of the meeting date, time, and location and shall be invited to attend a portion of the meeting. The resident may secure legal counsel, but shall not attend the meeting with any uninvited party.

Residents invited to attend a meeting may ask that any member recuse himself/herself from the meeting deliberations. Any member may recuse himself/herself, taking into consideration a resident’s request for
recusal, if the member believes that he/she will confront an unmanageable conflict of interest. No member shall be required to recuse except by his/her own volition.

Residents referred to the RHC will be asked to sign a consent and release on behalf of the GME Office and RHC to allow pertinent information related to the matter in question to be disclosed. Such information shall be requested by the DIO, RHC Chair or an RH:C member and may include, but is not limited to, urine and blood screening results, medical records, and counseling summaries. In the event that the resident declines to sign the consent and release, he/she will be temporarily suspended from clinical activity until such time as the RHC Chair, DIO, and PD determine that patient care is not possibly compromised.

The RHC shall meet to consider the case referred. Once a quorum is established, the members shall receive a summary of the case from the RHC Chair, a RHC member, or an invited guest who is knowledgeable about the case. The members may consider written documents including drug test results, residency performance files, or medical records. The resident who was referred shall then be invited to enter the committee room, be introduced to the members, and shall be informed of the nature and limitations of the RHC process. The resident will be offered an opportunity to hear a summary of the case and to address the committee with any information deemed pertinent to the case. A designated member may be appointed to lead a question period whereby members ask the resident to provide information to assist in making recommendations. After their question period, the resident shall be dismissed. The Chair or designee shall lead a discussion of the matter to arrive at a consensus regarding recommendations to be made to the DIO. If no reasonable consensus can be achieved for all recommendations, then any or all recommendations may be called to a vote by the RHC Chair. A voting record of each member shall be made for each recommendation. In the event that a vote does not result in a simple majority for one or more recommendations, then the Chair shall call another meeting of all members to be scheduled forthwith, and the meeting adjourned. Meetings scheduled to resolve a tie vote shall begin with deliberations, but may consider new information. The RHC shall consider recommendations for the following, among others:

1) Whether additional information is needed, and if so, what resource might best provide the information, including an independent evaluation;

2) Whether the resident should be placed on or continued on suspension;

3) Whether specific activities shall be restricted;

4) Whether the resident requires monitoring, treatment or other management to include drug or alcohol tests and therapy;

5) The duration of recommendations; and,

6) If the resident should be dismissed from the program.

The RHC recommendations shall be communicated in writing to the DIO. The DIO will discuss the recommendations with the PD and Departmental Chair. The DIO shall then revise the recommendations, if necessary, and include those accepted by the DIO in an Agreement of Understanding (Agreement) between the GME Office and the resident.

The Agreement of Understanding shall be signed by the DIO and provided to the resident for consideration. The resident shall have up to 7 days to accept or decline the Agreement, during which time the resident may remain on suspension.

If the Agreement includes monitoring, treatment, management, or referral to outside agencies, then the GME Office and program shall make efforts to assist the resident in achieving the recommendations.
Assistance may be in the form of financial reimbursement for treatment, coverage of duties when required to attend to therapy, or appointment of a responsible mentor, among others.

Cases that involve reportable activity, such as the commission of a crime or unethical behavior, or that result in recommendations that affect residency status, such as formal suspension, patient care restrictions, or termination from a program, shall be addressed by the DIO, Chair, and PE with involvement of other necessary parties, such as the sponsoring hospital or the Board of Medicine.

Residents retain the right to appeal any recommendations through the program, GME Office, or hospital systems.

If the resident fails to comply with any terms or conditions of the Agreement, such failure shall be reported promptly to the DIO who shall consider to consult with the PD or Department Chair, to reconvene the RHC to request additional recommendations, to restrict the resident’s activity, to suspend the resident, or terminate the resident. A record of the decision shall be made.

The RHC may close a case following disposition after which a new referral must be made prior to consideration of possible resident impairment. The RHC may also maintain an open file to be reviewed at the discretion of the RHC Chair and into which new data may be added, including information form the resident or other parties. The RHC may independently, or at the request of the DIO, make additional or revised recommendations to a standing Agreement of Understanding to be considered by the DIO in like manner as an original Agreement of Understanding. A record of open and closed cases shall be kept and provided annually to the DIO. All resident files shall be kept in the GME Office until a resident completes training, is terminated, or leaves a program, after which, the file shall be forwarded to be maintained with the department.

4. Resident Substance Abuse

Residents in programs based at OSF-SFMC are required to conform to OSF HealthCare’s policy on substance abuse (see Human Resources Manual, Policy 605). Excerpts from the policy are presented in italics below:

*OSF HealthCare is committed to providing an environment free of the effects of substance abuse in order to maintain a work environment that is safe for our patients, as well as our employees.*

*OSF HealthCare recognizes that safety and productivity is comprised by alcohol and drug abuse by increasing the potential for accidents, absenteeism, substandard performance, poor employee morale, and damage to OSF HealthCare’s reputation. OSF HealthCare has a zero tolerance for drugs and alcohol.*

a. Definition

The use, possession, and distribution of illicit drugs and alcohol, as well as unauthorized controlled substances, are strictly prohibited in the workplace. An employee at work with the unauthorized presence of illicit drugs, alcohol, or other controlled substances in the body for non-medical reasons is prohibited. “Possession” does not include possession of a substance which is prescribed solely intended to be delivered and administered to a patient under the care of a physician or by an authorized OSF HealthCare employee (Registered Nurse, Pharmacist, etc.). No employee may report to work impaired by, or under the influence, or has reason to believe the use of a legal drug may present a safety risk, is to
report such drug use to his/her department supervisor. The department supervisor will then schedule an appointment to determine fitness for duty. Any employee whose substance abuse problems jeopardize the safety of patients, employees, or visitors shall be deemed "unfit for work."

b. Employee Responsibility

OSF HealthCare does not wish to become unduly involved in the personal affairs and activities of its employees. It is primarily concerned with employees performing adequately and safely on the job.

If an employee’s job performance declines and this decline can be attributed or related to drug and alcoholic activities, the employee will be treated as any other employee with a health problem. OSF HealthCare recognizes drug dependency and/or alcoholism as a health problem and it will assist an employee who becomes dependent on alcohol and/or drugs.

OSF HealthCare maintains and encourages the use of its Employee Assistance Program (EAP), which provides help to employees who suffer from substance abuse, chemical dependency, or other personal problems. Our current group medical plan includes “Substance Abuse Treatment” coverage and the employee is eligible for a Medical Leave of Absence. It is the responsibility of the employee to seek voluntary and confidential help from the EAP before drug and alcohol problems lead to job impairment, poor performance, or unsafe behavior at work which can lead to disciplinary action, up to, and including termination.

If an employee refuses or is unable to correct his/her health problems and job performance is affected, the employee shall be subject to disciplinary action that pertains to all employees who cannot, or are not, performing their job duties and responsibilities at acceptable levels.

c. Pre-Placement Screening

OSF HealthCare may require candidates to submit to drug and alcohol testing as part of the pre-placement physical examination. If it is required, candidates must authorize a disclosure to the prospective employer and must satisfactorily pass both a panel drug and alcohol screen prior to reporting to work. If the temperature of the specimen does not register on the temperature strip, the employee will be required to submit to a direct observation specimen by a same gender individual. The candidate will be allowed forty (40) ounces of fluid and three (3) hours in which to complete the test. Offers of employment will be made contingent upon satisfactorily meeting these requirements. Based on a determination made by a Medical Review Officer (MRO), if the drug and alcohol screening procedures indicate the presence of alcohol, drugs, or controlled substances, the candidate will not be considered for further employment for a period of one (1) year after a positive test.

d. For-Cause Screening

Employees of OSF HealthCare may be prevented from engaging in further work and required to submit to a 5, 7, or 10 panel drug and/or alcohol testing if any supervisor or member of OSF HealthCare management staff has reasonable cause to suspect that an employee is under the influence of alcohol and/or drugs while on duty. Reasonable cause to suspect that an employee is under the influence of alcohol and/or drugs while on duty may be based upon specific, contemporaneous, articulate observations of a supervisor or member of the management staff concerning the appearance, behavior, speech, or body
odor of the employee. In determining whether “reasonable cause” exists, supervisors may consider factors including, but not limited to, the following:

- Direct observation of drug or alcohol use or possession and/or symptoms of being under the influence of drugs or alcohol.
- A pattern of aberrant or abnormal behavior, such as mood and behavioral swings and wide variations or changes in job performance.
- Arrest or conviction of a drug-related offense or identification of an employee as the subject of a drug-related criminal investigation.
- Information provided by a reliable and credible source(s).
- Newly discovered evidence that an employee tampered with a previous test.

The employee will be required to authorize disclosure of the test results to the employer. Refusal by an employee to authorize disclosure to the employer or to submit immediately to a drug or alcohol test when requested by the employee’s department supervisor or a member of OSF HealthCare management will subject him/her to disciplinary action for insubordination up to, and including termination. Refusal to test will be construed as a positive test.

Any employee caught tampering, or attempting to tamper, with his/her test specimen or the specimen of any other employee shall be subject to immediate termination.

If the test(s) is (are) positive, the Medical Director for the Center for Occupational Health or the Emergency Department will interview the employee and consult with Human Resources and the employee’s department supervisor to determine what appropriate disciplinary action may be taken, up to, and including termination.

5. Needle-Sticks, Exposure to Hepatitis, HIV, or other Blood-borne Pathogens

Residents exposed to viral Hepatitis or to material potentially contaminated by any blood-borne pathogen should report to Employee Health for immediate confidential medical evaluation and follow-up. When Employee Health is closed, the resident should report to the Emergency Medicine Department and call Employee Health the next morning. The source patient’s name, medical records number, and the name of the attending physician should be included on the report.

a. Type of Exposure

1) Parenteral (e.g., needle sticks, bites, cuts, abrasions)

2) Mucous membrane (eyes, mouth, genital)

3) Significant skin exposure (non-intact skin) to:
   a) Blood
   b) Semen
c) Vaginal secretions

d) Saliva in dental procedures

e) Any body fluid contaminated with visible blood

f) Cerebrospinal, amniotic, synovial, pleural, pericardial, peritoneal, and amniotic fluids (because the risk of transmission of HIV from these fluids has not yet been determined)

g) And all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

b. Post Exposure Follow-up

- Wash exposed area thoroughly with soap and water if a needle stick, sharps injury or non-intact skin exposure occurs. If the eyes are exposed, flush immediately with large amounts of water. Do not use soap or chemicals in eyes. If the exposure is to the mouth or other mucous membrane, rinse with large amounts of water.

- Call the Ask OSF Call Center to report the exposure at 888-627-5673. This is a 24-hour line.

- Print the Blood Borne Exposure Form from the Intranet Occupational Health site. You need to complete this form by the time you are seen and evaluated.

- Identify the source patient and have the chart reviewed for risk factors.

- If the source patient is an outpatient, try to have the patient remain at the hospital until blood work is drawn.

- **You must be evaluated within 2 hours of the exposure.** The CDC recommends preventive medication for HIV be taken within 2 hours after the exposure. You will be referred to Occupational Health during day shift. If the exposure occurs on second or third shift, or on weekends, you will be referred to the Emergency Department.

- **Questions?** Call Occupational Health at 655-2429, Mon.-Fri., 7am-3:30pm.

c. If Source is HIV Positive

Currently, it is estimated that HIV is transmitted to 0.4% of health care workers who sustain needle stick injuries or similar cutaneous injuries from an HIV positive source patient. The risk from mucosal and non-intact cutaneous exposure is not zero but is too low to be reliably estimated in the studies performed to date.

Exposure to HIV by any route is a frightening experience and necessitates provision of optimal post-exposure care. Prophylaxis in the form of antiretroviral agents will be considered for high-risk exposures and the decision to treat will be made jointly by the Medical Director of Employee Health or his/her designee and the exposed employee.
If the source patient is HIV positive or if testing the source patient is impossible, the employee should be evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure (baseline). If the employee is seronegative, testing should be repeated periodically for a minimum of 6 months after the exposure (i.e., 6 weeks, 12 weeks, 6 months) to determine whether an HIV infection has occurred.

d. Source Individual is HIV-Seronegative

If the source patient is HIV-seronegative and has no clinical manifestations of AIDS or HIV infection, employee health will continue monitoring/testing the exposed resident for 6 months. However, the resident may stop testing at any time.

e. Source Unknown

If the source patient cannot be identified, decisions regarding appropriate follow-up will be individualized. Baseline and serological testing will be offered to the exposed resident.

f. Post-Exposure Written Evaluation

The resident will be provided with a copy of the health care professional’s written opinion within 15 days of evaluation. The written opinion is limited to whether the vaccine is indicated and if it has been received, serial testing dates, source patient’s lab work results, and attending physician comments, tetanus status, and any other follow-up necessary (i.e., HBV, HBIG, serial enzyme testing).

L. RESIDENCY PROGRAM TRANSFER

1. Residents wishing to transfer from one residency program to another should discuss their desire with the Director of their current program and the Director of the program to which the resident wishes to be transferred. It is a GMEC policy that there be early and direct communication between Program Directors whenever a resident wishes to transfer among UICOMP residency programs.

2. The resident and Program Director of the specialty to which the resident desires to be transferred are responsible for notifying the new Board in writing of his/her intent to change programs and to obtain a letter from the Boards stating the remaining requirements to be eligible to sit for the board exam in the new specialty.

3. Acceptance into another program will depend upon position availability and satisfactory performance as determined by the Director of the program to which the resident desires to be transferred.

4. Approval for transfer within UICOMP must be obtained from the current Program Director, new Program Director, and the GMEC.

5. Assignment of training level in a new program will be made by the new Program Director acting upon the Board’s response to the resident’s request. The Program Director’s assignment of training level is contingent upon ACGME approval and will automatically determine the stipend and professional meeting benefits provided to the resident.

6. Transfer will be affected only upon signing and acceptance of a new Resident Agreement.
7. The Illinois temporary license issued to each resident is both institution and program specific. Therefore, the transfer form one training program to another requires a formal transfer of license through the IDPR. When this occurs, the first temporary license is returned to Springfield and a second license is issued for the new residency program. No such requirement exists for those with permanent licenses during a program transfer.

8. Transfer of residents to UICOMP programs from outside institutions should follow the Resident Transfer Policy detailed in the Policy Manual.

M. DIPLOMAS AND TRANSCRIPTS

1. A diploma will be issued by UICOMP upon satisfactory completion of a residency program and upon payment in full of any monies owed to UICOMP or OSF SFMC.

2. For any resident not completing a residency program, written verification of training completed will be issued by the Program Directors, if requested.

3. No diploma or transcript will be issued unless the resident completes the prescribed OSF SFMC employee termination process.

N. INSTITUTIONAL REVIEW OF PROGRAMS PROCESS FOR RESIDENCY PROGRAMS (see section II.N.10)

O. LEGAL INVESTIGATIONS/REQUESTS FOR INFORMATION FROM ATTORNEYS

When lawyers, including state’s attorneys, involved in criminal or juvenile matters approach house staff and medical staff regarding their investigations, all residents are expected to follow the guidelines described below:

1. The resident’s Program Director should be informed if a subpoena is issued to a resident or if an attempt is made to issue a subpoena to the resident.

2. All requests for information from an attorney without a subpoena should be referred to the Risk Management Office at OSF SFMC at 655-2769.

3. The resident will normally be informed of requests for information from an attorney with a subpoena by the Risk Management officer who will also deliver the subpoena to the resident. If any patient care-related subpoena is issued to the resident by another mechanism, the resident should inform Risk Management (655-2769) immediately.

After receiving a subpoena, and when requested, Risk Management will facilitate a meeting between the house staff member and the hospital attorney before the scheduled court date. The Program Director should be informed of such a meeting by Risk Management should he/she elect to attend.

House staff members are strongly encouraged to comply with any lawfully issued subpoena that requires court testimony.

P. INSTITUTIONAL REVIEW BOARD TRAINING

All UICOMP residents and fellows involved with research must be educated about the protection of research subjects and patient information. Residents are required to attend the Ethics lecture series, which includes an “Ethics and Research” lecture. UICOMP residents and fellows must
complete the appropriate Institutional Review Board (IRB) training module before initiating a project and complete the training modules as required in the IRB review process. Individual programs may require additional research education and training at the Program Director’s discretion. IRB information may be found at the UICOMP website at http://www.uicomp.uic.edu/Dept/IRB/Default.html.

Q. NEWS MEDIA INQUIRIES

All inquiries from the news media should be immediately referred to the Public Relations Department Director (655-2777).

IV. RESIDENT BENEFITS and OSF SFMC POLICIES

A. INTRODUCTION

1. The resident is considered a professional in training in a UICOMP sponsored residency and also an employee of OSF SFMC, the medical center in which clinical training takes place. This unique position does not allow absolute application of a traditional employee’s benefits. The UICOMP, GMEC, and the Administration of OSF SFMC have designed a package of benefits specifically for residents. To access on-line Human Resources Policies: Visit PolicyStat.

2. Stipend

   a. The stipend for each resident is specified in his/her Resident Agreement. Effective dates of stipends for in-cycle residents are July 1 through June 30.

   b. The stipend payment schedule is based on 26 pay periods per year (every two weeks).

   c. Stipends for the 2017-2018 academic year are:

      TL-1 $55,786  TL-3 $59,633  TL-5 $61,133  TL-7 $63,291  
      TL-2 $57,518  TL-4 $60,229  TL-6 $62,050

   d. Residents who serve as House Staff President or House Staff Vice President will receive a supplemental stipend of $180 per month.

   e. Chief Residents with significant administrative responsibilities will receive an additional stipend for this service. The amount of the stipend will be determined annually by the Administrative Council which will consider the size of the residency program and the number of Chief Residents appointed by the Program Director.

   f. The Administrative Council reviews stipends each Spring and presents the proposed revisions in salary for the next academic cycle to the Joint Oversight Committees of Academic Programs (JOCAPs) from OSF SFMC, UPHM, and to the GMEC for approval.

3. Education Allowance

   a. Residents in the TL-1 through TL-7 training years will receive a maximum of $1,200 per year for reimbursement of education-related purchases that have been pre-approved by their Program Directors. Residents may also use the $1,200 allowance to attend professional meetings, as discussed below. The latter use is intended to help defray the costs of registration, transportation, hotel accommodations, and meals during the conference period.
Residents must follow policies of the GME Department for submission of travel request vouchers and documentation of expenses.

b. Residents may use their $1,200 educational allowance for attending meetings, for education-related materials/service, for taking electives, or may divide the allowance between these categories of expenditure in any desired proportion. If monies are being requested to fund an outside elective, the Program Director will present the resident’s request to the GMEC for approval. GMEC approval is necessary for the program to request the release of funds to support the resident’s request.

4. Vacation and Leave

a. Vacation

1) Residents receive 3 weeks Paid Time Off (PTO) per year (i.e., 15 week days and 6 weekend days per year).

2) One week of PTO is considered seven consecutive days (i.e., 5 weekdays and 2 weekend days).

3) Residents are discouraged from taking individual PTO days.

4) One-Month Rotations:

   i. Residents may be absent from a one-month rotation for PTO in order to attend an educational conference, providing the absence is no longer than seven consecutive days.

   ii. The scheduling of absences for PTO or attendance at educational conferences should be accomplished through collaboration between the resident’s Program Director and the relevant rotation faculty, giving appropriate consideration to the needs of the resident and those of the rotation site.

5) The allocation of PTO time between home programs and other programs where residents rotate must be equitable, as established between Program Directors.

6) Exceptions may be made by the resident’s Program Director after concurrence with the Program Director or Chair of a department in which a rotation is proposed.

7) Approval Process:

   a) Residents are required to submit their PTO dates for the year to their respective Program Directors by October 1st. This enables the Program Director to develop the annual PTO plan for the department. Approval or denial of these requests will be completed by November 1st.

   b) PTO Request Forms are available in the Program Director’s Office.

8) PTO time is not cumulative from agreement year to agreement year. Monetary reimbursement will not be given for unused PTO hours from one agreement year to the
next. It is the Program Director’s responsibility to ensure that each individual resident utilizes the maximum amount of PTO time allotted during the agreement year.

9) Each resident is required to take three weeks PTO per year.

10) Prior to leaving for PTO:

a) Arrangements must be made for coverage of any patients from the resident’s outpatient clinics, according to departmental policies; and

b) The resident must be up-to-date on his/her medical records and inform the Health Information Services Department of the PTO.

b. Leave

1) Bereavement Leave (see OSF Policy #408)

OSF HealthCare recognizes the need for employees to have time off at the time of death for immediate family to make arrangements and/or attend services. Immediate family includes spouse, parent, child, brother, sister, daughter-in-law, son-in-law, mother-in-law, father-in-law, stepchild, stepbrother/sister, stepmother/father, stepparent-in-law, or legal guardian.

Regular employees working a minimum of 64 hours per pay period, may be granted up to three (3) days, up to a maximum of twenty-four (24) hours at his/her regular straight-time hourly rate for days on which the employee was scheduled to work. If the employee’s absence beyond three (3) days is necessary, and is approved by an employee’s department supervisor, Paid Time Off (PTO) must be used. If an employee does not have accrued benefit time available, he/she may request and receive with approval of the employee’s department supervisor, a personal leave of absence in accordance with the guidelines of the leave of absence policy.

One (1) day, up to a maximum of eight (8) hours of bereavement leave will be available to regular employees working a minimum of 64 hours per pay period to attend the funeral of a grandparent, grandchild, step-grandchild, sister/brother-in-law, stepsister/brother-in-law, or grandparent-in-law at his/her straight-time hourly rate for a day on which the employee was scheduled to work.

In case of a death in a part-time regular employee’s immediate family (as defined above), one (1) day, up to eight (8) hours of bereavement leave with pay is available if the employee is scheduled to work on the day of the funeral.

Bereavement leave is not included as hours worked for purposes of calculating overtime.

2) Family and Medical Leave

Residents that have been employed for at least one (1) year, have worked at least 1,250 hours in the past twelve (12) months, and have a qualifying event shall use Family Medical Leave time when time off work is needed. Employee must print the paperwork from the Benefits Portal at https://team.osfhealthcare.org/employeebenefits and call the OSF Benefits Help Center to complete their application at 1-877-683-5999. A qualifying event is defined as the following: the birth of a child by a resident or resident’s spouse, and to care for a child; for the placement of a child for adoption or foster care by a
resident or resident’s spouse; to care for a seriously ill spouse, child, or parent; or because of a serious health condition that prevents the resident from performing functions required of residents. A family and medical leave may not exceed twelve (12) weeks in a twelve (12) month period. Full information about family and medical leave, including the details of the application process is available from the OSF Benefits Help Center at 1-877-683-5999. Any resident considering family and medical leave should discuss this possibility with his/her Program Director before contacting the OSF Benefits Help Center, 1-877-683-5999.

3) Leaves of absence other than those covered under family and medical leave may be granted by the Program Director under unusual situations.

4) Residents interested in pursuing a leave of absence should begin by discussing the matter with their Program Director.

5) Leaves of absence must be approved by the Program Director and OSF Benefits Help Center.

6) All residents considering a leave of absence should understand that taking a leave of absence may result in:

i. An extension of residency training;

ii. Delay of issuance of a certificate of training; and

iii. Delay of approval to sit for the Board examination.

iv. Access to information related to the impact of leave on Board eligibility is available in your Program Director’s Office.

7) Details concerning leave of absence will be recorded in the resident’s permanent file.

8) Employee benefits do not accrue while residents are on leave of absence status. Employee health insurance continues during leave of absence status if the resident pays the employee component of health insurance cost.

9) Jury Duty

Residents called to jury duty must notify their Program Directors in a timely manner that his/her service has been so enlisted. Residents must provide a letter from the court indicating the exact times and dates they have actually served in order to receive full pay for the time spent in jury duty.

5. Professional Meetings

a. A resident must have prior approval from the Program Director for any lecture series, seminar, conference, or other educational meeting he/she wishes to attend that will involve time away from his/her residency duties or for which monetary reimbursement is requested. The educational need of the resident will be the primary consideration. Residents are required to attend at least one major professional meeting during their course of residency training at UICOMP/OSF SFMC. Residents wishing to attend meetings outside the continental United States must also obtain permission from his/her Program Director.
b. The maximum allowable absence from a training program for a professional meeting is seven (7) days, including weekend days, per year.

c. TL-1 residents who wish to attend a professional meeting must use a portion of their PTO time.

d. The Approval Process involves:

i. Discussion of the professional meeting with the Program Director

ii. Completion of a PTO/Professional Meeting Request Form, available in the Program Director’s Office.

iii. Obtaining signatures from the Program Director and the Chief of Service of the rotation to which he/she is assigned at the time of the meeting absence.

iv. Completion of an Absence Form, available from the Program Director, to be processed.

v. Upon return, resident completion of the travel expense form, detailing his/her actual expenses, providing receipts, and submit to the GME Office for processing of reimbursement.

vi. To better assure that the resident will have the opportunity to attend the meeting of his/her choice, application for attendance at professional meetings should be submitted six weeks prior to the event. Approval should be received within a period not to exceed two weeks.

vii. PTO time may be permitted to precede or follow meeting times at the discretion of the Program Director, but professional meeting reimbursement will not be extended to cover PTO expenses. Approval will not be granted if the combination of PTO and education leave results in absence from the training program that the Program Director deems excessive.

viii. Prior to leaving for a professional meeting:

a) Arrangements must be made for coverage of any patients from the resident’s outpatient clinic according to departmental policies; and,

b) The resident must be up-to-date on his/her medical records and inform the Health Information Services Department of the professional meeting.

e. Travel and Lodging Arrangements:

If the conference sponsor has negotiated reduced rates for hotel rooms and/or airfare, the GME Office encourages residents to take advantage of these discounts whenever possible.

f. Research-Related Cost for Residents:
1) Support is provided to assist residents with expenses incidental to the presentation of original research at scientific and professional meetings and/or to help defray the cost of publications.

2) Travel outside the continental United States will be considered on a case-by-case basis.

3) There is a limit of GME/OSF funds of $1,500 for travel or publication costs per resident per year.

4) There is a limit of one sponsored resident per presentation, unless approved by the PD and the DIO.

5) Each presentation must reflect new, not previously presented research.

6) Support for posters prepared by the UICOMP Division of Educational Services will be provided with a limit of $300 per accepted presentation.

7) Copies of the acceptance letter for the presentation and an abstract of the presentation must be provided to, and prior authorization must be given by the GME Office.

8) A copy of the manuscript accepted for publication, the acceptance letter, and a letter documenting publication cost, must be submitted to the GME Office for approval before any funds will be distributed.

6. Insurance

a. Medical and Dental Insurance

The OSF HealthCare System “Group Medical and Dental Plan” offers two options for coverage. The OSF Quality Care Plan benefits are designed to provide access to quality healthcare providers and to help ensure financial protection and security for employees and eligible family members. The High Deductible Health Plan benefit is designed to offer a national network of healthcare providers with a larger deductible and Health Savings Account, to which OSF contributes. Complete information about this plan will be provided to residents via webinars prior to the start of their residency.

Hospital and health insurance benefits for residents and their families begins the first day of employment. Enrollment is required.

b. Life

Residents working 64-80 hours/pay period will receive 150% of annual base hourly rate to the nearest $1000, to a maximum of $60,000.

c. Accidental Death and Dismemberment

Residents working 64-80 hours/pay period will receive 150% of annual base hourly rate to the nearest $1000, to a maximum of $60,000.
d. Professional Liability Insurance for Residents Employed by OSF SFMC

a. OSF SFMC maintains professional liability insurance coverage for residents for any exposure to liability arising from performance of his/her duties as an OSF employee, prescribed upon such terms and in such amounts as OSF SFMC provides for its other professional employees. Insurance coverage is provided through the OSF Self-Insured Trust on an “occurrence basis” (rather than on a “claims-made basis”). Liability limits for an individual resident are $2 million per person, $4 million per occurrence. This insurance cannot be converted for a departing resident. This coverage exists for the duration of training and also provides legal defense and protection against awards for claims reported or filed after the completion of the program, if the alleged acts or omissions of the resident are in the scope of the program.

b. This coverage does not protect the resident when engaged in professional activities outside the prescribed training program, notwithstanding the fact that prior written permission had to be obtained from the Program Director to engage in this activity.

c. The OSF Healthcare System shall defend, at its cost, any suit brought against a resident arising out of the professional services provide, or withheld by the resident within the scope of the resident’s employment. Indemnification for any judgment rendered against a resident or any settlement made involving a claim concerning the professional conduct of a resident shall be paid through the OSF Self-Insured Trust.

d. The OSF Healthcare System has the right to investigate, to negotiate, and to settle any suit or claim, as OSF Healthcare System deems appropriate. No suit or claim or potential claim, the basis of which involves professional services provided or withheld by a resident, will be settled without first informing the resident. The right to settle, however, remains with OSF Healthcare System in its sole discretion.

7. Employee Assistance Plan (EAP)

Residents and their eligible family members are eligible to receive confidential, professional assessment services for personal problems that may affect their health, personal well-being, or job performance through the UICOMP run Resident Health Committee or the EAP at OSF. The latter services are provided by Chestnut Global Partners, an external EAP vendor. EAP assistance may be sought for marital and family, financial, mental health, alcohol-related, drug-related, or legal problems. Up to four sessions of problem assessment are provided at no cost to the resident. If additional help is needed, the EAP counselor will facilitate a referral for cost-effective, professional assistance. To obtain EAP services, residents should call 800-433-7916.

8. Retirement Plan

401(k) Retirement Plan: Residents contribute a percentage of their salary (up to 90% up to IRS limit) to the 401(k) Plan each pay period. OSF matches this contribution 100%: $1.00 per $1.00, up to the first 5% of your eligible pay. Residents are immediately vested in their contributions, plus the OSF match. An additional discretionary contribution may be made annually based on age and years of service depending on OSF’s financial state. Residents would need to be hired at an OSF hospital post-residency for an additional 2 years to be fully vested in the discretionary contribution.

9. Illness and Disability Related Absence from Work
a. Sick Protection Hours

Sick protection hours are designed to protect an employee's earnings if he/she is absent from work due to an extended disability. Utilizing sick protection hours and Short-term Disability, employees are provided with 180 days of income protection in the event of an extended disability, not related to Worker's Compensation.

Residents are eligible to receive payment from sick protection hours. Sick protection hours are reestablished annually on the anniversary of the resident's agreement date. Hours are pro-rated for residents employed less than 90% of time. Each TL-1 through TL-4 resident employed 90%-time or greater receives a total of 120 hours (15 days) of sick protection hours per year. Each TL-5 through TL-7 resident employed 90%-time or greater receives a total of 160 hours (20 days) of sick protection hours per year. Up to one-half of the annual sick allotment (60 hours for TL-1 through TL-4 and 80 hours for TL-5 through TL-7) may be used for payment due to a family member illness. Covered by members include child, spouse, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent, or stepparent.

When residents are ill, they must notify their Program Director, their Program Coordinator, and the Chief Resident of the service from which they will be absent. The Chief Resident will also notify that resident's Program Coordinator. Individual programs may have additional established department guidelines for notification of illness. The resident should be aware of program-specific guidelines when rotating on that specialty service.

As stated above, at the completion of a resident's anniversary agreement year, sick protection hours will be reestablished. However, if a resident is utilizing extended sick protection hours at the time their anniversary agreement year occurs, the reestablishment of benefits will not occur until two (2) weeks after he/she has returned to work.

Because of individual residency program RRC length-of-training requirements, specialty boards length-of-training requirements, ACGME duty hour rules, and individual department call, or clinic requirements, residents may be called in to cover the service. This will be determined by individual specialty rules and individual department rules.

b. Short-Term Disability

Short-term disability is designed to protect a regular employee's earnings if he/she is absent from work due to an eligible extended illness/injury. The entire cost of this benefit is covered by OSF SFMC.

All residents employed 40%-time or greater are eligible for this benefit. Note: (pro-rated for part-time residents) per anniversary agreement year for the same disability.

An application for this benefit must be submitted by the resident on the first day of the disability period. Employee must provide documentation from a licensed healthcare provider to certify total and continuous disability prior to accessing this benefit and at periodic intervals as deemed necessary by OSF Healthcare.

Benefits begin the 31st calendar day of the disability or after all PTO and Sick Time are exhausted, whichever is later, and would continue up to a maximum of 180 calendar days from onset of the disability per 12-month rolling period. Disability benefits will be paid at the rate of 50% of the employee’s pre-disability hourly rate of pay for each normally scheduled workday missed. This pay is subject to all the appropriate taxes and payroll deductions.
If an employee returns to work and subsequently leaves for the same illness after working less than four (4) hours, the Short-term Disability benefits will be reinstated with no waiting period. The employee can continue to collect remaining benefits. For questions, please contact the Benefits Help Center at 1-877-683-5999.

c. Long-Term Disability

i. Residents are provided long-term group disability insurance from UNUM; the cost of this insurance is paid by OSF SFMC. Long-term disability benefits begin at the six-month point of a disability. Such benefits do not apply to disabilities that are associated with pre-existing conditions.

ii. General provisions of the long-term group disability insurance policy are outlined in booklets that are distributed to the residents upon their initial employment.

d. Related Issues

i. The amount of time used for sick protection hours, and short-and long-term disability may affect the timing of:

   a) Issuance of a certificate of training; and

   b) Approval to sit for the Board examination

10. Meals/Cafeteria Policies

a. Residents on duty who are wearing a photo ID badge may obtain food (excluding bulk candy) free of charge in the OSF SFMC Main Cafeteria by swiping their OSF SFMC ID badge through the magnetic reader at the cashier’s station. Note: On occasion, non-food items are available for sale in the cafeteria; such items are not included in a resident’s cafeteria benefit.

b. The OSF SFMC Main Cafeteria is open 24 hours per day, 365 days per year.

c. Residents may not obtain food for other individuals, including medical students, family, or staff members. Residents who violate this policy may lose their cafeteria benefits and may be subject to other disciplinary policies by his/her Program Director.

d. The Doctors’ Dining Room is open at all times to provide privacy to residents. Residents may eat in the Doctor’s Dining Room. Trays brought in by residents are to be taken to the trayveyor in the main dining room on completion of meals.

e. Telephone orders for food are not accepted.

11. Uniform Coats and Photo ID Badges

a. Uniform coats are supplied and laundered without cost to the residents (see policies regarding appropriate dress, section II.M.6.).

b. Photo ID badges are supplied and are to be worn at all times. Replacement or repair of photo ID badges should be arranged through the Human Resources Office.
12. Parking

a. Parking in designated areas is provided at no charge.

b. Residents should not park in areas designated for patients, visitors, or attendings.

c. Parking tags are provided through OSF SFMC’s Security Services. The $20 deposit normally charged to employees is waived for residents; however, residents will be charged $20 for a replacement if the original parking card is lost. Replacement cards may be obtained at the Security Services Office.

d. Damaged or broken cards are to be exchanged through the Parking Services Office.

13. Rotations Outside of OSF SFMC

a. Elective rotations within the Peoria area:

If the Program Director arranges for an elective rotation at an institution(s) within the Peoria area, prior to assigning a resident to such a rotation, a formal written agreement between UICOMP/OSF SFMC and the outside institution(s) is required, ensuring that the resident’s stipend, benefits, and liability coverage are continued.

b. Elective rotations outside the Peoria area:

Residents may desire to do elective rotations outside Peoria, particularly if they wish to engage in subspecialty training not offered by UICOMP. In such cases, the resident must have prior approval for such a rotation by his/her Program Director and the GME Office. Once GME approval is granted, prior to assigning a resident to the rotation, a formal written agreement between UICOMP/OSF SFMC and the outside institution(s) is required, ensuring that the resident’s stipend, benefits, and liability coverage are continued. For additional details, see “Rotations outside of the Peoria area” below.

c. Rotations outside the Peoria area:

i. Required Rotations

a) When a residency Program Director seeks to establish a required rotation at an off-campus site, the educational content of such rotations must be first approved by the GMEC, and the fiscal aspects of such rotations must be approved by the Administrative Council. When such approvals have been obtained, a written Program Letter of Agreement (PLA) must be established between UICOMP/OSF SFMC in collaboration with the Program Director and the outside institution as mandated by the ACGME. This agreement will delineate the goals and objectives of the rotation, the on-site Director of the rotation, and the persons/institutions responsible for the resident’s stipend, benefits, and professional liability insurance while participating in the rotation. The PLA must be signed by all parties before the resident may train at the off-campus site.

b) In cases where a required off-campus rotation is located beyond a reasonable commuting distance to Peoria, it may be necessary for residents participating in the rotation to obtain temporary housing in the vicinity of the rotation site. When the outside institution does not provide such housing, the Graduate Medical Education...
Office will provide the resident with financial assistance to help defray the costs of obtaining temporary housing. Assistance will be provided for the term of the outside rotation, to a maximum of three months. Residents will receive a cash advance of 100% of the base rental figure (i.e., the prevailing rental rate for a one-bedroom apartment in the locale of the required rotation, as determined by the Graduate Medical Education Office), or the actual rental charge, whichever is less. Residents will also receive a cash advance for parking expenses, to a maximum of $150 per month. In addition, the resident will be advanced funds to cover any security deposit that is required for apartment rental. Upon completion of the off-campus training, residents who received assistance for housing and parking must provide receipts for the expenses incurred, and must refund to the Graduate Medical Education Office the full amount of any security deposit advanced, regardless of the amount that is refunded to them by the landlord.

The resident is responsible for:

i. Obtaining his/her apartment and utilities

ii. Signing the lease

iii. Paying for utilities and telephone

iv. Transportation and meals, if not provided by the outside institution

c) In cases where a required off-campus rotation is located within a reasonable commuting distance to Peoria, residents will receive compensation to help defray the costs of travel to and from the off-campus site, subject to the following conditions:

i. The off-campus rotation site must be located beyond a 20-mile radius from OSF SFMC, as determined by the Graduate Medical Education Office.

ii. The compensation will be based on the round-trip mileage, from OSF SFMC to the off-campus rotation, as determined by the Graduate Medical Education Office.

iii. The per mile rate of compensation will be the rate currently paid to employees of OSF SFMC for the work-related travel of its employees.

iv. Compensation will be paid only to residents who travel in their own vehicle and actually incur the costs of such travel.

v. A log of resident travel which meets the requirements of this policy will be maintained by the residency Program Coordinator. This log will identify the dates of travel, the resident entitled to compensation, and the name and location of the off-campus rotation site. The log will be maintained on a daily basis, and will be reported to the Graduate Medical Education Office at the end of the month.

vi. Compensation for travel will be provided on a monthly basis by the Graduate Medical Education Office based upon the travel log.

ii. Elective Rotations
a) Prior approval for an elective rotation must be obtained by the Program Director and from the GME Office at least six weeks in advance.

b) A “Letter of Agreement” between UICOMP, OSF SFMC, and the ROTATION SITE must first be signed by the appropriate parties and on file at the GME Office before a resident may begin an outside, elective rotation. This letter identifies the rotation site supervisor, responsibilities for evaluations, and benefits including salary and liability insurance coverage, educational goals and objectives, and clinical responsibilities.

c) Supervising faculty on elective rotations require the approval of the program director. Unlike the LCME requirement, a UICOMP faculty appointment is not required for attending supervision of residents on outside rotations.

d) The resident taking an approved elective will continue to receive his/her stipend, liability insurance, and regular insurance benefits. Other benefits, such as meal and parking reimbursements, do not accompany the resident to the outside institution from SFMC.

e) Residents choosing to do an elective outside rotation will be expected to use their Education Allowance to cover the costs of room, board, travel, and other expenses. They will submit requests for reimbursement using the appropriate Educational Allowance Reimbursement Form. If expenses exceed their Education Allowance, the rotation may be denied, or the resident will be required to absorb the additional costs incurred while doing the rotation.

14. International Rotations – All off-campus rotations, including international rotations must be approved the both the program director and the GME Office. The GME Office will not approve an international rotation that will take place in a dangerous location. For rotations outside the United States, a dangerous location is considered an area which the United Stated Government considers “unsafe to travel” in.

15. Social Functions

UICOMP/MMCI is pleased to host a number of social functions for House Staff. Examples include an annual Holiday Party, Golf Outing and Dinner.

16. YMCA Privileges:

Privileges at the Peoria YMCA are provided as a benefit to residents, their spouses, and children. Residents may gain initial access to the YMCA by presenting his/her OSF identification badges to the YMCA desk personnel on duty, who will ask the residents to complete a YMCA membership application. After the application has been processed, a YMCA membership card will be issued and should be used for future admissions to the facility. Specific information about YMCA programs and services is available from the GME Office.

17. SFMC-Sponsored Advanced Life Support Courses:

When all residents in a program are required to complete an advanced life support class (e.g., ACLS, ATLS, APLS), the fees for the class are paid for by the GME Office for all residents who successfully complete their training.

18. Licensing Fee Reimbursement for incoming residents:
a. Temporary Certificates

Those obtaining temporary certificates will receive a reimbursement of ($230) when the Graduate Medical Education Office is supplied with the following documents:

1) A receipt for the full amount of the license fee from the Illinois Department of Professional Regulation or a copy of the issued license.

B. UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE – PEORIA

1. Educational Resources

UICOMP offers a variety of educational resources for the residents, including:

a. Computer Facilities
b. Library of Health Sciences
c. Instruction and Evaluation services
d. Research Laboratories which include animal facilities and an electron microscope
e. Media Production Services
f. Institutional Review Board Training
g. Educational Specialist to help residents with problems related to learning and communication

Residents should contact the GME Office (671-8450) for information about utilization and cost of these services.

2. Academic Counseling

Academic and career counseling is offered through the Offices of Graduate Medical Education and Academic Affairs. Information about USMLE Step 3 and fellowships are provided as well as residency information for those in preliminary programs.

V. RESIDENT DISCIPLINE AND GRIEVANCE PROCEDURES

A. GENERAL
1. All complaints and concerns about residents should be brought to the attention of the Program Director or his/her designee, who will conduct an investigation sufficient to clarify the issues, persons, and behaviors involved. This investigation must include an interview with the resident whose actions triggered the complaint or concern and, when appropriate, an interview of the person(s) who originated the complaint or concern.

2. When the Program Director determines that complaints or concerns raised may involve a significant violation of hospital rules and policies, he/she will so inform the administrator of the OSF SFMC Human Resources Department, the VP/CMO, and the Associate Dean for Graduate Medical Education. These persons will then confer to determine which disciplinary procedure (that of OSF SFMC or of UICOMP) is most appropriate for the circumstances.

3. Disciplinary action may include any of the following, not necessarily in sequential order:

   a. Educational Intervention: Resident receives a warning, issued by the Program Director, for example to complete delinquent records. Resident’s cafeteria privileges may be revoked for a length of time specified by the Program Director. Educational Intervention may not exceed (1) one month but may be renewable.

   b. Administrative Suspension:

      1) This is NOT a formal disciplinary action, and will NOT be reported to licensing and credentialing agencies, but will be documented in their portfolios/training files.

      2) During the period of administrative suspension, the resident may be removed from their clinical duties at the discretion of the Program Director.

      3) During the period of administrative suspension, the resident’s cafeteria privileges may be revoked at the discretion of the Program Director.

      4) If a resident chooses not to take vacation time, or has no vacation time available, the suspension status is considered time off without pay. The resident will be removed from their clinical duties for the duration of the suspension.

   c. Suspension: If a resident is placed on suspension:

      1) Program Director will document this lapse of professionalism in the resident’s permanent file. (see Resident Discipline and Grievance Procedures, and UICOMP (GMEC) Disciplinary Process, section V.). This IS a formal disciplinary action which will be reported to licensing and credentialing agencies. This information may be included in letters of recommendation.

      2) If a resident chooses not to take vacation time, or has no vacation time available, the suspension status is considered time off without pay. The resident will be removed from their clinical duties for the duration of the suspension.

      3) During this period, the resident will maintain health coverage but no other benefits including cafeteria privileges.

      4) Depending upon the educational requirements of the rotation and length of suspension, credit toward resident program fulfillment may be lost. In some cases, this may delay eligibility to sit for Board certification.
d. In extenuating circumstances, residents may appeal to their Program Director for a waiver of disciplinary action due to delinquent medical records. The residency Program Director will document the circumstances for the resident’s permanent file.

e. A resident with incomplete medical records who is suspended is not entitled to the right of review provided under the Resident Agreement. (see Resident Discipline and Grievance Procedures, section V.).

f. Residents are not permitted to violate the Institution’s duty hour rules in order to dictate charts.

B. OSF SFMC DISCIPLINARY PROCESS

1. Process

a. When an alleged infraction is pursued using the hospital’s disciplinary process, the administrator of the hospital’s Human Resources Department will ensure that the resident receives a copy of the current OSF SFMC HealthCare Human Resources Handbook, as well as copies of all written OSF SFMC Human Resource Policies that are relevant to the alleged infraction. Possible outcomes of the disciplinary process include exoneration, warning, probation, suspension, and termination of employment.

b. Continuation in a residency program requires that residents remain in good standing with OSF SFMC and with UICOMP. Therefore, residents whose employment is terminated by OSF SFMC will be simultaneously dismissed from their residency program.

c. Residents who are not satisfied with the outcome of the hospital’s disciplinary process may appeal using the hospital’s grievance procedures.

C. UICOMP (GMEC) DISCIPLINARY PROCESS

1. Possible Outcomes

a. Exoneration;

b. Educational Intervention;

c. Probation;

d. Suspension (disciplinary, automatic, or immediate);

e. Dismissal from the residency program.

2. Process

a. Educational Intervention

  1) Educational Intervention is a corrective action imposed by the Program Director that notifies the resident of specific deficiencies that must be corrected. While on educational intervention, residents receive credit for training time and salary and benefits remain in force.
2) A conference between the resident and the Program Director must be held prior to initiating educational intervention. In this conference, the reasons for educational intervention, the process for remediation, and the required outcomes must be identified. Within one week of this conference, the Program Director must provide the resident with a letter (copied to the Associate Dean for Graduate Medical Education) indicating the reasons for the educational intervention, the process of remediation, and the required outcomes.

3) A single educational intervention period may not be longer than one month. Multiple periods of educational intervention may follow each other, but each period requires a conference between the resident and the Program Director and a letter to the resident (with copy to the Associate Dean for Graduate Medical Education), describing the terms of the educational intervention.

4) At the end of the educational intervention period, another conference between the resident and the Program Director must be held, at which time the resident may be:

   a) Removed from educational intervention status;
   b) Placed on another period of educational intervention;
   c) Placed on probation.

b. Probation

   1) Probation is also a corrective action that notifies the resident of specific deficiencies that must be corrected in a stated period of time. While on probation, residents receive credit for training time and salary and benefits remain in force.

   2) In general, a resident is put on probation by the Program Director.

   3) A conference between the resident and the Program Director must be held when a resident is placed on probation. In this conference, the reasons for probation, the process for remediation, and the required outcomes (i.e. terms of remediation) must be identified. Within one week of this conference, the Program Director must provide the resident with a letter (copied to the Associate Dean for Graduate Medical Education) indicating the reasons for the probation, the process of remediation, and the required outcomes.

   4) A single probation period may not be longer than three months. Multiple periods of probation may follow each other, but each period requires a conference between the resident and the Program Director and a letter to the resident (with copy to the Associate Dean for Graduate Medical Education), describing the terms of the probation.

   5) At the end of the probation period, another conference between the resident and the Program Director must be held, at which time the resident may be:

   a) Removed from probation;
   b) Placed on another period of probation;
c) Informed that he/she will not be offered a Resident Agreement when the current agreement expires;

d) Entered into the dismissal process.

c. Suspension

1) Definition

Suspension is a corrective action that removes the resident from the usual program duties. While on suspension, the resident does not receive credit for training time or salary. However, health benefits continue. Details of suspension are recorded on a resident’s permanent record.

2) Types of suspension (see Grounds, section c.4). below for definitions)

   a) Disciplinary Suspension
   b) Administrative Suspension
   c) Immediate Suspension

3) Assignment

Suspension may be imposed by the Program Director, the Associate Dean for Graduate Medical Education, or the OSF Administrator or his/her representative.

4) Grounds

Grounds for suspension include, but are not limited to:

   a) Disciplinary Suspension

      i. Employment outside the residency program in violation of the Institutional Policy (see Moonlighting, section II.H.5.j.).

      ii. Disregard for OSF SFMC policies pertaining to dress, conduct, and other policies that are applicable to residents who work in this institution.

      iii. Disregard or noncompliance of any of the statutes, rules, or policies that are established by either UICOMP or OSF SFMC and apply to all residents (detailed in Institutional Policies, section II. and Benefits and OSF SFMC Policies, section IV.).

      iv. Disregard or noncompliance with the rules or policies that are established by a Program Director to apply to all residents in that program (detailed in the program-specific manual).

   b) Administrative Suspension

      i. Incomplete medical records are grounds for administrative suspension (see Resident Responsibilities, section III.G.2.).
ii. Note: Residents are not entitled to grieve administrative suspensions.

c) **Immediate Suspension**

i. Compromising patient and/or co-worker/colleague safety.

ii. Flagrant violations of rules and regulations governing residents (detailed in Institutional Policies, section II. and Benefits and OSF SFMC Policies, section IV. of this manual and in the program-specific manual).

5) **Conditions**

a) **Disciplinary Suspension**

This type of suspension is usually imposed after a warning letter has been sent to the resident that describes the reason, the time allotted for correction, and the starting date of the suspension if corrections are not made. However, in cases where egregious behavior is responsible for the suspension, the disciplinary suspension may be imposed without a prior warning letter.

b) **Immediate Suspension**

This type of suspension may be imposed verbally, and may begin immediately, with a timely follow-up letter to the resident documenting the reason.

6) **Review**

All immediate suspensions will be reviewed within three working days by the Associate Dean for Graduate Medical Education, and an administrative representative. (A working day is defined here as non-holiday, Monday through Friday).

7) **Removal of Suspension**

a) **Disciplinary Suspension**

i. This suspension will usually be removed when the initiating reason has been corrected.

ii. A disciplinary suspension lasting longer than ten (10) days without a significant effort toward correction may trigger the dismissal process.

d) **Dismissal**

1) **Definitions**

a) Dismissal means the discharge of a resident from the program even though he/she has signed a Resident Agreement.

b) Special Notice means written notice delivered via messenger or certified mail, return receipt requested.
2) Grounds for Dismissal

Grounds for dismissal include, but are not limited to, the following:

a) Failure of the resident to comply with law. Residents must comply with federal, state, and local laws. Infractions of more than a minor nature are cause for dismissal.

b) Failure of the resident to meet or advance in any of the competencies (medical knowledge, patient care, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice) at a rate commensurate with his/her training level.

c) Egregious Behavior: A resident may be dismissed at any time for behavior deemed “egregious”. Egregious termination may occur if a resident’s actions place a patient’s safety at risk; for competency issues in the domains of interpersonal and communication skills, patient care; practice based learning and improvement, medical knowledge or system’s based practice that significantly compromise patient care, for lapses of professionalism unbefitting a medical care provider; and/or for acts or omissions, which could lead to discipline, including termination as set forth in Medical Center Human Resources Manual and the Manual. A resident that exhibits egregious behavior may be terminated immediately. Egregious termination renders null and void the 4 month written notice requirement for non-renewal of resident contracts (section IIH, under Agreement of Appointment). A Resident may “grieve” dismissal due to egregious behavior by using the procedures detailed in section V of the House Staff Manual.

3) Process

PROCEDURES TO APPEAL TERMINATION, SUSPENSION, NONRENEWAL OF MEDICAL RESIDENTS AND PROBATION

Effective date: January 1, 2010

This Procedure to Appeal a termination, suspension, nonrenewal of a Resident and probation shall be the only means available to all Residents of The University of Illinois at Chicago College of Medicine to challenge said actions during the course of his/her medical education and clinical training program. The term “Resident” shall include any “intern” or “fellow”.

a. Applicability: The procedures provided under this Exhibit do not apply to the following:

   1. Departmental determinations relating to certification and/or evaluation of the Resident’s academic performance or clinical competence—Such certification shall be handled according to the standards of the various specialty boards.

   2. The nullification of the Resident Agreement as a result of the Resident’s failure to meet any or all of the pre-conditions set forth in Section IV of the Resident Agreement—Said nullification is not subject to appeal.

   3. Decisions to terminate a resident as a result of his/her name appearing on a federal, state or other mandated governmental exclusions/sanctions listing—Instead, the procedures set forth in GME policy number 38 shall apply.

b. Notice of Corrective Action: The Department Head shall provide to the Resident written notification of the termination/suspension/nonrenewal/probation within ten (10) days of imposition of that action. The notice shall
include an explanation of the reason(s) for such action and shall advise the Resident of his/her right to request an informal hearing pursuant to this Exhibit.

c. **Request for Hearing:** Within fourteen (14) days of issuance of written notification of the action, a Resident may request a hearing before a Committee, as more fully described below. The Resident's request must be in writing and submitted to the Department Head.

d. **Hearing Committee:** The Hearing Committee shall consist of at least three (3) faculty members from the Resident's department. The Department Head shall not be a member of the Committee. The Committee shall elect a member from the group to preside as Chair at the hearing. Each department may have a standing committee to conduct hearings requested under this Exhibit. If there is no standing committee, an ad hoc committee shall be appointed by the Associate Dean for Graduate Medical Education for each hearing requested.

e. **Conduct of Hearing:**
   1. The Committee shall convene the hearing within fourteen (14) days of receipt of the Resident's written request and shall notify the Resident in writing of the date, time, and place for the hearing as soon as reasonably possible, but no fewer than 72 hours in advance of the hearing.
   2. The Resident and the Department Head or his/her designee shall be present at the hearing and shall each present such information, witnesses or materials (oral or written) as he/she wishes to support his/her position. No other representatives shall be present during the hearing, with the exception of attorneys who represent the parties or the Hearing Committee. Attorneys will be allowed to attend only in an advisory role to his/her client and shall not be allowed to address the Hearing Committee, the other party or each other directly.
   3. Each party shall be permitted to review all materials submitted to the Committee during the hearing.
   4. The Hearing Committee shall have the sole right to determine what information, materials and/or witnesses are relevant to the proceedings and shall consider only that which they deem to be relevant.

f. **Hearing Committee Decision:**
   1. A majority vote of the Committee shall decide the issue(s) before it and the Department shall be bound by the decision.
   2. Regardless of the outcome of the hearing, the Committee will provide the Resident and Department Head with a written statement of its decision and the reason(s) for such decision within ten (10) calendar days from the date of the conclusion of the hearing. If written materials are submitted to the Committee, such materials shall be appended to the Committee's report.

g. **Appeal of Hearing Committee Decision:** A Resident may appeal the Committee's decision to the Associate Dean for Graduate Medical Education within ten (10) days of issuance of the Committee's decision. The Associate Dean shall review the Committee's decision and any documentation submitted to the Committee, and may conduct his/her own investigation of the matter. He/she may, but need not appoint another Committee, to review and discuss the matter. He/she shall render his/her decision in writing within a reasonable time, but not later than thirty (30) days after receipt of the request for appeal.

h. **Final Appeal:** The Resident may appeal the Associate Dean's decision to the Senior Associate Dean for Academic and Educational Affairs of the College of Medicine within ten (10) days from the date of issuance of the decision. An appeal to the Senior Associate Dean is permitted only on procedural grounds and a review of the record by the Senior Associate Dean for said appeal shall be limited only to procedural matters. The Senior Associate Dean shall render his/her decision within ten (10) days after receipt of the request for appeal and such decision shall be final and unappealable.
i. **UIC Academic Grievance Procedures:** The UIC Academic Grievance Procedures may not be used to appeal any corrective action, nor to appeal any decision made in accordance with the procedures outlined above.

j. **General Provisions:**
   1. All appeals or requests filed in the course of these procedures must be in writing, must enumerate any previously made findings of fact which are challenged and must state whether and, if so, how the Resident wishes to have modified the previous decision(s).
   2. All decisions must be in writing, shall list relevant findings of fact, shall outline the reasons for the conclusions reached, and shall state the decision clearly.
   3. All notices and decisions which are to be sent to the Resident shall be sent by messenger, certified mail (return receipt requested) or by some other means wherein the date of delivery/acceptance/refusal can be determined.
   4. All references in these Procedures to time periods are to calendar days, not working or business days.
UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA

Office of Graduate Medical Education

Sub. Approval:  
Sub. Approval:  
Initial Approval: 4-3-15  
Approved by: GMEC

Subject: Annual Institutional Review (AIR)

Page 1 of 1
Review Date:  
Revised Date:  
Reviewed Date:  
Effective Date: 4-2-15

PURPOSE: To establish a process by which the Graduate Medical Education committee (GMEC) must demonstrate effective oversight of the Sponsoring Institution’s accreditation through an Annual Institutional Review (AIR) I.B.5)

POLICY: In October of each year the GMEC will conduct an Annual Institutional Review (AIR) by reviewing established performance indicators. The time period of review for the AIR will be the previous academic year (July-June).

PROCEDURE: The AIR will be developed through review of the Annual Residency program reviews conducted by the Subcommittee for Annual Institutional Review of Programs (AIRPC) the institutional report card, and will focus on the following performance indicators:

1) Results of the most recent institutional self-study visit.
2) Results of Program response to the Annual Program Review.
3) Notification of ACGME-Accredited Programs accreditation status and self-study visits.
4) Results of ACGME Surveys of Residents/Fellows and Core Faculty.
5) Aggregate results of ACGME-Accredited Program performance indicators
6) Compliance with up to date signed institutional agreements.
   a. Affiliation Agreements
   b. Program Letters of Agreement (PLA)
7) Results of Annual Program Evaluation (APE)
8) Review Status of Residency Review Committee Citations.

Upon analysis of the above performance indicators, the GMEC will identify areas for growth and establish action plans for improvement. Action plans resulting from the AIR will be monitored by the Graduate Medical Education Office and reviewed with the Designated Institutional Official (DIO) regularly.

The DIO will submit a written annual executive summary of the AIR to the governing bodies of the institutional partners.
PURPOSE:

OSF HealthCare is dedicated to having Mission Partners present a professional appearance to those we serve. An organization may be judged not only by the quality of its services but by the appearance of those providing the services. Therefore, while freedom of individual expression and changing styles and fashion are recognized, it remains important to convey a sense of professionalism to patients and their families, visitors, and business associates. Appropriate clothing and good habits in personal hygiene are important aspects in personal appearance.

POLICY:

1. It is the responsibility of OSF leadership to assure that Mission Partners are dressed in an acceptable manner consistent with their specific environment and appropriate for interaction with individuals they come in contact with.

2. In order for OSF HealthCare to continue to maintain a professional atmosphere, attitude, and to promote safety for employees, the following information is intended to serve as a guide to help define appropriate dress for Mission Partners in various settings.
   a. It is not intended to be all inclusive.
   b. Rather, it sets the general parameters for proper attire and allows Mission Partners to make intelligent judgments about items that are not specifically addressed.
   c. Department leadership is responsible for interpretation of the guidelines, and as necessary, may require more stringent or restrictive, but not more lenient, dress codes, as deemed necessary by their functions.
   d. Department specific requirements are approved by the appropriate Vice President.

3. If there is any doubt about whether an article of apparel is appropriate, assume it is not.
   a. When in doubt, dress conservatively.
   b. Clothing is neat & clean, properly fitted, and meet the job specific requirements.
   c. Attire is not revealing and undergarments are not visible.

4. Exceptions to dress or uniform codes for bona fide physician certified health reasons may be made.

5. Non-compliance with the dress code is addressed through the Positive Discipline Policy.
6. Questions about specifics on this policy can be addressed through the department leader or Human Resources.

Specific guidelines follow below:

**Shirts**

1. Casual shirts with collars, knit tops, sweaters, turtlenecks, polo shirts, in high quality material are acceptable. These types of casual shirts may include approved OSF logos.

2. Inappropriate items include:
   
   a. shirts and jackets made from denim,
   
b. T-shirts,
   
c. sweatshirts,
   
d. tank tops,
   
e. halter tops,
   
f. hooded shirts,
   
g. tops with bare shoulders unless worn under another blouse or jacket, and
   
h. any shirts with messages, advertisements, slogans, photographs, large lettering or logos.

3. Shirts are of an appropriate length and cover the midriff when arms are extended over the head.

**Slacks**

1. Dress slacks are acceptable.

2. Dress capri's that are 4" below the knee are acceptable in non-clinical areas. (No jean style regardless of material is allowed.)

3. Inappropriate items include:
   
   a. denim jeans of any color,
   
b. cargo pants,
   
c. sweatpants/suits,
   
d. shorts,
   
e. bib overalls, and
   
f. spandex/other form fitting pants.

4. However, brown or black denim jeans may be allowed in Maintenance departments, if approved by the appropriate Vice President.

**Dresses and skirts**

1. Casual dresses, jumpers, skirts, and split skirts, not greater than 2 inches above the knee, are acceptable.

2. Dresses and skirts made from denim are not acceptable.

**Scrubs**

1. Some departments, as designated by the operating unit, are required to wear scrubs.
a. Only solid colored scrub pants may be worn. Scrub pants cannot drag on the floor.
b. Printed scrub tops may be worn, if the print is appropriate for the workplace.
c. A solid colored or white T-shirt may be worn underneath scrub tops, provided it does not hang out below the end of the scrub top.

2. Hospital scrubs are not to be worn or carried off OSF property without being signed out by proper authorization.

Casual Clothing

1. Casual clothing is acceptable for attendance at department meetings that require Mission Partners to come into the operating unit on a scheduled day off.

2. Casual clothing may also be worn by those Mission Partners coming and leaving work, if they change into appropriate attire once they get to their department.

Footwear

1. Footwear is professional and appropriate for the workplace.

2. For Mission Partners whose primary job is in a clinical area, footwear is limited to closed toe shoes without any holes on top, such as athletic shoes, tennis shoes, and non-vented Crocs/clogs with a strap around the heel.

3. For Mission Partners whose primary job is in a non-clinical area, open toe shoes and dress sandals, in addition to dress, closed toe shoes, are acceptable as long as department safety guidelines are not violated.
   a. Heel height is not be greater than 3 inches.
   b. Socks/stockings are not mandatory providing a professional appearance is maintained and the department specific dress code does not require them.
   c. Athletic shoes, tennis shoes, and sneakers are not to be worn, unless the department safety guidelines require them.

4. Flip flops, barefoot shoes, and slippers are not appropriate for any setting.

Settings Requiring Uniforms

1. Some departments may require a standard uniform as their dress code.

2. Specific dress code and uniform requirements are maintained for each department requiring a uniform.

3. It is the responsibility of Mission Partners to supply and clean their own uniforms, except in specialty areas as defined by OSF HealthCare.

Grooming

1. Good personal hygiene is expected of employees.

2. Hair needs to be clean, neatly styled, and manageable for the job performed.
   a. Hair ornaments are kept to a minimum and hair color is of a natural tone.
   b. If the length of the hair could impose a safety hazard for the job performed, it needs to be fastened away from the face.
c. Mission Partners who come into direct contact with patients and/or food preparation may be required to cover their hair and/or beard with a hair net or cap in order to comply with Public Health regulations.

3. Male personnel are expected to be clean shaven or wear neatly trimmed mustaches, sideburns, and beards not greater than two inches in length.

4. Make-up needs to be moderately applied and appropriate for professional/business appearance.

5. Tattoos are concealed and covered to maintain a professional appearance. If the tattoo is unable to be covered by clothing, it is covered by a bandage when at work.

6. Odors should not be excessive. No overpowering odors (fragrances, body odor, tobacco or other smoke, etc.) shall be noticeable from an employee during work hours.

7. Fingernails are to be neatly manicured and of reasonable length (less than ¼ inch in length from tip of finger for those Mission Partners providing direct patient care).
   a. For those individuals providing direct patient care, cleaning patient/treatment rooms, and/or preparing items that touch the patient or are used for patient care, artificial nails, extenders, or enhancements are not allowed.
   b. Anything applied to natural nails, other than nail polish, is considered an enhancement. Gel and shellac nail polish are considered an enhancement and not allowed for those individuals providing direct patient care.
   c. Nail polish colors need to be appropriate for professional/business appearance.

Accessories

1. Except for small conservative earrings placed in the ears, any other visible "piercing" jewelry (including nose, lips, eyebrow, and tongue piercings) is not acceptable.

2. Jewelry and other adornment are simple and appropriate for job duties.

3. Pins, stickers, or other adornments that are not OSF-provided, do not recognize an OSF HealthCare sponsored activity, and/or are not for employment-related certifications/qualifications are not allowed.

4. Hats/caps and sunglasses, unless authorized by the department leadership as specific to a job, are not to be worn while on duty.

Name Badges

1. Name badges must be worn by Mission Partners while on duty and for OSF related business.

2. Name badges are worn with the picture facing out and worn in a visible location, as appropriate per the work area.

3. Name badges and/or plastic badge holders are to be replaced if lost or the plastic becomes ragged.

4. Mission Partners are issued a name badge when employment begins and/or when any information on the name badge changes. The Mission Partner is responsible for the cost for a new name badge if they lose the badge or require a new badge for any reason outside of the control of the operating unit.

5. Pins may not be placed on or through the employee name badge.

6. Defacing, disguising or otherwise altering the identification badge is prohibited.

7. Upon termination, the employee returns the identification badge to Human Resources.

Jeans for a Cause Days
1. Senior leadership may, at their discretion, authorize a "Jeans for a Cause" work day.
   a. These days are limited to no more than once per month.
   b. All other aspects of this Personal Appearance policy is adhered to on "Jeans for a Cause" work days.
   c. Jeans worn on these days are free from holes or fraying.

2. In some patient care settings, Jeans for a Cause days are not appropriate and may not be approved by senior leadership.

REFERENCES:

Human Resources Policy #601, Positive Discipline

This policy is in effect for OSF Healthcare System, OSF Healthcare Foundation and all OSF Healthcare System subsidiaries and affiliates, except as limited in the header or body of this policy. For purposes of this policy, the terms "subsidiaries" and "affiliates" mean facilities or entities wholly owned or wholly controlled by OSF Healthcare System. The hospitals covered by this policy are:

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<td>Rebecca Karlowicz: COMP/BENEFITS PROJ SPECIALIST</td>
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<td>Sharon Dyer: SUPV HR SUPPORT SERVICES</td>
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<td>Bruce Mehl: SVP HUMAN RESOURCES</td>
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STANDARDS OF PROFESSIONAL RELATIONSHIPS

Policy
Saint Francis Medical Center ("Hospital") is committed to providing a work environment that supports the philosophy of teamwork, collaboration and professional growth. Hospital employees, physicians, contracted staff and vendors will utilize behaviors and interpersonal communication styles that demonstrate courtesy, dignity and respect in all interactions including e-mail and telephone.

Purpose
To create a work environment in the spirit of the Sisters’ Mission that facilitates a team approach to patient care, promotes professional collaboration, and respects the individuality of each team member.

Behavior Expectations
All employees, physicians, contracted staff and vendors will conduct themselves in a professional manner. Employees, physicians, contracted staff and vendors will be treated with courtesy and respect at all times. We will:

- Work together professionally regardless of past difficulties
- Remain open-minded and actively listen to others’ point of view
- Attend to problems that may disrupt the work environment
- Display common courtesy toward each other
- Verbalize disagreements with discretion
- Address issues with each other in a direct, prompt yet sensitive manner
- Address dissatisfaction with policies through appropriate grievance channels
- Take time to give positive feedback, as well as constructive criticism in an appropriate setting
- Respond to questions and clarify information in a prompt and timely manner
- Recognize and acknowledge the individual expertise of all team members
- Respect cultural differences
- Speak to each other in a respectful manner, both in person and on the telephone
- Use e-mail in a professional manner

All employees, physicians, contracted staff and vendors will refrain from utilizing behaviors that may be perceived as intimidating, hostile, or harassing. Conduct that falls into these categories will not be tolerated. Behaviors that may fall into these categories include, but are not limited to:

- Exaggerated tone of voice, screaming, yelling
- Invasion of physical/personal space
- Unwanted touching of another individual
- Grabbing objects from another individual
- Throwing objects
- Name calling and utilizing derogatory remarks towards another
- Use of expletives and foul language
- Berating individuals in front of others
- Stereotyping
- Coercion through intimidation
- Bolstering and disruptive activity
- Jokes telling that promotes discrimination towards gender, race, and ethnicity

Any employee or physician encountering these behaviors is encouraged to report the behavior to their immediate supervisor for investigation, documentation and recommendation of appropriate action in accordance with the Hospital’s harassment policy and other applicable policies (all referred to as "Policies").

Supervisory personnel should discuss the issue with the individuals involved and attempt to resolve the issue. If they are unable to resolve the issue, supervisors should use the appropriate administrative channels set forth in the Policies.

Employee-to-employee interactions should be handled through the Hospital/Organizational Development and Progressive Disciplinary Action policies.

Employee-physician encounters should be handled through the Hospital/Organizational Development and Progressive Disciplinary Action policies in collaboration with the Medical Department Chairs and/or the Chief Medical Director in accordance with the Policies and applicable Medical Staff Bylaws, rules, regulations and policies.

Employee-contractor/vendor encounters should be handled through the Hospital/Organizational Development and Progressive Disciplinary Action policies in collaboration with the Administrator responsible for the specific contractor/vendor account.

Revised by Executive Committee April 1, 2003
Approved by Governing Board 6/9/03
Revised by Governing Board — June 9, 2003
Approved by Governing Board — October 11, 2004
Reviewed by Governing Board — May 29, 2005
POLICIES

A. The faculty physician of record is responsible for the quality of all of the clinical services provided to his or her patients.

B. All clinical services provided by resident physicians must be supervised appropriately to maintain high standards of care, safeguard patient safety, and ensure high quality education.

C. Individual residency programs should have written guidelines governing supervision of residents; these guidelines will vary according to specialty, intensity of patient care responsibilities on a given rotation, level of experience, and educational requirements.

D. Program faculty directly responsible for the supervision of patient care services provided by resident physicians must be as available to participate in that care as if residents were not involved; the presence of residents to “cover” patients on in-patient services or to provide care in ambulatory settings does not diminish the standard of availability required of the physician of record.

E. Program faculty are responsible for determining when a resident physician is unable to function at the level required to provide safe, high quality patient care to assigned patients, and must have the authority to adjust assigned duty hours as necessary to ensure that patients are not placed at risk by resident physicians who are overly fatigued or otherwise impaired.

F. Each residency program has written supervision policies for all aspects of its program which are consistent with the Accreditation Council for Graduate Medical Education (ACGME) Institutional and Program Requirements, and provided to both residents and faculty. Each residency program, as a part of its supervision policies, has a mechanism for certifying that residents are competent on procedures which is available to appropriate hospital personnel. These policies are reviewed and approved by the GMEC upon initial development and each time they are revised thereafter. Copies are kept on file in the UICOMP Graduate Medical Education office.

G. The Sponsoring Institution and the programs must have a mechanism by which residents/fellows can report inadequate supervision in a protected manner that is free from reprisal.

H. The institution monitors the compliance of the residency programs with their supervision policies through the Institutional Review of Programs (IRP) process. A resident representative sits on the IRP committee and a resident feedback session is always conducted as a part of the IRP process to ensure that the supervision policies are being followed. At the conclusion of the IRP, a report including the supervision aspects is presented to the GMEC which has the prerogative to act upon it. The report and action items from the GMEC are forwarded to the OSF SFMC and UPHM Executive Committees.

I. The institution primarily becomes aware of the exceptions and critical instances of breakdown through the quality assurance process. Our residents are reviewed through the quality assurance mechanism used for all physicians at OSF SFMC and UPHM. If a breakdown occurs, the Residency Program Director is immediately notified.

J. Specific incidents that occur as a result of inadequate supervision are documented on formal incident reports, usually generated by nurses or physicians. Resident related incident reports are routed to the Vice President/CMO and Director of Academic Affairs.
(OSF SFMC) or Vice President/Chief Medical Officer (UPHM), and the Residency Program Director. If a critical incident occurs during on-call hours and requires an urgent response, the Residency Program Director is contacted immediately.

II.

GUIDELINES FOR RESIDENT SUPERVISION AND EVALUATION*

A. Residents performing patient care activities must always be supervised by a licensed independent practitioner. When residents perform patient care activities at hospitals and other institutions accredited by the Joint Commission on Accreditation of Healthcare Organizations, the supervising licensed independent practitioner must have been granted privileges through the medical staff process.

B. Residents may perform technical procedures only when they have been, (a) authorized to do so by the attending physician supervising the resident, and (b) certified to perform such procedures by the faculty, as represented by the departmental clinical competence committee.

C. Residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability, and experience.

D. Supervision of residents shall be consistent with ACGME Guidelines as detailed below:

Supervision and Accountability:

Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

In the learning and working environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by each Review Committee) who is responsible and accountable for that patient's care.

   a) This information must be available to residents, faculty members, other members of the health care team, and patients.
   b) Residents and faculty members must inform each patient of their respective roles in each patient's care when providing direct patient care.

Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site, or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback.
The program must demonstrate that the appropriate level of supervision is in place for all residents based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, appropriate to the situation.

Levels of Supervision

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

a) Direct Supervision – the supervising physician is physically present with the resident and patient.

b) Indirect Supervision:
   - with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
   - with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

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

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

a) The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.

b) Faculty members functioning as supervising physicians must delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).

a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

(1) Initially, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately
available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available.]

Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and delegate to the resident the appropriate level of patient care authority and responsibility.
GUIDELINES:

Supervision of residents in all UICOMP programs is under the auspices of the Program Director. The care delivered by residents at all levels of training will be supervised by Attending Physicians who maintain an academic appointment and meet the requirements of the specific UICOMP Department. UICOMP Attending Physicians will give increased levels of responsibility to residents as he or she progresses through the program’s curriculum. The level of responsibility and independence permitted will be granted by the responsible Attending Physicians based upon daily performance as well as periodic and formal faculty evaluations.

An operation may be considered in a framework of the six phases shown below. The degree of resident supervision required varies with each phase of the operation and with the experience and skill of the Resident involved.

- Induction of anesthesia
- The initial incision
- Confirmation of the original diagnosis
- Technical execution of the planned procedure
- Closing of the wound
- Reversal of anesthesia

The responsible Attending Surgeon shall be immediately available during **ALL** phases of the operation, in accordance with the ACGME guidelines for indirect supervision with direct supervision immediately available. This means that the Attending Surgeon is physically present in the medical center, although not necessarily in the operating room suite. The degree to which actual physical presence and personal technical assistance in the operating room is required during a given procedure shall be at the discretion of the responsible Attending Surgeon and rules of the operating room and payors. This decision shall be based upon personal knowledge of the experience, past performance and skill of the Surgical Resident as well as the complexity of the case and the phase of the operation.

In the event of a life-threatening emergency in which immediate operative intervention is required, the Senior Surgical Resident may proceed to the operating room with the patient and initiate whatever lifesaving measures are required, after having notified the responsible Attending faculty member.
GUIDELINES FOR MANAGEMENT OF POTENTIAL CONFLICTS OF INTEREST WITH HEALTH CARE INDUSTRY*

Introduction
The University of Illinois at Chicago College of Medicine Task Force on Relationships with Industry was established to develop guidelines to manage interactions between health care industry and our faculty, residents and students. The Task Force reviewed the current policies from each regional site, the AMSA PharmFree scoring system, and the AAMC document on Industry Funding of Medical Education June 2008. Topics covered came from the AMSA scoring system and the AAMC document. The task force realizes that there may be some regional differences needed in these guidelines. However, the agreed upon college standards should be adhered to as much as possible at each site. Members of the task force are Janet Jokela (Urbana), Sarah Kilpatrick (Chicago), Mitch King (Rockford), Brian McIntyre (Peoria), Linda Rowe (Peoria), and Mike Warso (Chicago). These guidelines pertain to all salaried faculty, residents, medical students, and graduate students of University of Illinois College of Medicine.

Objectives
It is recognized that interactions between the health care industry and faculty, residents, and students are multi-layered and complex. No set of rules or policies can cover or anticipate all exigencies. Therefore, each situation should be managed with the aim of ensuring that our educational curriculum, research and patient care decisions are independent of industry influence and that they allow appropriate opportunities for faculty and trainees to interact with industry to foster collaborations in a creative, scientific, and conflict free environment. In summary, each interaction should be managed so as to:

1. Prevent health care vendors from exercising influence over how faculty, residents and students practice medicine / treat patients, especially when such practice or treatment is delivered under the auspices of the U of I COM;
2. Prevent health care vendors from influencing how faculty, residents and students conduct research;
3. Prevent health care vendors from influencing the content of the curriculum of the U of I COM;
4. Prevent quid pro quo arrangements
5. Eliminate the actual or apparent endorsement by the U of I COM of any commercial health care product, service or for-profit corporation.

A. Compensation or Gifts

1. Personal gifts from an industry representative may not be accepted by any faculty, trainee, student or staff at any College of Medicine site, or at any location when participating in any University-related activity.

2. Individuals may not accept compensation, including reimbursement for expenses associated with attending a CME or other activity in which the attendee has no other role. Reasonable honoraria and payment of expenses may be provided for speakers at accredited educational meetings, consistent with guidelines developed by the Accreditation Council for Continuing Medical Education (ACCME) and University policy.

3. No gifts or compensation may be accepted in exchange for listening to a sales talk or similar presentation for a commercial interest that produces or distributes health care goods and services.

4. Faculty, trainees, students and staff are strongly discouraged from accepting gifts of any kind from industry as part of non-professional activities. Individuals should be aware of and comply with applicable policies, such as the:
   - AMA Statement on Gifts to Physicians from Industry (http://www.ama-assn.org/ama/pub/category/8484.html"
   - State of Illinois ethics regulations

5. Meals and other gifts or donations funded directly by industry may not be provided at any UIC College of Medicine location, including any site where UIC educational or social activities occur. Vendors and other industry representatives may provide unrestricted funds to departments or divisions for educational programs. The funds will be managed according to the Standards for Commercial Support of the ACCME and University policy.
6. No gifts may be accepted in exchange for modifying patient care, such as prescribing a specific medication. Support for research and educational programs must be provided without influence on clinical decision making.

7. Free samples, supplies or equipment designated for an individual are considered a gift and are prohibited. Vendors may donate products to a department or division when the intent is for evaluation or education regarding the product, if the University invites the donation, and if there is a formal evaluation process. Sample donations are restricted to the amount necessary to complete the evaluation. Other policies related to the management of samples must comply with the specific policies and procedures of each Medical Center. Faculty must abide by the policies developed at the clinical sites in which they practice.

B. Industry Support for Educational Programs

1. Commercial support for educational programs must be free of actual or perceived conflict of interest.

2. All educational programs within the College of Medicine must abide by the Standards for Commercial Support established by the ACCME. This requirement applies to all undergraduate, graduate and continuing medical education programs regardless of whether continuing medical education credit is offered.

3. All funds provided by industry or an industry representative to support educational programs must be given to the University as an unrestricted grant. The funds can be provided to the Department, Program or Division, but cannot be given to an individual faculty member, student or staff. This requirement applies to all funds for meals or refreshments, speaker honoraria, or any other expense related to an educational program and includes noon conference, grand rounds and lectures at all UIC sites. Funds that are provided by educational groups or other entities that act as "intermediaries" for industry must also be provided as unrestricted grants.
4. No gifts may be accepted in exchange for listening to a lecture or presentation by a representative of a commercial entity that produces health care or medical goods and services.

5. Vendors may provide educational activities on a UIC site only if they are requested to do so by the department chair or designee. Participants in an educational program may not be required to attend any educational session in which industry representatives disseminate information about their products or services except when such services are provided as part of a contract for in-service or other training as part of an executed purchase decision.

6. The content of all educational programs will be determined by UIC faculty and, when appropriate, the CME office. Industry sponsors of educational programs may not determine the content or selection of speakers for educational programs.

7. These requirements do not apply to meetings governed by ACCME Standards or meetings of professional societies and other professional organizations that may receive partial industry support. Individuals who actively participate in meetings or conferences that are supported in whole or in part by industry, including lecturing, organizing the meeting or moderating sessions should abide by the following requirements.
   - Financial support should be fully disclosed by the meeting sponsor
   - The content of the meeting or session should be determined by the speaker. If the sponsor dictates content of a session or talk, the faculty speaker must clearly delineate what information is so dictated.
   - The speaker must provide a fair and balanced discussion
   - The speaker must make clear that the comments and content reflects the individual views of the speaker and not the University of Illinois, the UIC College of Medicine or the Department

8. Faculty, trainees, students and staff should carefully evaluate whether it is appropriate to participate in off-campus meetings or conferences that are fully or partially sponsored by industry because of the high potential for real or perceived conflict of interest.
C. Provision of Scholarships or Other Educational Funds for Students and Trainees

1. Industry support for students and trainee participation in education programs must be free of any real or perceived conflict of interest. All educational grants or support of educational programs must be specifically for the purposes of education and must comply with the following requirements.
   - The College of Medicine, Department, Program or Division must select the student(s) or trainee(s) for participation
   - The funds must be provided to the Department, Program or Division and not directly to the student or trainee
   - The Department, Program, or Division must determine that the education conference or program has educational merit
   - There is no implicit or explicit expectation that the participant must provide something in return for participating in the educational program

2. This provision does not apply to regional, national or international merit-based awards that will be considered on a case-by-case basis.

D. Disclosure of Relationships with Industry

Faculty and staff must disclose all financial interests with outside entities in accordance with UIC and University of Illinois policies. The specific disclosure obligation and method is dependent on the activity. The place of disclosure currently is according to university policy.

- Member of the academic staff must complete an annual report disclosing and seeking approval for non-university income producing activity (RUNA). This requires retrospective and prospective disclosure of external activities. Prior written approval from the University is required before undertaking, contracting for, or accepting anything of value in return for consulting or research from any external person or organization. Additional disclosure is necessary whenever a substantial change in external activities occurs or when required by granting agencies. The University Policy on Conflicts of Commitment and Interest is available at:

- All publications must be in compliance with the guidelines of the International Committee of Medical Journal Editors (sss.icmje.org)
- Covered individuals must complete situation specific disclosures of potential conflicts of interest when required (eg procurement, IRB applications, grant proposals)
- All continuing medical educational activities must be disclosed and resolved as defined by the Office of Continuing Medical Education and the ACCME (http://www.accme.org)

2. Faculty or staff who serve as consultants, members of a speaker's bureau, have an equity interest in or another relationship with industry for which they receive personal compensation or other support must recuse themselves from deliberations or decision making regarding the selection of products or services to be provided to the Medical Center or College of Medicine (e.g., selection of drugs to be added to the formulary) by the company. While requests for formulary inclusion of medications can be made by conflicted faculty, these conflicts must be disclosed at the time of the requests. Faculty with such ties to industry shall not participate in decisions regarding the purchase of related items, drugs, procedures in their department unless specifically requested to do so by the purchasing unit and after full disclosure of the faculty member's industry relationship. Under all circumstances the financial relationship must be disclosed and any conflicts resolved prior to participation in any decision making.

3. Faculty and staff are prohibited from publishing articles that are substantially or completely "ghost" written by industry representatives. Faculty and staff who publish articles with industry representatives must participate in the preparation of the manuscript and shall be listed as authors or otherwise appropriately cited for their contribution. The financial interest of all authors shall be disclosed in accordance with the standards of the journal.

4. Faculty with financial relationships with industry must ensure that the responsibilities to the company do not affect or appear to affect the ability to properly supervise and educate students, residents, and other trainees,
nor influence employment decisions for faculty and staff. All such relationships must be disclosed particularly during educational or research activities pertinent to the industry relationship and resolved as defined by ACCME.

E. Access by Sales and Marketing Representatives to Faculty, Trainees, Staff and Students

1. Faculty, trainees, and staff at each UIC site must abide by the policies and procedures for each institution (VA, Chicago, Peoria and Rockford institutions) with regard to meeting with industry representatives. In general, representatives are permitted in non-patient care areas by appointment only. Company representatives are not permitted in any patient care areas except to provide scheduled and approved in-service training on devices and other equipment for which there is an executed University contract for these services. Involvement of students and trainees in such meetings should occur only for educational purposes and only under supervision of a faculty member.

F. Provision of Education by COM to faculty and trainees

Medical school curriculum objectives shall be formulated to train students and residents to understand conflict-of-interest and to recognize how industry promotion can influence clinical judgment. Curricular education on managing the relationship between physicians and industry will be developed for at least two years of medical education. Goal is to have this implemented by 2012.

G. CME
For all CME activities UIC COM follows the Accreditation Council for Continuing Medical Education (ACCME) standards available on their website http://www.accme.org/.

H. College Committee on Conflict of Interest
In 2010 the COM will create the COCI which will include at least 5 faculty members with at least one from Peoria, Rockford and Urbana, who are advisory to the Dean. These faculty members will be appointed by the Dean for three year terms. The initial committee will have staggered terms such that the entire committee does not rotate off in a single year. The charge of the committee will
be to review potential conflicts of interest referred to them by the dean or a head and develop guidelines for management. The committee will be staffed by an assistant.

I. Definition of Significant Financial Interest
The current definitions are the same as NIH and are:
- $10k expected in next 12 months for you and family aggregated
- OR 5% equity for you and family aggregated regardless of value.
Royalties paid through the university are excluded.
Because this threshold may change, please refer to the following university website to see the most current definition:
http://grants.nih.gov/grants/compliance/42_cfr_50_subpart_f.htm

J. Relationship to Other University Policies
The guidelines supplement University policies on Conflict of Interest and the requirements of the Department Compensation Plan. Faculty and staff should familiarize themselves with the policies and reporting obligations. If the guidelines and University policies conflict, then the more restrictive of the two will apply. Questions about the policies should be discussed with the department chair and/or administrative staff.

Other University documents

*For purposes of these guidelines, industry refers to any proprietary entity that produces health care and medical goods and services.

# The COM intends to further explore the best sites for disclosure of significant financial relationships with industry.