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/Fellow Agreement

Academic Year 2021-2022

Approved by:

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

Terrance Brady, M.D., Chair
June 14, 2021
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I. GENERAL INFORMATION

A. INTRODUCTION

1. The University of Illinois College of Medicine at Peoria (Sponsoring Institution)

The University of Illinois College of Medicine has been a nationally recognized leader for over 100 years in its three-fold commitment to making measurable improvements in personal and population health through integrated innovative research, education and patient care programs. Today the College of Medicine offers both undergraduate and graduate medical education programs at Peoria, 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/Fellows 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 resident/fellow 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 and Fellowship Programs, which are based at OSF SFMC. Postgraduate Medical Trainees 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/fellow has progressed within a specific residency/fellowship 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/Fellow Agreement. It provides an expanded definition of the commitments of UICOMP, OSF SFMC, and the resident/fellow. The House Staff is expected to comply with the institution’s general policies and rules as specified in this document.
C. POSTGRADUATE MEDICAL EDUCATION PROGRAMS SPONSORED BY THE UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA

<table>
<thead>
<tr>
<th>Program</th>
<th>Length (yrs)</th>
<th>Resident #</th>
<th>ACGME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Imaging Fellowship</td>
<td>1</td>
<td>2</td>
<td>N/A</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fellowship</td>
<td>3</td>
<td>9</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Medicine-Pediatrics</td>
<td>4</td>
<td>32</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>5</td>
<td>20</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>3</td>
<td>42</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>3</td>
<td>30</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Gastroenterology Fellowship</td>
<td>3</td>
<td>9</td>
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</tr>
<tr>
<td>Hospice/Palliative Care Fellowship</td>
<td>1</td>
<td>2</td>
<td>Initial Accreditation</td>
</tr>
<tr>
<td>Internal Medicine-C</td>
<td>3</td>
<td>36</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Internal Medicine-P</td>
<td>1</td>
<td>4</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Transitional</td>
<td>1</td>
<td>12</td>
<td>Initial Accreditation</td>
</tr>
<tr>
<td>Neonatal-Perinatal Fellowship</td>
<td>3</td>
<td>6</td>
<td>Initial Accreditation</td>
</tr>
<tr>
<td>Neurological Surgery</td>
<td>6</td>
<td>10</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Neurology</td>
<td>4</td>
<td>16</td>
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</tr>
<tr>
<td>Neuroradiology Fellowship</td>
<td>1-2</td>
<td>2</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>4</td>
<td>12</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Pediatrics-C</td>
<td>3</td>
<td>30</td>
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<tr>
<td>Pediatric Hospital Med. Fellowship</td>
<td>2</td>
<td>4</td>
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<tr>
<td>Psychiatry</td>
<td>4</td>
<td>16</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Pulmonary/Critical Fellowship</td>
<td>3</td>
<td>6</td>
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</tr>
<tr>
<td>Simulation Fellowship</td>
<td>1-2</td>
<td>1</td>
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<tr>
<td>Surgery-C</td>
<td>5</td>
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</tr>
<tr>
<td>Interventional</td>
<td>1</td>
<td>2</td>
<td>Continued Accreditation</td>
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<tr>
<td>Radiology Residency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine Obstetrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fellowship</td>
<td>1</td>
<td>2</td>
<td>N/A</td>
</tr>
<tr>
<td>Ultrasound (POCUS) Fellowship</td>
<td>1</td>
<td>1</td>
<td>N/A</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>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Biology and Pharmacology</td>
<td>Marcelo Bento de Mello Soares, Ph.D. (Head)</td>
</tr>
<tr>
<td></td>
<td>Professor, Senior Associate Dean for Research</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Joshua Kentosh, D.O. (Chair)</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Dermatology</td>
</tr>
<tr>
<td></td>
<td>Carl W Soderstrom, MD Professorship in Derm.</td>
</tr>
<tr>
<td>Health Sciences Education &amp; Pathology</td>
<td>Meenakshy Aiyer, M.D. (Head)</td>
</tr>
<tr>
<td></td>
<td>(Interim Regional Dean)</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Health Science Education</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Medicine</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>Timothy Schaefer, M.D. (Chair)</td>
</tr>
<tr>
<td></td>
<td>Clinical Professor of Emergency Medicine</td>
</tr>
<tr>
<td>Family and Community Medicine</td>
<td>Kelvin Wynn, M.D. (Chair)</td>
</tr>
<tr>
<td></td>
<td>Thomas &amp; Ellen Foster Endowed Chair</td>
</tr>
<tr>
<td></td>
<td>Associate Professor of Clinical Family Medicine</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Teresa Lynch, M.D. (Chair)</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Medicine</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Pediatrics</td>
</tr>
<tr>
<td>Medicine/Pediatrics</td>
<td>Matthew Mischler, M.D. (Director)</td>
</tr>
<tr>
<td></td>
<td>Clinical Professor of Medicine</td>
</tr>
<tr>
<td></td>
<td>Clinical Professor of Pediatrics</td>
</tr>
<tr>
<td>Neurology</td>
<td>Jorge C. Kattah, M.D. (Head)</td>
</tr>
<tr>
<td></td>
<td>Professor of Neurology</td>
</tr>
<tr>
<td></td>
<td>Professor of Neurosurgery</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Jeff Klopfenstein, M.D. (Head)</td>
</tr>
<tr>
<td></td>
<td>Associate Professor of Clinical Neurosurgery</td>
</tr>
<tr>
<td></td>
<td>Associate Professor of Clinical CBP</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>Stephen Thompson, M.D. (Interim Chair)</td>
</tr>
<tr>
<td></td>
<td>Assistant Professor of Clinical Ob/Gyne</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Manu Sood, M.D. (Interim Head)</td>
</tr>
<tr>
<td></td>
<td>William H. Albers Professor</td>
</tr>
<tr>
<td></td>
<td>Professor, Cancer Biology and Pharmacology</td>
</tr>
<tr>
<td>Psychiatry and Behavioral Medicine</td>
<td>Ryan Finkenbine, M.D. (Chair)</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Psychiatry</td>
</tr>
<tr>
<td>Radiology</td>
<td>Sean Meagher, M.D. (Chair)</td>
</tr>
<tr>
<td></td>
<td>Clinical Associate Professor of Radiology</td>
</tr>
<tr>
<td></td>
<td>Clinical Associate Professor of Neurosurgery</td>
</tr>
<tr>
<td>Surgery</td>
<td>Richard Anderson, M.D. (Chair)</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Surgery</td>
</tr>
<tr>
<td>Department</td>
<td>Chair</td>
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<tr>
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<tr>
<td>Anesthesiology</td>
<td>James Priepot, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Surgery</td>
</tr>
<tr>
<td>Cardiovascular Medicine</td>
<td>Marco Barzallo, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Medicine</td>
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<tr>
<td>Emergency Services</td>
<td>Benjamin Kemp, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Emerg. Medicine</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>Brad Stoecker, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Family and Community Medicine</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Teresa Lynch, M.D. (Chair)</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Medicine</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Pediatrics</td>
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<tr>
<td>Neurology</td>
<td>Arun Talkad, M.D.</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Andrew Tsung, M.D.</td>
</tr>
<tr>
<td></td>
<td>Patrick W. Elwood Associate Professor of Neurosurgery</td>
</tr>
<tr>
<td></td>
<td>Associate Professor of CBP</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>Stephen Thompson, M.D.</td>
</tr>
<tr>
<td></td>
<td>(Interim Chair)</td>
</tr>
<tr>
<td></td>
<td>Assistant Professor of Clinical Ob/Gyne</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>Miguel Ramirez, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Surgery</td>
</tr>
<tr>
<td>Health Sciences Education &amp; Pathology</td>
<td>Vidhu Kaushik, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Health Sciences Education and Pathology</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Kay Saving, M.D.</td>
</tr>
<tr>
<td></td>
<td>(Associate Head &amp; Section Chief)</td>
</tr>
<tr>
<td></td>
<td>Professor of Pediatrics</td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation</td>
<td>Jeffery Stedwill, M.D.</td>
</tr>
<tr>
<td>Psychiatry and Behavioral Medicine</td>
<td>Abraham Frenkel, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Psychiatry and Behavioral Medicine</td>
</tr>
<tr>
<td>Radiology</td>
<td>Kyle Bertrand, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Assistant Professor of Radiology</td>
</tr>
<tr>
<td>Surgery</td>
<td>Richard Anderson, M.D.</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Surgery</td>
</tr>
<tr>
<td>Transplantation</td>
<td>Timothy O’Connor, M.D.</td>
</tr>
<tr>
<td></td>
<td>Visiting Clinical Associate Professor of Surgery</td>
</tr>
<tr>
<td>Urology</td>
<td>Wendy Olson Padilla, M.D.</td>
</tr>
</tbody>
</table>
F. UICOMP RESIDENCY/FELLOWSHIP PROGRAM DIRECTORS

Graduate Medical Education Office
Francis McBee Orzulak, M.D.
Designated Institutional Official
Michelle Shearho, Accreditation Coordinator
Lisa Lovett, Institutional Coordinator

Breast Imaging Fellowship
Jessica Guingrich, M.D.
Clinical Associate Professor of Radiology

Cardiovascular Disease Fellowship
Sudhir Mungee, M.D.
Clinical Professor of Medicine

Diagnostic Radiology
Terrance M. Brady, M.D.
Professor of Clinical Radiology
Professor of Clinical Surgery

Emergency Medicine
John Hafner, M.D.
Clinical Professor of Emergency Medicine

Family Medicine
Jeff Leman, M.D.
Visiting Associate Professor of Clinical Family Medicine

Gastroenterology Fellowship
Sonu Dhillon, M.D.
Clinical Associate Professor of Medicine

General Surgery
Steven Tsoraides, M.D.
Associate Professor of Clinical Surgery

Hospice/Palliative Medicine Fellowship
Tayyaba Irshad, M.D.
Clinical Assistant Professor of Medicine

Internal Medicine
Peter Phan, M.D.
Professor of Clinical Medicine
Professor of Clinical Pediatrics

IM Transitional
Sidney Stewart, M.D.
Assistant Professor of Clinical Medicine
Assistant Professor of Clinical Pediatrics

Medicine-Pediatrics
Matthew Mischler, M.D.
Clinical Professor of Medicine
Clinical Professor of Pediatrics

Neonatal-Perinatal Fellowship
M. Jawad Javed, M.D.
Associate Professor Clinical Pediatrics

Neurology
Greg Blume, M.D.
Clinical Associate Professor of Neurology

Neuroradiology Fellowship
Lawrence Wang, M.D.
Clinical Assistant Professor of Radiology
G. PROGRAM DIRECTOR RESPONSIBILITIES

1. Each residency/fellowship program must have one faculty member appointed as Program Director with authority and accountability for the overall program, including compliance with all applicable program requirements. The Designated Institutional Official (DIO) of the University of Illinois College of Medicine at Peoria (UICOMP) and the GMEC 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 must 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. Specialty expertise and at least three years of documented educational and/or administrative experience acceptable to the Review Committee;
   b. Current certification in the specialty by the relevant American Board of Medical Specialties (ABMS) or by the American Board of Osteopathic Specialty Board or specialty qualifications that are acceptable to the Review Committee; and,
c. Current medical licensure and appropriate medical staff appointment.

d. On-going clinical activity

4. The Program Director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident/fellow recruitment and selection, evaluation, and promotion of residents/fellows, and disciplinary action; supervision of residents/fellow; and resident/fellow education in the context of patient care. The Program Director must:

a. Be a role model of professionalism
b. Design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of UICOMP and the mission(s) of the program
c. Administer and maintain a learning environment conducive to educating the residents/fellows in the ACGME Competency domains
d. Develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency/fellowship program education and at least annually thereafter (Common Program Requirements V.B)
e. Have the authority to approve program faculty members for participation in the residency/fellowship program education at all sites.
f. Have the authority to remove program faculty members from participation in the residency/fellowship program education at all sites
g. Have the authority to remove residents/fellows from supervising interactions and/or learning environments that do not meet the standards of the program
h. Submit accurate and complete information required and requested by the DIO, GMEC, and ACGME
i. Provide applicants who are offered an interview with information related to the applicant’s eligibility for the relevant specialty board examination(s)
j. Provide a learning and working environment in which residents/fellows have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation
k. Ensure the program’s compliance with UICOMP’s policies and procedures related to grievances and due process
l. Ensure the program’s compliance with UICOMP’s policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident/fellow
m. Ensure the program’s compliance with UICOMP’s policies and procedures on employment and non-discrimination. Residents/fellows must not be required to sign a non-competition guarantee or restrictive covenant.
n. Document verification of program completion for all graduating residents/fellows within 30 days
o. Provide verification of an individual resident/fellow completion upon the residents/fellows request, within 30 days
p. Obtain review and approval from UICOMP’s DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director’s Guide to the Common Program Requirements
q. The curriculum must be structured to optimize resident/fellow educational experiences, the length of these experiences and supervisory continuity.
r. Provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of addiction.
s. Implement policies and procedures consistent with the institutional and program requirements for resident/fellow duty hours and the working environment, including moonlighting, and, to that end, must:
1) Distribute these policies and procedures to the residents/fellows 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/fellow duty hours. Monitor resident/fellow 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.

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

u. Transitions of Care

The sponsoring institution must facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care; and, in partnership with its ACGME-accredited programs ensure and monitor effective, structured patient hand-over processes to facilitate continuity of care and patient safety at participating sites.

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/fellows 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/fellows currently responsible for care. Each program must ensure continuity of patient care, consistent with the program’s policy and procedures, in the event that a resident/fellow may be unable to perform their patient care responsibilities due to excessive fatigue or illness.

The following elements should be considered in resident/fellow 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, fellow or ideally faculty member should be present.
   4) Hand-off should be orally communicated but available in written form as well.
   5) Hand-offs should include non-clinician team members (e.g. nurses) when possible.

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

w. Team Building

The ACGME requires that residents/fellows 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 the specialty and larger health system. [Each Review Committee will define the elements that must be present in each specialty.]

x. Fatigue Mitigation

Responsibilities of the Program Director and Attending Physician:

The Program Director must educate all faculty, fellows and residents to recognize the signs of fatigue and sleep deprivation. (See section II.H.5.1)

Additional Responsibilities of the Program Director/Chairman:

If the removed resident/fellow absence impacts other residents/fellows, this should be accounted for immediately and resolved where required. The resident/fellow 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/fellow may be removed from patient care responsibilities indefinitely. A medical evaluation may be requested or required as the situations warrant.

y. Comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents/fellows, disciplinary action, and supervision of residents/fellows;

z. Be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

aa. 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/fellow 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/fellow 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,

bb. 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.

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

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

e. Scholarship:
   - The program demonstrates evidence of scholarly activities consistent with its mission and aims.
   - The program, in partnership with UICOMP must allocate adequate resources to facilitate resident, fellow, and faculty involvement in scholarly activities.
   - The program must advance resident/fellow knowledge and practice of the scholarly approach to evidence-based patient care.
   - Residents/fellows must participate in scholarship.
   - Faculty Scholarly Activity:
      Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains:
      • Research in basic science, education, translational science, patient care, or population health
      • Peer-reviewed grants
      • Quality improvement and/or patient safety initiatives
      • Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
      • Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
      • Contribution to professional committees, educational organizations, or editorial boards
      • Innovations in education
   - The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:
      • faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board
      • member, or editor, peer-reviewed publications.
H. FACULTY

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

Faculty must be role models of Professionalism.

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/fellows; and administer and maintain an educational environment conducive to educating residents/fellows in each of the ACGME competency areas.

Faculty members must directly observe, evaluate, and frequently provide feedback on resident/fellow performance during each rotation or similar educational assignment.

Faculty must regularly participate in organized clinical discussions, rounds, journal clubs, conferences.

Pursue faculty development designed to enhance their skills at least annually; as educators, in quality improvement and patient safety; in fostering their own and their residents/fellows well-being; in patient care based on their practice-based learning and improvement efforts.

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.

Core faculty members must have a significant role in the education and supervision of residents/fellows and must devote a significant portion of their entire effort to resident/fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents/fellows.

Core faculty members must be designated by the program director.

Core faculty members must complete the annual ACGME Faculty Survey.

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/fellows in scholarly activities.
I. PROGRAM COORDINATOR/Other Personnel

There must be a program coordinator. At a minimum, the program coordinator must be supported at 50 percent FTE for administration of program.

The program, in partnership with UICOMP, must jointly ensure the availability of necessary personnel for the effective administration of the program.

J. 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, specialty/subspecialty-specific Program, and Recognition Requirements; and Governing Body: The single entity that maintains authority over and responsibility for 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/Fellowship Programs’ ACGME Accreditation; overseeing submissions of the Annual Update for each program and Sponsoring Institution to the ACGME; approving all letters of agreement (PALs); improving the Institution’s Educational Program; developing and supporting Residency/Fellowship 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/fellows; after GMEC approval, oversee the submission of applications for ACGME accreditation and recognition, requests for voluntary withdraw and recognition, and requests for changes in program compliment; 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/fellowship programs with the National Residency Matching (NRMP) requirements.

K. 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/Fellows from all specialties;
   d. Organize hospital-wide activities for the House Staff;
   e. Serve as an Ombudsman for residents/fellows
3. The House Staff President may be contacted directly concerning problems between these persons or areas:
   a. Resident – Resident;
   b. Fellow - Fellow
   c. Resident/Fellow – Attending;
   d. Resident/Fellow – Teaching Faculty; and
   e. Resident/Fellow – Administration

L. 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 (or Listserve) which serves as an electronic means of communication for residents/fellows only.

M. CHIEF RESIDENT/FELLOW
   1. Each specialty program has one or more designated Chief Residents/Fellows.
   2. The role of the Chief Resident/Fellow varies somewhat from Program to Program, but in general this person conducts regular meetings for the residents/fellows in his/her Program and serves as a liaison between the residents/fellows and the Program Director.
   3. The Chief Resident/Fellow(s) may be contacted directly concerning minor complaints regarding the specific Residency/Fellowship Program and/or for Resident-Resident; Fellow-Fellow, Resident/Fellow-Attending; and Resident/Fellow-Teaching Faculty issues within a program.

N. 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/fellow 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/fellows.

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.

O. 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) together with the DIO. The GMEC provides oversight and coordinates all of the Sponsoring Institutions 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 June 2021. Committee has oversight of ACGME accreditation and recognition statuses of the Sponsoring Institution and each of its ACGME-accredited programs. 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 residency/fellowship programs will have 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(s) who will be permitted voting privileges and count towards the quorum in the absence of the chairman or Program Director. All fellowship programs will have one voting member. This member will be the Program Director. Additional voting members of the GMEC 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 Chief Medical Officer at OSF SFMC, and the Chief Medical Officer 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/fellows in all programs. These policies and procedures include:
a. Stipends and position allocation: Annual review and recommendations to the Sponsoring Institution regarding resident/fellow stipends, benefits, and funding for resident/fellow positions.

b. GMEC subcommittees actions 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/Fellow duty hours. The GMEC:

1) Develops and implement written policies and procedures regarding resident/fellow 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(s) and Self-Study(ies).

h. The provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided.

i. Oversight of resident/fellow supervision: Monitor programs’ supervision of residents/fellows which ensures that supervision is consistent with:

1) Provision of safe and effective patient care;

2) The educational needs of residents/fellows;

3) Progressive responsibility appropriate to residents’/fellows’ level of education, competence, and experience; and,

4) Other applicable Common and specialty/subspecialty-specific Program Requirements.
j. 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/fellow participation in patient safety and quality of care education; and,
3) The accreditation status of programs and any citations regarding patient care issues.

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

l. Resident/Fellow status: Selection, evaluation, promotion, transfer, discipline, and/or dismissal of residents/fellows in compliance with the Institutional and Common Program Requirements. Exceptionally qualified candidates for resident/fellow appointments who do not satisfy the Sponsoring Institution’s resident/fellow eligibility policy and or resident/fellow eligibility requirements in the Common Program Requirements.

m. 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.

n. 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.

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

p. 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/fellow complement;
3) Major changes in each of its ACGME accredited program structure or duration of education, including any change in the designation of a program’s primary clinical site;
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/fellow clinical and educational work hour requirements;
9) Voluntary withdrawal of program accreditation or recognition;

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.

q. 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

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

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

t. 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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<thead>
<tr>
<th>TOPIC</th>
<th>Notice Only</th>
<th>Approval Required</th>
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<tr>
<td>Program Director Appointment</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>New Program Accreditation</td>
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<td>Changes in Resident/Fellow Compliment</td>
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<td>Major change in Program structure</td>
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<td>Add/Delete of participating institutions</td>
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<td>Progress Reports requested by IR Committee</td>
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<td>Responses to adverse actions</td>
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<td>Requests for exceptions to Duty Hours</td>
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<td>Voluntary Withdrawals of Accreditation</td>
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<td>Request for appeal for adverse action</td>
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<td>Appeal to Board of Appeal or ACGME</td>
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<td>Reduction or Closure</td>
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<td>Outside Rotations</td>
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4. **GMEC Committee Roster**

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

**Combined Medicine Pediatrics:**
- Matthew Mischler, M.D.  Program Director
- Gregory Nulty, M.D.  Associate Program Director
- Alex Alonso, M.D.  Assist. Prog. Director, Alternate
- Mary Stapel, M.D.  Assist. Prog. Director, Alternate

**Emergency Medicine:**
- John Hafner, M.D.  Program Director
- Tim Schaefer, M.D.  Department Chair
- Greg Tudor, M.D.  Assoc. PD, Alternate
- Andy Vincent, M.D.  Assist. PD, Alternate

**Family Medicine:**
- Jeff Leman, M.D.  Program Director
- Kelvin Wynn, M.D.  Department Chair
- Aaron Costerisan, M.D.  Assoc. PD, Alternate
- Laura Smith, M.D.  Assoc. PD, Alternate

**Gastroenterology Fellowship:**
- Sonu Dhillion, M.D.  Program Director
- Daniel Martin, M.D.  Assoc. PD, Alternate

**General Surgery:**
- Steve Tsoraides, M.D.  Program Director
- Richard Anderson, M.D.  Department Chair
- Robin Alley, M.D.  Associate Program Director, Alternate

**Hospice/Palliative Care Fellowship:**
- Tayyaba Irshad, M.D.  Program Director

**Internal Medicine:**
- Peter Phan, M.D.  Program Director
- Teresa Lynch, M.D.  Department Chair
- Emily Horvath, M.D.  Associate Program Director, Alternate
- Manasa Kandula, M.D.  Assistant Program Director, Alternate

**Transitional:**
- Sidney Palmer-Hill, M.D.  Program Director

**Neonatal-Perinatal Fellowship:**
- Jawad Javad, M.D.  Program Director
- Ashley Fischer, M.D.  Assoc. Program Director

**Neurology:**
- Gregory Blume, M.D.  Program Director
- Elias Samaha, M.D.  Assistant PD
- Jorge Kattah, M.D.  Department Head
### Neuroradiology Fellowship:
- Lawrence Wang, M.D.  Program Director

### Neurosurgery:
- Julian Lin, M.D.  Program Director
- Jeff Klopfenstein, M.D.  Department Chair

### Ob/Gyn:
- Rayan Elkattah, M.D.  Program Director
- Stephen Thompson, M.D.  Department Chair
- Neelam Verma, M.D.  Assist. PD, Alternate

### Pediatrics:
- Bhavana Kandikattu, M.D.  Program Director
- Manu Sood, M.D.  Department Head
- Michele Beekman, M.D.  Associate PD, Alternate
- Amy Christison, M.D.  Assistant PD, Alternate
- Elizabeth Rose, D.O.  Assistant PD, Alternate
- Zohra Moeenuddin, M.D.  Assistant PD, Alternate

### Pediatric Hospital Medicine Fellowship:
- Harleena Kendhari, M.D.  Program Director
- Nadia Shaikh, M.D.  Assoc. Prog. Director

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

### Pulmonary/Critical Care Fellowship:
- Subramanyam Chittivelu, M.D.  Program Director
- Patrick Whitten, M.D.  Assoc. Prog. Director

### Radiology/Interventional Radiology:
- Terrance Brady, M.D.  Program Director
- Jane Maksimovic, M.D.  Associate PD, Alternate
- Sean Meagher, M.D.  Department Chair

### Simulation Fellowship:
- John Vozenilek, M.D.  Program Director
- Gregory Podolej, M.D.  Assistant PD, Alternate

### House Staff Officers:
- Farrah Malik, M.D.  TL-4, Med-Peds, OSF HS President
- Jordan Cascante, D.O.  TL-3, Med-Peds, OSF HS Vice-President
- Maritza Estrada-O’Brien, M.D.  TL-3, Family Medicine, UPHM Chief Resident
- Anjani Hagan, M.D.  TL-3, Family Medicine, UPHM Chief Resident
- Jonathan Rubenstein, M.D.  TL-4, Psychiatry, UPHM Chief Resident

### Ex-Officio Voting Members:
- Teresa Lynch, M.D.  Quality and Safety, OSF
- Francis McBee Orzulak, M.D.  DIO/Associate Dean of GME
- Marc Squillante, D.O.  IRP Committee Chair
Ex-Officio Non-Voting Members:
Meenakshy Aiyer, M.D.  Interim Regional Dean
Robert Sparrow, M.D.  Chief Medical Officer, OSF
Jessica Hanks, M.D.  Interim Associate Dean of Academic Affairs
Kevin Wombacher, PhD  Assist. Dean for Med. Education and Evaluation
Samer Sader, M.D.  Associate Chief Medical Officer, UPHM
Mary Gomez, D.D.S.  Dental Residency Program Director
Lisa Lovett  GME Administrative Assistant
Michelle Shearhod  GME ACGME Coordinator
Anthony Dwyer  Instructional Development Specialist

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/fellowship programs (i.e., is the Sponsoring Institution), and OSF SFMC is responsible for employing the residents/fellows and for providing a learning environment in which residents/fellows participate in patient care under the supervision of UICOMP faculty (i.e., is a major participating institution). UICOMP is responsible for the oversight of accreditation of all its residency and fellowship programs, resident/fellow assignments and the quality of the learning and working environment, which extends to all participating sites. In order to continue their employment by OSF SFMC and their enrollment in a residency/fellowship program, residents/fellows 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/fellow educational experiences occurring at other sites. UICOMP assures that each program has established program letters of agreements (PLAs) for all participating sites that governs the relationship between the program and the participating site providing a required assignment (i.e., required rotations of one or more months at institutions or facilities which are not affiliated with OSF) and off site rotations as mandated by the ACGME.

2. UICOMP, together with its education partner OSF, and the programs must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows, faculty members, senior administration staff members, and other relevant members of its academic community.

3. 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.

4. UICOMP, together with its education partner OSF, is committed to providing Graduate Medical Education (GME) that facilitates resident/fellow professional, ethical, and personal development. UICOMP and OSF, through curricula, evaluation, and resident/fellow supervision support safe, appropriate, learning and working environment that facilitate Patient Safety & Health Care Quality.
5. UICOMP, together with its educational partner OSF, ensures that the DIO and the GME Program Directors have sufficient financial support and protected time to effectively carry out their respective educational, administrative, and leadership responsibilities as described in the Institutional, Common, and specialty-specific Program Requirements.

6. UICOMP, together with its educational partner OSF and the program directors of its ACGME-accredited programs must provide a culture of professionalism that supports patient safety and personal responsibility.

7. UICOMP, together with its educational partner OSF and its ACGME-accredited programs must educate residents/fellows 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.

8. UICOMP must provide systems for education in and monitoring of residents/fellows and core faculty members fulfillment of educational and professional responsibilities, including scholarly pursuits; and accurate completion of required documentation by residents/fellows.

9. UICOMP must ensure that its ACGME-accredited programs provide a professional, respectful, and civil environment that is free from unprofessional behavior, including mistreatment, abuse and/or coercion of residents/fellows, other learners, faculty members, and staff members.

10. UICOMP, together with its ACGME programs must have a process for education of residents/fellows and faculty members regarding unprofessional behavior, and a confidential process for reporting, investigating, monitoring, and addressing such concerns.

11. UICOMP, together with its ACGME-accredited programs must oversee its ACGME-accredited programs fulfillment of responsibility to ensure healthy and safe learning and working environments that promote well-being of residents/fellows and faculty members, consistent with the Common and Specialty/Subspecialty Program Requirements, addressing areas of non-compliance in a timely manner.

12. UICOMP, together with its ACGME-accredited programs must educate faculty members and residents/fellows in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. This responsibility includes educating residents, fellows, and faculty members in how to recognize those symptoms in themselves, and how to seek appropriate care.
   - must encourage residents, fellows, and faculty members to alert their program director, DIO 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.
   - provide access to appropriate tools for self-screening
   - 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

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

14. UICOMP, together with its educational partner OSF, ensures that residents/fellows 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.
15. UICOMP, together with its educational partner OSF ensures that:
   - financial support and protected time for program director(s) to effectively carry out his/her educational, administrative, and leadership responsibilities, as described in the Institutional, Common and specialty/subspecialty-specific Program Requirements;
   - support for core faculty members to ensure both effective supervision and quality resident/fellow education;
   - the presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellow, and advanced practice providers, must enrich the appointed residents/fellows education. The program must report circumstances when the presence of other learners has interfered with the residents/fellows education to the DIO and the GMEC.
   - the DIO, program director and core faculty members support for professional development applicable to their responsibilities as educational leaders;
   - support and time for the program coordinator(s) to effectively carry out responsibilities; and
   - resources, including space, technology, and supplies, are available to provide effective support for each of its ACGME-accredited programs.
   - there are effective 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 maintain accreditation to provide patient care. Accreditation for patient care must be provided by an entity granted “deeming authority” for participation in Medicare under federal regulations; or an entity certified as complying with the conditions of participation in Medicare under federal regulations.

2. When accreditation of a major participating Institution of UICOMP that is a hospital is denied, suspended or revoked, or when UICOMP or participating site is required to curtail activities, or is otherwise restricted, UICOMP must notify and provide a plan for its response to the IRC within 30 days of such loss or restriction. Based on the particular circumstances, the ACGME may invoke its procedures related to alleged egregious and/or catastrophic events.

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

D. ELIGIBILITY AND SELECTION OF RESIDENTS

The University of Illinois College of Medicine at Peoria (UICOM-P) has written policies and procedures for resident/fellow recruitment, selection, eligibility, and appointment and monitors
programs for compliance that is consistent with ACGME Institutional and Common Program Requirements, and Recognition Requirements (if applicable).

A. Residents

1. In selecting residents:

   a. UICOMP ensures that its ACGME-accredited programs select from among eligible applicants on the basis of residency program-related requirements 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, AOA approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.

   c. Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME or CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.

A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the TL-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the TL-2 level based on ACGME Milestone evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. A Review Committee may permit the exception to the eligibility requirements specified in Section III.A.2.a (ACGME Common Program Requirements) for residency programs that require completion of a prerequisite residency program prior to admission.

An ACGME accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1-III.A.3 of the ACGME Common Program Requirements, but who does meet all of the following additional qualifications and conditions:

   Evaluation by the program director and residency selection committee of the applicants suitability to enter the program, based on prior training and review of the summative evaluations of this training; and review and approval of the applicants exceptional qualifications by the GMEC; and verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification.
Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation.

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 be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of the applicants eventual appointments. Information that is provided must include: stipends, benefits, vacation, leaves of absence, professional liability, coverage, and disability and insurance accessible to residents/fellows; health 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 graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association on Osteopathic College Accreditation (AOACOCA).

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. Showing 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. Holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME Accredited specialty/subspecialty program is located;

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 that 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.

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, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada. Neurosurgery programs are the exception with ACGME Accreditation or AOA approval only.

a. Fellowship programs must receive verification of each entering fellow’s level of competency in the required field, upon matriculation, using ACGME, ACMGE-I, or CanMEDS Milestones evaluations from the core residency program.

b. Fellow Eligibility Exception
A Review Committee may grant the following exception to the fellowship eligibility requirements based on the review committees policy:

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

1. Evaluation 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. Verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and

4. Applicants accepted by this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation.

**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/FELLOW COMPLEMENT

- The number of residency/fellowship positions that may be offered by each residency/fellowship program is determined by the Joint Oversight Committee for 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/fellowship 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/fellows appointed to the program. The program director may not appoint more residents/fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements.
F. **FINANCIAL SUPPORT FOR RESIDENTS/FELLOWS**

OSF SFMC will provide all residents/fellows 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/Fellow 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/fellows and their families; the conditions under which call rooms, meals, laundry services or their equivalents are provided; resident/fellow responsibility; and conditions for reappointment. Candidates who are selected for residency/fellowship positions under UICOMP sponsorship will be sent a Resident/Fellow 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/fellows with a written agreement of appointment/contract outlining the terms and conditions of appointment.

2. The Resident/Fellow 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/Fellow Survey and during the meeting with residents/fellows 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/Fellow Agreement contains or provides reference to the following institutional policies:
   a. Residents/Fellows’ Responsibilities (see Resident/Fellow Responsibilities, section III.)
   b. Duration of Appointment
   c. Financial Support
   d. Conditions for Reappointment:
      1) Signing a Resident/Fellow Agreement does not guarantee issuance of a Resident/Fellow Agreement for the next training period. However, residents/fellows 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/fellowship program. Residents/Fellows 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/fellow 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/fellow’s contract. In these circumstances, residents/fellows will receive as much written notice, prior to the end of their contract, as circumstances allow.

2) Residents/fellows 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/fellows 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/fellows 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/fellows that could result in dismissal, non-renewal of a resident/fellow’s agreement, non-promotion of a resident/fellow to the next level of training, or other actions that could significantly threaten a resident/fellow’s intended career development and,

2) Adjudication of resident/fellow 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/fellows 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/fellows 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 health insurance benefits for the residents/fellows 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/fellows 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/fellows 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/fellows with:
a) Access to Program Requirements concerning the effect of leave(s) of absence, for any reason, on satisfying the criteria for completion of the residency/fellowship program and;

b) Access to information relating to eligibility for certification by the relevant certifying board.

i. Clinical and Educational Work (see section II.J.)

1) Program Director’s Responsibilities in Relation to Clinical and Educational Work

a) Residency and fellowship Program Directors will ensure that their programs are in compliance with ACGME, RRC, and Program clinical and educational work requirements.

b) Residency and Fellowship Program Directors must develop procedures to monitor the clinical and educational work 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 clinical and educational work requirements. Such reports will include the description of a plan to bring the program into compliance with ACGME requirements, violations, and the number of residents/fellows 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 Clinical and Educational Work

a) The Associate Dean for Graduate Medical Education will use the ACGME anonymous survey documents for residents/fellows to report their compliance or noncompliance with the clinical and educational work requirements.

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

c) Depending on the findings of the ACGME Resident/Fellow Survey Summary the DIO may request a meeting with the Program Director, faculty and/or residents/fellows to discuss clinical and educational work to resolve any issues which may be interfering with programmatic compliance with ACGME requirements. The results of such a meeting will be communicated to the GMEC by the DIO.

d) The GMEC will require the program director to correct any areas of programmatic noncompliance with the clinical and educational work requirements, and to report progress made in correcting those violations at subsequent meeting(s) of the GMEC until the program is in full or substantial compliance with the requirements.

3) Resident/Fellow Responsibilities in Relation to Clinical and Educational Work

a) Residents/fellows are expected to comply with the ACGME, RRC, and program clinical and educational work requirements.
b) Residents/fellows will inform their Program Director when circumstances prevent them from being in compliance with ACGME, RRC, and program clinical and educational work requirements.

c) Residents/fellows who choose to do so may report infractions of the clinical and educational work requirements to the OSF House Staff President or Vice President, one of the UPHM Chief Residents, or the Associate Dean for Graduate Medical Education (671-8450).

j. Educational Program:

The curriculum must contain the following educational components:

1. A set of program aims consistent with UICOMP’s mission (UICOMP mission is to make measurable improvements in personal and population health through integrated innovative research, education and patient care programs), the needs of the community it serves, and the desired distinctive capabilities of its graduates. The program aims must be made available to program applicants, residents/fellows, and faculty members.

2. Competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents/fellows and faculty members.

3. Delineation of resident/fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision.

4. A broad range of structured didactic activities. Residents must be provided with protected time to participate in core didactic activities.

5. Advancement of resident/fellow knowledge of ethical principles foundational to medical professionalism.

6. Advancement in the resident/fellow knowledge of the basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care.

ACGME Competencies:
The program must integrate the following ACGME competencies into the curriculum:

Professionalism:
Residents must demonstrate a commitment to professionalism and an adherence to ethical principles.

Residents must demonstrate competence in:
- compassion, integrity, and respect for others;
- responsiveness to patient needs that supersedes self-interest;
- respect for patient privacy and autonomy;
- accountability to patients, society, and the profession;
- respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation;
- ability to recognize and develop a plan for one’s own personal and professional well-being;
- appropriately disclosing and addressing conflict or duality of interest.
Patient Care and Procedural Skills:
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and promotion of health. Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

Medical Knowledge:
Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Practice-based Learning and Improvement:
Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

Residents must demonstrate competence in:
- identifying strengths, deficiencies, and limits in one’s knowledge and expertise;
- setting learning and improvement goals;
- identifying and performing appropriate learning activities;
- systematically analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement;
- incorporating feedback and formative evaluation into daily practice;
- locating, appraising, and assimilating evidence from scientific studies related to their patients’ health problems;
- using information technology to optimize learning.

Interpersonal and Communication Skills:
Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Residents must demonstrate competence in:
- communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- communicating effectively with physicians, other health professionals, and health related agencies;
- working effectively as a member or leader of a health care team or other professional group;
- educating patients, families, students, residents, and other health professionals;
- acting in a consultative role to other physicians and health professionals;
- maintaining comprehensive, timely, and legible medical records, if applicable.

Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.

System-based Practice:
Residents/fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of healthy, as well as the ability to call effectively on other resources to provide optimal health care.

Residents must demonstrate competence in:
- working effectively in various health care delivery settings and systems relevant to their clinical specialty;
- coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty;  
- advocating for quality patient care and optimal patient care systems;  
- working in interprofessional teams to enhance patient safety and improve patient care quality;  
- participating in identifying system errors and implementing potential systems solutions;  
- incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate;  
- understanding health care finances and its impact on individual patients’ health decisions.

Residents must learn to advocate for patients within the health care system to achieve the patient’s and family’s care goals, including, when appropriate, end-of-life goals.

k. Moonlighting

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

a) Residents/fellows are not required to engage in moonlighting.

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

c) Residents/fellows 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/fellow’s file should a resident/fellow elect to engage in moonlighting.

e) Moonlighting must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program and must not interfere with the residents/fellows fitness for work nor compromise patient safety. The resident/fellow’s performance will be monitored for the effect of these activities and adverse effects on resident/fellow 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/fellowship program approved activities.

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

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

i) Time spent by residents/fellows 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.
I. Counseling Services

UICOMP/OSF SFMC will ensure that resident/fellow are provided with access to confidential counseling, and behavioral health services (see Resident/Fellow Health Policies, section III.J.3-4. and Benefits, IV.A.7.).

m. Physician Impairment

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

n. Harassment

UICOMP/OSF SFMC is committed to creating and maintaining an environment in which residents/fellows, students, faculty and administrative academic staff can work together in an atmosphere free of all forms of harassment, discrimination, exploitation or intimidation, on any basis prohibited by law including harassment based on sex (see Complaints, III.I.2.). The process allows residents/fellows access to processes to raise and resolve complaints in a safe and non-punitive environment and in a timely manner, consistent with applicable laws and regulations. Intimidation of residents/fellows may lead to removal from the teaching faculty.

o. Discrimination

UICOMP/OSF SFMC has policies and procedures, not necessarily GME-specific, prohibiting discrimination in employment and in the learning and working environment, consistent with all applicable laws and regulations.

p. Accommodation for Disabilities

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

q. The resident/fellow should contact the Program Director directly concerning:

1) Resident/Fellow Agreements;
2) Documentation required by the Resident/Fellow Agreement;
3) Licensure, Federal Drug Enforcement Administration Registration, Illinois Controlled Substances Registration;
4) Parking cards and name badges;
5) Certificate of training;
6) Resident/Fellow 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/fellowship program;

13) Desired program transfer; and

14) Resignation (see section II.M.8.).

r. Closures and Reductions

UICOMP/OSF SFMC has a written policy for residency/fellowship 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/Fellowship program will be accomplished by attrition, i.e., by reducing the number of new residents/fellows accepted into the program. UICOMP/OSF SFMC will continue to support the residency/fellowship program until all current residents/fellows have completed the program. NB: A residency/fellowship candidate that has been offered a position, and has signed a resident/fellow agreement [i.e., contract for employment as a resident/fellow], is considered to be a current resident/fellow.

2) The DIO, GMEC and relevant residents/fellows 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/fellows 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.

s. Restrictive Covenants

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

I. RESIDENT/FELLOW PARTICIPATION IN EDUCATION AND PROFESSIONAL ACTIVITIES

1. UICOMP ensures that each program provides effective educational experiences for residents/fellows 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/fellows:

   a. Have the opportunity to participate in committees and councils whose actions affect their education and/or patient care. A resident/fellow 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/fellows sit on the Resident Safety Council, UICOMP Well-Being Task Force, Resident/Fellow 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, OB Interdisciplinary Committee, Acute Care Disciplinary Committee, Pharmacy & Therapeutics Committee, Patient Safety Committee, and CPR Committee.

J. THE EDUCATION AND WORKING ENVIRONMENT

UICOMP, together with its education partner OSF, ensures that residency/fellowship 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/fellows today
2. Excellence in the safety and quality of care rendered to patients by today’s residents/fellows 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, fellows, 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/fellows 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/fellows 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/fellows 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/fellows will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents, fellows, 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. Residents/fellows 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/Fellow 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/fellows to develop and apply.
   a. All residents/fellows must receive training in how to disclose adverse events to patients and families.
   b. Residents/fellows 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/fellows 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, fellows, 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/fellows must have the opportunity to participate in interprofessional 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/fellows (see Policy on Resident/Fellow Supervision, Attachments 5 and 6).

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/fellow’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, fellows, faculty members, other members of the health care team, and patients.
   b. Residents, fellows, 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/fellow can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site, or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident/fellow-delivered care with feedback.
   a. The program must demonstrate that the appropriate level of supervision in place for all residents/fellows is based on each resident/fellow’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.]
b. The Program must define when physical presence of a supervising physician is required.

C. **Levels of Supervision:**

To promote appropriate resident/fellow 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/fellow during the key portions of the patient interaction or, PGY-1 residents must initially be supervised directly, only as described in specialty requirements. The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly. The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

2. **Indirect Supervision** – the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident/fellow for guidance and is available to provide appropriate 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/fellow must be assigned by the program director and faculty members.

   a. The program director must evaluate each resident’s and fellow’s abilities based on specific criteria, guided by the Milestones.
   
   b. Faculty members functioning as supervising physicians must delegate portions of care to resident/fellow, based on the needs of the patient and the skills of each resident/fellow.
   
   c. Senior residents or fellows should serve in a supervisory role to junior residents and/or fellows 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/fellows must communicate with the supervising faculty member(s).

   a. Each resident/fellow must know the limits of their scope of authority, and the circumstances under which the resident/fellow is permitted to act with conditional independence.

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

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**B. Professionalism**

1. Programs, in partnership with UICOMP/OSF SFMC, must educate residents, fellows, 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/fellows 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, fellows, 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, fellows, 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 served by transitioning that patient’s care to another qualified and rested provider.

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

C. Well-Being
Residents, fellows, and faculty members are at 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/fellowship training. Programs, in partnership with UICOMP/OSF SFMC, have the same responsibility to address well-being other aspects of resident/fellow competence.

1. The responsibility must include:
a. efforts to enhance the meaning that the resident/fellow 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/fellow well-being;

c. evaluating workplace safety data and addressing the safety of residents, fellows, and faculty members;

d. policies and programs that encourage optimal resident and faculty member well-being; and,

Residents/fellows 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, fellow, and faculty member burnout, depression, and substance abuse. The program, in partnership with UICOMP/OSF SFMC, must educate faculty members, fellows, and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents, fellows, 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, fellows, and faculty members to alert the program director, DIO 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/fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents/fellows unable to perform their patient care responsibilities. Programs must have policies and procedures in place to ensure coverage of patient care. These policies must be implemented without fear of negative consequences for the resident/fellow who is or was unable to provide the clinical work.

In the event that a resident/fellow is unable to begin or finish a shift, he/she will report the situation to the Chief Resident/Fellow. The Chief Resident/Fellow will then contact the resident/fellow on “standby” (or “jeopardy”) who will then assume the infirmed resident/fellow shift. If the Chief Resident/Fellow 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/fellow who is on duty, the infirmed resident/fellow 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/fellow through the Nursing Supervisor on call.

3. All residents and fellows will be provided voluntary access to, and anonymity of identity in the evidence-based tool the Well-Being Index. This access, at no cost to the fellow or resident, and with the assurance of both voluntary and
anonymous utilization of the Well-Being Index, may be specifically used for the purpose of self-assessment of: likelihood of burnout, sense of meaning in work, quality of life and fatigue severity.

Owing to the anonymous structure of the Well-Being Index (a service provided by contract with the Well-Being Index developed at the Mayo Clinic), the Sponsoring Institution may only receive aggregate data of Well-Being trends, with thresholds of aggregation preventing identification of any individual fellow or resident, for the purpose of performance improvement. This performance improvement shall focus on resources and services that may be developed strategically to provide improved and diversified well-being services to fellows and residents as a whole.

D. Fatigue Mitigation

1. Programs must:
   a. educate all faculty members, fellows and residents to recognize the signs of fatigue and sleep deprivation;
   b. educate all faculty members, fellows, and residents in alertness management and fatigue mitigation processes; and,
   c. encourage residents/fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.
   d. 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/fellow 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/fellows who may be too fatigued to safely return home.
   - **OSF Residents/Fellows:** may ask for a travel voucher for a taxi from the night supervisor or a social worker during the day.
   - **UPHM Residents/Fellows:** may be provided transportation to and from the hospital via the patient delivery system; if the latter is 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/fellow must be based on PGY level, patient safety, resident/fellow 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/fellows 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/fellows 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/fellows 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/fellow 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/fellow 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.
   5. The Hand-off should include an interprofessional member of the care team (preferably a nurse) if possible.

F. Clinical Experience and Education

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

Definition of the clinical and educational work hours under the requirement limiting them to 80 hour per week (averaged over a four week period).

i. Clinical and educational work hours are defined as all clinical and academic activities related to the residency/fellowship program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care, such as completing medical records, ordering and review lab tests, and signing orders.

ii. For call from home, time devoted to clinical work done from home and time spent in the hospital after being called in to provide patient care count toward the 80-hour weekly limit. Types of work from home that must be counted include using an electronic health record and taking calls. Reading done in preparation for the following day’s cases, studying, and research done from home do not count toward the 80 hours.

iii. Hours spent on activities that are required in the accreditation requirements, such as membership on a hospital committee, or that are accepted practice in residency/fellowship programs, such as residents’/fellows’ participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours.

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

3. Maximum Clinical Work and Education Period Length
   a. Clinical and educational work periods for residents/fellows 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/fellow education.
      II. Additional patient care responsibilities must not be assigned to a resident/fellow during this time.

4. Clinical and Educational Work Hour Exceptions
   In rare circumstances, after handing off all other responsibilities, a resident/fellow, on their own initiative, may elect to remain or return to the clinical site in the following 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/fellow to achieve the goals and objectives of the educational program, and must not interfere with the resident/fellow fitness for work nor compromise patient safety.
   b. Time spent by residents/fellows 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/fellows 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/fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.
   b. At-home call must not be frequent or taxing as to preclude rest or reasonable personal time for each resident/fellow.
   c. Residents/Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient care must be included in the 80-hour maximum weekly limit.

**K. RESIDENT/FELLOW AIDS IN THE WORK ENVIRONMENT**

1. **UICOMP provides an educational and work environment in which all residents/fellows from within and across UICOMP ACGME-accredited programs can communicate and exchange information with other residents/fellows relevant to their ACGME-accredited programs and their learning and working environment. They 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.J.). Mechanisms which facilitate achievement of an appropriate work environment for the resident/fellow 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/fellows 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. Monthly meetings between the House Staff President and Vice-President, the DIO, and OSF SFMC Director of Medical and Academic Affairs to discuss any resident/fellow-related issues that are brought to the attention of house staff officers.

   d. An annual meeting of the House Staff President with all residents/fellows which serves as an open forum where resident/fellows concerns may be expressed.

2. **UICOMP’s educational partner, OSF SFMC, provides services and has developed a health care delivery system to minimize residents’/fellows’ 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.

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'/fellows’ education, quality assurance activities, and provide a resource for scholarly activity.

c. 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.

d. Quality Improvement: access to data to improve systems of care, reduce healthcare disparities, and improve patient outcomes. Residents/fellows 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/fellows 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/fellows on call are provided with sleep/rest facilities that are safe, quiet, clean, and private, and that must be available and accessible for residents/fellows, with proximity appropriate to in-house patients to support education and safe patient care.

c. Clean and private facilities for lactation with proximity appropriate for safe patient care, and that have clean and safe refrigeration resources for the storage of breast milk. (See attachment #11)

d. Accommodations for residents/fellows with disabilities consistent with the sponsoring institutions and facility policy.

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

L. EVALUATION

1. Resident/Fellow 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, at least one of whom is a core faculty member.

   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/fellows 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/fellow evaluations semi-annually;
   b) Determine each residents/ fellows progress on achievement of the specialty-specific Milestones;
   c) Meet prior to the residents/fellows semi-annual evaluations and advise the program director regarding each residents/fellows progress.
   d) Prepare and ensure the reporting of Milestones evaluations of each resident/fellow semi-annually to ACGME; and
   e) Advise the program director regarding resident/fellow progress, including promotion, remediation, and dismissal.

2. Formative Evaluation
   a. The faculty must directly observe, evaluate and frequently provide feedback on resident/fellow performance during each rotation or similar assignment. Evaluate resident/fellow 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/fellow performance improvement appropriate to educational level;
   iv. Provide that information to the Clinical Competency Committee for its synthesis of progressive resident/fellow performance and improvement toward unsupervised practice.
   v. Meet with and review with each resident/fellow their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones;
   vi. Assist residents/fellows in developing individualized learning plans to capitalize on their strengths and identify areas for growth;
   vii. Develop plans for residents/fellows failing to progress, following institutional policies and procedures;

c. The evaluations of resident/fellow performance must be accessible for review by the resident/fellow, in accordance with institutional policy.

3. Summative Evaluation
   a. At least annually, there must be a summative evaluation of each resident/fellow that includes their readiness to progress to the next year of the program and must be accessible for review by the resident/fellow.

4. Final Evaluation
   a. The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as one of the tools to ensure residents/fellows are able to engage in autonomous practice upon completion of the program.
b. The program director must provide a final evaluation for each resident/fellow upon completion of the program. The evaluation must:
i. Become part of the resident/fellow permanent record maintained by the institution, and must be accessible for review by the resident/fellow in accordance with institutional policy;

ii. Document the resident’s/fellow’s performance during the final period of education; and

iii. Verify that the resident/fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.

iv. Consider recommendations from the Clinical Competency Committee;

v. Be shared with the resident/fellow upon completion of the program

5. Faculty Evaluation

   i. At least annually, the program must evaluate faculty performance as it relates to the educational program.

   ii. These evaluations must include a review of the faculty’s clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.

   iii. This evaluation must include at least annual written, anonymous, and confidential evaluations by the residents/fellows.

   iv. Faculty members must receive feedback on their evaluations at least annually.

   v. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.

6. Program Evaluation and Improvement

   i. The program director must appoint the Program Evaluation Committee (PEC) to conduct and document the Annual Program Evaluation as part of the programs continuous improvement process.

   The Program Evaluation Committee:

   a) Must be composed of at least two program faculty members, at least one of whom is a core faculty member and at least one resident/fellow;

   b) Must have a written description of its responsibilities; and should participate actively in:

      i. Act as an advisor to the program director, through program oversight;

      ii. Review of the program’s self-determined goals and progress toward meeting them;

      iii. Guiding ongoing program improvement, including development of new goals, based upon outcomes;

      iv. Review of the current operating environment to identify strengths, challenges, opportunities and threats as related to the program’s mission and aims;

      v. Planning, developing, implementing, and evaluating educational activities of the program;

      vi. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;

      vii. Addressing areas of non-compliance with ACGME standards; and

      viii. Reviewing the program annually using evaluations of faculty, residents, fellows, 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, through the PEC must monitor and track each of the following areas:

   a) Curriculum

   b) ACGME letters of notification, including citations, Areas of Improvement, and comments;

   c) Quality and safety of patient care

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d) Aggregate Resident, fellow, and Faculty:
  Well-being
  Recruitment and retention
  Workforce diversity
  Engagement in quality improvement and patient safety
  Scholarly activity
  ACGME Resident/Fellow and Faculty Survey
  Written evaluations of the program
  Aggregate resident/fellow: Achievement of the Milestones
  In-Training examinations
  Board pass and certification rates
  Graduate performance
  e) Aggregate Faculty:
     evaluation
     professional development
  f) Progress on the previous year’s action plan(s).

iii. The PEC must evaluate the program’s mission and aims, strengths, areas for improvement, and threats. 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 distributed and discussed with members of the teaching faculty and residents/fellows documented in meeting minutes.
  b) A copy of the Annual Program Evaluation must be submitted to the DIO/GMEC.

M. Advancement

The Program Director has the ultimate responsibility for the recommendation of resident/fellow 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/Fellow Agreement process and to forward the Agreements to the OSF Administrator.

iv. For residents/fellows 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/fellows on probation or to be dismissed, see Resident/Fellow 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/fellows must pass all parts of the USMLE or COMLEX exam as a requirement for graduation from his/her program. It is mandated that residents/fellows complete taking all parts of the licensing exam before the end of his/her second year of residency/fellowship 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/FELLOWS

1. Extraordinary Circumstances (Disaster/Substantial Disruptions in Patient Care or Education Policy)

UICOMP/OSF SFMC has developed a policy to define the process and procedures for graduate medical education programs in the event of an extraordinary circumstance, in the case of disaster/substantial disruption in patient care or education. (see Policy Manual).

2. Relationships with Industry Policy

UICOMP/OSF SFMC has guidelines for resident, fellow, and faculty to manage interactions between the healthcare industry and its faculty, residents, fellows, and students (see Relationships with Industry – Attachment 10).

3. Resident/Fellow Deposition Policy

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

4. Licensure

a. Prior to the start of each postgraduate training year (PGY), all residents/fellows 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/fellowship-training program with a temporary certificate. **Individual Program Directors may require permanent licensure of all residents/fellows 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/fellow’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/Fellow 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/fellow.

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 residents/fellows to obtain their National Provider Identifier (NPI) prior to start of residency.

e. It has become standard policy for residents/fellows to be registered in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) for the Medicaid Management System (MMIS).

f. 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/fellow for use until a Federal DEA number is obtained. Use of the hospital DEA number with the three digit resident/fellow identifier, shall therefore serve as:

i. A physician identifier, and

ii. Shall permit the resident/fellow 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/fellowship training. The Hospital Assigned DEA number is not for personal or family use and may not be used in any non-residency/fellowship-related activity. Note: there may be programmatic restrictions to this policy for 1st year residents. Please see the program specific manuals.

g. Prior to beginning a residency/fellowship program at training levels 4 and above, the resident/fellow 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/fellow 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/fellow, who must then provide copies of both licenses to the Program Director’s office and GME Office.

h. Following receipt of the permanent medical license and Illinois Controlled Substance License, the resident/fellow 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/fellow must provide copies of the DEA certification to the Program Director’s Office and GME Office on receipt of such certification.

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

j. The resident/fellow 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/fellow 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/fellows 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/fellow 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/fellow will provide quality health care to the best of his/her abilities.
   
      ii. Residents/fellows will provide quality health care in a manner that is not demeaning to any patient.
   
      iii. The resident/fellow 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** *(see OSF Policy “Scrub Usage Policy”, Attachment 3)*

      i. The House Staff uniform is a blue pinstriped laboratory coat with a UICOMP insignia. The resident/fellow is expected to wear clean professional clothing with a well-kept House Staff uniform *(see OSF Policy #115 for details)*.
   
      ii. House Staff Physicians on-call may wear personal scrub suits with laboratory coat during the hours of call. However, scrub suits must be changed when entering a designated clean environment.

      iii. Personal 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. However, residents/fellows scheduled in the Operating Room, or on Trauma, Medical Intensive Care Unit, Night Float, or Emergency Medicine Services may wear personal scrub suits for hospital duties.
   
      iv. Hospital-laundered scrubs are worn in Labor and Delivery, Surgical Suites, and Recovery, the Neonatal Intensive Care Unit, and special procedures rooms for infection control purposes of maintaining a clean environment.
   
      v. Hospital-laundered Scrubs provided by the medical center for use in surgical/procedural areas and are not to be worn outside of the medical center.
   
      vi. Removal of hospital-laundered scrubs from the hospital will be considered theft and result in Positive Disciplinary Plan.

7. **Resident/Fellow Resignation**

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

b. A resident/fellow may elect not to continue his/her employment as a resident/fellow by not signing a renewal Resident/Fellow Agreement when it is offered. Those who elect this option will be allowed to continue as residents/fellows, 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.I.)

9. **Institutional Review of Programs Policy**

**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, 2017.

**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 programs Annual Program Evaluation and GME Dashboard annually. Programs will have a full Institutional Review of Program at the mid-cycle of the 10 yr. site visit. When the review process is initiated, it is documented in the GMEC 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 an Institutional Review of Programs Committee (IRPC), which will include, at minimum:

1. Chair of the Review Committee appointed by the DIO.
2. Co-Chair of the Review Committee appointed by the DIO.
3. An ad-hoc faculty member from a program other than that which is under review.
4. An ad-hoc senior resident/fellow from a program other than that which is under review.
5. GME administrative personnel 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.

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/Fellows assigned in-house calls OSF-SFMC

1) On call hours for residents/fellows are determined by the Program Director of the department or by the section to which the resident/fellow 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/fellow signing-over call responsibility to another resident/fellow must follow these guidelines:

   1) obtain prior approval of the substitute resident/fellow.
   2) The substitute resident/fellow 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/Fellows will be provided access to specific, current information, by program, related to eligibility for board exam.
III. RESIDENT/FELLOW 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/fellow 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/fellow has been provided with relevant education and training for these functions, and (ii) that the Program Director considers the resident/fellow 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/fellows 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. Fellows will sign a waiver if they have received this training during residency.

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/fellow and that are not inconsistent with the Resident/Fellow Agreement, including the House Staff Manual, which is a component of the Resident/Fellow 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/fellows, 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/Fellow receives notice that a corrective action is required by the Program Director. Not a formal disciplinary action and not reportable to licensing and credentialing agencies.

   Resident’s/Fellow’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/fellow may be removed from their clinical duties at the discretion of the Program Director. During the period of administrative suspension, the resident’s/fellow’s cafeteria privileges may be revoked and the resident/fellow may be required to take vacation time at the discretion of the Program Director. If a resident/fellow chooses not to take vacation time, or has no vacation time available, the suspension status is considered time off without pay. The resident/fellow will be removed from their clinical duties for the duration of the suspension.

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

Program Director will document this lapse of professionalism in the resident’s/fellow’s permanent file. (see Resident/Fellow 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 4).

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

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

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

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

4) To comply with the ACGME requirements for recognizing fatigue

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

C. TEACHING

Residents/Fellows 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/fellows must have a faculty appointment to teach at the College of Medicine.

D. CLINICAL TEACHING OF MEDICAL STUDENTS

1. Medical students in clinical learning situations involving patient care must be appropriately supervised at all times in order to ensure patient and student safety, that the level of responsibility delegated to the student is appropriate to his or her level of training, and that the activities supervised are within the scope of practice of the supervising health professional.

2. Residents and fellows in the medical education programs who supervise or teach medical students should be familiar with the learning objectives of the course or clerkship and are
prepared for their roles in teaching and assessment. The medical school provides resources to enhance resident, fellow, and non-faculty instructors teaching and assessment skills, and provides central monitoring of their participation in those opportunities.

E. PAGING SYSTEM - OSF

1) Each resident/fellow 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/Fellow availability through the pager unit is determined by the resident's/fellow's current assignments.

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

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

F. ON-CALL SCHEDULE

1) A resident/fellow 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/fellows to in-house call for the department.

G. 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/Fellows. 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/fellows in the house should respond to Blue Alerts.

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

6) The resident/fellow in charge of running adult Blue Alerts will be the resident/fellow 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/fellow in charge will be responsible for directing resuscitation of the patient and for organizing or dismissing available personnel.
H. RESIDENT’S/FELLOW’S PERMANENT FILE

1. All records concerning each resident’s/fellow’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/fellow’s official file and all letters of reference with respect to each resident/fellow 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/fellow 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/Fellow Agreements;
   d. Resident/Fellow Performance Rating Scale evaluation forms;
   e. All correspondence including official faculty or administrative actions, actions of committees, or other correspondence relating to the resident/fellow;
   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.

I. HEALTH INFORMATION SERVICES (MEDICAL RECORDS)

1. Resident/Fellow Identification

   When a resident/fellow 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/fellow to maintain all medical records at UPHM, 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/fellow’s duty to check their EPIC in-basket daily and complete their outstanding records. The resident/fellow 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/fellow to communicate with the attending or supervising physician to clearly understand the resident/fellow 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/Fellows should complete the oldest records first.

d. A summary report of all physicians’ delinquent records is produced weekly. It is the resident’s/fellow’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/fellowship Program Directors resident-specific data when a resident/fellow 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/fellow 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/Fellow receives a notice, issued by the Program Director to complete delinquent records. Resident’s/Fellow’s cafeteria privileges may be revoked for a length of time specified by the Program Director. This is not a formal disciplinary action and will not be reported to licensing and credentialing agencies.

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/fellow may be removed from their clinical duties at the discretion of the Program Director.

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

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

   a) Program Director will document this lapse of professionalism in the resident's/fellow's permanent file. (see Resident/Fellow 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/fellow chooses not to take vacation time, or has no vacation time available, the suspension status is considered time off without pay. The resident/fellow will be removed from their clinical duties for the duration of the suspension.

   c) During this period, the resident/fellow 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/fellow program fulfillment may be lost. In some cases, this may delay eligibility to sit for Board certification.

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

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

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

J. EMPLOYMENT OUTSIDE THE RESIDENCY/FELLOWSHIP PROGRAM

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

K. COMPLAINTS

1. General

   Residents/fellows who believe that they have been treated inappropriately or unfairly in the course of the performance of their duties as residents/fellows should bring such situations to the attention of their leadership, as described below. The leadership’s first response to resident’s/fellow’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 resident/fellow complaints involving discrimination or sexual harassment. Discrimination occurs when a resident/fellow 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/fellow 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 (624-4060)
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/fellows 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/Fellows 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/Fellow and/or the Program Director for informal resolution. The resident/fellow, 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
Francis McBee Orzulak, M.D., Associate Dean for Graduate Medical Education, UICOMP (671-8450)
Robert Sparrow, M.D., Chief Medical Officer, OSF SFMC (624-4060)

4. Grievances

When informal efforts to resolve a complaint fail to produce results that satisfy the resident/fellow making the complaint, the resident/fellow may initiate a written complaint
(grievance), which describes the alleged infraction and also the desired outcome or resolution. The procedures for responding to residents’/fellows’ 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., Chief Medical Officer, OSF SFMC (655-4060) and Labor Relations and HR Compliance, OSF SFMC (655-6931)

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.

L. RESIDENT/FELLOW 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/fellows are required to have an initial Health Assessment performed through the Center for Occupational Health to complete the Resident/Fellow Agreement.

2. Personal Illness

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

b. It is the primary responsibility of the resident/fellow 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/fellow 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/Fellow Impairment

UICOMP has established a Resident/Fellow Health Committee that is responsible for dealing with impaired residents/fellows. The Committee’s charter composition and operating procedures are detailed below:
Purpose

The purpose of the UICOMP Graduate Medical Education (GME) Resident/Fellow Health Committee (RHC) is to assure patient safety through appropriate recommendations to support an impaired resident/fellow. The RHC serves as a resource to ACGME-accredited training programs in the management of impaired residents/fellows. Impairment includes any physical or mental illness that interferes with a resident’s/fellow’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/fellow impairment and the signs of impairment.

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

Self-Referral

Residents/fellows 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/fellow has self-referred.

The DIO, with the input of the resident’s/fellow’s referral information, the PD, and the Chair shall determine if the report involves a possible impairment that may negatively affect the resident’s/fellow’s capacity to complete duties or provide safe patient care. If the DIO judges in the affirmative, then the DIO shall refer the resident/fellow 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/fellow to his/her PD who may proceed with other resident/fellow 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/fellow 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/fellow 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/fellow’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/fellow for drug testing and/or may temporarily suspend the resident/fellow from clinical activities.

In the event a resident/fellow 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/fellow’s patient care services.

**Resident/Fellow 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/fellows 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/fellows 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/Fellows.

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/fellow referred shall be informed of the meeting date, time, and
location and shall be invited to attend a portion of the meeting. The resident/fellow may secure legal counsel, but shall not attend the meeting with any uninvited party.

Residents/fellows 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/fellow'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/fellows 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/fellow 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/fellowship performance files, or medical records. The resident/fellow 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/fellow 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/fellow to provide information to assist in making recommendations. After their question period, the resident/fellow 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/fellow should be placed on or continued on suspension;

3) Whether specific activities shall be restricted;

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

5) The duration of recommendations; and,

6) If the resident/fellow 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/fellow.
The Agreement of Understanding shall be signed by the DIO and provided to the resident/fellow for consideration. The resident/fellow shall have up to 7 days to accept or decline the Agreement, during which time the resident/fellow 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/fellow 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/fellowship 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/fellows retain the right to appeal any recommendations through the program, GME Office, or hospital systems.

If the resident/fellow 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/fellow's activity, to suspend the resident/fellow, or terminate the resident/fellow. 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/fellow 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/fellow 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/fellow files shall be kept in the GME Office until a resident/fellow completes training, is terminated, or leaves a program, after which, the file shall be forwarded to be maintained with the department.

4. Resident/Fellow Substance Abuse

Residents/fellows 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/Fellows 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/fellow 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/fellow for 6 months. However, the resident/fellow 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/fellow.

f. Post-Exposure Written Evaluation

The resident/fellow 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).

M. RESIDENCY/FELLOWSHIP PROGRAM TRANSFER

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

2. The resident/fellow and Program Director of the specialty to which the resident/fellow 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/fellow 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/fellow’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/fellow.

6. Transfer will be affected only upon signing and acceptance of a new Resident/Fellow Agreement.

7. The Illinois temporary license issued to each resident/fellow is both institution and program specific. Therefore, the transfer form one training program to another requires a formal transfer of license through the IDFPR. When this occurs, the first temporary license is returned to Springfield and a second license is issued for the new residency/fellowship program. No such requirement exists for those with permanent licenses during a program transfer.

8. Transfer of residents/fellows to UICOMP programs from outside institutions should follow the Resident/Fellow Transfer Policy detailed in the Policy Manual.
N. DIPLOMAS AND TRANSCRIPTS

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

2. For any resident/fellow not completing a residency/fellowship 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/fellow completes the prescribed OSF SFMC employee termination process.

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

P. 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/fellows are expected to follow the guidelines described below:

1. The resident’s/fellow’s Program Director, coordinator, and Risk Management should be informed if a subpoena is issued to a resident/fellow or if an attempt is made to issue a subpoena to the resident/fellow.

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/fellow 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/fellow. If any patient care-related subpoena is issued to the resident/fellow by another mechanism, the resident/fellow 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 the Resident/Fellow (as informational only, Program Directors will not be attending meetings between residents/fellows and attorney’s).

House staff members must comply with any lawfully issued subpoena that requires court testimony. Failure to do so can lead to contempt of court and arrest.

Q. RESEARCH SERVICES AND 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 follow the appropriate approval process before starting a research project, projects must be reviewed by Research Services (exceptions are Neurology, Neurosurgery, Pediatrics and Family Medicine which has their own review process). Once project has been approved by the proper mechanism, they must complete the appropriate Institutional Review Board (IRB) review before starting the projects and complete the training modules as required in the IRB review process. Individual programs may require additional research education and training. IRB information can be found at the UICOMP website at http://www.uicomp.uic.edu/Dept/IRB/Default.html
R. NEWS MEDIA INQUIRIES

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

IV. RESIDENT/FELLOW BENEFITS and OSF SFMC POLICIES

A. INTRODUCTION

1. The resident/fellow is considered a professional in training in a UICOMP sponsored residency/fellowship 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/fellows. To access on-line Human Resources Policies: Visit PolicyStat.

2. Stipend
   a. The stipend for each resident/fellow is specified in his/her Resident/Fellow Agreement. Effective dates of stipends for in-cycle residents/fellows 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 2021-2022 academic year are:

      - TL-1 $59,499
      - TL-2 $61,650
      - TL-3 $63,916
      - TL-4 $66,478
      - TL-5 $68,130
      - TL-6 $70,483
      - TL-7 $71,215
   d. Residents/Fellows who serve as House Staff President or House Staff Vice President will receive a supplemental stipend of $198 per month.
   e. Chief Residents/Fellows 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/fellowship program and the number of Chief Residents/Fellows appointed by the Program Director.
   f. The Graduate Medical Education Office 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/Fellows 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/fellows 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/fellows must follow policies of the GME Department for submission of travel request vouchers and documentation of expenses.
   b. Residents/Fellows 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. Note that reimbursements for some items are taxable by IRS code, such as electronics, the tax will be
deducted from the reimbursement amount. If monies are being requested to fund an outside elective, the Program Director will present the resident’s/fellow’s request to the GME Office for approval. GME Office approval is necessary for the program to request the release of funds to support the resident’s/fellow’s request.

4. Vacation and Leave

a. Vacation

1) Residents/Fellows 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/Fellows are discouraged from taking individual PTO days.

4) One-Month Rotations:

   i. Residents/fellows 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/fellow’s Program Director and the relevant rotation faculty, giving appropriate consideration to the needs of the resident/fellow and those of the rotation site.

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

6) Exceptions may be made by the resident’s/fellow’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/Fellows 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/fellow utilizes the maximum amount of PTO time allotted during the agreement year.

9) Each resident/fellow 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/fellow's outpatient clinics, according to departmental policies; and

b) The resident/fellow 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/fellows 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/fellow or resident’s/fellow’s spouse, and to care for a child; for the placement of a child for adoption or foster care by a resident/fellow or resident’s/fellow’s spouse; to care for a seriously ill spouse, child, or parent; or because of a serious health condition that prevents the resident/fellow from performing functions required of residents/fellows. 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/fellow 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/fellows 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/fellows considering a leave of absence should understand that taking a leave of absence may result in:

   i. An extension of residency/fellowship 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/fellow’s permanent file.

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

9) Jury Duty

Residents/fellows called to jury duty must notify their Program Directors in a timely manner that his/her service has been so enlisted. Residents/Fellows 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/fellow 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/fellowship duties or for which monetary reimbursement is requested. The educational need of the resident/fellow will be the primary consideration. Residents/fellows are required to attend at least one major professional meeting during their course of residency/fellowship training at UICOMP/OSF SFMC. Residents/fellows 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/fellow 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/fellow 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/fellow’s outpatient clinic according to departmental policies; and,
      b) The resident/fellow 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/fellows to take advantage of these discounts whenever possible.

f. Research-Related Cost for Residents/Fellows:

   1) Support is provided to assist residents/fellows 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/fellow per year.

4) There is a limit of one sponsored resident/fellow 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/fellows via webinars prior to the start of their residency/fellowship. 
Hospital and health insurance benefits for residents/fellows and their families begins the first 
day of employment. Enrollment is required.

b. Life

Residents/fellows 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/fellows 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/fellows Employed by OSF SFMC

a. OSF SFMC maintains professional liability insurance coverage for residents/fellows 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/fellow are $2 million per person, $4 million per occurrence. This 
insurance cannot be converted for a departing resident/fellow. 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/fellow are in the scope of the program.

b. This coverage does not protect the resident/fellow 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/fellow arising out of the professional services provide, or withheld by the resident/fellow within the scope of the resident’s/fellow’s employment. Indemnification for any judgment rendered against a resident/fellow or any settlement made involving a claim concerning the professional conduct of a resident/fellow 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/fellow, will be settled without first informing the resident/fellow. The right to settle, however, remains with OSF Healthcare System in its sole discretion.

7. Employee Assistance Plan (EAP)

Residents/fellows 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/Fellow 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/fellow. If additional help is needed, the EAP counselor will facilitate a referral for cost-effective, professional assistance. To obtain EAP services, residents/fellows should call 800-433-7916.

8. Retirement Plan

401(k) Retirement Plan: Residents/fellows 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/fellows 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/fellows would need to be hired at an OSF hospital post-residency/fellowship 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/fellows are eligible to receive payment from sick protection hours. Sick protection hours are reestablished annually on the anniversary of the resident's/fellow’s agreement
date. Hours are pro-rated for residents/fellows employed less than 90%-time. Each TL-1 through TL-4 resident/fellow 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/fellow 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/fellows are ill, they must notify their Program Director, their Program Coordinator, and the Chief Resident/Fellow of the service from which they will be absent. The Chief Resident/Fellow will also notify that resident’s/fellow’s Program Coordinator. Individual programs may have additional established department guidelines for notification of illness. The resident/fellow should be aware of program-specific guidelines when rotating on that specialty service.

As stated above, at the completion of a resident’s/fellow’s anniversary agreement year, sick protection hours will be reestablished. However, if a resident/fellow 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/fellowship program RRC length-of-training requirements, specialty boards length-of-training requirements, ACGME duty hour rules, and individual department call, or clinic requirements, residents/fellows 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/fellows employed 40%-time or greater are eligible for this benefit. Note: (pro-rated for part-time residents/fellows) per anniversary agreement year for the same disability.

An application for this benefit must be submitted by the resident/fellow 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/fellows 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/fellow 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/fellows 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/fellow’s cafeteria benefit.

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

c. Residents/fellows may not obtain food for other individuals, including medical students, family, or staff members. Residents/fellows 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/fellows. Residents/fellows may eat in the Doctor’s Dining Room. Trays brought in by residents/fellows are to be taken to the tray-veyor 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/fellows (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/fellows should not park in areas designated for patients, visitors, or attendings.
c. Parking tags are provided thorough OSF SFMC’s Security Services. The $20 deposit normally charged to employees is waived for residents/fellows; however, residents/fellows will be charged $20 for a replacement if the original parking card is lost. Replacement cards may be obtained at the Securities 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/fellow to such a rotation, a formal written agreement between UICOMP/OSF SFMC and the outside institution(s) is required, ensuring that the resident’s/fellow’s stipend, benefits, and liability coverage are continued.

b. Elective rotations outside the Peoria area:
   Residents/Fellows 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/fellow 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/fellow to the rotation, a formal written agreement between UICOMP/OSF SFMC and the outside institution(s) is required, ensuring that the resident’s/fellow’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/fellowship 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/fellow’s stipend, benefits, and professional liability insurance while participating in the rotation. The PLA must be signed by all parties before the resident/fellow 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/fellows 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/fellow 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/fellows will work with GME to secure appropriate housing (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.
Upon completion of the off-campus training, residents who received assistance for housing must provide receipts for the expenses incurred. The resident/fellows 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/fellows 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/fellows who travel in their own vehicle and actually incur the costs of such travel.

v. A log of resident/fellow travel which meets the requirements of this policy will be maintained by the residency/fellowship Program Coordinator. This log will identify the dates of travel, the resident/fellow 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/fellow 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/fellows on outside rotations.

d) The resident/fellow 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/fellow to the outside institution from SFMC.

e) Residents/fellows 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/fellow 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 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/OSF/UPHM 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, fellows, their spouses, and children. Residents/fellows 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/fellows 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/fellows 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/fellows who successfully complete their training.

18. Licensing Fee Reimbursement for incoming residents/fellows:

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/fellows, including:

a. Computer Facilities

b. Library of Health Sciences

c. Instruction and Evaluation services

d. Research Laboratories which include animal facilities

e. Institutional Review Board Training

f. Educational Specialist to help residents/fellows with problems related to learning and communication

g. Statistical support following approval of a research project by the GME office

Residents/fellows 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/fellowship information for those in preliminary programs.

V. RESIDENT/FELLOW DISCIPLINE AND GRIEVANCE PROCEDURES

A. GENERAL

1. All complaints and concerns about residents/fellows 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/fellow 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 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/Fellow receives a notice, issued by the Program Director, for example to complete delinquent records. Resident’s/Fellow’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/fellow may be removed from their clinical duties at the discretion of the Program Director.

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

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

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

1) Program Director will document this lapse of professionalism in the resident’s/fellow’s permanent file. (see Resident/Fellow 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/fellow chooses not to take vacation time, or has no vacation time available, the suspension status is considered time off without pay. The resident/fellow will be removed from their clinical duties for the duration of the suspension.

3) During this period, the resident/fellow 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/fellow program fulfillment may be lost. In some cases, this may delay eligibility to sit for Board certification.

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

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

f. Residents/fellows 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/fellow 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/fellowship program requires that residents/fellows remain in good standing with OSF SFMC and with UICOMP. Therefore, residents/fellows whose employment is terminated by OSF SFMC will be simultaneously dismissed from their residency/fellowship program.

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

C. UICOMP (GMEC) PROCESS FOR NON-DISCIPLINARY AND DISCIPLINARY MEASURES

1. Possible Outcomes
   a. Exoneration;
   b. Educational Plan;
   c. Educational Intervention;
   d. Probation;
   e. Suspension (disciplinary, automatic, or immediate);
   f. Dismissal from the residency/fellowship program.

2. Non-Disciplinary Measures

   Non-disciplinary actions are intended to be educational in nature. These measures are should not be reported by the resident/fellow or program to employers, licensing bodies or credentialling bodies.

   a. Educational Plan

      1) An Educational Plan is an action implemented by the Program Director that notifies the resident/fellow of specific deficiencies in their progress that need to be corrected with a plan that is developed in conjunction with the resident/fellow. While on an Educational Plan the resident/fellow receives credit for training time and salary and benefits remain in force.

      2) A conference between the resident/fellow and the Program Director (or their designee) must be held prior to implementing an Educational Plan. In this conference, the reasons for the plan should be explained, a process for improvement should be determined with the resident/fellow’s input and the required outcomes should be identified. Within one week of the conference the Program Director must provide the resident/fellow with a letter outlining the reason for the plan, process for improvement and required outcomes.

      3) A single educational plan period can be in place for up to 90 days. Multiple periods of educational plan may follow each other but each period requires a conference between the resident/fellow and the Program Director (or their designee) and a letter to the

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1 The GMEC recommends Program Directors consider holding meetings in the presence of an administrative staff (e.g. Program Coordinator) who is present to take notes
resident/fellow. The Program Director or their designee should meet with the resident/fellow at least monthly during any Educational Plan period.

4) At the end of the educational plan period, another conference between the resident/fellow and the Program Director (or their designee) must be held, at which time the resident/fellow may be:

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

b. Educational Intervention

1) Educational Intervention is a corrective action imposed by the Program Director that notifies the resident/fellow of specific deficiencies that must be corrected. An educational intervention is usually implemented when a resident/fellow has failed to successfully complete an Educational Plan or when two or more ACGME core competencies (i.e. interpersonal and communication skills, patient care, practice based learning and improvement, medical knowledge, professionalism and systems base practice) require improvement. Certain concerns may merit implementation of an Educational Intervention without a prior Educational Plan. While on educational intervention, residents/fellows receive credit for training time and salary and benefits remain in force.

2) A conference between the resident/fellow and the Program Director must be held prior to initiating educational intervention. In this conference, the reasons for educational intervention, the process for improvement, and the required outcomes must be identified. Within one week of this conference, the Program Director must provide the resident/fellow with a letter (copied to the Associate Dean for Graduate Medical Education) indicating the reasons for the educational intervention, the process for improvement, and the required outcomes.

3) A single educational intervention period can be in place for up to 90 days. Multiple periods of educational intervention may follow each other, but each period requires a conference between the resident/fellow and the Program Director and a letter to the resident/fellow (with copy to the Associate Dean for Graduate Medical Education), describing the terms of the educational intervention. The Program Director or their designee should meet with the resident/fellow at least monthly during any Educational Intervention period.

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

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

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2 The GMEC recommends Program Directors consider holding meetings in the presence of an administrative staff (e.g. Program Coordinator) who is present to take notes.
c) Placed on probation.

3. Disciplinary Measures

Details of disciplinary actions should be recorded as part of the resident’s/fellow’s permanent record. Disciplinary actions are discoverable and should be reported by the resident/fellow and program to employers, licensing bodies and credentialling bodies.

a. Probation

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

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

3) A conference between the resident/fellow and the Program Director must be held before a resident/fellow 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/fellow 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/fellow and the Program Director and a letter to the resident/fellow (with copy to the Associate Dean for Graduate Medical Education), describing the terms of the probation. The Program Director or their designee should meet with the resident/fellow at least monthly during any probationary period.

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

   a) Removed from probation;

   b) Placed on another period of probation;

   c) Informed that he/she will not be offered a Resident/Fellow Agreement when the current agreement expires;

   d) Suspended

   e) Entered into the dismissal process.

b. Suspension

1) Definition

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3 The GMEC recommends Program Directors consider holding meetings in the presence of an administrative staff (e.g. Program Coordinator) who is present to take notes.
Suspension is a corrective action that removes the resident/fellow from the usual program duties. While on suspension, the resident/fellow does not receive credit for training time or salary. However, health benefits continue. Details of suspension are recorded on a resident’s/fellow’s permanent record.

2) Types of suspension (see Grounds, section b.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 their representative(s).

4) Grounds

Grounds for suspension include, but are not limited to:
   a) Disciplinary Suspension
      i. Employment outside the residency/fellowship program in violation of the Institutional Policy (see Moonlighting, section II.H.5.j.).
      ii. Disregard for OSF SFMC or UPH policies pertaining to dress, conduct, and other policies that are applicable to residents/fellows.
      iii. Disregard or noncompliance of any of the statutes, rules, or policies that are established by UICOMP, OSF SFMC or UPH (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/fellows in that program (detailed in the program-specific manual).
   b) Administrative Suspension
      i. Incomplete medical records are grounds for administrative suspension (see Resident/Fellow Responsibilities, section III.G.2.).
      ii. Note: Residents/fellows 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/fellows (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

Disciplinary Suspension is usually implemented after a resident/fellow has been unsuccessful meeting the expectations of other non-disciplinary or disciplinary measures. However, Disciplinary Suspension may be implemented without any prior interventions or notice when a resident/fellow significantly fails to meet the expectations of the program or OSF SFMC. Failure to meet expectations that may warrant Disciplinary Suspension include, among others, actions or inactions that cause undue patient or workplace risk or negative outcome; serious competency issues in ACGME core competencies (i.e. interpersonal and communication skills, patient care, practice based learning and improvement, medical knowledge, professionalism and systems base practice); and acts or omissions that are in violation of the rules, guides, and expectations of the program, GME, University, of OSF SFMC.

b) Immediate Suspension

Immediate Suspension may be implemented without any prior interventions or notice, verbally, and immediately for the grounds stated in 4)c. above.

6) A conference between the resident/fellow and the Program Director or the person responsible for implementing suspension (see above), should be held, if possible, before or at the time of notification, a resident/fellow is suspended. In this conference, the reasons for suspension should be provided to the resident/fellow verbally or in writing.

7) Review:

Information about Disciplinary or Immediate Suspension will be reviewed by the Program Director, the Associate Dean for Graduate Medical Education (or GME representative), and an OSF SFMC administrative representative within three working days after the resident/fellow is suspended. (A working day is defined as non-holiday, Monday through Friday). Thereafter, within three working days following this review, the terms of Disciplinary and Immediate Suspension must be provided in writing to the resident/fellow, the Associate Dean for Graduate Medical Education, and OSF representative. The terms should include the reason(s) for suspension and the process for improvement with the outcomes required before suspension may be removed. The resident/fellow may request a conference with the PD and/or Associate Dean for Graduate Medical Education to discuss and review the terms of suspension.

8) Removal of Suspension

Disciplinary or Immediate Suspension may be removed after the resident/fellow has successfully met the terms of suspension. Removal of

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4 The GMEC recommends Program Directors consider holding meetings in the presence of an administrative staff (e.g. Program Coordinator) who is present to take notes.
c. Dismissal

1) Definitions

a) Dismissal means the discharge of a resident/fellow from the program even though he/she has signed a Resident/Fellow 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/fellow to comply with law.

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

c) Significant failure to meet the expectations of the program or OSF SFMC. A resident/fellow may be dismissed at any time, without notice for significant failure to meet the expectations of the program of OSF SFMC. Such failure may include: egregious behavior; actions or inactions that cause serious or undue patient or workplace risk or negative outcome; and acts or omissions that are in serious violation of the rules, guides, and expectations of the program, GME, University, of OSF SFMC.

d) Failure of the resident/fellow to meet the expectations of other non-disciplinary or disciplinary measures.

3) A resident/fellow may be Suspended prior to Dismissal (see above).

4) Review

Information about Dismissal will be reviewed by the Program Director, the Associate Dean for Graduate Medical Education (or GME representative), and an OSF SFMC administrative representative prior to Dismissal. The reasons for Dismissal must be provided in writing to the resident/fellow, the Associate Dean for Graduate Medical Education, and OSF representative at the time of dismissal. The resident/fellow may request a conference with the PD and/or Associate Dean for Graduate Medical Education to discuss and review the reasons for Dismissal.

A resident/fellow that exhibits egregious behavior may be dismissed immediately. Egregious termination renders null and void the 4-month written notice requirement for non-renewal of resident’s/fellow’s contracts (section IIH, under Agreement of Appointment). A
Resident/Fellow 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/FELLOWS AND PROBATION

Effective date: January 1, 2010

This Procedure to Appeal a termination, suspension, nonrenewal of a Resident/fellow and probation shall be the only means available to all Residents/Fellows of The University of Illinois at Chicago College of Medicine Peoria 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 Program Director shall provide to the Resident written notification of the termination/suspension/nonrenewal/probation within ten (10) working 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 the procedures outlined in this Manual.

c. Request for Hearing: Within ten (10) working 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 Program Director.

d. Hearing Committee: The Hearing Committee shall consist of at least three (3) faculty members from the Resident's department who are not part of the program’s Clinical Competence Committee. If there are insufficient faculty from the department willing or able to serve on the committee, the Associate Dean for Graduate Medical Education will appoint members from other departments. The Program Director 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 program 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) working 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 Program Director 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 resident/fellow and the University. 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. Any materials to be presented at the Hearing by either party must be provided to the Committee at least three (3) working days prior to the hearing. A copy of any materials submitted to the Committee by either party will be provided to the other party at least one (1) working day prior to 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) working days from the date of the conclusion of the hearing.

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. The Associate Dean for Graduate Medical Education may, or may not appoint an Appeals Committee, to review and discuss the matter. The committee will have at minimum 3 members and the make-up of the Appeals Committee will be at the discretion of the Associate Dean. He/she shall render his/her decision in writing within a reasonable time, but not later than twenty (20) working 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) working 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) working 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 working days, not calendar days.
UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA
Office of Graduate Medical Education

Subject: Annual Institutional Review (AIR)

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 April 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-May).

PROCEDURE: The AIR will be developed through review of the Residency/Fellowship Annual Program Evaluations, ACGME Resident and Faculty Surveys, reviews conducted by the Subcommittee for Institutional Review of Programs (IRPC), and the institutional dashboard, and will focus on the following performance indicators:

1) Results of the most recent institutional letter of notification.
2) Results of Program response to the Annual Program Review.
3) Each of the ACGME-Accredited Programs ACGME accreditation information, including accreditation statuses and citations.
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 must submit a written annual executive summary of the AIR to UICOMP’s governing body. The written executive summary must include a summary of institutional performance on indicators for the AIR and action plans and performance monitoring procedures resulting from the AIR.
PURPOSE:

OSF HealthCare is dedicated to having Mission Partners present a professional appearance to those we serve. 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 ensure 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 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. Rather, it sets the general parameters for proper attire.
   b. Leadership is responsible for interpretation of the guidelines, and as necessary, may require more stringent or restrictive dress codes, as deemed necessary by their functions.
   c. 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 physician certified health reasons may be made.

Specific guidelines follow below:

Shirts

1. Casual shirts with collars, knit tops, sweaters, turtlenecks, and polo shirts are acceptable. These types of casual shirts may include approved OSF logos.

2. Inappropriate items include:
a. shirts, vests and jackets made from denim,
b. t-shirts,
c. hooded sweatshirts,
d. tank tops,
e. halter tops,
f. tops with bare shoulders unless worn under another blouse or jacket, and
g. 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.

Pants

1. Dress pants 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. Leggings are acceptable if worn with an appropriate length top.
4. 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.
5. 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.

Scrub

1. Some departments, as designated by Leadership, 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 workplace on a scheduled day off.

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 are acceptable as long as department safety guidelines are not violated.
   a. Heel height is not be greater than 3 inches.
   b. Socks/hosiery 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.

Grooming

1. Good personal hygiene is expected of Mission Partners.
2. Hair needs to be clean, neatly styled, and manageable for the job performed.
   a. 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.
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 when at work.
6. Odors should not be excessive. No overpowering odors (fragrances, body odor, tobacco or other smoke, etc.) shall be noticeable from a Mission Partner 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 adornments are simple and appropriate for job duties.
3. Pins, stickers, or other adornments that are not OSF-provided, do not recognize an OSF sponsored activity, and/or are not for employment-related certifications/qualifications are not allowed.
4. Hats/caps and sunglasses, unless authorized by Leadership as specific to a job, are not to be worn while on duty.

Identification Badges
1. Identification badges must be worn by Mission Partners while on duty and for OSF related business.
2. Identification badges are to be properly displayed with the picture facing out and worn in a visible location, as appropriate per the work area.
3. Identification badges and/or plastic badge holders are to be replaced if not readable, are lost or the plastic becomes ragged.
4. Mission Partners are issued an identification 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 OSF.
5. Pins may not be placed on or through the Mission Partner identification badge.
6. Defacing, disguising or otherwise altering the identification badge is prohibited.
7. Upon termination, the Mission Partner returns the identification badge to OSF.

Jeans for a Cause Days
1. Senior leadership may, at their discretion, authorize a "Jeans for a Cause" work day.
   a. All other aspects of this Personal Appearance policy is adhered to on "Jeans for a Cause" work days.
   b. 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.

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:

Name as listed with Medicare:
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<td>Sister Diane Marie: PRESIDENT</td>
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<td>Senior VP, Human Resources</td>
<td>Sharon Dyer: SUPV HR SUPPORT SERVICES</td>
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<td>Stephanie McCarthy: HR COMPLIANCE OFFICER</td>
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<td>Christen Bergstresser: RESOURCE DOCUMENT SPECIALIST</td>
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<td>Stephanie McCarthy: HR COMPLIANCE OFFICER</td>
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Scrub Usage Policy

PURPOSE:
To detail guidelines for wearing hospital-provided scrub attire for Mission Partners required to wear hospital-laundered scrubs at OSF HealthCare Saint Francis Medical Center (SFMC).

POLICY:

1. OSF HealthCare Saint Francis Medical Center (SFMC) supplies hospital laundered scrub attire to designated staff in compliance with Illinois Department of Public Health Administrative Code 77 Chapter 1, subchapter b, section 250.1300.

2. Individual(s) wearing SFMC-supplied scrubs that are not employed or contracted by SFMC may present a security risk to the Hospital.

3. Personnel in the following departments are required to wear scrubs provided by SFMC as designated below:
   a. Sterile Processing Department (SPD)
   b. Pre-Op, Intra-Op, Post-Op, PACU
   c. Anesthesia
   d. Cardiac Catheterization Lab, Electrophysiology
   e. Interventional Radiology
   f. Labor and Delivery
   g. Radiation Oncology (Surgery Shift Only)
   h. X-Ray (Surgery Shift Only)
   i. MRI (Surgery Shift Only)
   j. PICC Services
   k. NICU Providers and NICU APNs
   l. Pathology, Cytology, Histology (Surgery Shift Only)
   m. Pharmacy (Surgery Shift Only)
   n. GI Lab Assistant (Scope Cleaning Room)
4. Mission Partners who are required to wear hospital-provided scrubs are allowed one pair of hospital-
laundered scrubs per shift unless scrubs are contaminated during work shift.

5. Scrub tops, bottoms and jackets are SFMC property and are not worn or taken off the hospital campus.
   - Wearing and / or taking invasive area scrubs off the SFMC campus is considered an act of theft.

6. Scrub tops, bottoms, and jackets are not to be defaced or altered in any way.

7. Scrubs supplied by SFMC are laundered by an accredited Hospital Laundering Facility to meet regulatory
   requirements.

8. Hospital-laundered scrub tops, bottoms, and jackets are not to be stockpiled for later use.


10. Hospital-laundered scrubs are to be changed daily and whenever visibly soiled, contaminated, or wet.

11. Hospital-provided scrubs are considered hypoaallergenic.

12. Any needed additional accommodations are to be discussed with Occupational Health.

REFERENCES

   Denver: AORN, Inc.

2. IDPH Administrative Code, Title 77: Public Health, Chapter 1, subchapter b, section 250.1300. IDPH b 
   4(i) and
   IDPH b (1)

HYPERLINK

Bloodborne Pathogen Exposure Policy

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<td>SFMC Policy Steering Committee</td>
<td>Elizabeth Brooks: CHILDRENS SURG PROG MANAGER</td>
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<td>Notification Step</td>
<td>Gayle Lucas: NURSING STANDARDS SPECIALIST</td>
<td>6/20/2019</td>
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DEFINITIONS:

1. **Medical Staff Member**: Physician, Dentist, or Podiatrist who is privileged to provide care in the Hospital and/or who has been granted status as part of the Hospital’s Medical Staff.

2. **Allied Health Professional**: Advanced Practice Nurse, Certified Nurse Specialist, Physician Assistant, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Psychologist, Surgical Technician, Audiologist, and any other provider who has been granted privileges to provide care in the Hospital (some institutions refer to Allied Health Professional as Affiliated Health Professional).

3. **Student Learner**: Medical student, resident, fellow, or nursing student whose educational program involves learning within the Hospital.

4. **Healthcare Professional**: Medical Staff Member, Allied Health Professional, or Student Learner.

PURPOSE:

1. A culture of respect, civility, kindness supports a culture whose atmosphere, discipline and life enables optimal patient experience and helps assures quality and safety. In short, where the OSF Values are consistently embodied in actions and attitudes, teams are able to not only function but flourish.

2. To support teamwork, a positive workplace environment, and effective delivery of safe, compassionate, and quality patient care by promoting:
   a. Professional conduct by all Healthcare Professionals; and
   b. A culture of accessible and safe reporting of professional conduct concerns where such concerns are reliably addressed.

POLICY:

1. Consistent with OSF HealthCare’s mission, values, and organizational policies, all Healthcare Professionals are expected to display Professional Conduct. OSF believes that all persons possess inherent God-given dignity and that respectful, kind and cooperative relationships are a response to human dignity. In addition, respectful relationships are expected by medical and nursing codes of ethics. Therefore, Healthcare Professionals shall do the following: conduct themselves professionally; treat patients, patient family members, visitors. Healthcare Professionals, volunteers, or any OSF HealthCare employee, contractor, administrator, or member of the Board of Directors, and each other with respect; and foster a collaborative work environment that supports team performance. By promoting personal and
team accountability for reporting unprofessional behavior, OSF HealthCare identifies and reliably addresses single occurrences and patterns of behavior and performance that undermine a culture of safety. OSF HealthCare policies and the OSF HealthCare Toolkit for Addressing Behaviors that Undermine a Culture of Safety provide additional guidance. Additionally, all Healthcare Professionals are expected to comply with the OSF HealthCare Code of Conduct, applicable to all Mission Partners.

2. Professional Conduct is demonstrated by the following:
   
a. Treating all persons, including patients, patient family members, visitors, Healthcare Professionals, volunteers, Hospital employees, contractors, administrators, or member of the Board of Directors, with respect, courtesy, kindness, dignity, and a sense of fairness and with recognition of and sensitivity to the needs of individuals from diverse backgrounds.
   
b. Aligning behavior, actions and attitudes to our OSF Mission, Vision, Values and Standards of Performance.
   
c. Communicating openly, respectfully and directly with patients, patient family members, Healthcare Professionals, Hospital employees, and referring providers to optimize health services and to promote mutual trust and understanding.
   
d. Encouraging, supporting, and respecting the rights and the responsibility of all individuals to assert themselves to ensure patient safety and the quality of care, including participation in disclosure as appropriate.
   
e. Resolving conflicts and counseling colleagues in a non-threatening and constructive manner. Collegiality is a hallmark of the healthcare professions; conflict resolution supports professionalism.
   
f. Teaching, conducting research, and/or caring for patients with professional competence, intellectual honesty, and high ethical standards. Promptly reporting any individual who may be impaired in his or her ability to perform assigned responsibilities due to any cause. Professional codes of ethics expect such reporting to protect patients and the integrity of the profession.
   
g. Promptly reporting adverse events and potential safety hazards and encourage colleagues to do the same.
   
h. Willingly participating in investigations of adverse events.
   
i. Exercising personal and/or professional judgment to advocate for patient care interests, the medical profession, community health care needs, and medical staff matters.
   
j. Conveying supportive and constructive feedback in a responsible and appropriate manner.
   
k. Using an effective communication style for the situation, including a direct tone or language in the context of emergent patient care.
   
l. Using social media appropriately.
   
m. Upholding the policies of OSF HealthCare.
   
3. Healthcare Professionals will not behave in a manner that undermines a culture of safety. Further, OSF Leadership embodies their accountability and responsibility to engage such behaviors effectively, efficiently and with integrity, based on our OSF Mission. Authentic service of care and love does not enable, avoid such behaviors, nor does such love abide complicity in the face of such behaviors.
   
4. While this policy provides guidance on how unprofessional conduct should be addressed, it is imperative that each circumstance be individually evaluated. This policy does not prohibit corrective action under the
Medical Staff Bylaws or OSF formal discipline or other action under Human Resources policies as appropriate.

5. This policy uses a staged approach to respond to unprofessional conduct. A staged approach is a progressive approach to managing behavior in which the response is dictated by the behavioral trigger. Generally, Inappropriate Behavior results in a Stage One intervention, while Disruptive Behavior results in a Stage Two or Stage Three intervention (as detailed in OSF HealthCare Toolkit for Addressing Behaviors that are Unprofessional and Undermine a Culture of Safety). Because behavioral problems may occur along a continuum of intensity and frequency, judgment must be used to determine when a higher level and more formal intervention is required to address behavior problems.

6. Inappropriate Behavior and Disruptive Behavior are defined as follows:
   a. Inappropriate Behavior - conduct that is unwarranted and is reasonably interpreted by a reasonably prudent person under similar circumstances to be demeaning or offensive. Persistent, repeated inappropriate behavior will be subject to treatment as Disruptive Behavior.
      i. Examples of Inappropriate Behavior:
         a. Using belittling or berating statements to patients, patient family members, or members of the patient care team;
         b. Using profanity or disrespectful language in a patient care context or environment;
         c. Making inappropriate comments in the medical record.
         d. Failing to respond to simple patient care needs or staff requests;
         e. Lack of cooperation with other members of the patient care team without good cause;
         f. Refusing to return phone calls, pages, or other messages concerning patient care or safety;
         g. Using condescending language that negatively impacts patient care;
         h. Making degrading or disparaging comments regarding a patient, patient family member, visitor, Healthcare Professional, volunteer, or any Hospital employee, contractor, administrator, or member of the Board of Directors; and
         i. Making inappropriate comments on social media.
   b. Disruptive Behavior - abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others. It does not include reasonable behavior by a Healthcare Professional in the context of a care environment that has become unsettled by the behavior of a patient, patient family member, or visitor. (See OSF Policy 603)
      i. Examples of Disruptive Behavior:
         a. Using physically threatening language directed at anyone in the Hospital including a patient, patient family member, visitor, Healthcare Professional, volunteer, or any Hospital employee, contractor, administrator, or member of the Board of Directors;
         b. Making physical contact with a patient, patient family member, visitor, Healthcare Professional, volunteer, or any Hospital employee, contractor, administrator, or member of the Board of Directors that is threatening or intimidating;
         c. Throwing instruments, charts, or other things;
         d. Making threats of violence or retribution against a patient, patient family member, visitor,
Healthcare Professional, volunteer, or any Hospital employee, contractor, administrator, or member of the Board of Directors;

e. Sexual Harassment toward a patient, patient family member, visitor, Healthcare Professional, volunteer, or any Hospital employee, contractor, administrator, or member of the Board of Directors;

f. Other forms of harassment toward a patient, patient family member, visitor, Healthcare Professional, volunteer, or any Hospital employee, contractor, administrator, or member of the Board of Directors, including, but not limited to, repeated frivolous threats of litigation; and

g. Persistent inappropriate behavior.

ii. Harassment - conduct toward others based on their race, color, religion, age, sex (gender), pregnancy, sexual orientation, nationality, ethnicity, military status, or handicap/disability which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating, or otherwise hostile work environment.

a. Examples of Harassment:

i. Negative comments, characterizations, slurs or stereotyping

ii. Threatening, intimidating or hostile acts

iii. Belittling or maligning jokes

iv. Displaying or circulating written or graphic material that belittles, maligns or shows hostility or aversion toward individual or group

iii. Sexual Harassment - 1) demanding sexual favors in exchange for an employment benefit or to avoid a negative employment action or 2) unwelcome sexual advances, requests for sexual favors, or verbal or physical activity which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating, or otherwise hostile work environment.

a. Examples of Sexual Harassment:

i. Deliberate, repeated, unsolicited verbal comments

ii. Sexually oriented pictures, posters, or other material sexually offensive to others (including dissemination of sexually offensive written materials via computer/internet communications or transmission)

iii. Sexual jokes or ridicule

iv. Physical gestures or actions of a sexual physical nature

v. Solicitations for sexual favors

7. Our professional culture of interactions with each other and our patients and their families is built one interaction at a time. OSF strongly believes in the importance of our culture of care and the ongoing work of tremendously dedicated persons to build and sustain our culture. Within OSF Healthcare, a work of the Catholic Church, we have ready access to a number of key sources and foundational texts which convey the preferred and expected vision for our culture and for our individual behaviors while serving within this culture. Each of these sources can be seen as aligning and intersecting and so no one source stands entirely isolated from another. For example, any behavior spoken to above can and should be considered in light of: the Ethical and Religious Directives for Catholic Health Care Services, which will always
represent our core policy; the OSF Code of Conduct; the OSF Mission, Vision and Values and the OSF Standards of Performance, among others. Careful and thoughtful recourse to and deliberation of these texts helps to clearly identify what is accepted and/or preferred in this culture and what it to be rejected.

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- OSF Saint Anthony's Health Center
- OSF Saint Anthony Medical Center
- OSF St. Francis Hospital & Medical Group
- OSF Holy Family Medical Center
- OSF Saint Elizabeth Medical Center
- OSF Saint Luke Medical Center
- OSF Saint Paul Medical Center
- OSF Heart of Mary Medical Center
- OSF Sacred Heart Medical Center

Name as listed with Medicare:

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- SAINT FRANCIS MEDICAL CENTER
- SAINT JAMES HOSPITAL
- ST JOSEPH MEDICAL CENTER
- OSF HEALTHCARE SYSTEM
- SAINT ANTHONY MEDICAL CENTER
- ST FRANCIS HOSPITAL
- OSF HEALTHCARE SYSTEM
- Ottawa Regional Hospital & Healthcare Center
- OSF HEALTHCARE SYSTEM
- Mendota Community Hospital
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- OSF HEALTHCARE SYSTEM

Attachments

- OSF Toolkit for Disruptive Behavior

Approval Signatures

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UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA

Office of Graduate Medical Education

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Approved by: GMEC

Effective Date: 4/12/21

Sub. Revision: 3/19/21
Original Date: June 2005
Sub. Review: 3/15/21
Sub. Review: 4/10/19
Sub. Review: 2/10/17
Sub. Review: 3/11/14
Reviewed Date: 3/1/15

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/fellow physicians must be supervised appropriately to maintain high standards of care, safeguard patient safety, and ensure high quality education.

C. Individual residency/fellowship programs should have written guidelines governing supervision of residents/fellows; 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/fellow physicians must be as available to participate in that care as if residents/fellow were not involved; the presence of residents/fellows 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/fellow 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/fellow physicians who are overly fatigued or otherwise impaired.

F. Each residency/fellowship 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, fellow, and faculty. Each residency/fellowship program, as a part of its supervision policies, has a mechanism for certifying that residents/fellows 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/fellowship programs with their supervision policies through the Institutional Review of Programs (IRP) process. A resident/fellow representative sits on the IRP committee and a resident/fellow 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/fellows are reviewed through the quality assurance mechanism used for all physicians at OSF SFMC and UPHM. If a breakdown occurs, the Residency/Fellowship 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/fellow 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/Fellowship Program Director. If a critical incident occurs during on-call hours and requires an urgent response, the Residency/Fellowship Program Director is contacted immediately.

II. GUIDELINES FOR RESIDENT/FELLOW SUPERVISION AND EVALUATION*

A. Residents/fellows performing patient care activities must always be supervised by an appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable specialty program requirements). When residents/fellows perform patient care activities at hospitals and other institutions accredited by the Joint Commission on Accreditation of Healthcare Organizations, the supervising licensed attending physician (or licensed independent practitioner as specified by the applicable specialty program requirements) must have been granted privileges through the medical staff process.

B. Residents/Fellows may perform technical procedures only when they have been, (a) authorized to do so by the attending physician supervising the resident/fellow, and (b) certified to perform such procedures by the faculty, as represented by the departmental clinical competence committee.

C. Residents/fellows must be supervised by teaching staff in such a way that the residents/fellows assume progressively increasing responsibility according to their level of education, ability, and experience.

D. Supervision of residents/fellows 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/fellow’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, fellow, faculty members, other members of the health care team, and patients.
b) Residents, fellows, 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/fellow can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site, or by means of telecommunications technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident/fellow delivered care with feedback.

The program must demonstrate that the appropriate level of supervision is in place for all residents/fellows based on each resident/fellow’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.

The Program must define when physical presence of a supervising physician is required.

Levels of Supervision

To promote appropriate resident/fellow 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/fellow during the key portions of the patient interaction or, PGY-1 residents must initially be supervised directly, only as described in specialty requirements. The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly. The supervising physician and/or patient is not physically present with the resident and the supervising physician is currently monitoring the patient care through appropriate telecommunications technology.

b) Indirect Supervision:
the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident/fellow for guidance and is available to provide appropriate 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/fellow must be assigned by the program director and faculty members.

a) The program director must evaluate each resident/fellow’s abilities based on specific criteria, guided by the Milestones.

b) Faculty members functioning as supervising physicians must delegate portions of care to residents/fellows, based on the needs of the
patient and the skills of the residents/fellows.

c) Senior residents or fellows should serve in a supervisory role of junior residents/fellows 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/fellows must communicate with the supervising faculty member(s).

a) Each resident/fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

b) 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/fellow and delegate to the resident/fellow 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.
DEFINITIONS:

Confidential Information: Any proprietary or non-public information including, but not limited to, information relating to OSF HealthCare financial information, business transactions, contracts, payment sources, trade secrets, trademarks, research; Protected Health Information (PHI); and information that is protected by policy, law or regulation such as patient, financial, facility and personnel information belonging to OSF and accessible to Mission Partners through the course of their employment.

Protected Health Information: (PHI) is demographic or health information that identifies (or could be used to identify) an individual, and is or was created or received by a health care provider, health plan, employer or health clearinghouse, that relates to the individual’s health or medical condition, provision of health care or payment for health care, which may be transmitted or maintained in any medium.

OSF Information: Any proprietary or non-public information including, but not limited to, information relating to OSF’s financial information, business transactions, contracts, payment sources, trade secrets, trademarks, research, patents, strategic plans, marketing strategies, and similar competitive information.

PURPOSE:

To outline the responsibilities of Mission Partners in maintaining and protecting the confidentiality of patient, personnel, and OSF business information that may be gained as part of their job duties. All Confidential Information must be held in the strictest confidence and not released without the proper authorization, both during and after employment with OSF.

POLICY:

1. Protected Health Information (PHI) is held in strictest confidence.
   
   A. It is the Mission Partner’s professional responsibility not to violate this confidence through indiscriminate discussion/disclosure pertaining to patients and their treatment or progress, co-workers, and OSF business, without proper authorization.

   i. Any unauthorized disclosure of PHI is a violation of the law and may easily cause embarrassment or harm to the patients, OSF HealthCare, its Mission Partners, or other guests and seriously affects our relations with the community.

   ii. Accessing PHI without a need-to-know is a violation of this policy. This includes, but is not limited to, a Mission Partner accessing their own medical record or a family member’s medical
record unless the Mission Partner has gone through the appropriate authorized processes.

B. For more detailed information about the confidentiality and privacy practice requirements, as stated under the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 see the Ministry Compliance "HIPAA Orientation and Confidentiality Statement" policy (CC-307)

2. Accessing OSF personnel or other OSF information without a need-to-know is a violation of this policy. This includes a Mission Partner accessing their own personnel information unless the Mission Partner has gone through the appropriate authorized processes.
   a. Mission Partners must obtain prior authorization before disclosing Confidential Information.
   b. Mission Partners should take all reasonable steps to protect Confidential Information from disclosure, ie. password protecting computers and/or storing/filing confidential paperwork in a locked drawer, etc.
   c. Mission Partners should not electronically forward or store confidential information so as to give access to those without a legitimate need-to-know.

3. Examples of inappropriate actions include, but are not limited, to the following:
   a. Discussion of Confidential Information in open areas (ie. cafeterias, hallways, etc) where individuals without a need-to-know this information could overhear the conversation.
   b. Repeating Confidential Information to friends, relatives, or other outside parties when said information is learned in the course of employment.
   c. Asking co-workers about Confidential Information without a need-to-know.

4. All requests from news media and other organizations for information must be referred to the OSF Marketing department.

5. Mission Partners who disclose Confidential Information without proper prior authorization will be subject to the Positive Discipline Policy and depending on the severity of the violation, may be terminated immediately and subject to a "Do Not Re-Hire" designation in their personnel file.

6. This responsibility does not end when a Mission Partner ends employment with OSF. Mission Partners are also expected to return materials containing Confidential Information at the time of separation from employment and not discuss Confidential Information with their subsequent employer(s) or others.

7. This policy is not intended to restrict Mission Partners communications or actions that are protected or required by state or federal law, including protected rights under Section 7 of the National Labor Relations Act.

REFERENCES:

1. Human Resources Policy #601. Positive Discipline
2. HIPAA Orientation and Confidentiality Statement (CC-307)
3. CC-701. Conflict of Interest and Disclosure Process

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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<tr>
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**Attachments**

No Attachments

**Approval Signatures**

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<td>Education/Communication</td>
<td>Sharon Dyer: Supv HR Support Services</td>
<td>10/27/2020</td>
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<tr>
<td>Executive Steering Committee</td>
<td>Ronda Long: Coord Clinical Policy</td>
<td>10/22/2020</td>
</tr>
<tr>
<td>President, OSF Healthcare</td>
<td>Sister Diane Marie: President-Sister</td>
<td>10/13/2020</td>
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<td>HR SVP and VPs</td>
<td>Stephanie McCarthy: HR Compliance Officer</td>
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<td>Notification</td>
<td>Stephenie McCarthy: HR Compliance Officer</td>
<td>9/8/2020</td>
</tr>
</tbody>
</table>
Websites & Social Media (143)

DEFINITIONS:

Website: Any public-facing collection of information on the Internet.

Social Media: Any website or mobile application that allows for open two-party communication and sharing of information on the Internet including, but not limited to:

a. Social Networking Sites (i.e., LinkedIn, Facebook, Yammer);
b. Micro-blogging Sites (i.e., Twitter);
c. Blogs (including company and personal blogs);
d. Video and photo-sharing websites (i.e., YouTube, Flickr, Instagram, Snapchat)

PURPOSE:

1. To provide guidelines to all Mission Partners, volunteers, and students who create, purchase, develop or manage websites or participate in the use of social media on behalf of OSF HealthCare.

2. Mission Partners’ management of websites and social media can pose risks to OSF-owned confidential and proprietary information, reputation and brands, can expose the organization to discrimination and harassment claims and can jeopardize the organization’s compliance with business rules and laws.

3. To minimize these business and legal risks, to avoid loss of productivity and distraction from Mission Partners’ job performance, and to ensure that IT resources and communications systems are used appropriately, OSF expects its Mission Partners to adhere to the following guidelines and rules regarding the creation, purchase, development and management of websites and social media.

4. This policy is not intended to restrict communications or actions protected or required by state or federal law.

POLICY:

1. The same principles and guidelines found in all OSF policies apply to your activities online.

2. Harassment, bullying, discrimination or retaliation that would not be permissible in the workplace is not permissible between co-workers on websites and social media.

3. Mission Partners may be personally legally responsible for defamatory, obscene, or libelous statements made on websites and social media.
4. Abusive language, hate speech and personal attacks of any kind on websites are grounds for immediate and permanent suspension of access and subject to Positive Discipline.

5. Unless explicitly given permission to do so by Ministry Marketing and Communications, do NOT create, purchase, develop or manage websites on behalf of OSF nor represent yourself as a spokesperson for OSF. This includes establishing social media accounts using OSF entity names and branding.

6. Limit the use of social media during working hours to that which is work-related and authorized by your Leader.

7. Caregivers are discouraged from interacting with patients and their families on Social Media to comply with HiPAA and maintain professional boundaries and the therapeutic relationship.

8. Mission Partners' content should be accurate when developing website and social media content. Never post any information or rumors that you know to be false about OSF, its Mission Partners, or its patients.

9. Mission Partners should refrain from endorsing or promoting any personal opinion, cause or political candidate on any OSF website, except as specifically permitted by Section 7 of the National Labor Relations Act.

10. Mission Partners should only express personal opinions, recommendations or endorsements on external social media. Where your connection to OSF is apparent, make it clear that you are speaking for yourself and not on behalf of OSF. In those circumstances, you should include this disclaimer: "The views expressed on this [blog; website] are my own and do not reflect the views of my employer." If the site has an "About me" section, add the above disclaimer to your blog or social media profile.

11. Internal social media, such as Yammer and blogs, is to be used for noncommercial purposes only.

12. Do not share confidential or proprietary information that you acquire in the course of your employment with OSF on an OSF website. Examples of confidential or propriety information include protected health information (as defined by HiPAA), information about prospective OSF business plans, trade secrets, systems, processes, products, know-how, technology, internal reports, procedures, or other internal business-related confidential communications. Maintain patient privacy as required by HiPAA and all other relevant rules, regulations and policies. Be aware that protected health information includes any information that could be used to identify a patient, such as a diagnosis, a procedure or a room number, even if the patient's name is not used.

13. Respect all copyright and other intellectual property laws. For the protection of OSF, as well as yourself, it is critical that you show proper respect for the laws governing copyright, fair use of copyrighted material owned by others, trademarks and other intellectual property, including OSF-owned copyrights, trademarks, and brands.

14. Mission Partners are solely responsible for their individual content posted to websites.
   a. OSF reserves the right, in its sole discretion, to disallow the use of a particular website or to terminate any user's access at any time;
   b. OSF reserves the right to remove any content that Mission Partners post to an OSF website.

15. The Director of Digital Marketing and the Chief Security Officer must approve Internet domain, Secure Sockets Layer (SSL) certificate and hosting service purchases.

REFERENCES:
1. Marketing Policies and Procedures
2. Human Resources Policies and Procedures
3. **Electronic Communications policy (104)**
4. **Standards of Conduct policy (604)**
5. **OSF Compliance policies**

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>Education/Communication Step</td>
<td>Sharon Dyer: SUPV HR SUPPORT SERVICES</td>
<td>8/23/2019</td>
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<td>Board of Directors</td>
<td>Danielle McNear: EXECUTIVE ASSISTANT</td>
<td>8/19/2019</td>
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<td>President, OSF HealthCare</td>
<td>Sister Diane Marie: PRESIDENT</td>
<td>7/29/2019</td>
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<tr>
<td>Senior VP, Human Resources</td>
<td>Sharon Dyer: SUPV HR SUPPORT SERVICES</td>
<td>7/29/2019</td>
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<td>HR Executive Directors</td>
<td>Stephanie McCarthy: HR COMPLIANCE OFFICER</td>
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<td>Director, Digital Marketing</td>
<td>Michael Vujovich: DIR DIGITAL MARKETING</td>
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<tr>
<td>Policy Review Group</td>
<td>Marci Fletcher: RESOURCE DOCUMENT SPECIALIST</td>
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The University of Illinois College of Medicine Peoria

Summary of Salaries and Benefits for Residents/Fellows
based at OSF Saint Francis Medical Center (OSF SFMC)

Salaries for the 2021-2022 Academic Year

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<th>TL-1</th>
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<td>$70,483</td>
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**Educational Allowance:** Residents receive an annual education allowance of $1,200, which provides reimbursement for education-related purchases that have been pre-approved by the program director.

**Temporary Medical License:** Residents receive a reimbursement of $230 for fees paid to obtain a temporary medical license.

**Tuition for Advanced Life Support Courses:** Fees for the Advanced Cardiac Life Support Course, and other required advanced life support courses, are paid by OSF SFMC.

**Practice Management Course:** A free course is provided to senior residents and their spouses/significant others.

**Financial Assistance for Outside Rotations:** Residents receive financial assistance to help defray the costs of obtaining housing and parking associated with performing required rotations outside the Peoria area. The amount provided is usually sufficient to cover the costs. Residents who drive to required off-campus rotations that are greater than 20 miles from Peoria receive a travel allowance.

**Vacations:** Residents receive three (3) weeks of Paid Time Off per year, i.e., 15 week days and 6 weekend days per year.

**Professional Leave:** TL-2 and above residents receive a maximum of seven (7) days off per year to attend professional meetings approved by the program director.

**Family and Medical Leave of Absence:** Residents who have been employed by OSF for at least one year and who have a qualifying event may take a maximum of twelve (12) weeks of family/medical leave in a twelve (12) month period. Qualifying events include the birth of a child, and to care for a child; the placement of a child for adoption or foster care; the need to care for a seriously ill spouse, child, or parent; or a serious health condition that prevents the employee from performing the functions of the job.
Sick Leave (Sick Protection Hours): TL-1 through TL-4 residents receive a total of 120 hours (15 days) of sick protection hours. TL-5 and above residents receive a total of 160 hours (20) days of sick protection hours.
*Per Sick Leave Policy

Bereavement Leave: Residents may receive three (3) days of bereavement leave for the death of a parent, step-parent, or parent-in-law, sibling, step-sibling, spouse, or child.

Professional Liability Insurance: Residents are provided with professional liability insurance that protects them from exposure to liability arising from the performance of residency program duties. This coverage is provided on an “occurrence basis.” Liability limits for an individual resident are $1,000,000 per person, $3,000,000 per occurrence. This coverage does not protect the resident when engaged in professional activities outside the prescribed training program.

Medical and Dental Insurance: Comprehensive medical and dental group health insurance is available to residents and their eligible dependents from either the OSF Quality Care Plan or the OSF High Deductible Health Plan. This benefit is provided on a cost-shared basis, with OSF paying the majority of the cost.

Counseling and Psychological Support Services: Residents may receive up to four (4) sessions per year of confidential professional problem assessment, consultation, or counseling at no cost to them through the OSF HealthCare Employee Assistance Program. Residents are also eligible for psychological services provided through their OSF Medical Insurance program.

Disability Insurance: Residents receive both short-term and long-term disability insurance. The cost of this insurance is paid by OSF SFMC.

Life Insurance: OSF SFMC provides residents with life insurance and accidental equal to 150% of the annual salary, to a maximum of $60,000.

Accidental Death & Dismemberment Insurance: OSF SFMC provides residents with accidental death and dismemberment insurance equal to 150% of the annual salary, to a maximum of $60,000.

Meals: While on duty residents are provided with meals at the SFMC Main Cafeteria.

Uniform Coats and Laundry: Uniform coats are supplied and laundered without cost to the residents.

Parking: Parking in designated areas is provided to residents at no charge.

YMCA Privileges: Membership in the Peoria YMCA is provided as a benefit to residents and their spouses and children.

Additional information about our residency programs and OSF Saint Francis Medical Center can be obtained on the following web sites:

- [http://go.illinois.edu/peoriaGME](http://go.illinois.edu/peoriaGME)
- [http://www.osfsaintfrancis.org](http://www.osfsaintfrancis.org)
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 sponser 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.
Nursing Mothers in the Workplace

PURPOSE:

OSF Healthcare is committed to providing a workplace environment that supports mothers who choose to continue nursing or expressing milk after their return to work.

POLICY:

1. In compliance with applicable state and federal laws, OSF will provide a Mission Partner with reasonable break time to express breast milk for their nursing child for one year after the child’s birth.

2. Any Mission Partner wishing to express breast milk for their infant after her return to work should notify their Leader so that the department may make the necessary arrangements.

3. Any Mission Partner making such a request will want to consider what may be required to complete their work, given their role and the demands on their time. The Mission Partner should discuss the department’s accommodations and the break schedule with their Leader to ensure the Mission Partner’s request may be accommodated.

4. Leaders who receive a request for an accommodation to express milk shall take the necessary steps to ensure a nursing Mission Partner is provided:
   a. a reasonable break time, and
   b. a private location, other than a restroom, that is shielded from view and free from intrusion of others, to express milk.

5. All requests for an accommodation to express milk shall be granted unless the break would create an undue hardship as defined by the Illinois Human Rights Act. This determination will be made by the Leader.

6. The Mission Partner must work with her Leader to schedule the appropriate break time. OSF recognizes the nursing needs of every mother are different, but the following are general guidelines:
   a. The break time must, if possible, run concurrently with break times already provided to the Mission Partner.
   b. In general, a Mission Partner will be provided 20 to 30 minutes per break. This time includes actual expressing milk and additional time to set-up and take down equipment, as well as washing equipment and storing milk. Many mothers need to express every 2 to 4 hours. Therefore it is contemplated that in an average 8 hour work day, a break would be taken in the morning, at lunch and in the afternoon. Mission Partners working a 12 hour shift may need one or two additional breaks.
c. The policy is meant to allow Mission Partners a reasonable amount of time to express milk. Thus, if a Mission Partner's circumstance requires a longer amount of time expressing/pumping, the Mission Partner should request additional time through their department Leader.

7. Both exempt and non-exempt Mission Partners will be compensated for the reasonable time needed to express milk.
   a. Non-exempt Mission Partners must, if possible, utilize their unpaid meal break to express milk. They will not be compensated for this time.

8. Expressed milk may be placed in personal coolers or Mission Partner refrigerators, but must be kept in a leak-proof container. If placed in an Mission Partner refrigerator, the Mission Partner should label the container of breast milk with their name and store it on the lowest level of the refrigerator in case of a leak.

9. Mission Partners must provide, maintain, and clean their own breast pumps and equipment.

REFERENCES:

1. *Meal and Break Period policy* (119)

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. Specifically, this policy applies to:

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<tr>
<th>Facility Name</th>
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<td>OSF Saint James – John W. Albrecht Medical Center</td>
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**Attachments**

No Attachments
## Approval Signatures

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<td>Sharon Dyer: SUPV HR SUPPORT SERVICES</td>
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<tr>
<td>Board of Directors</td>
<td>Danielle McNear: EXECUTIVE ASSISTANT</td>
<td>3/19/2019</td>
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<tr>
<td>President, OSF Healthcare System</td>
<td>Sister Diane Marie: PRESIDENT</td>
<td>2/28/2019</td>
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<tr>
<td>Senior VP, Human Resources</td>
<td>Sharon Dyer: SUPV HR SUPPORT SERVICES</td>
<td>2/28/2019</td>
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<tr>
<td>HR Executive Directors</td>
<td>Stephanie McCarthy: HR COMPLIANCE OFFICER</td>
<td>2/27/2019</td>
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<td>HR Employee Relations Directors/OSF Legal Services</td>
<td>Stephanie McCarthy: HR COMPLIANCE OFFICER</td>
<td>2/27/2019</td>
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