HOUSE STAFF MANUAL

UNIVERSITY OF ILLINOIS COLLEGE
OF MEDICINE AT PEORIA

RESIDENCY AND FELLOWSHIP PROGRAMS
BASED AT
UNITY POINT HEALTH-METHODIST

Academic Year
2021 – 2022
HOUSE STAFF MANUAL

UNIVERSITY OF ILLINOIS COLLEGE
OF MEDICINE AT PEORIA

RESIDENCY AND FELLOWSHIP PROGRAMS
BASED AT
UNITY POINT HEALTH- METHODIST

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., Chairman
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 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) Unity Point Health-Methodist

a. Mission Statement
The mission of the University of Illinois College of Medicine at Peoria Residency/Fellowship Programs at Unity Point Health-Methodist is to train high quality physicians who will serve as providers of health care appropriate to the patient and community needs including those in the greater Peoria area, the central Illinois region, the state of Illinois, and the Midwest.

b. Unity Point Health-Methodist Mission Statement
We are committed to delivering outstanding healthcare. Period. We are committed...We work to make a positive difference. We use our talents, skills and expertise as healthcare providers and as community leaders to improve the quality of life for area people. To Delivering...We assist the people of our community when, where, and how they need it. We deliver healthcare to patients and their families to all people regardless of age, gender, race, religion, social status, or ability to pay. Outstanding healthcare...The right care, at the right time, in the right setting, at the right cost, with the best possible outcome. We are successful when what we do makes things better for people, improving the health and well-being of body, mind and spirit. Period...No excuses, no wavering, no distractions. This is simply what we do.

c. Unity Point Health Corporation Vision Statement
Unity Point Health System’s vision statement, "Best Outcome Every Patient Every Time," succinctly highlights the work we’re doing every day.

3) 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. A genuine compassion for the patient, and

b. A commitment to teaching.

OSF SFMC House Staff is composed of all postgraduate physician trainees participating in UICOMP sponsored residency/fellowship programs, which are based at OSF SFMC. Residents/fellows are made full partners in this tradition of compassion and commitment to teaching.

4) Post Graduate Year (PGY and TL years)

The Post Graduate Year designates the number of levels through which a resident/fellow progresses and is promoted within the residency/fellowship program. For example, first year residents are designated as PGY-1 until completion of all requirements for promotion to the second, or PGY-2 level. The steps on the graduated salary scale are organized according to these PGY levels.

The training level (TL) 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 UPHM 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, UPHM, and the residents/fellows. 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 AND BASED AT UNITY POINT HEALTH METHODIST

<table>
<thead>
<tr>
<th>Program</th>
<th>Length of Program (years)</th>
<th>Approved Positions (number)</th>
<th>Accreditation Status by ACGME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>3</td>
<td>30</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>4</td>
<td>16</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Family Medicine Obstetrics</td>
<td>1</td>
<td>2</td>
<td>N/A</td>
</tr>
</tbody>
</table>

N/A, Programs for which the ACGME has no accreditation process
D. 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>
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<tbody>
<tr>
<td>Breast Imaging Fellowship¹</td>
<td>1</td>
<td>2</td>
<td>N/A</td>
</tr>
<tr>
<td>Cardiovascular Disease Fellowship¹</td>
<td>3</td>
<td>9</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Medicine-Pediatrics¹</td>
<td>4</td>
<td>32</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Diagnostic Radiology¹</td>
<td>5</td>
<td>20</td>
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</tr>
<tr>
<td>Emergency Medicine¹</td>
<td>3</td>
<td>42</td>
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</tr>
<tr>
<td>Family Medicine²</td>
<td>3</td>
<td>30</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Gastroenterology Fellowship¹</td>
<td>3</td>
<td>9</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Hospice/Palliative Care Fellowship¹</td>
<td>1</td>
<td>2</td>
<td>Initial Accreditation</td>
</tr>
<tr>
<td>Internal Medicine-C¹</td>
<td>3</td>
<td>36</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Internal Medicine-P¹</td>
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<td>4</td>
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</tr>
<tr>
<td>Transitional¹</td>
<td>1</td>
<td>12</td>
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<tr>
<td>Neonatal-Perinatal Fellowship¹</td>
<td>3</td>
<td>6</td>
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<tr>
<td>Neurological Surgery³</td>
<td>6</td>
<td>10</td>
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<tr>
<td>Neurology¹</td>
<td>4</td>
<td>16</td>
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<tr>
<td>Neuroradiology Fellowship¹</td>
<td>1-2</td>
<td>2</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Obstetrics/Gynecology³</td>
<td>4</td>
<td>12</td>
<td>Continued Accreditation</td>
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<tr>
<td>Pediatrics-C¹</td>
<td>3</td>
<td>30</td>
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<tr>
<td>Pediatric Hospital Med. Fellowship¹</td>
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<td>Initial Accreditation</td>
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<tr>
<td>Psychiatry²</td>
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<td>16</td>
<td>Continued Accreditation</td>
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<tr>
<td>Pulmonary/Critical Fellowship¹</td>
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<tr>
<td>Simulation Fellowship¹</td>
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<td>Surgery-C¹</td>
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<tr>
<td>Interventional Radiology Residency¹</td>
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<td>2</td>
<td>Continued Accreditation</td>
</tr>
<tr>
<td>Family Medicine Obstetrics Fellowship²</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>Ultrasound (POCUS) Fellowship¹</td>
<td>1</td>
<td>1</td>
<td>N/A</td>
</tr>
</tbody>
</table>

¹ Based at OSF SFMC
² Based at UnityPoint Health Methodist
³ Based at OSF SFMC with certain rotations performed at Unity Point Health Methodist
⁴ Full Accreditation includes ACGME Osteopathic Recognition Track
C, Categorical
P, Preliminary
N/A, Programs for which the ACGME has no accreditation process
<table>
<thead>
<tr>
<th>Area</th>
<th>Chair/Head</th>
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</thead>
<tbody>
<tr>
<td>Cancer Biology and Pharmacology &amp; Pharmacology</td>
<td>Marcelo Bento Soares, Ph.D. (Head)</td>
</tr>
<tr>
<td></td>
<td>Professor</td>
</tr>
<tr>
<td></td>
<td>Senior Associate Dean for Research</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Joshua Kentosh, M.D. (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 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>Assoc. Professor of Clinical Family Practice</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>Medicine/Pediatrics</td>
<td>Matthew Mischler, M.D. (Director)</td>
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<tr>
<td></td>
<td>Clinical Professor of Medicine</td>
</tr>
<tr>
<td></td>
<td>Clinical Professor of Pediatrics</td>
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<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>
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<tr>
<td>Neurosurgery</td>
<td>Jeff Klopfenstein, M.D. (Head)</td>
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<tr>
<td></td>
<td>Associate Professor of Clinical Neurosurgery</td>
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<td></td>
<td>Associate Professor of Clinical CBP</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>Steven Thompson, M.D. (Interim Chair)</td>
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<tr>
<td></td>
<td>Assistant Professor of Clinical Ob/Gyne</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Manu Sood, M.D. (Head)</td>
</tr>
<tr>
<td></td>
<td>William H. Albers Professor</td>
</tr>
<tr>
<td></td>
<td>Professor, Cancer Biology and Pharmacology</td>
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<tr>
<td>Psychiatry and Behavioral Medicine</td>
<td>Ryan Finkenbine, M.D. (Chair)</td>
</tr>
<tr>
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<td>Professor of Clinical Psychiatry</td>
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<tr>
<td>Radiology</td>
<td>Sean Meagher, M.D. (Chair)</td>
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<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>
</tbody>
</table>
F. **UPHM DEPARTMENT CHAIR ROSTER WITH UICOMP APPOINTMENTS**

Active Medical and Dental Staff Officers:
- Jeff Leman, M.D.  
  President  
  Visiting Associate Professor of Clinical Family Medicine
- Alex Alonso, M.D.  
  President – Elect  
  Clinical Assistant Professor of Family and Community Medicine

Anesthesiology  
Adrian Costin, M.D. (Chair)

Emergency Medicine  
Nathan Fredrick, D.O. (Chair)

Family Medicine  
Asim Jaffer, M.D. (Chair)  
Clinical Assistant Professor of Family and Community Medicine

Internal Medicine  
Brian Cohen, M.D. (Chair)

Obstetrics and Gynecology/Pediatrics  
Tamara Olt, M.D. (Chair)  
Clinical Assistant Professor of Ob/Gyne

Pathology  
Elizabeth Bauer-Marsh, M.D. (Chair)  
Clinical Assistant Professor of Pathology

Psychiatry and Behavioral Medicine  
Andrew Lancia, M.D. (Chair)  
Associate Professor of Clinical Psychiatry

Radiology  
David Nathan, M.D. (Chair)  
Clinical Assistant Professor of Radiology

Surgery  
Eric Elwood, M.D. (Chair)  
Associate Professor
G. **UICOMP RESIDENCY/FELLOWSHIP PROGRAM DIRECTORS**

<table>
<thead>
<tr>
<th>Program</th>
<th>Director</th>
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<tbody>
<tr>
<td>Graduate Medical Education Office</td>
<td>Francis McBee Orzulak, M.D.</td>
</tr>
<tr>
<td></td>
<td>Designated Institutional Official</td>
</tr>
<tr>
<td></td>
<td>Michelle Shearhod, Accreditation Coordinator</td>
</tr>
<tr>
<td></td>
<td>Lisa Lovett, Institutional Coordinator</td>
</tr>
<tr>
<td>Breast Imaging Fellowship</td>
<td>Jessica Guingrich, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Associate Professor of Radiology</td>
</tr>
<tr>
<td>Cardiovascular Disease Fellowship</td>
<td>Sudhir Mungee, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Associate Professor of Medicine</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>Terrance M. Brady, M.D.</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>Professor of Clinical Radiology</td>
</tr>
<tr>
<td></td>
<td>Professor of Clinical Surgery</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>John Hafner, M.D.</td>
</tr>
<tr>
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<td>Clinical Professor of Emergency Medicine</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>Jeff Leman, M.D.</td>
</tr>
<tr>
<td></td>
<td>Visiting Associate Professor of Clinical Family Medicine</td>
</tr>
<tr>
<td>Gastroenterology Fellowship</td>
<td>Sonu Dhillion, M.D.</td>
</tr>
<tr>
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<td>Clinical Associate Professor of Medicine</td>
</tr>
<tr>
<td>Hospice/Palliative Medicine</td>
<td>Tayyaba Irshad, M.D.</td>
</tr>
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<td>Clinical Assistant Professor of Medicine</td>
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<tr>
<td>General Surgery</td>
<td>Steven Tsoraiades, M.D.</td>
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<tr>
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<td>Associate Professor of Clinical Surgery</td>
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<tr>
<td>Internal Medicine</td>
<td>Peter Phan, M.D.</td>
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<td>Associate Professor of Clinical Medicine</td>
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<tr>
<td>Transition Year</td>
<td>Sidney Palmer Hill, M.D.</td>
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<tr>
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<td>Assistant Professor of Clinical Medicine</td>
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<td>Assistant Professor of Clinical Pediatrics</td>
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<tr>
<td>Medicine-Pediatrics</td>
<td>Matthew Mischler, M.D.</td>
</tr>
<tr>
<td></td>
<td>Clinical Professor of Medicine</td>
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<tr>
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<td>Clinical Professor of Pediatrics</td>
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<td>Neonatal-Perinatal Fellowship</td>
<td>Jawad Javed, M.D.</td>
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<td>Associate Professor of Clinical Pediatrics</td>
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<td>Neurology</td>
<td>Greg Blume, M.D.</td>
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<td>Clinical Associate Professor of Neurology</td>
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</table>
Neuroradiology Fellowship  Lawrence Wang, M.D.
Clinical Assistant Professor of Radiology

Neurosurgery  Julian Lin, M.D.
Associate Professor of Clin. Neurosurgery

Obstetrics/Gynecology  Rayan Elkattah, M.D.
Assistant Professor of Clinical Ob/Gyne

Pediatrics  Bhavana Kandikattu, M.D.
Associate Professor of Clinical Pediatrics

Pediatric Hospital Med. Fellowship  Harleena Kendhari, M.D.
Assistant Professor of Clinical Pediatrics

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

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

Simulation Fellowship  John Vozenilek, M.D.
Professor of Clinical Emergency Medicine
   Duane & Mary Cullinan Professorship of Simulation Outcomes

Family Medicine Obstetrics Fellowship  Rahmat Na’Allah, M.D.
Professor of Clinical Family Medicine

Ultrasound (POCUS) Fellowship  Joe Peters, D.O.
Clinical Assoc. Professor of Emerg. Med.

H. 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. Ongoing 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 GMEC that identifies any significant, recurring exceptions to the duty hour requirements. Such reports will include the description of a 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 programs 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-off.
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-physician members of the healthcare team preferably 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. Alertness Management and Fatigue Mitigation

Responsibilities of the Program Director and Attending Physician:

The Program Director must educate all faculty, fellows and residents to recognize the sign of fatigue and sleep deprivation. (See Section II.H.5.p.)

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 demonstrate 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.

I. FACULTY

At each participating site, there must be a sufficient number of faculty member 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; an 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;
- Participation in national committees or educational organizations.

Faculty should encourage and support residents/fellows in scholarly activities.

J. 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.

K. ASSOCIATE DEAN FOR GRADUATE MEDICAL EDUCATION

The Associate Dean for Graduate Medical Education (GME) is the Designated Institutional Official (DIO) at UICOMP. The DIO, in collaboration with the Graduate Medical Education Committee (GMEC), has authority and responsibility for the oversight and administration of each of the Sponsoring Institution’s ACGME-accredited programs, as well as for ensuring compliance with the ACGME Institutional, Common, and specialty/subspecialty-specific Program, 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; overseeing submissions of the Annual Update for each program and Sponsoring Institution to the ACGME; approving all letters of agreement (PLAs); 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.
L. CHIEF RESIDENT

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

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

3) The Chief Resident(s) may be contacted directly concerning minor complaints regarding the specific Residency Program and/or for Resident-Resident; Resident-Attending; and Resident-Teaching Faculty issue within a program.

M. UICOMP GME ADMINISTRATIVE COUNCIL

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

2) Functions. The Administrative Council shall be responsible for:

   a. The establishment and administration of financial policies for GME, including, but not limited to:
      1) Funding of Required Away Rotations
      2) Inter-institutional financial agreements between participating hospitals for resident/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.

N. GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)

1) Charge to the Committee: The Graduate Medical Education Committee (GMEC) is appointed by the Regional Dean of the University of Illinois College of Medicine at Peoria (UICOMP) together with the DIO. The GMEC provides oversight and to coordinate 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 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 Associate to the Chief Medical Officer at UPHM. All actions of the Committee are based on simple majority. The GMEC Chairman votes only in case of a tie. A majority of the membership 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. Subcommittees that address required GMEC responsibilities. (Note such subcommittees must include 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 implements 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 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 Institutions 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/fellows for exceptions of resident clinical and educational work 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, fellows, 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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<tr>
<th>TOPIC</th>
<th>Notice Only</th>
<th>Approval Required</th>
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<tr>
<td>Program Directors 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>Experimentation and Innovations</td>
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<td>Advancement Recommendations</td>
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### Resident/Fellow Benefits

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### 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.  Assistant Prog. Director, Alternate
- Mary Stapel, M.D.  Assistant 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 Year:**
- Sidney Palmer Hill, M.D.  Program Director

**Neonatal-Perinatal Fellowship**
- Jawad Javed, M.D.  Program Director
- Ashley Fischer, M.D.  Associate 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.  Interim Department Chair
Neelam Verma M.D.  Assoc. PD, Alternate

Pediatrics:
Bhavana Kandikattu, M.D.  Program Director
Mnau Sood, M.D.  Interim Department Head
Michele Beekman, M.D.  Associate PD, Alternate
Amy Christison, M.D.  Assistant PD, Alternate
Zohra Moenuddin, M.D.  Assistant PD, Alternate

Pediatric Hospital Medicine Fellowship
Leena Kendhari, M.D.  Program Director
Nadia Shaikh, M.D.  Associate Program 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.  Associate Program 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, MMC-I Chief Resident
Anjani Hagan, MD  TL-3, Family Medicine, MMC-I Chief Resident
Jonathan Rubenstein, M.D.  TL-4, Psychiatry, MMC-I 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
Samer Sader, M.D.  Associate Chief Medical Officer, UPHM
Jessica Hanks, M.D.  Interim Associate Dean of Academic Affairs
Kevin Wombacher, PhD  Asst. Dean for Med. Education and Evaluation
II. INSTITUTIONAL RESPONSIBILITIES

A. COLLABORATIVE NATURE OF GRADUATE MEDICAL EDUCATION

A major affiliation agreement between the Unity Point Health Methodist and the University of Illinois College of Medicine at Peoria establishes that all graduate medical education programs at UPHM 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 UPHM 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/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 UPHM and their enrollment in a residency/fellowship program, residents/fellows must remain in good standing with both institutions.

B. UICOMP/UPHM General Policies:

1. Name badges must be displayed at all times

2. Residents/fellows must comply with the UPHM dress code (see Appearance and Dress Code, section M.6. and in the UPHM Employee Handbook).

3. Residents/fellows must comply with the rules concerning vendor gifts and tokens, as specified in the UICOMP Relationships with Industry (see Policy Manual) and in the UPHM Employee Handbook.

4. The use of intoxicating substances or drug abuse and/or the condition of being under the influence of these substances on UPHM, SFMC, or UICOMP premises while on duty is strictly forbidden and may result in suspension or dismissal. The UPHM Substance Abuse policy is detailed in the UPHM Employee Handbook.

5. Individual residents/fellows that have been deemed responsible for careless or willful misuse of UPHM, SFMC, or UICOMP property will be assessed for the damages and may be subject to disciplinary action.

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 UPHM) and off site rotations as mandated by the ACGME.

2. UICOMP, together with its education partner UPHM, 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 UPHM, is committed to providing Graduate Medical Education (GME) that facilitates resident/fellow’s professional, ethical, and personal development. UICOMP and UPHM, 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 UPHM, ensures that the DIO and the GME Program Directors have sufficient financial support and protected time to 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 UPHM 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 UPHM 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/fellow 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 UPHM, 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 UPHM, 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 UPHM ensures that:

   i. 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;

   ii. support for core faculty members to ensure both effective supervision and quality resident/fellow education;

   iii. the presence of other learners and other care providers, including, but limited to residents from other programs, subspecialty fellows, 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.

   iv. the DIO, program director and core faculty members support for professional development applicable to their responsibilities as educational leaders;

   v. support and time for the program coordinator(s) to effectively carry out his/her responsibilities; and

   vi. resources, including space, technology, and supplies, are available to provide effective support for each of its ACGME-accredited programs.

16. There are effective transitions of Care: (Refer to H.1.)

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

1. UPHM 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 UPHM 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) and UPH have 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 residents 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 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 ACMGE-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, vacations, leave 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 or Osteopathic 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 a 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-I, 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.

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

iii. Verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification;

iv. 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 UPHM 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 compliment 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

UPHM 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 programs.

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 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 for hospital scrubs 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. for additional information regarding benefits provided for house staff).

H. AGREEMENT OF APPOINTMENT

1. UICOMP/UPHM 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 UPHM HealthCare System.

3. UICOMP/UPHM 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 DIOs 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 the latter circumstance, residents/fellows will receive 
         as much written notice, prior to the end of their contract, as the 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 UPHM grievance procedure to appeal a contract non-renewal.

e. Grievance Procedures and Due Process

UICOMP/UPHM 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/UPHM provides residents/fellows with professional liability coverage and with a summary of pertinent information regarding this coverage (described in Benefits, section IV.A.11.).

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.11.).

g. Health and Disability Insurance

UICOMP/UPHM provides hospital and 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 UPHM policy for employees. UICOMP/UPHM 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.10.). 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/UPHM has institutional policies on resident/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.-5.).
2) UICOMP/UPHM ensures that each program provides residents/fellows with:

i. Access to Program Requirements concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency/fellowship program and;

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

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

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 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 clinical and educational work requirements to 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 making 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/UPHM 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/UPHM will ensure that resident/fellow are provided with access to confidential counseling, and medical and psychological support services (see Resident/Fellow Health Policies III.L.3-4. and Benefits, section IV.A.12.).

m. Physician Impairment

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

n. Harassment

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

o. Discrimination

UICOMP/UPHM 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 and UPHM 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 or program support staff 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.L.);
7) Program transfer; (see section III.M.);
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.N.8.).

r. Closures and Reductions

UICOMP/UPHM 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, UPHM, to close or reduce the size of a residency/fellowship program will not be accomplished by attrition, i.e., by reducing the number of new residents/fellows accepted into the program. UICOMP/UPHM will continue to support the residency/fellowship program until all current residents/fellows have completed the program. Note: 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/fellow will be informed about any decision on the part of UICOMP/UPHM 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/UPHM 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 Clinical Competency Committee. The House Staff President and one of the Unity Point Health Methodist Chief Residents are *ex officio*, voting members of the GMEC. The House Staff President sits on the Professional Staff Quality Improvement Committee and Quality Safety Board of OSF SFMC and 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 Unity Point Health 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 UPHM, 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/UPHM 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/UPHM 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 inter-
   professional quality improvement activities. This should include
   activities aimed at reducing health care disparities.

2. **Supervision and Accountability**:
   UICOMP and its educational partners have guidelines for the supervision of
   residents/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/UPHM, 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/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/fellows, 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 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.
   b. Initially, TL-1 residents must be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which TL-1 residents progress to be supervised indirectly with direct supervision available.]

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

B. Professionalism

1. Programs, in partnership with UICOMP/UPHM, 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

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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/UPHM, 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/UPHM, have the same responsibility to address well-being and 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,
1. 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/UPHM, 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/UPHM 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/fellows 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’s 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 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/UPHM, 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/UPHM, 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. Hand-offs should include non-physician members of the healthcare team such as nurses whenever possible.

F. **Clinical Experience and Education**

Programs, in partnership with UICOMP/UPHM, 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’s 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.K.). Mechanisms which facilitate achievement of an appropriate work environment for the resident/fellows include:

   a. Meetings of the OSF House Staff President and with UPHM resident representatives and 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. An annual meeting of the OSF House Staff President with all residents/fellows which serves as an open forum where resident/fellow concerns may be expressed.

2. UICOMP’s educational partner, UPHM, provides services and has developed a health care delivery system to minimize resident/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.

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

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

e. Quality Improvement: access to data to improve systems of care, reduce healthcare disparities, and improve patient outcomes. Residents/fellows can participate in the Resident/Fellow 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, UPHM, ensures a healthy and safe work environment that provides for:

a. Food services: Food from the UPHM Cafeteria is provided free of charge to residents/fellows while on duty. Food is not to be provided by residents/fellows to other persons. Residents/fellows are expected to be reasonable regarding the quantity of food taken per meal.

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.

d. Accommodations for residents/fellows with disabilities consistent with 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 resident/fellow progress on achievement of the specialty-specific Milestones;
         c) Meet prior to the resident/fellow 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 resident/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’s 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/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
   a. At least annually, the program must evaluate faculty performance as it relates to the educational
      program.
   b. 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.
   c. This evaluation must include at least annual written, anonymous, and confidential evaluations by
      the residents/fellows.
   d. Faculty members must receive feedback on their evaluations at least annually.
   e. Results of the faculty educational evaluations should be incorporated into program-wide faculty
      development plans.

6. Program Evaluation and Improvement
   a. The program director must appoint the Program Evaluation Committee (PEC) to conduct and
      document the Annual Program Evaluation as part of the program’s continuous improvement
      process.
      The Program Evaluation Committee:
      i. 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;
      ii. Must have a written description of its responsibilities; and should participate actively in:
         a) Act as an advisor to the program director, through program oversight;
         b) Review of the program’s self-determined goals and progress toward meeting them;
         c) Guiding ongoing program improvement, including development of new goals, based
            upon outcomes;
         d) Review of the current operating environment to identify strengths, challenges, opportunities and
            as related to the program’s mission and aims;
         e) Planning, developing, implementing, and evaluating educational activities of the
            program;
         f) Reviewing and making recommendations for revision of competency-based curriculum
            goals and objectives;
         g) Addressing areas of non-compliance with ACGME standards; and
h) Reviewing the program annually using evaluations of faculty, residents, fellows, and others, as specified below.

b. 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:

i. Curriculum
ii. ACGME letters of notification, including citations, areas of improvement, and comments;
iii. Quality and safety of patient care;
iv. 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 Surveys
   Written evaluations of the program
v. Aggregate Resident/Fellow;
   Achievement of the Milestones
   In-Training examinations
   Board pass and certification rates
   Graduate performance
vi. Aggregate Faculty;
   Evaluation
   Professional development
vii. Progress on the previous year’s action plan(s).

c. The PEC must evaluate the program’s mission and aims, strengths, areas of 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

i. The action plan should be distributed and discussed with members of the teaching faculty and residents/fellows documented in meeting minutes.
ii. A copy of the Annual Program Evaluation must be submitted to the DIO/GMEC.

M. ADVANCEMENT

1. 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.

2. Mechanism:

a. 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.
b. The material on which the recommendation is based is made available to the GMEC through the Program Director.

c. Approval by the GMEC instructs the Program Director to complete the Resident/Fellow Agreement process and to forward the Agreements to the UPHM Administrator.

d. 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.

e. For residents/fellows on probation or to be dismissed, see Resident/Fellow Discipline and Grievance Procedures, section V.

3. 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. **Substantial Disruptions in Patient Care or Education Policy**

   UICOMP/UPHM has developed a policy to define the process and procedures for graduate medical education programs in the event of a disaster or substantial disruption in patient care or education. (see UPH Policies and UICOMP Policy Manual).

2. **Relationships with Industry Policy**

   UICOMP/UPHM has guidelines for resident, fellow, and faculty to manage interactions between the healthcare industry and its faculty, residents, fellow, and students (see Relationships with Industry – Attachment 9).

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/fellows has provided care as part of his/her training program (see Policy Manual and Resident/Fellow Responsibilities, section III.P.).

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 PGY-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/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 Identification (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

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 UPHM. (See attachments 2 & 3)

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

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

   c. 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.

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

b. Uniform Coats and Scrub Suits – see program specific manual.

   i. The House Staff uniform is a blue pinstriped laboratory coat with UICOMP and Family Medicine or Psychiatry insignias. Clean clothing consistent with UPHM Dress Code Policy and a well-kept house staff uniform coat reflect a concern for one’s patient as well as one’s self.

   ii. See program specific manual for further details.
c. Identification Badge

i. You will be issued a name identification badge as you begin employment. You must always wear your identification badge while on duty. It should be worn at shoulder level or on a lanyard. You should make requests for replacement badges to Human Resource Services. Replacement badges due to transfers or name changes will be provided to you free of charge. There will be a charge for all replacement requests due to a badge being lost or damaged.

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/fellow termination of employment by UPHM, 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/fellow’s letter of resignation, will be maintained in the resident/fellow’s permanent file in the residency/fellowship program office and the UPHM 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 (See Section II.H.5.p)

1. 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 initiative (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. **Program Self-Evaluation**

a. Program self-evaluation will, in part, be accomplished by performance of an annual program review. In addition to the Program Director, participants in the annual program review will include two key clinical faculty members and one or more members of the house staff. The annual program review will assess the effectiveness of all aspects of the program including, but not limited to, core lectures, elective and required rotations, and other conferences (Grand Rounds, Morbidity and Mortality Conferences).

b. Resident/fellow input into the formative evaluation of the programs of the residency/fellowship is solicited and welcome.

c. Resident/fellow input into the quality of the program may take place via several vehicles:

1) **Resident/fellow retreats** – This is a quarterly day-long meeting mandatory for all residents/fellows and other departmental personnel as appropriate, faculty, and invited administrative staff. The retreat is chaired by the Chief Residents/Fellow. Minutes are kept and published. Residents/fellows are excused from all other activities for the day.

   **Objectives:** To identify, discuss, and resolve problems and suggestions for long-range planning concerning all facets of the residency/fellowship program. Agenda items are generated from all personnel of the department. Those items considered are often those requiring more prolonged discussion, or outside input, than can be addressed in the regular residents’ meetings.

2) **Presentation to the Chief Residents/Fellow** – see I.L. Chief Resident/Fellow.

3) **At the conclusion of each rotation, each resident/fellow will be asked to fill out an evaluation form on that particular rotation and attending.** These evaluations will be reported back to the attending and Program Director. No particular resident/fellow will be identified as completing the evaluation, but it will simply state, “in the course of last year these evaluations of the residents/fellows on your service.” It is important that these evaluations be filled out as factually as possible so that an honest appraisal of our program can be made.

d. **Additional methods by which residency/fellowship programs evaluate themselves include:**

1) **Performance of residents/fellows on the In-training Examination.**

2) **Feedback from residents/fellows regarding rotations, conferences, workshops, and orientation using written forms.**

3) **Feedback from residents, fellows, faculty, and staff at residency/fellowship retreats.**

4) **Feedback from residents/fellows at evaluation sessions.**
5) Performance of graduates on ABFP or ABPN exams.

6) Results of graduate surveys.

7) Results of QA (evaluation of patient care quality at the facility).

8) Discussion and interpretation of RRC and internal reviews.

11. **Call Schedules**

   a. Call schedules while on rotations at UPHM will be assigned by the Chief Residents/Fellow.

   b. Call schedules for rotations at SFMC (including NICU and Pediatrics) will be prepared by the Chief Residents/Fellow on these services, if applicable.

12. **General In-House Call Policies:** Residents/Fellows assigned in-house call at UPHM

   a. Residents/Fellows assigned in-house calls at UPHM or SFMC must remain at these locations while on duty. A resident/fellow will not be scheduled for in-house calls more often than every third night, when averaged over a month.

   b. The Chief Residents/Fellows will assign residents/fellows to in-house calls at UPHM:

   c. A preliminary call schedule will be posted approximately 4 weeks prior to onset of the following month.

   d. The final call schedule will be posted and distributed to all residents, fellows, hospital operators, nursing units and ambulatory clinics one week prior to the onset of the following month.

   e. Adjustments in the call schedule can be made upon the agreement between residents/fellows involved, and notification of the Chief Residents/Fellow prior to the posting of the final call schedule. No adjustments to the final call schedule will be made for the first half of the month unless approved by the Chief Residents/Fellow. Adjustments for the second half of the month can be arranged between residents/fellows prior to posting of revised final call schedule on or about the 15th day of the month. Once the revised final call schedule is posted, no changes to the schedule will be allowed without approval of the Chief Residents/Fellows.

   f. If alterations to the call schedule are made, the Chief Residents/Fellows will be responsible for notifying all appropriate parties of the change, including through imposition of a program level requirement for notification.

13. **Resident Scheduling Crises – Illness/Emergency Leave**

    When a resident/fellow is ill, or requires absence from the residency/fellowship program for any reason on short notice, the procedure is as follows:
a) Psychiatry Residency: The resident or proxy MUST call or text the Program Coordinator and the Chief Residents as soon as possible and, for psychiatry rotations, must call the supervising attending. Information to be provided includes:

1) The ROTATION that will be affected.

2) Whether rotation ATTENDINGS have been notified.

3) How the CALL SCHEDULE will be affected.

4) How OTHER DUTIES will be affected.

5) UPHM patients need to be seen.

b) Family Medicine Residency: The resident or proxy MUST call or email the Program Coordinator and MUST call the Chief Resident as soon as possible. The resident must also call rotation attending and the FMC clinic if the absence will affect the clinic schedule.

c) Guidelines for notification:

1) UPHM Patients In-House
   a) The Chief Resident/Fellow will notify the appropriate parties including the attending, regarding the resident/fellow’s absence.

2) Call and Weekend Coverage Schedule
   a) After the Chief Residents/Fellows are notified, he/she will make every effort to work out a call trade between residents/fellows, rearrange the call schedule and notify the UPHM switchboard.
   
   b) If a resident/fellow on home call or weekend coverage requires absence from on-call duties, and no alternative coverage can be arranged, the slot will be “left open.” The attending on call will be available to assist, if required.
   
   c) If the resident assigned to in-house OB calls requires absence from on-call duties, the PGY-2 resident will assume OB call responsibilities with back-up by the PGY-3 on-call, if required.

3) Other Resident/Fellow Duties
   a) After notification from the Chief Residents/Fellows, he/she will reassign coverage to outside clinics as required. The Chief Residents/Fellow will notify residents/fellows affected and the clinical sites of the change.

14. Master Call and Coverage Schedule

   a. The Chief Residents/Fellows will prepare the call schedule. Each resident/fellow should review the schedule for errors and bring any conflicts to the attention of the Chief Residents/fellows as soon as possible for appropriate changes.
b. The Chief Residents/Fellows will, with approval of the Program Director, prepare the YEARLY rotation schedule and post it at the beginning of the academic year.

1) Request for changes to the rotation schedule must be addressed to the Chief Residents/Fellows who will review the request with the Program Director.

2) Requests for rotation change must be made no later than 60 days prior to the onset of the original rotation.

15. Holiday Call Schedule for Family Medicine

a. Christmas/New Year holiday blocks will be assigned by the Chief Resident early in the academic year.

b. Holiday blocks will not count as vacation days away from the residency.

16. Orientation for Family Medicine and Psychiatry Residency

a. Goals

Residents will be introduced to Unity Point Health Methodist through an orientation period. The goals of this orientation are to:

1) Familiarize new residents with the physical layout of the hospital.

2) Familiarize new residents with hospital benefits.

3) Familiarize new residents with hospital and residency policies.

4) Introduce new residents to basic residency precepts.

5) Introduce new residents and their families to stress management skills.

6) Certify new residents in CPR, ACLS, ALSO, PALS, and Neonatal Resuscitation if applicable.

7) Orient new residents to commonly performed procedures.

8) Familiarize residents with basic computer skills.

9) Develop teamwork and camaraderie within the residency program.

b. Residents Starting after Orientation

Residents who begin their residency on a date other than July 1 will have specific orientation as indicated for their needs. The goals listed above will serve as a guideline for planning the orientation.
17. Rotations and Minimum Requirements for Graduation

a. Required rotations are those which the residency/fellowship program requires to conform to the standards of the ACGME Special Requirements, and the certifying Board requires to allow the resident/fellow to sit for boards. Credit for required rotations taken prior to entering this residency/fellowship is subject to approval by the certifying Board. A resident/fellow must be present at least fifteen (15) days in a (4) week rotation, and at least eight (8) business days in a two-week rotation to receive credit.

b. Required rotations away from UPHM, with the exception of those rotations which are routinely located at SFMC or Proctor, will be permitted providing that the resident/fellow can demonstrate substantial value in using the alternate site, that the alternate rotation at least meets the same standards as our own, and that an equivalent evaluation of the resident/fellow’s performance is provided. Approval by the Graduate Medical Education Committee is necessary and approval by the certifying Board may be necessary.

c. Residents/fellows must receive satisfactory evaluations for all rotations. Rotations for which the resident/fellow receives an unsatisfactory evaluation must be repeated. One (1) block or month of elective time may be used for remediation.

d. Electives are those rotations that are not required to become certifiable.

1) Selecting an elective – Residents/fellows will receive a listing of electives offered at UPHM in the Spring. This will be compiled by each program. Each resident/fellow will choose the preferred electives and indicate a preference of attending(s). The Chief Residents/Fellow will then arrange the schedule, based on the preferences of the residents/Fellow and availability of the rotation.

2) Arranging for a Special Elective – Special electives are those not listed by the residency/fellowship. Arranging for these electives must be done by the resident/fellow who wishes to take the special elective. Approval of the elective must be given in advance by the Residency/Fellowship Director and/or Executive Associate Director, and the GMEC. All electives must have written objectives and an evaluation system based on the objectives.

a) Special electives at sites away from UPHM will be considered only if a like educational experience cannot be achieved on this campus or within the University of Illinois system. If approved for Family Medicine, these may not interrupt continuity of care for longer than two months in each of the PGY-2 and PGY-3 years. Upon return, the resident must provide continuity of care for his/her patients for at least two months before leaving for any additional remote experiences.

b) Special electives taken away from UPHM must meet the requirements for special electives and the requirements for rotations taken away from UPHM.

c) Special electives can be designated as Medicine Electives if they address General Internal Medicine or a recognized sub-specialty of Internal Medicine.

d) A “program Letter of Agreement” (PLA) between UICOMP, Methodist Medical Center, and the ROTATION SITE must be signed by the appropriate parties and
on file in the Program Director’s Office with a copy in the GME Office. No resident/fellow may begin an outside rotation before a fully executed written agreement exists for this specific elective rotation. This letter identifies the rotation site supervisor, responsibilities for evaluations, benefits including salary and liability insurance coverage, educational goals and objectives, and clinical responsibilities.

e) The resident/fellow taking an approved elective continues 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 Methodist Medical Center.

f) 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 by working with the residency/fellowship staff prior to leaving for elective. If expenses exceed their Education Allowance, the rotation may be denied or the resident/fellow may be required to assume the additional cost.

e. Receipt of the diploma and documentation of graduation will also be contingent upon the resident/fellow’s completion of required paperwork. If all responsibilities and training are not completed prior to your scheduled last day, you may not be eligible to sit for boards.

18. Absence Policy

a. The Absence Policy defines requirements for any absence from residency/fellowship duties, such as vacations, site visits, illnesses, and leaves of absence. Additional information can be found in the UnityPoint Health Methodist Employee Handbook.

b. Family Medicine Residency: Absences must be approved via request submitted through New Innovations.
   Psychiatry Residency: Absences must be approved via the Resident Request Absence Form (available from Residency Program Coordinator and/or through the Program Director or his/her designee in the case of emergencies).

c. Residents/fellows are strongly urged to include scheduled vacations for the academic year when submitting rotation choices for that year (see Vacations #7). Requests for changes in vacations, or other absences, must be approved two months prior to the scheduled absence. Due to scheduling issues, not all requests can be honored (for practice opportunity absences, see Site Visit Absence #13).

d. The Vacation and Leave of Absence policies are detailed in the Benefits section, IV.

e. Family Medicine Resident Physician Responsibility

   1) Comprehensive and continuing care of families in health and sickness in the hospital and the clinic for the entire length of the residency are basic and integral parts of the residency. Therefore, absence from the program (and the care of such people) should not be excessive, i.e., to the extent that such continuity is lost. In the usual practice, the responsible physician is seldom gone longer than two-to-four
weeks at any one time. If absent from his/her practice, for any reason, the responsible practitioner must arrange for competent continuation of care for his/her families. To perform responsibly, this same concept is expected of residents.

2) The resident is responsible for requesting approval for absence from the residency program (i.e., vacations or conferences) through New Innovations. Requests should be submitted at least two months in advance to allow proper time for approval and notification.

19. Rotations Outside of UPHM

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 UPHM and the outside institution(s) is required, ensuring that the resident/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, a formal written agreement between UICOMP/UPHM and the outside institution(s) is required, ensuring that the resident/fellow's stipend, benefits, and liability coverage are continued. For additional details, please see "Rotations outside of the Peoria area" below.

c. International Rotations – All off-campus rotations, including international rotations must be approved by both 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 States government considers “unsafe to travel” in.

d. Rotations outside the Peoria area:

1) 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/UPHM 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 and the persons/institutions responsible for the resident/fellow’s stipend, benefits, and professional liability insurance while participating in the rotation. The PLA must be signed by all parties before the resident may train at the off-campus site.
b) In cases where a required off-campus rotation is located beyond a reasonable commuting distance of 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 Office of Graduate Medical Education 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 arrange for the base rental figure (i.e., the prevailing rental rate for a one-bedroom apartment in the locale of the required rotation, as determined by the Office of Graduate Medical Education), or the actual rental charge, whichever is less.

Upon completion of the off-campus training, residents/fellows who are requesting assistance for housing and parking may provide receipts for the expenses incurred, and submit those for a refund to the Residency/Fellowship Support Staff.

c) The resident/fellow 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 outside institution.

d) In cases where a required off-campus rotation is located within a reasonable commuting distance of 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 UPHM, as determined by the Office of Graduate Medical Education.

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

iii. The per mile rate of compensation will be the rate currently paid to employees of UPHM 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 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 Office of Graduate Medical Education at the end of each month.

vi. Compensation for travel will be provided on a monthly basis by the submission to the Residency/Fellowship Office Support Staff based upon the travel log.

2) 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, UPHM, 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 requires 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 UPHM.

   e) Residents/fellow 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 by working with the residency/fellowship support staff. If expenses exceed their Education Allowance, the rotation may be denied, or the resident/fellow may be required to absorb the additional costs incurred while doing the rotation.

   f) International Rotations – All off-campus rotations, including international rotations must be approved by 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 United States Government considers “unsafe to travel” in.

20. 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/Fellows 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 UPHM and 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 UPHM, SFMC, and UICOMP 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.

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/fellows receives a 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/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/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/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 the Institutional Requirements as they relate to duty hours (also see Duty Hours, section II.H.5.i.):

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

b. Residents/fellows will inform their Program Director when circumstances prevent them from being in compliance with ACGME, RRC, and program duty hours’ requirements.

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

3. To meet the physical, mental, interpersonal, environmental, and educational requirements as outlined in the program specific manual.

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 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

a. 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.

b. Resident/fellow availability through the pager unit is determined by the resident/fellow’s current assignments.

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

d. For repair or replacement of pager units, call Help Desk, ext. 4357

F. “CODE BLUE ADULT” and “CODE BLUE PEDIATRICS” CALLS AT UPHM (Family Medicine Residents)

a. UPHM has a well-organized team approach to Code Blue calls, and is monitored by the UPHM CPR Committee. Any concerns about Code Blue episodes should be addressed to the Executive Associate Director of the Residency Program or the Chief Residents, who will take them to the CPR Committee.

b. Advance Cardiac Life Support Certification and Pediatric Advanced Life Support Certification are required for residents.

c. All family medicine residents, MICU residents and the on-call team should respond to all Code Blue calls. The residents during the day and the MICU on-call team at night are to carry Code Blue pagers.

d. Individual residents should respond to Code Blue ADULT and PEDIATRIC calls occurring to their assigned patients, in accordance with departmental policies. Residents on other rotations should also respond to Code Blue calls if they are in close proximity to the call and can give more immediate assistance.

e. The most senior resident present should assume responsibility for running the code, and should make this fact known to everyone participating in the resuscitation. The charge physician is responsible for organizing the code team and directing resuscitation efforts.

f. Attending Emergency Medicine physicians also respond to Code Blue calls and will be available for assistance/advice during resuscitative effort.

g. Residents involved in codes are strongly encouraged to participate in debriefings following codes, and to discuss outcomes with attendings, behavioral medicine faculty, and team members.
G. “CODE BLUE NEONATAL” CALLS AT UPHM (Family Medicine Residents)

a. The most senior resident trained in Neonatal Resuscitation and having completed required NICU rotation month will be the physician code leader in collaboration with the senior RN certified in neonatal resuscitation.

b. The senior RN’s responsibilities will be to identify concerns with the interventions being implemented, request additional staff or remove staff form the area and designate appropriate personnel to complete specific procedures. The shift coordinator will record the events and acts as a resource to the code team.

c. The Neonatologist or physician code leader will intubate if necessary.

d. The emergency physician responds as needed to offer assistance to the code leader.

e. The code will be called overhead and by pager as a “Code Blue Neonatal.” Only the following should respond to the call:

i. Neonatologist

ii. Residents assigned to OB and Peds services

iii. Labor and Nursery nurses

iv. Shift Coordinator

v. Respiratory Therapy

vi. Anesthesia personnel

H. RESIDENT/FELLOW’S PERMANENT FILE

1. All records concerning each resident/fellow’s participation in the Graduate Medical Education Program at UPHM will be retained in confidential files in the Program Director’s Office. Employment information will be retained in confidential UPH/HR files.

2. The resident/fellow may review the contents of the permanent file by giving the Program Director’s Office reasonable time to produce the file for review.

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

a. Application to the Residency/Fellowship at UPHM

b. UPHM employment application

c. Resident/Fellow agreements

d. Resident/Fellow evaluation forms
e. All correspondence including official faculty or administrative actions, actions of committees, or other correspondence relating to the resident

f. Licensure documentation

g. All disciplinary records

4. The permanent file falls 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, title, and physician identification number.

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. The Joint Commission on Accreditation of Health Care Organizations requires that medical records on discharged patients should be completed within 14 days after discharge of the patient. Therefore, UPHM and OSF SFMC have adopted the following regulations for all members of postgraduate training programs.

b. It is the resident/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.

c. 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.

d. In order to facilitate continuity of care and patient transitions between settings, Discharge Summary Reports are expected to be completed in all cases within 14 (fourteen) days of discharge date. Discharge summary reports completed later than 14 days post discharge will be considered untimely. Residents/fellows should complete the oldest records first.

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

f. Weekly, Health Information Services will send to residency/fellowship Program Directors resident/fellow-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).

g. 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 14 days of discharge.

h. 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/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/fellow’s cafeteria privileges may be revoked and the resident/fellow may be required to 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/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/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 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. CLINICAL AND EDUCATIONAL WORK

The Institutional policy on resident/fellow responsibilities related to Clinical and Educational Work is detailed in section II.J.F. of this Manual and in the Policy Manual.

K. 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.

L. 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/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 residents/fellows’ 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 (655-4060)

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:

Director of Human Resource Services, UPHM (672-4862)

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

UPHM Chief Resident in Psychiatry or Family Medicine

Kelvin Wynn, M.D., Family Medicine Department Chair (672-4598)

Ryan Finkenbine, M.D., Psychiatry Department Chair (671-8393)

Francis McBee Orzulak, M.D., Associate Dean for Graduate Medical Education, UICOMP (671-8450)

Samer Sader, M.D., CMO, UPHM (672-5560)

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.

M. RESIDENT/FELLOW HEALTH POLICIES

House Staff members are subject to Employee Health Policies as applied to all UPHM 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. UnityPoint Health Methodist is a Drug Free Workplace and employee’s will be tested and required to review and sign the Drug Free Workplace Statement.

2. Personal Illness

a. In the event of any personal illness necessitating absence from duties, the resident/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 UPHM 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:

University of Illinois College of Medicine at Peoria
Resident/Fellow Health Committee

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/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, fellow, 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 diverted 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/fellow’s referral information, the PD, and the Chair shall determine if the report involves a possible impairment that may negatively affect the resident/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 suspected 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/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 from clinical activities.

[drug test process, resident declines]

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/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 at, and is an employee of OSF SFMC/UPH. 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/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 RHC 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 PD 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/fellows 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/fellow’s activity, to suspend the resident/fellow, or to 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 from 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 UPHM are required to conform to UPHM’s policy on substance abuse (see UPHM Human Resources Manual). Briefly, UPHM is committed to providing an environment free of the effects of substance abuse in order to maintain a work environment that is safe for patients, as well as its employees. UPHM recognizes that safety and productivity is compromised by alcohol and drug abuse by increasing the potential for accidents, absenteeism, substandard performance, poor employee morale, and damage to UPHM’s reputation.

UPHM has 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 UPHM 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

UPHM 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. UPHM recognizes drug dependency and/or alcoholism as a health problem and it will assist an employee who becomes dependent on alcohol and/or drugs.

UPHM 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

UPHM 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 nicotine, 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 UPHM 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 UPHM 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:

1) Direct observation of drug or alcohol use or possession and/or symptoms of being under the influence of drugs or alcohol.

2) A pattern of aberrant or abnormal behavior, such as mood and behavioral swings and wide variations or changes in job performance.

3) Arrest or conviction of a drug-related offense or identification of an employee as the subject of a drug-related criminal investigation.

4) Information provided by a reliable and credible source(s).

5) 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 UPHM 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 at 672-4894 for immediate confidential medical evaluation and follow-up. Incident Report Forms are available in all patient areas and must be completed. Residents/fellows must report to the Emergency Department within 2 hours of the incident. The source patient’s name, medical record 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), and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

b. Post Exposure Follow-up

Post exposure medical evaluation and follow-up will be made available immediately for residents/fellows who have had an exposure. Such residents/fellows will be asked to complete “Employee Report of Occupational Injuries or Illnesses.”

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).

N. 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/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 IDPR. 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.

O. 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 UPHM.

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 UPHM employee termination process.

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

Q. 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/fellow’s Program Director 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 UPHM.

3. The resident/fellow will normally be informed of requests for information from an attorney with a subpoena by personnel from Risk Management, 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 immediately.

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

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

R. 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

S. NEWS MEDIA INQUIRIES

All inquiries from the news media should be immediately referred to Marketing at (672-5695).

T. RESIDENT/FELLOW RESPONSIBILITIES RELATED TO ABSENCE

1. As stated above, comprehensive and continuing care of families in health and sickness in the hospital and the clinic setting for the entire residency/fellowship are basic and integral parts of the residency/fellowship. Therefore, absence from the program (and the care of such people) should not be excessive, i.e., to the extent that such continuity is lost. In usual practice, the responsible physician is seldom gone longer than two to four weeks at any one time. If absent from his/her practice, for any reason, the responsible practitioner must arrange for competent continuation of care for his/her families. To perform responsibly, this same concept is expected of all UPHM residents.

2. **Family Medicine**: The resident is responsible for requesting approval for absence from the residency program (i.e., vacations or conferences) through New Innovations. **Requests should be submitted at least two months in advance** to allow proper time for approval and notification.

   **Psychiatry**: The resident should follow the Psychiatry Supplemental Manual to request and process absences.
IV. RESIDENT/FELLOW BENEFITS

A. BENEFITS TO THE RESIDENT AS AN UPHM EMPLOYEE

1. Introduction

The resident/fellow is considered a professional in training in a UICOMP sponsored residency/fellowship and also an employee of UPHM, 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 UPHM have designed a package of benefits specifically for residents/fellows training in UPHM as detailed below.

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:

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<th>PGY</th>
<th>Amount</th>
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<tbody>
<tr>
<td>PGY-1</td>
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<td>$68,130</td>
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<tr>
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<td>$70,483</td>
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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 or Associate 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 or Associate 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. PGY-1 through PGY-4 residents and fellows, will receive a maximum of $1,200 per year for reimbursement of education-related purchases that have been pre-approved by their Program Directors or Executive Associate Director of the residency/fellowship program. 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.

c. If monies are being requested to fund an outside elective, the Program Director will present the resident/fellow’s request to the GMEC for approval. GMEC approval is necessary for the program to request UPHM to release funds to support the resident/fellow’s request.

d. The educational allowance cannot be “carried over” to subsequent academic years.

4. Resident/Fellow Absence Policy

Sick
Personal time off is 20 days per year (fifteen days for vacation and five days for sick) leave.

Maternity/Paternity
Residents/fellows may use sick or vacation days for maternity/paternity absences due to birth or adoption of a resident/fellow’s, spouses, or partner’s child. FMLA or short-term disability may be available per UPHM policy after sick and vacation time runs out.

Bereavement
Residents/fellows follow the GME/UPHM policy for bereavement.

Jury Duty
Residents/fellows follow the GME/UPHM policy for jury duty.

FAMILY MEDICINE RESIDENCY:
Residents must submit a vacation request for elective absences through New Innovations 60 days prior to departure. Exceptions must be approved by the Program Director. See New Innovations for complete Absence Policy.

• PGY-1 Residents are allowed 20 business days of personal time off (PTO) fifteen days for vacation and five days for sick leave.

• PGY-2 Residents are allowed 20 business days of PTO, fifteen days for vacation and five days for sick leave, and 5 business days for conference. Conference time may not be used for vacation.

• PGY-3 Residents are allowed 20 business days of PTO, fifteen days for vacation and five days for sick leave, and 5 business days of conference time, and 5 business days for checking into practice opportunities. Conference time may not be used for vacation. No vacations are allowed during the last two weeks of residency.

The American Board of Family Medicine Policy indicates that a resident’s absence from the program for vacation, illness, personal business, leave, etc. must not exceed one month per calendar year. Time away from the residency program for educational purposes, such
as workshops or continuing medical educational activities, are not counted in the limitation on absences but should not exceed 5 days annually. Leaves of absence from the residency, exclusive of the one month vacation/sick time, may interrupt continuity of patient care for a maximum of three months in each of the PGY-2 and PGY-3 years of training. Following a leave of absence of any length duration the resident must return to the program and maintain care for his or her panel of patients for a minimum of two months before subsequent leave. Time off from the residency in excess of 30 days within the academic year (PGY-1, PGY-2, PGY-3 year) must be made up before the resident advances to the next training level and the time must be added to the projected date of completion of the required 36 months of training.

**PSYCHIATRY RESIDENCY:**

Psychiatry residents should follow the Psychiatry Supplemental Manual to request and process absences.

5. **Elective Absences**

Electives at sites away from this campus will be considered only if a like educational experience cannot be achieved on this campus or within the University of Illinois system. If approved, these may not, alone, or in combination with vacation or conference time, exceed 6 weeks, unless approved by the Program Director.

6. **Professional Meetings for Family Medicine**

   a. Residents are encouraged to attend professional meetings. A resident must have prior approval from the Program Director for any lecture series, seminar, conference, or other educational meeting he/she wishes to attend that will involve time away from his/her residency duties or for which monetary reimbursement is requested. The educational need of the resident will be the primary consideration.

   b. The maximum allowable absence from a training program for a professional meeting is seven (7) days, including weekend days, per year.

   c. The Approval Process involves:

      1) Discussion of the professional meeting with the Program Director

      2) See residency staff to complete an Employee Travel Authorization form if CME reimbursement is desired.

      3) **Family Medicine:** Residents must request time away from the residency by submitting the request through New Innovations.

         **Psychiatry:** Resident must request time way from the residency and obtain signatures from the Program Director and the Attending Physician of the rotation to which he/she is assigned at the time of the meeting absence.
4) Upon return, the resident must furnish proof of conference attendance (i.e. Conference nametag, certificate) and receipts for any charges incurred that the resident desires to submit for reimbursement.

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

6) Vacation 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 vacation expenses. Approval will not be granted if the combination of vacation and education leave results in absence from the training program that the Program Director deems excessive.

7) Prior to leaving for a professional meeting:

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

d. Travel and Lodging Arrangements:

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

7. Research-Related Cost for Residents/Fellows:

   a. GME/UPHM 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.

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

   c. There is a limit of GME/UPHM funds of $1,500 for travel or publication costs per resident/fellow per year.

   d. There is a limit of one sponsored resident/fellow per presentation, unless approved by the PD and the DIO.

   e. Each presentation must reflect new, not previously presented research.

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

   g. 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.
h. A copy of the manuscript accepted for publication, the acceptance letter, and a letter documenting publication costs must be submitted to the GME Office before any funds will be distributed.

8. Health Care Benefits:

Residents/fellows at UPHM have the option of enrolling in the Employee Health Care Plan with premium discounts available with completion of the comprehensive wellness program. Participation in the health care plan is optional and premiums are deducted through payroll on a bi-weekly basis. Dental/Vision coverage is available. Pre-tax “Flexible Spending Accounts” and “Dependent Care Spending Accounts” are also available as allowed by the IRS.

In accordance with ACGME institutional requirements, hospital and health insurance benefits for residents/fellows and their families begin on the first recognized day of their program.

9. Flexible Life Insurance:

Life and AD&D coverage equal to 1 times your annual salary is provided at no cost by the Medical Center. Additional life insurance options (dependent coverage, supplemental life and group universal life) are also available; premiums are deducted through payroll on a bi-weekly basis.

10. Disability Benefit:

You are eligible for disability coverage after 6 months of active full-time employment. After the first 2 weeks of total and continuous disability, you receive 60% of your salary for the first 6 months, and 50% thereafter, subject to all provisions of the Disability Benefit Program. Details on this benefit are available in the UPHM Benefits Office.

11. Professional Liability Insurance for Residents/Fellows Employed by UPHM:

a. UPHM maintains professional liability insurance coverage for residents/fellows for any exposure to liability arising from performance of his/her duties as a UPHM employee, prescribed upon such terms and in such amounts as UPHM provides for its other professional employees. 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 UPH System shall defend, at its cost, any suit brought against a resident arising out of the professional services provide, or withheld by the resident/fellow within the scope of the resident/fellow’s employment.
d. The UPH System has the right to investigate, to negotiate, and to settle any suit or claim, as UPH 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 UPH System in its sole discrimination.

12. Employee Assistance Program and Resident/Fellow Health Committee:

Residents/fellows desiring assistance with personal, family, or job-related problems have the option of the UICOMP run Resident/Fellow Health Committee or the EAP at UPHM. A Center for Wellbeing (within the Department of Psychiatry and Behavioral Medicine) counselor or local mental health clinicians are available for counseling. UPHM also provides an Employee Assistance Program which provides, without cost to the resident/fellow, confidential assessment and counseling services for personal, family, alcohol and drug-related, and financial problems. (Telephone: 800-433-7916) for more information or to schedule an appointment. Impaired physician assistance is also available through the Illinois Academy of Family Physicians when appropriate.

13. Child Care Center:

In order to assist employees in meeting their child care needs, UPHM has established a Child Care Center. This program is offered to employees at competitive fees.

14. Parking:

Parking is provided for residents/fellows at no charge in the UPHM parking decks.

15. Bus/Entertainment Tickets:

A variety of discounted tickets, ranging from local movie tickets to Six Flags to Disneyland/Disney World, are available at the UPH Methodist Perkspot Program on the UPH Hub.

16. Meals while on duty:

Food from the UPHM cafeteria is provided free-of-charge to residents/fellows while on duty.

17. Methodist Atrium Wellness Center:

Access to the state-of-the-art recreational facilities and pool is provided free-of-charge to residents/fellows and their spouses by the residency/fellowship program.

18. 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 their UPHM 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.

19. Lab coats and scrub uniforms are available to residents/fellows at no charge.

20. Reimbursement for Travel by Automobile to Required Off-Campus Rotations:

In cases where a required off-campus rotation is not located within a reasonable commuting distance of 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:

The rotation is not available in Peoria.

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

b. The compensation will be based on the round trip mileage, from UPHM to the off-campus rotation, as determined by the IRS standard rate.

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

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

e. 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 each month.

f. Compensation for travel will be provided on a monthly basis by UPHM based upon the travel log. Requests for compensation from UPHM will be prepared by the Graduate Medical Education Office.

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

22. Social Functions:

UICOMP/UPHM/OSF is pleased to host a number of social functions for House Staff. Examples include an annual Holiday Party, Golf Outing and Dinner.
23. UPHM-Sponsored Advanced Life Support Courses:

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

24. Licensing Fee Reimbursement for incoming residents/fellows:

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

   1) A canceled check or receipt for the full amount of the license fee from the Illinois Department of Professional Regulation; and,

   2) A copy of the completed license application.

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 and an electron microscope

   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 UPHM 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 UPHM 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 that a corrective action is needed, for example to complete delinquent records. Resident/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/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/fellows 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/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/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. UPHM 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 UPHM Human Resources Handbook, as well as copies of all written UPHM 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 UPHM and with UICOMP. Therefore, residents/fellows whose employment is terminated by UPHM 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 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

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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.
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;

   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

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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
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

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)

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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.
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 UPHM 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 UPH 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 UPH 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 UPH. 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 UPH.

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 UPH 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 UPH 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 suspension is determined by the Program Director in consultation

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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 UPH. A resident/fellow may be dismissed at any time, without notice for significant failure to meet the expectations of the program of UPH. 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 UPH.

d) Failure of the resident/failure 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 UPH 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 UPH 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.
c. **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.
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.
I. POLICY
All team members shall adhere to the dress code policy and guidelines.

II. PURPOSE AND STANDARD
Ensure a standardized, professional image of all team members in order to promote patient confidence in UnityPoint Health as a healthcare provider. Promote a recognizable UnityPoint Health image across all clinical settings.

III. POLICY SCOPE
This Policy applies to Methodist Health Services Corporation and any of its team members and/or members of the medical staff engaging in the procedures described herein.

IV. GENERAL INFORMATION
Our goal as an organization is to consistently meet or exceed customer expectations. An important step towards achieving this goal is a professional appearance. The way team members look and dress is important to the success of UnityPoint Health.

Image and professionalism also include grooming habits and hygiene. Team members are expected to be neatly groomed – hair clean, fingernails trimmed and clean, and free of bad breath and body odor. Smoke odors are prohibited. The use of perfumes, colognes, or perfumed products (hand/body lotion, etc.) is strongly discouraged and may be prohibited in some areas. When in direct patient contact, shoulder length hair must be pulled back for safety and infection prevention. For team members who provide care to patients, no artificial nails, wraps, extensions or other fingernail adornments are allowed and nail length is limited to ¼ inch beyond the fingertip.

Jewelry or adornments that undermine the professional image, diminish the effectiveness of the team member, create a safety hazard or are excessive are prohibited. Facial Jewelry and tongue piercings must be removed. A very small nose stud may be worn. Offensive or vulgar tattoos must be covered; it is preferred that all other tattoos be covered when working in a patient care area. T-shirts, beach style sandals, sweatshirts, shorts and jeans or jean style are not allowed.

Team member must exercise common sense and good judgment when dressing for work.

Clothing should be professional in appearance – clean, properly fitting, and in good repair. Extreme styles and appearance, which include low cut tops, tops that expose the stomach, short skirts that when seated expose the upper thigh, and extreme piercings are not acceptable. Clothing which is too tight or too loose fitting negatively impacts the professionalism of the team members and the organization. Undergarments should not be exposed during normal movement. Excessive long pant hem lines are not permitted.

Face Masks: When wearing a face mask is required, recommended, or preferred based on personal preference, UnityPoint at Home will have masks available for use. Team members may elect to provide their own mask of their choice if a specific type of mask is not required during the provision of direct patient care. Face masks must align with the dress code policy. Face masks may be made of fabric that has a pattern, design, animals, characters, or logos. Face masks may not contain prohibited content. Prohibited content includes, but is not limited to designs, characters, insignias, or language that is:
Obscene, Sexually explicit, Advocate discrimination based on: Race, Color, Religion, National origin, Age, Sex, including gender presentation and sexual orientation, Citizenship; and Disability
In addition, face masks that symbolize affiliation with gangs, weapons, supremacist or extremist groups, advocate illegal drug use, depict nudity, or are of a nature such as to bring discredit to UnityPoint Health or any of its affiliates are prohibited and may not be worn.

Leadership are accountable to ensure the team member meets the standards set and have the discretion to establish higher standards. Questions regarding the dress code, including medical exceptions, should be directed to the Director/Manager. Team members who do not abide by departmental standards will be sent home to change to more suitable attire or appropriate grooming. This will be without pay. Continued failure to follow standards will be grounds for corrective action.

In cases involving team members who object to these guidelines on grounds of religious belief; Human Resources should be contacted.

V. PROCEDURE
   A. Name Tag
      1. Identification of a team member is as important as good grooming habits and appropriate attire.
      2. Name badges must be worn in the chest area, clearly visible at all times to patients and visitors.
   B. Leadership Team
      1. Executives and Directors shall wear business attire
         i. Men: jacket, long-sleeved dress shirt and pants, tie when appropriate.
         ii. Women: jacket or jacket-like sweaters or sweater sets, slacks or skirt, or professional looking dress.
      2. Managers
         i. Men: long sleeve dress shirt and pants, tie optional.
         ii. Women: jacket or jacket-like sweaters or sweater sets, conservative top, slacks or skirt, or professional looking dress.
         iii. Leaders in clinical or support departments may wear the required uniform for their department when appropriate or business dress and a white lab coat or blue lab coat.
      3. Business casual allowed on Friday.
   C. Clinical Departments
      1. Labor & Delivery, OR, Cath Lab, Interventional Radiology, IV Pharmacy team members and individuals who go to Surgery shall wear hospital provided scrubs.
      2. Mental Health and Hospice team members shall wear street clothes (as outlined in department dress code policy).
      3. All other Clinical team members shall wear:
         i. UnityPoint Health blue top and pants/skirt or dress. Blue and white piping on top is permitted. Solid blue top/bottom can be combined with solid white top/bottom.
         ii. Royal blue and white for outer wear lab coats and scrub jackets only. No hoodies or fleece jackets.
         iii. Blue or white solid color undershirt may be worn.
         iv. Clean and professional closed toe shoes, socks or hosiery shall be worn with pants.
      4. NPs, RNs, and LPNs may choose to wear all white.
      5. Pediatric unit team members may wear child-themed patterned top that coordinates with UnityPoint Health blue or white pant/skirt.
6. Faculty supervising clinical students are required to wear designated school uniform or white pants and white lab coat, shoes and hosiery as described above and appropriate identification.

D. Support Departments

1. Staff in support departments shall wear either a professional uniform or business casual.

2. Due to the nature of responsibilities, team member working outside and at either Child Care Center may adjust dress based on environmental factors with Director approval.

E. UnityPoint Health Offices and Clinics

1. Clinical Team Members and Front Office Team Members shall wear:
   i. UnityPoint Health blue top and pants/skirt or dress and optional UnityPoint Health blue or white lab coat. Blue and white piping on top is permitted. Solid blue top/bottom can be combined with solid white top/bottom.
   ii. Blue or white solid color undershirt may be worn.
   iii. Clean and professional closed toe shoes, socks or hosiery shall be worn with pants.
   iv. NPs, RNs, and LPNs may choose to wear all white.

2. Pediatric staff may wear child-themed patterned top that coordinates with UnityPoint Health blue or white pant/skirt.

3. Faculty supervising clinical students are required to appropriate and professional attire, shoes and hosiery as described above and appropriate identification.

4. Office Managers/Supervisors may wear the required scrub uniform when appropriate or casual wear.

5. For safety and infection control purposes ties are optional when providing patient care.

F. Business Casual

UnityPoint Health logo wear, polo shirt with collar, casual shirts, and sweaters are acceptable. Denim is permitted only on Education Days and on executive approved Jean Days for Charity.

G. Education Days

On Education Days when staff will not be present in unit, department, or office casual dress is acceptable which includes: jeans (not faded or with holes), casual pants, leggings with long top, jumpers, skirts and shorts of appropriate length, casual shirts, sweatshirts, UnityPoint Health logo attire, and casual shoes. A good rule of thumb is: when in doubt, don’t wear it.

H. Holiday Season

Fun scrubs may be worn for seven days preceding Valentine’s, St. Patrick’s, Easter, July 4th, Halloween, and Thanksgiving and 14 days before Christmas/Hanukkah/Kwanza.

I. Exceptions

Exceptions must be reviewed by the Executive Team and approved in writing.

J. Approved Team Days

Jeans if approved by manager, fun scrubs-pants and tops, UnityPoint Health logo wear t-shirts are acceptable.

Any and all revisions or modifications to this policy must be approved by the Regional Vice President of Human Resources/CHRO.
Title: Code of Conduct

Effective Date: 04/98; Rev.: 09/03, 08/04, 03/07, 12/12, 07/14, 02/15, 09/19, 05/20 (scope update only)

POLICY: This Code of Conduct has been adopted by the Iowa Health System, d/b/a UnityPoint Health ("UPH") Board of Directors ("Board") to provide standards by which directors, officers, team members, reporting physicians and volunteers will conduct themselves in order to protect and promote organization-wide integrity and to enhance UPH’s ability to achieve its mission. The term reporting physicians means members of the Medical Staff with department head responsibilities and powers similar to those of officers and directors. All of these persons are “Covered Persons” for the purposes of this Code of Conduct.

SCOPE: UPH system wide. As used in this Code of Conduct, “UPH” means UPH and each of its affiliates, divisions, subsidiaries and operating or business units including, but not limited to, hospitals, ambulatory surgery centers, home care programs, physician practices, and all Covered Persons. The terms “directors, officers, team members, reporting physicians and volunteers” include anyone who fill such roles at UPH, its affiliates or any of their divisions, subsidiaries, or operating or business units. While this Policy does not directly apply to joint ventures in which UPH or one of its affiliates has a direct or indirect interest or control that is fifty percent (50%) or less, it does apply to directors, officers, team members, reporting physicians and volunteers in their UPH capacity related to their involvement in such joint ventures. See attached Addendum A.

PROCEDURES: The Code of Conduct contains principles describing the policy of the organization and standards which apply to all Covered Persons. Additional guidance for Covered Persons functioning as members of the Boards of Directors of UPH entities and for Covered Persons acting in managerial or administrative capacities is set forth as well. The principles contained in this Code of Conduct shall be distributed periodically to all Covered Persons. All Covered Persons are responsible to ensure that their behavior and activity is consistent with the Code of Conduct.

1. **Legal Compliance.** UPH will strive to ensure all activity by or on behalf of the organization is in compliance with applicable laws.

The following standards are intended to provide guidance to assist Covered Persons in their obligation to comply with applicable laws. These standards are neither exclusive nor complete. Covered Persons are required to comply with all applicable laws, whether or not specifically addressed in these policies. If questions regarding the existence of, interpretation or application of any law arise, they should be directed to the UPH Law Department.
1.1 **Antitrust.** All Covered Persons are responsible for compliance with applicable antitrust and similar laws which regulate competition. *(See Policy 1.LL.2, Antitrust Compliance.)* Examples of conduct prohibited by the laws include:

1.1.1 agreements to fix prices, bid rigging, collusion (including price sharing) with competitors;

1.1.2 boycotts, certain exclusive dealing and price discrimination agreements; and

1.1.3 unfair trade practices including bribery, misappropriation of trade secrets, deception, intimidation and similar unfair practices. Covered Persons are expected to seek advice from management or the UPH Law Department when confronted with business decisions involving a risk of violation of the antitrust laws.

1.2 **Tax.** As a nonprofit tax exempt entity, UPH has a legal and ethical obligation to act in compliance with applicable laws, to engage in activities in furtherance of its charitable purpose, and to ensure that its resources are used in a manner which furthers the public good rather than the private or personal interests of any individual. Consequently, UPH and Covered Persons will avoid compensation arrangements in excess of fair market value, will accurately report payments to appropriate taxing authorities, and will file all tax and information returns in a manner consistent with applicable laws.

1.3 **Fraud and Abuse.** UPH expects Covered Persons to refrain from conduct which may violate the fraud and abuse laws. These laws prohibit:

1.3.1 direct, indirect or disguised payments or remuneration of any kind to induce the referral of patients or the ordering of a service or supply paid for by a governmental health care program;

1.3.2 the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and

1.3.3 making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service. Covered Persons are expected to seek advice from management or the UPH Law Department when confronted with business decisions involving a risk of violation of the fraud and abuse laws.

1.4 **Billing and Coding.** As a health care provider, UPH is committed to fair billing practices that accurately reflect claims for services provided and comply with all
applicable laws, regulations, UPH policies and contractual commitments. UPH has implemented a compliance program to facilitate accurate billing practices to all parties, including government entities such as Medicare and Medicaid, private insurance payers and patients. UPH prohibits its Covered Persons from knowingly presenting or causing to be presented any claims for payment or approval which are false or fraudulent.

1.4.1 Duty to Bill Accurately. UPH will exercise due care to assign diagnostic, procedural and billing codes that accurately reflect the services provided.

1.4.2 Requirements to Maintain Appropriate Medical Record Documentation to Support Billing. UPH will bill only for services provided and documented in the patient’s medical record. When claims for services are submitted, UPH will require that medical records include appropriate documentation of medical necessity. To facilitate appropriate documentation in support of billing, all Covered Persons who contribute to the medical record must provide complete and accurate information in the medical record in a timely manner. Covered Persons who contribute to the medical record must follow UPH policies when making any additions or corrections to the medical record. It is important that Covered Persons not destroy any part of the medical record. Medical records should be retained in compliance with the requirements under Policy 1.AD.03, Record Retention.

1.4.3 Duty to Report Billing Irregularities. All Covered Persons must report any suspected billing irregularity or concerns about compliance with billing laws, regulations or requirements to an appropriate supervisor, manager, Affiliate Compliance Officer, the UPH Compliance Officer or to the Compliance Helpline.

1.4.4 Standards for Vendors Involved in Billing and Coding. UPH expects that any vendors involved with performing billing or coding services will have the required compliance programs, policies and procedures, skills, quality control review processes and technical systems and/or training needed to ensure any coding or billing completed on behalf of UPH is complete, accurate and timely.

1.4.5 Discounts. UPH will not provide discounts on charges for health care services provided to patients other than discounts that are permitted under UPH policies (see Policy 1.BR.33, Discounts for Uninsured Patients).

1.5 False Claims Act. The federal government, state governments, and UPH policy provide protection to team members for the reporting of wrongdoing. Generally, people who report suspected wrongdoing to the government or to their employer are called “whistleblowers” because they are “blowing the whistle” on activity they think is wrong, like a referee blows the whistle in a sports contest to detect wrongdoing.
1.5.1 **Federal False Claims Act.** The primary federal law that protects whistleblowers is called the False Claims Act. This law is intended to reduce the waste of government monies due to the submission of false claims to the government. This law allows individuals to bring a claim, or lawsuit, against their employer if the individual believes false or fraudulent claims are being submitted by the employer to the government. These lawsuits are called *qui tam* claims.

In health care, claims for payment submitted by a provider to a government health care program (i.e., Medicare or Medicaid) that are fraudulent can be a False Claims Act violation. The False Claims Act applies when a provider or person:

1.5.1.1 knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment;

1.5.1.2 knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government;

1.5.1.3 conspires with others to get a false or fraudulent claim paid by the federal government;

1.5.1.4 knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government.

As an example, if a health care provider, such as a hospital, knowingly "upcodes" or overbills so that the government overpays, the hospital can be liable for a False Claims Act violation.

1.5.2 **State False Claims Acts.**

1.5.2.1 **Iowa False Claims Act.** Iowa law provides serious penalties for using false means to get a claim paid by the government. Iowa Code § 249A.50 provides that a person who knowingly makes (or causes to be) made false statements or misrepresentations of fact, or knowingly fails to disclose facts related to claims for Iowa Medicaid funds, commits a “fraudulent practice.” Iowa Code Ch. 714 provides that a “fraudulent practice” constitutes a criminal offense that varies from a class “C” felony to a simple misdemeanor, depending on the amount of money involved. The state also has the authority to recover the incorrectly paid amounts.

1.5.2.2 **Illinois False Claims Act.** Illinois state law also provides serious penalties for false claims activities. 740 ILCS 175 provides that a person who knowingly submits (or causes to be submitted) a false claim to the State for payment of claims (including Medicaid
claims), or knowingly makes or uses a false record or statement that is material to a false claim is subject to civil penalties ranging from $5,500 to $11,000 per claim, plus three (3) times the amount of damages. Also, 720 ILCS 5/Art. 46 provides that actions related to false claims constitute a criminal offense and provides penalties that vary from a misdemeanor to a felony.

1.5.2.3 Wisconsin False Claims Act. Similar to Iowa and Illinois, Wisconsin law provides serious penalties for false claims against the Wisconsin Medicaid program referred to as the Medical Assistance program, including knowingly presenting, or causing to be presented to the state a false claim for medical assistance, as well as knowingly making, using or causing to be made or used a false record or statement to obtain approval or payment of a false claim for medical assistance;

Wisconsin Statute 20.931 provides that penalties for violations of the false claims act range up to three times the amount of damages incurred by the state as the result of the individual’s action and the person involved will forfeit not less than $5,000 and not more than $10,000 for each violation.

1.5.3 Reporting of Suspected Wrongdoing. UPH encourages team members’ reporting of any suspected activity that could result in the government being billed for false or fraudulent claims.

Team members may report concerns in a variety of ways, including the methods described in Section 1.6, and/or through the Office of Inspector General’s Fraud and Abuse Hotline, 1-800-447-8477.

1.5.4 Protections for People Who Bring False Claims Act/Qui Tam Cases. To encourage people to report violations of the False Claims Act, protections are in place to shield the individual from retaliation for bringing suit against his or her employer. The False Claims Act protects anyone who lawfully acts in support of a claim under the Act. The individual is protected against discharge, demotion, suspension, threats, harassment, and discrimination. Acts in violation of these protections entitle the team member to reinstatement with seniority, double back pay, interest on back pay, compensation for discriminatory treatment, reasonable attorneys’ fees, and other litigation costs. The Sarbanes-Oxley Act is another federal law that protects individuals for reporting suspected illegal activity.

In addition to the False Claims Act and other protections described above, UPH’s policies provide protections. These protections are contained in the following policies:
1.5.4.1 Guide to Employee Conduct;

1.5.4.2 Guidance for Business Partners;

1.5.4.3 Policy 1.CE.05, Compliance Helpline, Section 2;

1.5.4.4 Policy 1.CE.01, Corporate Compliance Program, Section 10.4;

1.5.4.5 Policy 1.CE.06, Reporting and Investigating Dishonest, Illegal, or Fraudulent Activities, Section 2;

1.5.4.6 Policy 1.BR.12, Facility Coding and Documentation for Inpatient Services, Section 12.4;

1.5.4.7 Policy 1.BR.13, Coding Documentation for Hospital Outpatient Services, Section 9.4;

1.5.4.8 Policy 1.MR.01, HIPAA-General Privacy Rules and Glossary, Section 16; and

1.5.4.9 UnityPoint Health Governance Effectiveness Guidelines, Section III (B).

1.5.5 **Iowa Services Contracts.** UPH will not take disciplinary or adverse employment action against any team member who discloses information about suspected wrongdoing in the administration of a service contract to: (1) the Iowa state agency that is administering a service contract that is the subject of the report; (2) to the State of Iowa Office of Citizen’s Ombudsman (515-281-3592); (3) the Auditor of the State of Iowa (515-281-5834); or (4) to the Iowa Attorney General (515-281-5164).

1.5.6 **Report Retaliation.** If team members feel retaliated in any way for the reporting of suspected wrongdoing, that retaliation is wrong and may be contrary to the False Claims Act, federal and state law and UPH policies. Team members are requested to report the retaliation in any of the ways described in Section 1.6. *(See personnel policies and procedures regarding Protections for Reporting of Wrongdoing, as well as Policy 1.CE.06, Reporting and Investigating Dishonest, Illegal, or Fraudulent Activities.)*

1.5.7 **Compliance Policies.** UPH is committed to detecting and preventing fraud, waste and abuse. The organizations have adopted many compliance policies that can be found on the Hub in the “Policies and Compliance” module *(https://uphealth.sharepoint.com/sites/intranet)*. Copies of the policies are also available through your supervisor, manager, affiliate compliance officer, corporate compliance officer or the compliance hotline. Each Covered Person has the responsibility to report suspected wrongdoing. Covered Persons will be disciplined for failing to promote a culture of
compliance, and anyone reporting suspected wrongdoing in good faith will be protected from any retaliation for their report.

1.6 Reporting a Possible Violation. Covered Persons are responsible for reporting questionable behavior. If a Covered Person believes there has been a violation of a law or have any concern or question regarding compliance, a Covered Person should speak with his or her supervisor, utilize the Compliance Helpline (1-800-548-8778) or online at http://www.unitypoint.alertline.com, or call UPH Audit Services (515-241-6120) or the UPH Compliance Officer (515-241-6937 or 24/7 Digital Pager 515-242-2227 or 515-241-5699 Call Center). Covered Persons will not be retaliated against by UPH or the Covered Person’s Supervisor for, in good faith, reporting actual or suspected violations of the law or UPH Compliance Policies. Such retaliation may result in disciplinary action, up to and including termination. Further, some federal laws impose severe criminal penalties against entities and individuals who engage in illegal retaliation.

1.7 Lobbying/Political Activity. UPH expects Covered Persons to refrain from engaging in activity which may jeopardize the tax exempt status of the organization, including a variety of lobbying and political activities. (See Policy 1.TX.02, Political Contributions/Activities, for additional information.)

1.7.1 UPH Covered Persons may not make any agreement to contribute any money, property, or services at UPH’s expense to any political candidate, party, organization, committee or individual in violation of any applicable law. Covered Persons may personally participate in and contribute to political organizations or campaigns, but they must do so as individuals, not as representatives of UPH, and they must use their own funds.

1.7.2 Where its experience may be helpful, UPH may publicly offer recommendations concerning legislation or regulations being considered. In addition, it may analyze and take public positions on issues that have a relationship to the operations of UPH when UPH’s experience contributes to the understanding of such issues.

1.7.3 UPH has many contacts and dealings with governmental bodies and officials. All such contacts and transactions shall be conducted in an honest and ethical manner. Any attempt to influence the decision-making process of governmental bodies or officials by an improper offer of any benefit is absolutely prohibited. Any requests or demands by any governmental representative for any improper benefit should be immediately reported to the UPH Law Department.

1.8 Environmental. It is the policy of UPH to manage and operate its business in the manner which respects our environment and conserves natural resources. UPH Covered Persons will strive to utilize resources appropriately and efficiently, to recycle where appropriate and otherwise dispose of all waste in accordance with
applicable laws and regulations, and to work cooperatively with the appropriate authorities to remedy any environmental contamination for which UPH may be responsible.

1.9 Discrimination. UPH believes that the fair and equitable treatment of team members, patients and other persons is critical to fulfilling its vision and goals. (See Policy 2.HR.07, Equal Employment Opportunity, for additional information.)

It is a policy of UPH to treat patients without regard to the race, color, religion, sex, national origin, age, disability, veteran status, sexual orientation, or genetic information or any other classification prohibited by law.

It is a policy of UPH to recruit, hire, train, promote, assign, transfer, layoff, recall and terminate team members based on their own ability, achievement, experience and conduct without regard to race, color, religion, sex, national origin, age, disability, veteran status, sexual orientation, or genetic information or any other classification prohibited by law.

UPH will seek to eliminate any form of harassment or discrimination on the basis of race, color, religion, sex, national origin, age, disability, veteran status, sexual orientation, or genetic information or any other classification prohibited by law. Each allegation of harassment or discrimination will be promptly investigated in accordance with applicable Human Resources policies. UPH prohibits any Covered Person from retaliating against anyone for raising, in good faith, a concern regarding harassment or discrimination.

2. Quality of Care and Clinical Values. UPH strives to provide high-quality medical services that are appropriate, safe and in compliance with all applicable laws, regulations and professional standards.

2.1 Credentials. UPH will employ and staff team members with proper credentials, experience and expertise in meeting the needs of our patients and the communities we serve. (See Policy 2.HR.11, Screening of Employee Applicants, and also Human Resources policies and procedures on Licensure/Certification Compliance.)

2.2 Safety. UPH and Covered Persons will take reasonable precautions to ensure our safety, as well as the safety of our patients, visitors and team members.

2.3 Respect for Patients. UPH and Covered Persons will treat patients with consideration and respect, recognizing each patient’s dignity. UPH will meet the health care needs of our patients regardless of race, color, religion, sex, national origin, age, disability, veteran status, sexual orientation, or genetic information.

2.4 Medically Appropriate. UPH and Covered Persons will strive to ensure that admissions, transfers and discharges are medically appropriate and in accordance with legal requirements.
2.5 **Emergency Treatment.** In the event of a medical emergency, UPH will not deny care and services on any other grounds unrelated to the individual's need for the service or the availability of the needed service. (*See Policy I.BR.33, Discounts for Uninsured Patients, Section 2.1, and also affiliate policies on compliance with the Emergency Medical Treatment and Labor Act (EMTALA).*)

2.6 **Effective Communication.** UPH and Covered Persons will communicate effectively with patients and families and respond to patient's treatment needs, requests and concerns. UPH will address any outcome of care, including unanticipated ones and/or medical mistakes, by reporting these to a supervisor who can assess the problem and take appropriate action.

2.7 **Use, Management and Distribution of Drugs.** UPH will comply with all laws and regulations governing the use, management and distribution of drugs. All controlled substances and pharmaceuticals should be properly stored, secured and inventoried. Covered Persons should promptly report to management missing supplies or drugs.

2.8 **Maintain Appropriate Boundaries.** UPH workforce members are expected to act in the best interests of their patients, and to maintain appropriate distance and involvement in those relationships.

3. **Patient Rights.** UPH and Covered Persons will comply with the Medicare Patient Rights requirements and any similar applicable state law requirements, including, but not limited to, those listed below.

3.1 **Responsive Communication.** UPH will respond to patient questions, concerns, complaints, grievances and needs in a timely and sensitive manner.

3.2 **Respect for Patient Values and Beliefs.** UPH will show respect for cultural, spiritual and personal values and beliefs of patients in the care and treatment provided to patients.

3.3 **Inclusion in Care Decisions.** UPH and members of its treatment teams will strive to include patients in clinical and ethical decisions about their care, treatment and services. When appropriate, UPH and members of its treatment teams will seek informed consent prior to the provision of treatment.

3.4 **Protection from Abuse and Harassment.** UPH seeks to protect patients from mental, physical, sexual or verbal abuse, neglect, or exploitation in the care setting by anyone, including physicians, health professionals, staff, other patients, visitors or family members. Any concerns about potential abuse, neglect or exploitation should be immediately reported to a supervisor, manager or compliance officer, and, if required, reported directly to state regulatory authorities.
3.5 Protection from Discrimination. UPH seeks to establish a patient care environment that is free of harassment, including sexual harassment, and that is free from unlawful discrimination on the basis of race, color, religion, sex, national origin, age, disability, veteran status, sexual orientation, or genetic information or any other clarification that is protected by law. Any concerns about potential discrimination should be immediately reported to a supervisor, manager or compliance officer.

3.6 Respect for Patient Rights in Research. UPH will protect patient rights in research involving human subjects through compliance with all applicable legal requirements, including use of an Institutional Review Board or equivalent measure to evaluate and govern research involving patients where appropriate.

3.7 Freedom from Restraints or Seclusion. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

4. Business Ethics. In furtherance of UPH’s commitment to high standards of business ethics and integrity, Covered Persons will accurately and honestly represent UPH and will not engage in any activity or scheme intended to defraud anyone of money, property or honest services.

The standards set forth below are designed to provide guidance to ensure that UPH business activities reflect high standards of business ethics and integrity. Covered Persons’ conduct not specifically addressed by these standards must be consistent with this Section.

4.1 Honest Communication. UPH requires candor and honesty from individuals in the performance of their responsibilities and in communication with our attorneys and auditors. Covered Persons should make truthful and accurate statements to any patient, person or entity doing business with UPH about other patients, persons or entities doing business or competing with UPH, or about the products or services of UPH or its competitors.

4.2 Misappropriation of Proprietary Information. UPH Covered Persons are responsible to assure that no misappropriation of confidential or proprietary information belonging to another person or entity occurs nor utilization of any publication, document, computer program information or product information in violation of a third party’s interest in such product. All UPH Covered Persons are responsible to ensure they do not improperly copy for their own use documents or computer programs in violation of applicable copyright laws or licensing agreements. Covered Persons shall not utilize confidential business information obtained from competitors, including customers lists, price lists, contracts or other information in violation of a covenant not to compete, prior employment
agreements, or in any other manner likely to provide an unfair competitive advantage to UPH.

4.3 **Professional Standards and Judgment.** Covered Persons are expected to conform to the standards of their professions and exercise reasonable judgment and objectivity in the performance of their duties.

4.4 **Safe Work Environment.** UPH will provide a safe work environment that complies with environmental, health and safety laws and regulations.

5. **Right to Personal Privacy and Confidential Treatment of Records.** UPH Covered Persons shall strive to maintain the confidentiality of patient information and other confidential information in accordance with applicable legal and ethical standards.

UPH Covered Persons are in possession of and have access to a broad variety of confidential, sensitive and proprietary information, the inappropriate release of which could be injurious to individuals, UPH’s business partners and UPH itself. Every UPH Covered Person has an obligation to actively protect and safeguard confidential, sensitive and proprietary information in a manner designed to prevent the unauthorized disclosure of confidential information.

5.1 **Patient Information.** All UPH Covered Persons have an obligation to conduct themselves in accordance with the principle of maintaining the confidentiality of patient information. Covered Persons shall refrain from revealing any personal or confidential information unless expressly authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as updated by the HITECH Act, or other state or federal laws or regulations. If questions arise regarding an obligation to maintain the confidentiality of information or the appropriateness of releasing information, Covered Persons should seek guidance from business unit management, applicable HIPAA Compliance Policies on the UPH Hub, the entity’s Privacy Officer or the UPH Law Department. This Section is supplemented by more specific UPH HIPAA privacy and security policies, including Policy 1.MR.01, HIPAA-General Privacy Rules and Glossary.

5.2 **Proprietary Information.** Information, ideas and intellectual property assets of UPH are important to organizational success. Information pertaining to UPH’s competitive position or business strategies, payment and reimbursement information, and information relating to negotiations with Covered Persons or third parties should be protected and shared only with Covered Persons having a need to know such information in order to perform their job responsibilities or other roles with the organization. Covered Persons should exercise care to ensure that intellectual property rights, including patents, trademarks, copyrights and software are carefully maintained and managed to preserve and protect its value. *(See Human Resources policies and procedures regarding Confidentiality of Company Operational/Proprietary Information and Patient Information.)*
5.3 **Personnel Actions/Decisions.** Salary, benefits and other personnel information relating to Covered Persons shall be treated as confidential. Personnel files, payroll information, disciplinary matters and similar information shall be maintained in a manner designed to ensure confidentiality in accordance with UPH policy and applicable laws. Covered Persons will exercise due care to prevent the release or sharing of information beyond those persons who may need such information to fulfill their job function.

6. **Social Media.** UnityPoint Health team members are encouraged to visit and interact with UnityPoint Health’s hosted social media sites. Social media may be used by UnityPoint Health team members subject to the restrictions set forth in Policy 2.HR.25, Social Media. These restrictions are intended to ensure compliance with legal and regulatory restrictions, privacy and confidentiality agreements and UnityPoint Health’s Values and Standards of Behavior.

6.1 **Social Media Guidelines.** Whether using social media networks for personal or professional reasons, team members need to follow guidelines for responsible and safe social media activities. Team members:

6.1.1 May not let social media activities interfere with work, unless the social media activities are part of team member’s job duties.

6.1.2 May not provide unauthorized endorsements of people, products or vendors on behalf of UnityPoint Health.

6.1.3 Should not initiate or accept friend requests with patients unless an in-person friendship pre-dates the treatment relationship.

6.1.4 May not use or disclose any patient identifiable information or protected health information of any kind on any social media sites without the express written permission of the patient. Even if an individual and/or patient is not identified by name within the information, if there is a reasonable basis to believe that the person could still be identified from that information, you may not disclose.

6.1.5 May not use social media to speak on behalf of UnityPoint Health in an official capacity unless you have been officially designated as someone who can. Team members may not say or do anything that might reasonably create the impression that they are communicating on behalf of or as a representative of UnityPoint Health without the express permission of their manager, supervisor, UnityPoint Health Communications/Marketing Department and/or Human Resources Department.

6.2 The social media policy does not apply to content that is personal in nature to team members and non-business related to UnityPoint Health except or unless (1)
the content is being accessed during an team member’s working time or on UnityPoint Health equipment; or (2) it is obscene, defamatory, profane, threatening, libelous, or otherwise violates federal or state law (e.g., employment discrimination statutes) or our non-harassment policies and the content is reasonably likely to negatively affect UnityPoint Health.

7. Conflicts of Interest.

7.1 Definition of Conflict of Interest. A conflict of interest may occur if a UPH Covered Person’s outside activities, personal financial interests, or other personal interests influence or appear to influence his or her ability to make objective, unbiased decisions in the course of the Covered Person’s role at UPH. A conflict of interest may also exist if the demands of any outside activities hinder or distract a Covered Person from the performance of his or her duties or cause the individual to use UPH resources or UPH confidential information for other than UPH purposes. UPH Covered Persons are obligated to ensure they remain free of conflicts of interest in the performance of their duties at UPH. Any Covered Person whose decision or recommendations are or may be affected by any actual or potential conflict of interest must report the circumstances to management, the entity’s compliance officer, the UPH General Counsel or the Chair of the Board, as appropriate. If Covered Persons have any question about whether a certain outside activity or personal interest might constitute a conflict of interest, they must obtain the approval of their supervisor before pursuing the activity or obtaining or retaining the interest.

7.2 Examples of Potential Conflicts of Interests. While not inclusive, the following are examples of types of activities that, if engaged in by a Covered Person, may be a conflict of interest: performing work or rendering services (outside the normal course of his or her role at UPH) for any competitor of UPH; serving as a director, officer, or consultant of such an organization; or permitting one’s name to be used in any fashion that would tend to indicate a business connection with such organization. Covered Persons must obtain approval from his/her supervisor prior to serving as a member of the Board of Directors/Trustees of any organization whose interest may conflict with those of UPH. All fees/compensation (other than reimbursement for expenses arising from such Board of Directors/Trustees participation) that are received by the Covered Person for outside Board services or other services provided during normal work time shall be paid directly to UPH. UPH retains the right to prohibit membership by Covered Persons on any Board of Directors/Trustees, or evaluate such membership by a director, where such membership might conflict with the best interest of UPH.

7.3 Heightened Duty for Certain Covered Persons. All decisions by persons serving in key decision-making capacities within the organization should be based on the individual’s unbiased determination of what is in the best interest of the organization exercising his or her best care and judgment and being free of unreported or impermissible conflicts of interest in making that determination.
Certain Covered Persons, including UPH directors, officers, management and key team members (as defined in the Policy 1.CE.03, Conflict of Interest) have a heightened duty of undivided and unqualified loyalty to UPH. Persons holding such positions are expected to regulate their activities so as to avoid actual impropriety and even the appearance of impropriety which might arise from the influence of those activities on business decisions of UPH, or from disclosure or private use of business affairs or plans of UPH. *(See Policy 1.CE.03, Conflict of Interest, for detailed guidance on potential conflicts of interest.)*

8. **Business Relationships.** Covered Persons are responsible to assure that business transactions with vendors, contractors and other third parties are transacted free from offers or solicitation of gifts and favors or other improper inducements in exchange for influence or assistance in a transaction. The Federal Anti-kickback Statute prohibits the provision of any remuneration, or payment, of any kind in exchange for, or to induce, the referral of any patient or the ordering of any service or supply paid for by a governmental health care program. Criminal penalties may result from violation of this statute. Questions or concerns about this law should be directed to the organization’s compliance officer or to the UPH Law Department.

The standards set forth below are intended to guide Covered Persons in determining the appropriateness of the listed activities or behaviors within the context of UPH business relationships, including relationships with vendors, providers, contractors, third party payors and government entities. *(See Policy 1.CE.14, Gifts and Business Courtesies, for a more detailed statement of the UPH policy on these topics.)* It is the intent of UPH that this Policy be construed broadly to avoid even the appearance of improper activity. If there is any doubt or concern about whether specific conduct or activities are ethical or otherwise appropriate, you should contact your supervisor, the organization’s compliance officer, the President of your organization, the UPH Director of Internal Audit Services, or the UPH Law Department. Nothing in this Policy is intended to affect an entity’s ability to settle or compromise patient complaints or disputed claims with a third party. Nor shall this Policy prohibit a business unit or supervisor from establishing stricter rules relating to the acceptance of gifts, gratuities or other things of value from outside interests or vendors. For purposes of this Section, the term “Gifts and Business Courtesies” includes anything received at reduced or no cost from persons or entities outside of UPH or given by UPH team members, entities or Board Members at reduced or no cost to persons or entities outside UPH. Included are meals, entertainment, social events, professional courtesy discounts, tickets, golf fees, and other gifts or business courtesies of any type. Gifts and Business Courtesies include both tangible and intangible gifts.

8.1 **Gifts and Business Courtesies.** It is UPH’s desire to at all times preserve and protect its reputation and to avoid the appearance of impropriety. Consequently, the following Basic Rules apply to all Gifts and Business Courtesies extended or received by Covered Persons *(see Policy 1.CE.14, Gifts and Business Courtesies, for dollar value limits on gifts).* It is improper for a Covered Person to extend or accept a Gift or Business Courtesy if it violates one of these Basic Rules:
8.1.1 A Gift or Business Courtesy cannot improperly influence decision-making. Decisions made by team members, officers and directors must be objective, unbiased decisions that are in the best interests of the UPH entity and that the person be free of inappropriate conflicts of interest.

8.1.2 No purpose of a Gift or Business Courtesy can be to induce the referral of a patient or the ordering of a service or supply paid for by a governmental health care program.

8.1.3 No Gift or Business Courtesy can be in the form of cash or cash equivalent.

8.1.4 No Gift or Business Courtesy given to an independent physician by a UPH Covered Person or entity or received by a UPH Covered Person from an independent physician can be determined in a manner that takes into account the volume or value of referrals or other business generated between the UPH entity and the independent physician or physician group.

8.2 Acceptance of a Gift or Business Courtesy by UPH Team Members. If the receipt of a gift does not violate the Basic Rules (above) then Covered Persons can receive:

8.2.1 Tangible Gifts or Business Courtesies that are not substantial in value and not more than $100 per gift or $300 in the aggregate per year, from any one vendor or person.

8.2.2 Event-related or intangible Gifts or Business Courtesies that are not more than $100 per person, do not include travel or expenses, are infrequent (not more than four (4) times per year), and the host is present at the event.

8.2.3 Exceptions must be approved in advance by the Covered Person’s compliance officer or CEO.

8.3 Offering or Giving of Gifts or Business Courtesies by Covered Persons or UPH Entities. If the offering of a Gift or Business Courtesy does not violate Basic Rules then Covered Persons can extend:

8.3.1 Tangible Gifts or Business Courtesies that have a value of less than $75 per Gift or Business Courtesy, but not more than $200 in the aggregate per year.

8.3.2 Event-related or intangible gifts if the value is no more than $125 per person, no travel or expenses are paid, the occurrence of such Gift is infrequent (not more than four (4) times per year), and the host is at the event and business is discussed.

8.3.3 Exceptions must be approved in advance by the Covered Person’s supervisor and the entity’s compliance officer or CEO.
8.4 **Special Rules for Acceptance of Gifts and Business Courtesies from Vendors.** Vendors include all non-UPH individuals or entities that provide or may provide goods or services of any kind to a UPH entity.

8.4.1 The same Basic Rules set forth in Section 7.1.1 apply to the acceptance of Gifts and Business Courtesies from Vendors.

8.4.2 **Meals Supplied by Vendors.** Whether to permit meals to be accepted from Vendors by Covered Persons is up to each entity. If the entity allows meals to be accepted, the following parameters should be followed: (a) the meal is modest (as if at your own expense); and (b) appropriate education or information is provided. Dine and dash meals are not acceptable.

8.4.3 **Vendor Sponsored Events.** Special rules also apply to seminars sponsored by Vendors, seminars, conferences and training funded by a Vendor, and to Covered Persons who evaluate a Vendor’s product or service. *(For these rules, and other rules applicable to Vendors, refer to Policy 1.CE.14, Gifts and Business Courtesies, Section 47.)*

8.5 **Gifts to or from Patients.** Covered Persons may not offer or accept non-monetary Gifts and Business Courtesies from patients unless the following apply:

8.5.1 The Basic Rules set forth in Section 7.1 are not violated, and:

8.5.1.1 the Gift or Business Courtesy has a value of no more than $15 per person or $75 total per patient per year; and

8.5.1.2 exceptions require approval from the UPH team member’s supervisor and the entity’s compliance officer or CEO.

Team members are prohibited from soliciting or asking for tips or gratuities from patients. If a patient seeks to give a monetary gift of more than a nominal value, the patient should be referred to the appropriate foundation office.

8.6 **Faculty/Speakers and Consultants.** For rules applicable to Faculty/Speakers, Consultants and Researchers, and for additional guidance on the acceptance and offering of Gifts and Business Courtesies by Covered Persons *(see Policy 1.CE.14, Gifts and Business Courtesies.)*

8.7 **Contracting.** Covered Persons may not inappropriately use “insider” information for any business activity conducted by or on behalf of UPH. All business relations with contractors must be conducted at arms’ length both in fact and in appearance and in compliance with UPH policies and procedures. Covered Persons must disclose personal relationships and business activities with contractor personnel which may be construed by an impartial observer as influencing the Covered Person’s performance, or decision-making. Covered Persons have a responsibility
to obtain clarification from management on questionable issues which may arise and to comply, where applicable, with Policy 1.CE.03, Conflict of Interest.

8.8 **Business Inducements.** Covered Persons are responsible to assure that they do not seek to gain any advantage through the improper use of payments, Gifts and Business Courtesies or other inducements. Offering, giving, soliciting or receiving any form of bribe or other improper payment is prohibited.

Appropriate commissions, rebates, discounts and allowances are customary and acceptable business inducements provided that they are approved by UPH management and that they do not constitute illegal or unethical payments. Any such payments must be reasonable in value, competitively justified, properly documented, and made to the business entity to whom the original agreement or invoice was made or issued. Such payments should not be made to individual persons or agents of business entities.

In addition, Covered Persons may provide gifts, entertainment and meals of nominal value to UPH customers and current and prospective business partners when such activities have a legitimate business purpose, are reasonable and are consistent with this Policy, Policy 1.CE.14, Gifts and Business Courtesies, and all applicable laws.

9, **Relationships Among Colleagues.** UPH seeks to encourage and facilitate positive working relationships between colleagues.

9.1 **Personal Relationships.** From time to time, personal relationships, romantic or otherwise, may exist or develop between two Covered Persons with a reporting relationship or who are otherwise positioned to influence one or both of the Covered Person’s professional interests. Such relationships can pose conflict-of-interests issues, either in fact, or in appearance, in the minds of colleagues, the public, or patients. UPH recognizes that these types of relationships may occur and appropriate notification or assignment steps may need to be taken to prevent such relationships from resulting in a professional issue for the organization or the team members involved. Such relationships must be reported by the persons involved to their immediate supervisor(s) and affiliate Human Resources as soon as possible to determine what, if any, notifications or assignment changes need to be made.

9.2 **Gifts Among Colleagues.** No Covered Person should feel obligated to give a gift to another UPH Covered Person. Lavish gifts should not be given to supervisors or other Covered Persons of influence in the organization in an attempt to gain favor.

9.3 **Fundraising Requests.** No Covered Person should feel compelled to participate in fundraising by another individual or groups of individuals within the organization. When UPH decides to collect donations for a charitable organization, no Covered
Person should feel compelled to donate and whether or not a Covered Person donates will not impact performance evaluations or selection for promotion within UPH.

10. **Substance Abuse and Ability to Perform Job Functions.** UPH will provide a safe work environment. All Covered Persons must report to work without being subject to the influence of alcohol, illegal drugs, prescription drugs used outside the scope of a prescription or other substances including prescription drugs used within the scope of prescription that may hinder job performance or judgment. The illegal use, sale, dispensing, distribution, possession, or manufacture of illegal drugs or other controlled substances by any team member is prohibited and could lead to discipline, up to and including termination. UPH reserves the right to suspend a team member if UPH has reason to believe a team member may not be able to perform his or her job safely.

11. **Protection of Assets.** All Covered Persons will strive to preserve and protect UPH’s assets by making prudent and effective use of UPH resources and properly and accurately reporting its financial condition.

The standards set forth below are intended to guide Covered Persons by articulating UPH’s expectations as they relate to activities or behaviors which may impact UPH’s financial health or which reflect a reasonable and appropriate use of the assets of a nonprofit entity.

11.1 **Internal Control.** UPH has established control standards and procedures to ensure that assets are protected and properly used and that financial records and reports are accurate and reliable. All Covered Persons share the responsibility for maintaining and complying with required internal controls.

Management will institute and maintain internal controls and procedures for financial disclosure and reporting. On an annual basis, Management will present an internal control report to the UPH Board of Directors containing an assessment, as of the end of UPH’s most recent fiscal year, of the effectiveness of UPH’s internal control structure and procedures for financial reporting. Portions of the report applicable to affiliates will be communicated to affiliate Boards.

11.2 **Financial Disclosure and Management Duty to Report and Disclose.** The Chief Executive Officer, Chief Financial Officer and General Counsel of UPH shall report to the Board at each of its regular meetings, and at the meetings of its Executive and other committees as requested.

In periodic and annual reports, Management has a duty to disclose the following information to the Board: the financial performance of UPH, including trends, demands, commitments, events, risks or uncertainties that have a material effect on UPH’s financial condition; the liquidity and capital resources of UPH; and the results of operations.
Management will cooperate with the external auditor’s audit and provide the external auditor with truthful and accurate information. All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is contrary to the policy of UPH and may be in violation of applicable laws.

Management further has a duty to report on corporate matters, including: actual or anticipated material legal action against UPH or adverse media coverage; and actual or anticipated material noncompliance with any policy of the Board. When circumstances warrant, management may also disclose other matters to the Board which may include the view of Covered Persons and external opinions regarding UPH. The information must be presented in a manner that will permit the Board to make informed choices.

All management reports to the Board shall be timely, complete and accurate and shall be presented in a clear and concise manner.

When a management topic is present on the agenda of the UPH Board of Directors, management will distribute reports and documents to the Board in a timely manner which allows Board Members to adequately review and analyze the reports or documents prior to the meeting where such materials will be discussed. It is recognized that there will be extenuating circumstances when a matter may need to appear before the Board in an immediate timeframe and in such circumstances, management may not have time to distribute reports and documents prior to discussion of such materials at a Board meeting.

11.3 Travel and Entertainment. Travel and entertainment expenses should be consistent with the Covered Person’s job responsibility and the organization’s needs and resources. It is UPH’s policy that a Covered Person should not suffer a financial loss nor a financial gain as a result of business travel and entertainment. Covered Persons are expected to exercise reasonable judgment in the use of UPH’s assets and to spend the organization’s assets as carefully as they would spend their own. Covered Persons must also comply with UPH policies relating to travel and entertainment expense.

11.4 Personal Use of Corporate Assets. All Covered Persons are expected to refrain from converting UPH assets to personal use. All property and business of the company shall be conducted in the manner designed to further UPH’s interest rather than the personal interest of a Covered Person. Covered Persons are prohibited from the unauthorized use or taking of UPH’s equipment, supplies, materials or services. Prior to engaging in any activity on company time which will result in remuneration to the Covered Person or the use of UPH’s equipment, supplies, materials or services for personal or non-work related purposes, Covered Persons
shall obtain the approval of the appropriate business unit or other management of UPH.

11.5 **Responsible Use of Equipment and Property.** All Covered Persons are expected to use equipment in a safe manner and in conformance with operating instructions. Covered Persons shall protect the physical property of UPH and any assets entrusted to his or her care by the organization against loss, theft, destruction, misappropriation or misuse. UPH and Covered Persons shall dispose of surplus, obsolete, or unusable property only in accordance with established policies and procedures. Covered Persons should never permit any unauthorized or inappropriate use of computer systems, software, office equipment, telephones, or other UPH property.

12. **Responsibilities of Leaders.** UPH expects that its leaders will be models for others within the organization in exhibiting behavior and ethics that comply with the standards set forth for all Covered Persons in the Code of Conduct. Leaders at UPH include board members, senior executives, medical staff leaders, directors, managers, and shift supervisors.

12.1 **Professional Integrity.** Leaders at UPH are expected to conduct professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect well upon the organization.

12.2 **Standards for Patient Care and Workplace Environment.** Leaders are called upon to create a culture within the organization of high ethical standards, to respect the importance of compliance with legal requirements and to establish a working environment in which all Covered Persons are encouraged to raise concerns and contribute ideas to achieve the organization’s goals in a safe and healthy work environment that is free from harassment, coercion to perform illegal or unethical acts, and discrimination. Leaders should not permit any abuse of power that compromises patients or any other persons served. *(See Policy 2.HR.19, Employees and the Workplace Environment, and Policy 2.HR.08, Workplace Violence/Bullying.)*

12.3 **Training and Education.** UPH encourages its leaders to develop and maintain good healthcare management skills by taking advantage of training resources, including those available through Human Resources and Compliance, to ensure that they are familiar with applicable laws, regulations and business best practices for doing business in a health care setting.

12.4 **Accountability.** Leaders at UPH are expected to hold Covered Persons who report to them accountable for any behavior that does not meet the principles and standards set forth in this Code of Conduct.

12.5 **Duty to Avoid Improper Personal Gain.** Leaders will avoid the improper exploitation of professional relationships for personal gain.
12.6 Disclosure of Financial and Other Conflicts of Interest. Leaders at UPH are expected to review and be familiar with UPH policies on disclosure of conflicts of interest (see Policies 1.CE.03, Conflict of Interest, and Policy 1.CE.03(a), Conflict of Interest (Accountable Care Organizations)) and gifts and business courtesies (see Policy 1.CE.14, Gifts and Business Courtesies) and to properly disclose financial and other conflicts of interest.

12.7 Avoidance of Activities Damaging Credibility and Dignity of UPH or its Leadership. Leaders at UPH should avoid participating in any activity that damages or demeans the credibility and reputation of UPH in the communities it serves.

12.8 Support for Nonprofit/Not-For-Profit Mission and Improving Healthcare of the Communities We Serve. When fulfilling roles in nonprofit or not-for-profit entities, leaders at UPH are expected to demonstrate support and fiduciary duty for the organization’s mission as a tax-exempt organization to provide community benefit through programs or activities that provide treatment and/or promote health and healing as a response to identified community needs.

12.9 Good Financial Stewardship/Drive Sustainable Results. Leaders at UPH will support and promote financial viability through a culture of financial discipline and adoption of best practices in both critical patient care and business processes.

12.10 Risk Tolerance. Leaders at UPH are expected to make decisions in accordance with the UPH Statement of Risk Tolerance (see Attachment A).

12.11 In addition to the attributes and responsibilities listed above, leaders at UPH are expected to demonstrate the following competencies:

12.11.1 Ability to manage talent;

12.11.2 Lead change proactively;

12.11.3 Focus on the team;

12.11.4 Be engaging and inspiring; and

12.11.5 Use patient/customer centered decision making and problem solving.

13. Administration and Application of this Code of Conduct. UPH expects each Covered Person to whom this Code of Conduct applies to abide by the principles and standards set forth in this Code and to conduct the business and affairs of UPH in a manner consistent with the general statement of principles set forth in this Code.

Failure to abide by this Code of Conduct or the guidelines for behavior which the Code of Conduct represents may lead to disciplinary action. For alleged violations of the Code of Conduct, UPH will weigh relevant facts and circumstances, including, but not limited to, the extent to which the behavior was contrary to the express language or general intent of
the Code of Conduct, the egregiousness of the behavior, the Covered Person’s history with the organization and other factors which UPH deems relevant. Discipline for failure to abide by the Code of Conduct may, in UPH’s discretion, range from a verbal warning to termination. In the event that a Covered Person is covered by the terms of a collective bargaining agreement, discipline shall be in accordance with the provisions of the collective bargaining agreement.

Nothing in this Code of Conduct is intended to nor shall be construed as providing any additional employment rights to Covered Persons or other persons.

While UPH will generally attempt to communicate changes concurrent with or prior to the implementation of such changes, UPH reserves the right to modify, amend or alter the Code of Conduct without notice to any Covered Person.

/s/ Kevin E. Vermeer
Kevin E. Vermeer
UPH President

Selected Bibliography:


L. Brown and A. Kandel, The Legal Audit - Corporate Internal Investigations, Clark, Boardman (Callaghan (1991)).


Heffelfinger, Compliance Program Checklist, 12 Preventive Law Reporter 33 (Spring 1994).


*PhRMA Code on Interactions with Healthcare Professionals*, (July 1, 2002).


Addendum A: Legal Entity Operating Hospital

The entities listed below are accurate as of March 20, 2020. A current listing of legal named entities can be found at: https://uphealth.sharepoint.com/sites/intranet/policies/UPHandSystemwide/Addendum%20A.pdf

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<th>Legal Entity Operating Hospital</th>
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<tr>
<td>CEDAR RAPIDS</td>
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<td>ST. LUKE'S/JONES REGIONAL MEDICAL CENTER</td>
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<tr>
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<td>CENTRAL IOWA HOSPITAL CORPORATION</td>
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<tr>
<td>MADISON</td>
<td>MERITER HOSPITAL, INC.</td>
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Attachment A

UnityPoint Health
Statement of Risk Tolerance

Risk tolerance means the amount of risk that an organization is prepared to accept in pursuit of its objectives. A low level of risk tolerance means that the organization wishes to take very little risk. A higher level of risk tolerance means that the organization is prepared to accept more risk in order to achieve its objectives.

UnityPoint Health operates within a variable risk range, depending on the area and type of risk. UnityPoint Health’s lowest risk tolerance relates to patient and employee safety and the quality of clinical care. Compliance risk evaluation requires a balancing of risk and cost. A higher risk tolerance may apply to financial and clinical data reporting objectives, and the greatest risk-taking tolerance may apply to the organization’s strategic and operational objectives. This means that reducing to reasonably practicable levels the risks relating to the provision of healthcare services, our work environment, and material compliance risks, will normally take priority over other business objectives.

This statement of risk tolerance should be applied consistently at all levels of UnityPoint Health.
Safeguards for Protecting Protected Health Information

Effective Date: 04/03; Rev. 04/05, 08/07, 02/10, 02/17, 07/20 (scope update only)

POLICY: All Iowa Health System, d/b/a UnityPoint Health ("UPH") affiliated Covered Entities will comply with state and federal regulations to ensure reasonable safeguards are in place to prevent inappropriate use and disclosure of Protected Health Information ("PHI").

SCOPE: System wide. All UPH affiliate facilities including, but not limited to, hospitals (see attached Addendum A), ambulatory surgery centers, home care programs, physician practices, all UPH and affiliate departments and covered group health plans, as applicable. References to UPH in this policy include UPH, its affiliates, and all organizations more than 50 percent controlled directly or indirectly by UPH.

BACKGROUND: The purpose of this Policy is to comply with the Health Insurance Portability and Accountability Act of 1996 and the accompanying regulations ("HIPAA").

PROCEDURE:

1. Definitions. All capitalized terms shall have the meaning assigned to them in Policy 1.MR.01, HIPAA – General Privacy Rules and Glossary, unless otherwise defined in this Policy.

2. Safeguard Policies and Procedures. All UPH affiliated Covered Entities must have in place reasonable administrative, technical and physical safeguards to prevent inappropriate use and/or disclosure of PHI.

   2.1 Safeguards must reasonably prevent intentional or unintentional use or disclosure of PHI that is in violation of privacy policies and procedures.

   2.2 Safeguards must reasonably limit incidental uses and disclosure made pursuant to an otherwise permitted or required use or disclosure.


   3.1 Safeguards for the protection of the privacy and security of confidential and sensitive information should be targeted to foreseeable threats to the privacy or security of such information. It is appropriate to consider UPH’s actual experience over the years with security and privacy when assessing risk or safeguards.

   3.2 Safeguards should be reasonable. They should be designed to prevent improper access to, or use and disclosure of, confidential or sensitive information by workforce and others, but they should not interfere with
UPH's ability to conduct its business. It is important to balance these objectives.

3.3 Safeguards should be reasonably affordable. It is appropriate to engage in cost benefit analysis. UPH recognizes that it will not always be able to select the most effective solution in an area due to the cost of the solution or the potential detriment to other areas of compliance or operations that may result.

3.4 Safeguards must be evaluated within the resources and capabilities of the organization. These are UPH's responses to perceived threats to the privacy and security of information at UPH, and they should be tailored to fit UPH's specific needs.

3.5 The selection of safeguards, such as the assessment of risk, is to be regarded as dynamic in light of UPH's operating and compliance experience and understanding of applicable laws and regulations. All compliance steps should be open to reevaluation and change. Criticism and suggestions should be encouraged.

3.6 Certain implementation specifications set forth in the HIPAA Security Rule are classified as "Addressable." UPH shall evaluate these implementation specifications. In the event that it is not reasonable and appropriate to meet an addressable implementation specification, then the Corporate Information Security Officer in coordination with each affiliate Information Security Officer shall document why it would not be reasonable and appropriate to implement the specification, and shall implement an equivalent alternative measure.

4. **Guidelines.** The following guidelines are listed to offer assistance to Covered Entities in creating or refining policies and procedures, which will meet the requirements of this Policy. All policies and procedures must be consistent with policies noted in Policy 1.MR.01, HIPAA – General Privacy Rules and Glossary.

4.1 Share PHI only with those authorized to use and disclose PHI and take reasonable steps to limit the PHI shared to what is minimally necessary to accomplish the task. See Policy 1.MR.07, Protected Health Information – Minimum Necessary Requirement.

4.2 Take reasonable steps to verify the identity of persons to whom you disclose PHI.

4.3 Protect access to electronically stored PHI. Do not share your user password, or use another person's user identification or password to access the system.

4.4 Take steps to ensure the privacy of faxed PHI (i.e., location of fax machine, cover sheet with confidentiality statement, use of autodial when possible).
4.5 Use or disclose PHI only in the performance of one’s responsibilities and duties and only to which you are authorized to do so.

4.6 Limit discussion regarding PHI in the presence of persons not entitled to such information or in public places (elevators, lobbies, cafeterias, off premises, etc.).

4.7 Discard all materials containing PHI in a manner that protects the confidentiality of the patient. Destroy PHI materials until there is no possibility of reconstruction. Refer to Policy 1.AD.04, Protection of Information Guidelines.

4.8 Designated users with permitted access, i.e., all employees, medical staff members (including residents), students, volunteers, teachers/educators, researchers, and board members and others granted access to UPH PHI must sign an Information Security Agreement to demonstrate that they agree to the confidentiality rules and privacy/security practices.

4.9 Educate Workforce to notify their supervisor or, where this is not possible, the Affiliate Privacy Officer or designee when aware of a possible inappropriate use or disclosure of PHI.

5. Documentation of Safeguards. A Covered Entity shall document the following and retain such documentation according to Policy 1.AD.03, Record Retention:

5.1 The process of selecting appropriate safeguards, including the cost benefit analysis if applicable; and

5.2 The actual safeguards implemented.

/s/ Kevin E. Vermeer

Kevin E. Vermeer
UPH President

REFERENCES: 45 C.F.R. §§ 164.530(c), (i).
Addendum A: Legal Entity Operating Hospital

The entities listed below are accurate as of March 20, 2020. A current listing of legal named entities can be found at: https://uphealth.sharepoint.com/sites/intranet/policies/UPHandSystemwide/Addendum%20A.pdf

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# Supervision of Residents and Fellows

## 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. |
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.

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/FELLOWS 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.
Title: Social Media

Effective Date: 11/09; Rev. 03/14, 08/15, 06/17, 11/20

POLICY: This policy is intended to provide Iowa Health System, d/b/a UnityPoint Health ("UPH") team members with guidelines for participation in Social Media, including UPH-hosted Social Media and in non-UPH-hosted Social Media.

SCOPE: System wide. All UPH affiliate facilities including, but not limited to, hospitals (see attached Addendum A), ambulatory surgery centers, home care programs, physician practices, all UPH and affiliate departments and covered group health plans, as applicable. References to UPH in this policy include UPH, its affiliates, and all organizations more than 50 percent controlled directly or indirectly by UPH.

BACKGROUND:

1. **Definitions.**

1.1. **Confidential/Proprietary Information.** Information, in any format, that is confidential, privileged, or proprietary to UPH, its affiliates, vendors, suppliers, or donors. Confidential/proprietary information includes trade secrets and proprietary UPH information (business, financial and marketing strategies). These are given as examples only and do not cover the range of what UPH considers confidential, privileged and/or proprietary.

1.2. **Electronic Media.** Non-computing device, e.g., flash memory drives, CDs, DVDs, tapes, hard disks, internal memory, and any other interchangeable, reusable, and/or portable electronic storage media that (1) on which electronic information is stored, or (2) which are used to move data among computing systems/devices including all phones and tablets.

1.3. **Patient Identifiable Information ("PII").** Any individually identifiable information regarding a patient of UPH collected, received, created, transmitted, or maintained in connection with his/her status as a patient, such as PHI, as defined herein. PII includes, but is not limited to, information about a patient's physical or mental health, the receipt of health care, or payment for that care; patient premium records, enrollment and disenrollment information; name, address, Social Security Number, account number, security code, information from or about transactions, driver's license number, financial or credit account numbers, phone
numbers, ISP and Internet domain addresses, and other personal identifiers.

1.3.1. PII does not include individually identifiable information in UPH employment records; however, it may be subject to other state and federal privacy protections. PII does not include individually identifiable information (such as a cell, home or business phone number) that a workforce obtains, transmits, or maintains about another person in the workforce in connection with a personal or employment-related relationship with that person.

1.4. Podcast. A collection of digital media files distributed over the Internet, often using syndication feeds, for playback on portable media players and personal computers.

1.5. Protected Health Information ("PHI"). Individually identifiable information (oral, written, or electronic) about a patient's physical or mental health, the receipt of health care, or payment for that care. PHI includes individually identifiable patient payment, dues, enrollment and disenrollment information. Individually identifiable health information in UPH employment records is not PHI; however, it may be subject to other state and federal privacy protections.

1.6. RSS Feeds or Syndication Feeds. A family of different formats used to publish updated content such as blog entries, news headlines, or podcasts and "feed" this information to subscribers via e-mail or by an RSS reader.

1.7. Social Media. Includes, but is not limited to, blogs, podcasts, discussion forums, on-line collaborative information and publishing systems that are accessible to internal and external audiences (i.e., Wikis), microblogs such as Twitter and Yammer, RSS feeds, video sharing, consumer ranking sites such as Yelp, and social networks such as Facebook, Instagram, Snapchat and LinkedIn.

1.8. UPH Hosted Sites. A site that is created or maintained by UPH such as UPH's Facebook or Twitter sites.

1.9. Web Log or Blog. A site that allows an individual or group of individuals to share a running log of events and personal insights with online audiences.

1.10. Wiki. Allows users to create, edit, and link Web pages easily; often used to create collaborative Web sites and to power UPH Web sites.

POLICY:
1. Social Media may be used by UPH team members subject to the restrictions set forth in this policy. These restrictions are intended to ensure compliance with legal and regulatory restrictions, privacy and confidentiality agreements and UPH’s Values and Standards of Behavior.

2. A violation of this policy may result in corrective action, up to, and including termination.

3. **Notwithstanding any provision in this policy that could suggest a contrary application, nothing in this policy will be interpreted to limit or interfere with an individual’s rights to discuss the terms and conditions of his/her employment or other rights under Section 7 of the National Labor Relations Act.**

4. **UPH-Hosted Sites.**

4.1. **Using Social Media.** Team members are encouraged to visit and interact with UPH-hosted sites. Team members are expected to adhere to UPH compliance requirements and UPH’s policies including UPH’s Values and Standards of Behavior when using or participating in Social Media.

4.1.1. All rules that apply to other UPH communications apply here, specifically, but not limited to: protecting PHI, UPH Confidential/Proprietary Information, safeguarding and proper use of UPH assets, and UPH’s Workplace Harassment policy or local affiliate policy on harassment.

4.2. **Be Respectful.** Team members may not post any material that is obscene, defamatory, profane, threatening, libelous, or otherwise violates federal or state law (e.g., employment discrimination statutes) and/or UPH’s Workplace Harassment policy or local affiliate policy on harassment.

4.3. **UPH-Hosted Blogs.** UPH-hosted blogs must focus on subjects related to UPH.

4.4. **Abide by Copyright Laws.** Team members may not post content or conduct any activity that fails to conform to any and all applicable state and federal laws. For example, it is important for UPH’s and our team members’ protection that everyone abide by the copyright laws by ensuring that they have permission to use or reproduce any copyrighted text, photos, graphics, video or other material owned by others.

4.5. **Obtain pre-approval before setting up UPH-Hosted Sites.** Team members must seek and obtain approval from their manager, supervisor, Communications/Marketing Department and/or Human Resources
Department before setting up a UPH-hosted blog created to communicate information about UPH.

5. **Non-UPH-Hosted Sites.**

5.1. **Confidential/Proprietary Information.** Team members may not disclose any Confidential/Proprietary Information, as defined herein, of or about UPH, its affiliates, vendors, or suppliers.

5.2. **Patient Confidentiality.** Team members may not use or disclose any PII or PHI of any kind on any Social Media without the express written permission of the patient. Even if an individual is not identified by name within the information you wish to use or disclose, if there is a reasonable basis to believe that the person could still be identified from that information, then its use or disclosure could constitute a violation of the Health Insurance Portability and Accountability Act (“HIPAA”) and UPH policy.

5.3. **Self-Hosted Sites.** Team members may not say or do anything that might reasonably create the impression that they are communicating on behalf of or as a representative of UPH without the express permission of their manager, supervisor, UPH Communications/Marketing Department and/or Human Resources Department.

5.4. This policy does not apply to content that is personal in nature to team members and non-business related to UPH EXCEPT OR UNLESS the content is being accessed during an team member’s working time or on UPH equipment. Notwithstanding the above, the policy does apply to content that is personal in nature to team members and non-business related to UPH if it is obscene, defamatory, profane, threatening, libelous, or otherwise violates federal or state law (e.g., employment discrimination statutes) and/or UPH’s non-harassment policy or the local affiliate policy on harassment and the content impacts UPH.

5.5. **Use of Emblems or Logos.** Respect all copyright and other intellectual property laws. For UPH’s protection as well as your own, it is critical that you abide by the laws governing copyright, fair use of copyrighted materials owned by others, trademarks and other intellectual property, including UPH’s own copyrights, trademarks and brands.

**PROCEDURES:**

1. **Social Media Guidelines.** The following guidelines provide for responsible and safe Social Media activities, whether you are using Social Media networks for personal or professional reasons. If you have questions about anything you see here, contact Human Resources or Marketing.
1.1. **Use a Disclaimer.** Whether you publish a blog or participate in someone else's, make it clear that what you say is representative of your views and opinions and not necessarily the views and opinions of UPH. The following standard legal disclaimer language may be used: "The postings on this site are my own and don't represent UPH's positions, strategies, or opinions." OR "DISCLAIMER: This is a personal website, produced in my own time and solely reflecting my personal opinions. Statements on this site do not represent the views or policies of my employer, past or present, or any other organization with which I may be affiliated."

1.2. **Follow All Applicable UPH Policies.** For example, you must not share Confidential/Proprietary Information, as defined herein, and you are required, at all times, to maintain patient privacy. If it will help, reread the policies most relevant to this discussion, including those about acceptable use of technology resources, patient confidentiality, standards of professional conduct, UPH's Workplace Harassment policy or local affiliate policy on harassment.

1.3. **UPH Team Member Badges.** Do not post pictures of yourself or other team members with visible UPH badges on Social Media.

1.4. **Stay Focused on Your Job.** Do not let your Social Media activities interfere with your work.

1.5. **Use Your Own Personal Email Address.** Use your personal email address – not your work email address – when registering for external Social Media intended for personal use.

1.6. **Protect Yourself.** Be careful about what personal information you share online. Also, be mindful of the connection that your personal Social Media accounts have with your professional Social Media accounts and statements posted on one may have impact on the other.

1.7. **Don't Use Social Media to Speak on Behalf of UPH in an Official Capacity.** Don't use Social Media to speak on behalf of UPH in an official capacity unless you have been officially designated as someone who can. Anyone interested in speaking on behalf of UPH through existing or news channels must obtain written permission from their manager, supervisor, Communications/Marketing Department and/or Human Resources Department.

1.8. **Starting Your Internal Blog.** Before starting your own internal UPH blog, get your manager's approval. Follow the proper local procedures to establish a blog.
1.9. **Disclose Your Affiliation.** Be sure to disclose your connection to UPH (and your role in the organization) if you are communicating on the public internet on behalf of UPH.

1.10. **Be Careful Not to Provide Any Endorsements.** Do not provide endorsements of people, products or vendors on behalf of UPH. Our organization does not provide endorsements in Social Media or any other forum without the express approval of their manager, supervisor, Communications/Marketing Department and/or Human Resources Department.

1.11. **Team Members: Don’t “Friend” Patients.** Team members in patient care roles should not initiate or accept friend requests unless an in-person friendship pre-dates the treatment relationship.

1.12. **Managers/Supervisors: Friend Requests.** Managers or supervisors are discouraged from initiating or accepting friend requests from team members he/she supervises unless the in-person relationship pre-dates the employment relationship. This does not apply to professional networks such as LinkedIn.

1.13. **Abide by Copyright Laws.** Respect the laws regarding copyrights, trademarks, rights of publicity and other third-party rights. To minimize the risk of a copyright violation, you should provide references to the source(s) of information you use and accurately cite copyrighted works you identify in your online communications. For UPH’s protection as well as your own, it is critical that you show proper respect for copyrighted material owned by others including text and images.

1.14. **Talking About Your Work Environment?** There are a lot of ways you can do this outside of Social Media, but note that no matter where you state your concerns, non-supervisory and non-managerial team members are protected under the National Labor Relations Act (“NLRA”) to band together, including to join unions or come together even without being in a union, to petition their employer regarding terms and conditions of employment. Accordingly, while team members are expected to comply with the requirements of this Social Media policy, they retain all of the rights provided by the NLRA, and nothing in these guidelines should be read to restrict those rights. UPH encourages team members to talk with their managers, supervisors, and/or Human Resources about any concerns about the work environment.

\[/s/ Susan K. Thompson\]

Susan K. Thompson  
UPH Interim President and CEO
Addendum A: Legal Entity Operating Hospital

The entities listed below are accurate as of March 20, 2020. A current listing of legal named entities can be found at:
https://uphealth.sharepoint.com/sites/intranet/policies/UPHandSystemwide/Addendum%20A.pdf

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The University of Illinois College of Medicine at Peoria  
Summary of Salaries and Benefits for Residents  
based at UnityPoint Health – Methodist

Salaries for the 2021-2022 Academic Year

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<td>$63,916</td>
<td>$66,478</td>
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We have a lot to offer you in addition to our quality training program. Residents receive a competitive benefits package, including:

- Paid personal time off for vacation and sick (20 days per year)
- Employee Health Service
- Hospitalization, major medical, and dental insurance for resident and eligible dependents
- Prescription drug benefits
- Disability insurance
- Temporary and training license reimbursement
- Reimbursement of permanent state physician license, state and federal controlled substances licenses if enrolled in UPH moonlighting opportunities or entering into UPH permanent employment opportunities
- Family leave
- Life insurance
- Liability Insurance. Residents receive professional liability insurance coverage for medical activities within this training program. This insurance provides “occurrence basis” coverage, with limits of $1 million per occurrence and $3 million aggregate.
- Free meals while on duty
- Free parking
- Free lab coats and scrub suits
- $1,200 annually for professional meetings or approved educational materials
- Reimbursement up to $1500 for moving expenses
- Training days available for approved professional meetings or CME
- Free CPR, Neonatal, PALS, ALS, and ACLS provider and recertification courses for Family Medicine
- Free CPR, CPI and ACLS provider and recertification courses for Psychiatry
- Ancillary support personnel allow more time for educational endeavors for Family Medicine
- Full-service medical libraries with free photocopy privileges
- Night call not to exceed every third night averaging Q5; third year call from home for Family Medicine
- Duty-hour compliant call for Psychiatry
- Customary hospital lodging while on call
- Free 2-day practice management seminar for resident and spouse
- Co-ed bowling and softball team with Family Medicine residents
- Social outings for residents and their guests, educational retreats
- Fitness Center free of charge to resident and immediate family
- On-campus day care centers
- Credit union providing share draft accounts, (similar to bank checking accounts), payroll deduction deposits, and ATM machine on-site for easy access of funds

Signing Bonus
In order to encourage students to enter careers in primary care specialties, medical students who match with our Family Medicine residency program through the 2020 NRMP (but not the Supplemental Offer and Acceptance Program; SOAP) will receive an $10,000 incentive payment.

Fourth-year Electives
Fourth-year medical students are encouraged to experience our state-of-the-art facilities and welcoming educational environment first-hand by taking an elective in Peoria. Please call 800-669-0604 to learn more.

For Additional Information:

Family Medicine: http://go.illinois.edu/peoriaGME or e-mail our residency coordinator at kimm.walker@unitypoint.org

Psychiatry: peoriapsych.com or e-mail our residency coordinator at Jamie.Hassall@unitypoint.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 sponsor dictates content of a session or talk, the faculty speaker must clearly delineate what information is so dictated.
   - The speaker must provide a fair and balanced discussion
   - The speaker must make clear that the comments and content reflects the individual views of the speaker and not the University of Illinois, the UIC College of Medicine or the Department

8. Faculty, trainees, students and staff should carefully evaluate whether it is appropriate to participate in off-campus meetings or conferences that are fully or partially sponsored by industry because of the high potential for real or perceived conflict of interest.
C. Provision of Scholarships or Other Educational Funds for Students and Trainees

1. Industry support for students and trainee participation in education programs must be free of any real or perceived conflict of interest. All educational grants or support of educational programs must be specifically for the purposes of education and must comply with the following requirements.
   - The College of Medicine, Department, Program or Division must select the student(s) or trainee(s) for participation
   - The funds must be provided to the Department, Program or Division and not directly to the student or trainee
   - The Department, Program, or Division must determine that the education conference or program has educational merit
   - There is no implicit or explicit expectation that the participant must provide something in return for participating in the educational program

2. This provision does not apply to regional, national or international merit-based awards that will be considered on a case-by-case basis.

D. Disclosure# of Relationships with Industry

Faculty and staff must disclose all financial interests with outside entities in accordance with UIC and University of Illinois policies. The specific disclosure obligation and method is dependent on the activity. The place of disclosure currently is according to university policy.

- Member of the academic staff must complete an annual report disclosing and seeking approval for non-university income producing activity (RUNA). This requires retrospective and prospective disclosure of external activities. Prior written approval from the University is required before undertaking, contracting for, or accepting anything of value in return for consulting or research from any external person or organization. Additional disclosure is necessary whenever a substantial change in external activities occurs or when required by granting agencies. The University Policy on Conflicts of Commitment and Interest is available at:

- All publications must be in compliance with the guidelines of the International Committee of Medical Journal Editors (sssi.cmje.org)
- Covered individuals must complete situation specific disclosures of potential conflicts of interest when required (e.g. 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.