University of South Alabama Health

Graduate Medical Education

Policy and Procedure Manual

2024-2025

I. Introduction

Note: To the extent that there is a conflict between the USA Graduate Medical Education (GME) Institutional Policies and Procedures and policies and procedures developed by specific GME programs (except for polices relating to specialty specific Accreditation Council of Graduate Medical Education (ACGME) certifying board requirements such as leave policies), the Institutional GME Policies and Procedures shall control.

A. Sponsoring Institution (SI)

1. USA GME Programs operate under the authority and control of one sponsoring institution, University of South Alabama Health (USAH) whose governing body is the USAH Executive Committee.
2. USAH assumes ultimate financial and academic responsibility for the GME Programs consistent with the ACGME Institutional Requirements.
3. Oversight of the trainees' educational assignments and the quality of the learning and working environment by USAH extends to all participating sites.
4. USAH and its ACGME accredited programs will only assign trainees to learning and working environments that facilitate patient safety and health care quality.

B. USA GME Mission Statement

1. It is the mission of University of South Alabama Graduate Medical Education to prepare the next generation of diverse, professional physicians to deliver evidence-based, safe, equitable, patient-centered care as leaders in interdisciplinary teams that help people live longer, better lives in our community and beyond.

C. Compliance with ACGME Requirements, Policies and Procedures

1. USAH must be in substantial compliance with the ACGME Institutional Requirements and must ensure that its GME Programs are in substantial compliance with the Institutional Requirements and Common and specialty/subspecialty-specific Program Requirements.
2. Failure of USAH to comply substantially with the Institutional Requirements and maintain accreditation will jeopardize the accreditation of all its GME Programs.
3. USAH and its GME Programs must be in substantial compliance with the ACGME Policies and Procedures for ACGME Review Committees (RC).
4. Of note are those policies and procedures that govern "Administrative Withdrawal" of accreditation, an action that could result in the closure of a USAH GME Program(s) and cannot be appealed.
5. Program directors, teaching faculty, and administrative staff should review the ACGME Policies and Procedures located on the ACGME website at www.ACGME.org.
6. The ACGME Institutional Requirements and Common and specialty/subspecialty-specific Program Requirements are also located on the ACGME website.

7. All program directors, teaching faculty members, and administrative staff of GME Programs should read and become familiar with these requirements.
8. Program directors and administrative staff of GME programs should also read and become familiar with the requirements for certification by their program's corresponding specialty boards.

D. Advancing Health Equity

1. The Sponsoring Institution, in partnership with the programs, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of trainees, faculty members, senior administrative staff members, and other relevant members of its academic community who are interested in serving underserved communities.
2. The USA GME office and Graduate Medical Education Committee (GMEC) work in partnership with the USA Vice President of Medical Affairs along with the GME Advancing Health Equity subcommittee, to implement initiatives to represent all communities in the GME workforce in our academic community.
3. Website: https://www.southalabama.edu/colleges/com/administration/diversity/

II. INSTITUTIONAL RESPONSIBILITIES

A. Administration of Graduate Medical Education

1. USAH administration of GME provides the necessary resources to allow for effective oversight of all GME Programs. The primary institutional components of this administrative structure are the University of South Alabama College of Medicine and University of South Alabama Health, and include a Designated Institutional Official, GME office and GMEC.
2. This administrative system ensures institutional officials, administrators, program directors, faculty members and trainees are provided with the necessary institutional support, ancillary services, access to adequate communication technologies and technological support, space, supplies, and support for professional development necessary to effectively carry out their responsibilities as educational leaders.
3. Trainees are provided with administrative support and a mechanism for having a voice in affairs affecting the trainees and GME Programs via the USA Housestaff Council and peer-selected trainee representation on the GMEC.
4. University of South Alabama College of Medicine (USACOM)
    a. The Dean of USACOM / Vice President for Medical Affairs has responsibility for the College of Medicine's affairs and activities related to undergraduate, graduate, and continuing medical education, including the appointment of teaching faculty members in the various disciplines of medicine.
    b. All teaching members of the medical staff of USAH hold faculty appointments at the USACOM.

c. The Dean of USACOM / Vice President for Medical Affairs appoints an Associate Dean for Graduate Medical Education to oversee all aspects of the USACOM's affairs related to GME at the University of South Alabama.

d. The Associate Dean for Graduate Medical Education serves as Chair of the GMEC and Designated Institutional Official (DIO).

5. University of South Alabama Hospitals

a. USAH is the sponsoring institution for all GME Programs.

b. USA Health University Hospital (USAUH), USA Health Children's and Women's Hospital (USACW) and Providence Hospital are participating hospitals under the governance of USAH.

c. USAH must comply with the ACGME Institutional Requirements and ensure that all GME Programs are in substantial compliance with the Institutional Requirements and Common and specialty-/subspecialty-specific Program Requirements established by the ACGME and its Review Committees (RC).

d. All GME Programs operate under the authority and control of USAH.

6. Designated Institutional Official (DIO)

a. The Designated Institutional Official is appointed by the Dean of USACOM / Vice President for Medical Affairs and has the authority and responsibility for the oversight and administration of USAH GME Programs in collaboration with the GMEC.

b. The responsibilities of the DIO include, but are not limited to:

1) Ensuring and monitoring compliance with ACGME Institutional Requirements and Common and specialty-/subspecialty-specific Program Requirements.

2) Oversight of the GME office;

3) Serving as Chair of the GMEC, as well as the liaison for USAH with program directors, trainees, medical staff, teaching faculty members, officials of affiliated institutions, and the departments responsible for providing ancillary and support services for the GME Programs and participating in meetings, activities, and program oversight activities including but not limited to program self-studies and special reviews;

4) Establishing and implementing procedures to ensure that they, or a designee in their absence, (the Associate DIO), review and approve GME Program documents or correspondence prior to submission for ACGME approval by program directors.

5) Other oversight responsibilities include but are not limited to:

a) All applications for ACGME accreditation of new GME Programs,
b) Changes in trainee complement,
c) Major changes in program structure or length of training,
d) Additions and deletions of participating institutions,
e) Appointment of new program directors,
f) Progress reports requested by any Review Committee,
g) Responses to all proposed adverse actions,
h) Requests for exceptions of trainee work hours,
i) Voluntary withdrawals of program accreditation,
j) Requests for an appeal of an adverse action,
k) Appeal presentations to a Board of Appeal or the ACGME,

l) Approval of program letters of agreement (PLAs) that govern relationships between each program and each participating site providing a required assignment for trainees in the program,
m) Submissions of the Annual Update for each program and the Sponsoring Institution to the ACGME; and,
n) Sponsoring Institution's Self-Study and Accreditation Site Visits.

c. Presenting a written executive summary of the Annual Institutional Review (AIR) to the sponsoring institution's governing body (USAH Executive Committee) that includes at a minimum:

a) a summary of institutional performance on indicators for the AIR; and,
b) action plans and performance monitoring procedures resulting from the AIR.

7. Graduate Medical Education Office

a. The GME office provides administrative support for USAH, USACOM, GMEC, GME Programs, and participating institutions/sites in the administration and oversight of all activities related to graduate medical education.

b. The GME office is under the direction of the Associate Dean for Graduate Medical Education, who reports directly to the Dean of USACOM / Vice President for Medical Affairs.

c. The GME office serves as a liaison with GME Programs, trainees, and affiliated institutions.

d. Responsibilities of the GME office include, but are not limited to the following:

1) Communicating GME policies, procedures and requirements to program directors, trainees and appropriate administrative and support staff;
2) Providing counsel and monitoring of compliance with GME policies and procedures by GME Programs and trainees and reporting of these to USAH and GMEC;
3) Maintaining appropriate institutional files on all trainees currently in training and those who have completed training in GME Programs;
4) Maintaining appropriate institutional records and statistics for each GME Program;
5) Ensuring facilities and support services are provided for trainees;
6) Providing administrative support to the GMEC, maintaining the minutes of the GMEC, and ensuring special reviews are scheduled and conducted in accordance with policy;
7) Coordinating and overseeing participation in the National Resident Matching Program (NRMP) by USAH and GME Programs;
8) Planning and conducting new trainee orientation to USAH and the Institution's policies governing graduate medical education; and
9) Preparation and monitoring of institutional agreements and program letters of agreement with affiliated locations participating in the education of trainees and maintaining the institutional records on same.

B. Graduate Medical Education Committee (GMEC)

1. GMEC Oversight, Membership and Monitoring (Non-Work Hour)

a. A major directive of the ACGME includes “An organized administrative system, led by a Designated Institutional Official (DIO) in collaboration with a GMEC, must oversee all ACGME-accredited programs of the Sponsoring Institution.”

b. The activities of the GMEC are reported to the Dean of USACOM / Vice President for Medical Affairs.

c. The DIO and GMEC must have authority and responsibility for the oversight and administration of USAH GME Programs and responsibility for assuring compliance with ACGME Institutional Requirements and Common and specialty-/subspecialty specific Program Requirements.

d. The GMEC is responsible for oversight of the following:

   1) ACGME accreditation status of the Sponsoring Institution and its ACGME-accredited programs;
   2) Quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites;
   3) Quality of the educational experiences in each ACGME-accredited program that leads to measurable achievement of educational outcomes as identified in the ACMGE Common and specialty-/subspecialty-specific Program Requirements.
   4) ACMGE-accredited programs’ annual program evaluations and Self-Studies;
   5) Clinical Learning Environment Review related activities;
   6) Processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution; and,
   7) The provision of summary information of patient safety reports to trainees, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided.
   8) Reports will be made available to the GMEC and will be documented in the meeting minutes. Reports will then be disseminated to programs to share with their trainees, faculty and other clinical staff as appropriate within their departments.

e. The GMEC is responsible for review and approval of the following:

   1) Institutional GME policies and procedures;
   2) GMEC subcommittee actions that address required GMEC responsibilities
   3) Annual recommendations to the Sponsoring Institution’s administration regarding trainee stipends and benefits to make sure that these are reasonable and fair;
   4) Applications for ACGME accreditation of new programs;
   5) Requests for permanent changes in trainee complement;
   6) Trainee evaluation and promotion;
   7) Major changes in ACGME-accredited programs’ structure or duration of education, including any change in the designation of a program's primary clinical site;
   8) Additions and deletions of ACGME-accredited programs’ participating sites;
   9) Appointment of new and interim program directors;
   10) Annual accreditation letters and other correspondence to and from the ACGME;
   11) Action plans for corrective areas of noncompliance;
   12) Progress reports requested by a Review Committee;

13) Response to CLER reports;
14) Requests for exceptions to clinical and educational work hour requirements;
15) Voluntary withdrawal of ACGME program accreditation;
16) Requests for appeal of an adverse action by a Review Committee;
17) Appeal presentations to an ACGME Appeals Panel;
18) Exceptionally qualified candidates for trainee appointments who do not satisfy the SI's trainee eligibility policy and/or trainee eligibility requirements in the Common Program Requirements;
19) Each of its ACGME-accredited programs' ACGME accreditation information, including accreditation statuses and citations; and
20) Effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR) by identifying performance indicators for the AIR, to include, at a minimum:
    a) The most recent ACGME institutional Letter of Notification;
    b) Results of ACGME surveys of trainees and core faculty members; and,
    c) Each of its ACGME-accredited programs' ACGME accreditation information, including accreditation statuses and citations; and,
    d) Determining monitoring procedures for action plans resulting from the review
21) Effective oversight of underperforming program(s) through the GMEC Special Review Process (Focused and Full Reviews): The Special Review Process is a non-punitive action undertaken in a collaborative manner for the betterment of the program under review.
    a) Criteria for Identifying Underperforming Programs
        (1) Internal Criteria
            (a) Self-identification by the program director /Program Evaluation Committee (PEC). This may be particularly beneficial when the program leadership is having difficulty obtaining adequate resources or support from their department or the sponsoring institution.
            (b) Concerns identified and communicated to the DIO by the program's trainees/faculty/departmental leadership or the sponsoring institution.
            (c) DIO review of Annual Program Evaluations, ADS Annual Program Updates, board pass rates, DIO review of citations and areas for improvement in ACGME Letters of Notification.
            (d) Persistent failure to submit GME office/GMEC required data on or before identified deadlines.
        (2) External Criteria
            (a) Annual ACGME Resident Survey pattern of concerning downward category trends.
            (b) Annual ACGME Faculty Survey pattern of concerning downward category trends.
            (c) RC Letters of Notification, specifically accreditation statuses of Initial Accreditation with Warning, Continued Accreditation with Warning, and adverse accreditation statuses as described by ACGME policies.
22) Special Review Process

a) Program concerns identified through either internal or external criteria will first be investigated by the DIO to determine if the issue can be resolved with GMEC oversight only, with a focused review of a specific or limited concern by the DIO or their designee with reporting to the GMEC (Focused Review), or if a full review by a special review task force is indicated (Full Review).
b) If a program feels that a Full Review is unwarranted; the Program Director (PD) may meet with the DIO to discuss the matter. However, the DIO's decision regarding moving forward with Focused Review versus Full Review following discussion is final.

23) Special Review Task Force
a) When a Full Review is conducted, the DIO will appoint a Special Review Task Force (SR Task Force) to conduct the review.
b) SR Task Force Composition
(1) PD, APD, or faculty member with GME experience from another specialty (preferably a specialty similar to the program undergoing the full special review (SR).
(2) This individual will be responsible for chairing the task force, preparing reports for the DIO/GMEC and report presentation to the GMEC.
(3) A program coordinator (PC) from another specialty (the PC may be from the same or a different specialty as that of the SR Task Force Chair).
(4) A senior trainee from another specialty.
(5) The DIO and staff from the GME office serve as a resource and advisory panel during the process and coordinate and oversee the scheduling of reports to the GMEC by the SR Task Force Chair and PD of the program under review as needed.
(6) Non-physician administrators as appropriate.
c) SR Task Force Responsibilities
(1) Participate in an orientation meeting conducted by the DIO at the beginning of the review process;
(2) Review of provided materials and data in advance of the program review;
(3) Conduct interviews with the PD (SR Task Force Chair), PC (SR Task Force program coordinator member), faculty (SR Task Force Chair), peer-selected trainees from each level of training or all trainees for small programs (SR Task Force trainee member), and stakeholders outside the program as determined by the SR Task Force Chair and DIO. The SR Task Force PC and trainee members submit a written summary of their findings to the task force chair to incorporate into the SR Task Force final report; and,
(4) Maintain strict confidentiality about task force activities and information.
d) The DIO will orient the SR Task Force to the concerns about the program under review and will provide program-related materials and data for assessment, which may include:
(1) ACGME Institutional, Common, specialty-subspecialty specific program requirements;
(2) Letters of notification from previous RC reviews and if applicable, progress reports to the RC;
(3) Reports from previous GMEC mandated reviews of the program, the program director's response to corrective action plans and follow-up;
(4) ACGME Resident and Faculty Surveys;
(5) PEC meeting minutes;

(6) Competency-based, rotation specific goals and objectives for each rotation at each level of training;
(7) Annual Program Evaluation(s) and action plan(s);
(8) ADS Annual Program Update;
(9) NRMP results;
(10) Board pass rate;
(11) Evaluations;
(12) Procedure minimums and trainee procedure logs;
(13) Policies on work hours, supervision, moonlighting, patient handoffs;
(14) Block schedule/call schedule;
(15) Trainee wellness-related policies and procedures; and,
(16) Other (SR Task Force chair may request additional materials for review).

e) The SR Task Force chair will meet with the underperforming program's PD to review documents/data and develop an understanding of the causes/barriers faced by the program.
   (1) The SR Task Force chair may request additional documentation to further understanding of the issues at hand.
   (2) The PC of the underperforming program may also attend this meeting.

f) The SR Task Force PC member and underperforming program's PC will meet to address any concerns specific to the PC role and to gather data about the areas of concern from a PC perspective.

g) The SR Task Force trainee member will hold a confidential forum with the underperforming program's peer-selected trainees from each PGY level to gather information from the trainees' perspective. Information will be compiled and reported anonymously.
   (1) For programs with one fellow, trainees from the sponsoring program may be included to protect the anonymity of the fellow.
   (2) Anonymous surveys may also be employed at the discretion of the task force to gather additional information from faculty, trainees, and staff.
   (3) Other activities as deemed necessary by the SR Task Force/Task Force Chair may also be pursued.

h) Task Force Report
   (1) The SRTF Chair will meet with the underperforming program's PD and the DIO to discuss the task force findings and recommendations.
   (2) The SRTF Chair will draft a report for submission to the DIO and GMEC using the USA GME Special Review Task Report template.

i) Underperforming Program SR Action Plan and GMEC Follow-up:
   (1) The PD of the underperforming program must share the SRTF findings with the trainees and faculty for discussion/input.
   (2) The PD and PEC devise a quality improvement plan of action with implementation timeline recorded on the GME Action Plan and Follow-up spreadsheet.
   (3) The SRTF Chair presents the report findings to the GMEC at the next meeting, and the PD of the underperforming program presents the action plan and timeline for GMEC discussion/approval.

j) Special Review Monitoring of Action Plans
   (1) The DIO assigns deadlines for the Special Review Task Force during the special review process to ensure the Task Force completes its work in a timely fashion.

(2) The DIO assigns PD updates to the GMEC at least quarterly once an action plan has been approved by the GMEC to ensure continual, timely oversight of the action plan resulting from the special review. Program directors must report any potential delays in progress reports to the DIO.

f. GMEC Membership

1) The Associate Dean for GME shall serve as Chair of the GMEC.

2) GMEC membership shall include program directors and associate program directors, peer-selected trainees, hospital administration representatives, a QI/patient safety designee and additional individuals at the discretion of the Associate Dean for Graduate Medical Education and the Dean of USACOM / Vice President for Medical Affairs.

3) Official appointments are made by the Dean of USACOM / Vice President for Medical Affairs with oversight by the Chair of the GMEC and are reviewed annually.

4) Voting membership on the committee includes:

a) Designated Institutional Official

b) Program director or Associate/Assistant program director from each ACGME accredited program.

c) Peer-selected resident and fellow representatives selected from the following ACGME accredited programs:

(1) Two (2) from the primary care specialties (Internal Medicine, Family Medicine, Pediatrics, Med/Peds);

(2) One (1) from the surgery specialties (General Surgery, Orthopedic Surgery, OB/Gyn, and Urology);

(3) One (1) from the remaining fields (Emergency Medicine, Neurology, Pathology, Psychiatry, Radiology); and,

(4) One (1) representative from the fellowships (Cardiovascular Disease, Child and Adolescent Psychiatry, Clinical Neurophysiology, Gastroenterology, Hematology Oncology, Family Medicine Sports Medicine, Pulmonary Disease and Critical Care, Addiction Medicine, Gynecologic Oncology and Surgical Critical Care).

d) Resident and fellow representatives are selected for the GME committee and its subcommittees by their peers using the following steps:

(1) When a committee position is vacated, the chief residents and senior fellows are contacted by the GME office through their program coordinators and asked to submit nominees who are in good standing in their programs to the GME office.

(2) For fellowships with a single fellow, provided the fellow is in good standing in the program, they are invited to appear on the ballot.

(3) Nominees are placed on a ballot and distributed via an anonymous electronic survey to all USA residents and fellows by the GME office.

(4) Ballots are compiled and peer-selected residents and fellows and their GME Programs are notified of appointment to the GMEC.

e) USAH Administration liaison.

f) USAH Housestaff Council Chair.

g) USAH Quality and Safety Council Chair.

g. The complement of voting members present at a meeting of the GMEC shall constitute a quorum. The quorum must include at least one resident or fellow.

h. Non-voting Members

1) Institutional QI/Patient Safety Representative;
2) Clinical Librarian;
3) USA Immigration Coordinator;
4) Director, USA Continuing Medical Education;

i. GMEC Meeting Schedule

1) GMEC meetings are generally held monthly.

j. GMEC Subcommittees

1) GMEC Subcommittees are appointed by the Associate Dean for Graduate Medical Education and include at least one peer-selected trainee member.
2) Subcommittees are generally long-standing committees for ongoing work to address GME related topics.
3) Actions of the subcommittee related to required GMEC responsibilities are reviewed and approved by the GMEC.

2. GMEC Focus Groups

a. GMEC Focus Groups are appointed by the Associate Dean for Graduate Medical Education and include at least one trainee member.

b. GMEC focus groups are intended to address a single GME related topic to facilitate a more rapid recommendation to the GMEC.

c. Actions of the focus group related to required GMEC responsibilities are reviewed and approved by the GMEC.

3. Resident Forum

a. The USA Housestaff Council consists of a chief resident representative from each ACGME-accredited program and a senior fellow representative from each ACGME-accredited fellowship program.

b. Officers, including a Chair and Vice-chair, are elected annually by the Housestaff Council.

c. The Housestaff Council provides trainees with a forum to communicate and exchange information with each other relevant to their learning and working environments and their respective educational programs.

d. The Council meets monthly.

e. Program directors are informed about the meetings so that trainees may be released from other responsibilities.

f. The council meets independently during the first 15 minutes of the meeting after which they are joined by the DIO, hospital administration GME liaison, EHR representative, and quality and safety GME liaison for follow-up and discussion.

g. The GME office provides administrative support to the Council. The Housestaff Council may request that items be added to the GMEC agenda.

1) The role of the Housestaff Council includes, but is not limited to the following:
a) Serves as a trainee advocacy group and voice throughout USAH;
b) Provides Housestaff representation as it pertains to USAH affairs;

c) Promotes educational resources for trainees, education regarding GME policies and procedures, and interaction with medical staff and hospital administration;
d) Re-evaluates/reinforces the policies and procedures of GME at USAH; and
e) Serves as a mechanism for anonymous reporting of trainee concerns.

C. Institutional Agreements and Participating Institutions

1. Responsibility: USAH retains responsibility for the quality of graduate medical education, including trainee education that occurs at other sites. Assignments to participating institutions (major or participating) should:
   a. Be based on a clear educational rationale,
   b. Have clearly stated learning goals and objectives, or should note where these can be found, e.g., Residency Program Handbook, attachment, etc.
   c. Provide resources not otherwise available to the GME Program,
   d. Be of sufficient length to ensure a quality educational experience and should provide sufficient opportunity for continuity of care, and
   e. Demonstrate the ability to promote the GME Program's goals and objectives and peer activities.
2. The program, with approval of its Sponsoring Institution, must designate a primary clinical site defined as the most utilized site of clinical activity for the program.
3. The program's primary clinical site must be approved by the DIO and designated in ADS.
4. Site, as defined by the ACGME, is "an organization providing educational experiences or educational assignments/rotations" for trainees as follows:
   a. Major Participating Site, as defined by the ACGME, is "an RC-approved site to which all trainees in at least one program rotate for a required educational experience.
      1) To be designated as a major participating site in a two-year program, all trainees must spend at least four months in a single required rotation or a combination of required rotations across both years of the program.
      2) In programs of three years or longer duration, all trainees must spend at least six months in a single required rotation or a combination of required rotations across all years of the program.
      3) The term 'major participating site' does not apply to sites providing required rotations in one-year programs. "
   b. Participating Site, as defined by the ACGME, is "an organization providing educational experiences or educational assignments/rotations" for trainees.
      1) Examples of such sites include a university, a medical school, a teaching hospital which included its ambulatory clinics and related facilities, a private medical practice or group practice, a nursing home, a school of public health, a health department, a federally qualified health center, a public health agency, an organized health care delivery system, a health maintenance organization (HMO), a medical examiner's office, a consortium, or an educational foundation."
5. Program Letters of Agreement (PLAs) originate at the program level.

a. It is the responsibility of USAH to assure that each of its GME Programs have established PLAs with its participating sites in compliance with the Common Program Requirements.

b. GME Programs must submit a PLA for all participating sites providing an educational experience or educational assignment/rotation for trainees. PLAs are not required for sites that are under the governance of USAH including USA MCI, USA Strada Patient Care Center, USAH UH, USAH CW, USAH Ambulatory Clinics. **Note:** PLAs are not required for Providence Hospital.

c. The GMEC must review/approve additions/deletions of programs' participating sites.

   1) Upon learning a new participating site is needed, but no fewer than six weeks prior to the date trainees are anticipated to begin rotating to the participating site, the program director must submit a written educational rationale, a copy of the rotation goals and objectives and assurance that sufficient support to meet the goals and objectives will be available at the participating site to the DIO for initial review.

   2) If indicated, the request may also be forwarded to the Dean College of Medicine and Vice President for the USAH System by the DIO for approval.

   3) The DIO will then add the request to the agenda for discussion at the next GMEC meeting for review and approval or conduct an electronic vote.

d. USAH utilizes a standardized PLA that is available in New Innovations. It is the responsibility of the program director to be up to date on specialty-specific requirements that their RC may have further specified regarding participating sites and PLAs.

e. The PLA must include, at a minimum, the following information as outlined in the ACGME Common Program Requirements (CPR):

   1) At each participating site there must be one faculty member designated as the local site director who is accountable for trainee education at that site, in collaboration with the program director.

   2) Specify faculty member responsibilities for teaching, supervision, and formal evaluation of trainees,

   3) Specify the duration and content of the educational experience; and,

   4) State the policies and procedures that will govern trainee education during the assignment.

   5) PLAs must be signed by the program director, local site director at the participating site, the Hospital Contract Officer, and the DIO.

   6) PLAs must be renewed every 10 years. They must also be renewed if there is a change in site director or goals and objectives for the rotation.

   7) **Note:** A new PLA is no longer needed for a change in Program Director.

6. Non-Hospital Setting Agreements (NHSA) must be completed for all non-hospital assignments to which the trainees rotate, regardless of the location (i.e., USA Clinics, private physician, etc.).

   a. These are required by USAH and all questions should be directed to your program liaison.

   b. Non-hospital agreements must be renewed annually.

c. Agreements prepared by other entities that are not in the required format and do not contain the required elements are invalid for purposes of trainee education and will be returned to the GME Program for resubmission. Templates of the current agreements are available on New Innovations®.

7. Processing
   a. Following GMEC approval, all agreements (PLA and NHSA) are created by the program coordinator and sent to their program liaison for review prior to sending for signatures.
   b. Once approved by the liaison, the agreements will then be submitted via Adobe Sign to the Program Director, Local Site Director, the USAH CFO/Contract Officer, and the DIO.
   c. Once all signatures are obtained, the document is loaded into New Innovations by the Program Coordinator. Once this is complete, the coordinator will advise their GME liaison.
   d. The GME office will then request ACGME to make available the participating site in ADS.
   e. The program coordinator and program director are notified by the GME office when the site is available to add the participating site in ADS for their program.
   f. Similarly, following GMEC approval of the deletion of a participating site, the GME office staff will delete the participating site in ADS.
   g. The program coordinator and program director are notified by the GME office staff to delete the participating site in ADS for their specific program.
8. Occupational Exposure
   a. Should a trainee sustain an occupational exposure to communicable disease/occupational injury while at a participating site, the policies and procedures for evaluating occupational exposures and injuries at that site should be initiated by the local site director on behalf of the trainee.

D. Extramural Rotations of a Trainee

1. To initiate an extramural rotation request on behalf of a trainee, program directors must submit an educational rationale with supporting documents to the GME office.
2. Any rotation where training occurs outside the USAH System is considered an extramural rotation, and supporting documents must include the required, signed Hospital and Program Letters of Agreement.
3. Upon review, the GME office will forward the request to the Vice President for the USAH System for approval as indicated. GMEC and DIO approval must be obtained before submitting information or requests to the ACGME.
4. Approved extramural rotations are considered part of the GME Program and are not charged as leave.

E. Restrictive Covenants

1. In accordance with ACGME requirements, neither USAH nor its GME Programs may require trainees to sign a non-competition guarantee.

F. Accreditation for Patient Care

1. All hospitals sponsoring or participating in GME Programs must maintain accreditation to provide patient care. Accreditation for patient care must be provided by:
    a. an entity granted "deeming authority" for participation in Medicare under federal regulations, e.g., Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
    b. an entity certified as complying with the conditions of participation in Medicare under federal regulations.
2. If an entity, such as USAH or a participating site that is a hospital should lose its accreditation for patient care, or have its license be denied, suspended or revoked, or be required to curtail activities or be otherwise restricted, the Institutional Review Committee (IRC) will be notified, and a response plan will be provided within 30 days of such loss or restriction.

G. Quality Assurance and Patient Safety

1. USAH conducts extensive quality assurance, process improvement and clinical effectiveness programs.
    a. Trainees receive an overview of the quality assessment and improvement programs during new trainee orientation.
    b. The USAH Housestaff Quality and Safety Council meets monthly with the Chief Medical Officer (CMO) to provide recommendations for the development of policies and programs based on the Clinical Learning Environment Review (CLER) pathways.
    c. These recommendations are presented to the multidisciplinary USAH Performance Improvement Council, which maintains current knowledge about quality concepts, sets priorities for hospital-wide performance improvement activities, provides for communication of priorities, allocates resources for quality initiatives, and ensures training of the hospital staff.
    d. Responsibility for the education and inclusion of trainees in the Quality Assurance and Quality Improvement activities specific to the department and/or clinical service is carried out in conjunction with the program directors.
    e. USAH is committed to providing structured processes to facilitate continuity of care and patient safety while minimizing the number of transitions in patient care.
    f. USAH is committed to its responsibility for oversight and documentation of trainee engagement in patient safety and quality improvement activities. In addition, USAH ensures trainees have access to the RL6 system for reporting errors, adverse events, unsafe conditions and near misses in a protected manner free from reprisal, and data to improve systems of care, reduce health care disparities and improve patient outcomes.

III. INSTITUTIONAL TRAINING REQUIREMENTS

A. Trainee Eligibility

1. Each GME Program will be required to have a policy in place for trainee eligibility.
2. This policy must ensure all applicants under consideration for residency training in the GME Program meet the eligibility requirements of USAH and the ACGME.
3. Medical Education
    a. Applicants must complete their medical education in one of the following ways:
        1) Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME),
        2) Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA),
        3) Graduates of Medical Schools outside the United States and Canada who meet one of the following qualifications:
            a) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment, or,
            b) Have a full and unrestricted license to practice medicine in the USA licensing jurisdiction in which the ACGME-accredited program is located.
4. Visa Status
    a. The entry of foreign nationals to the United States is governed by the US Immigration and Nationality Act, as amended, which is administered by the US Department of Homeland Security, US Customs, and Immigration Service (USCIS) and US Department of Labor regulations.
    b. All offers of employment must be contingent upon the foreign national being able to secure the appropriate permissions to work in the US, which then shall be provided to USAH as part of the I-9 process before, or on the first day of employment. Failure to complete the I-9 process before or on the first day of employment is a violation of US employment regulations and will result in termination of the offer of employment.
    c. Program directors considering foreign national applicants must carefully review the applicant's US immigration status and obtain approval from the University of South Alabama Office of Immigration to ensure the applicant holds or is eligible to apply for a US immigration status valid for appointment prior to extending an offer or adding to the rank order list in NRMP.
    d. The appropriate immigration statuses for medical trainees include:
        1) United States citizenship,
        2) Legal Permanent Resident of the United States,
        3) J-1 visa (Note: This is NOT a University of South Alabama issued document),
        4) EAD (Employment Authorization Document),
        5) Other Visa statuses may be considered on a case-by-case basis.
    e. H-1B visas WILL NOT be sponsored for trainees at the University of South Alabama.

5. Prerequisite Residency Training
    a. 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.
    b. Residency programs must receive verification of each trainee's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.
    c. The Review Committees may further specify prerequisite postgraduate clinical education and it is the program director's responsibility to stay up to date on this information.
    d. A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-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 PGY-2 level based on ACGME Milestones evaluations at the ACGME accredited program.
    e. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.
6. Trainee Eligibility Exception
    a. Some Review Committees will allow the following exception to the trainee eligibility requirements:
        1) A Review Committee may permit the eligibility exception if the specialty requires completion of a prerequisite residency program prior to admission.
        2) If the specialty-specific Program Requirements define multiple program formats, the Review Committee may permit the exception only for the format(s) that require completion of a prerequisite residency program prior to admission.
        3) If this language is not applicable, this section will not appear in the specialty specific requirements.
    b. An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed above, but who does meet all the following additional qualifications and conditions:
        1) Evaluation by the program director and residency selection committee of the applicant's suitability to enter the program, based on prior training and review of the final evaluations of this training; and,
        2) Review and approval of the applicant's exceptional qualifications by the GMEC; and,
        3) Verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification.
        4) Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation.

7. The GMEC must approve trainee eligibility exceptions for both ACGME accredited and non-accredited programs.
    a. Individual RC policies and procedures must be followed regarding Trainee Eligibility Exceptions.
    b. Program directors must contact the DIO prior to approaching an applicant about an eligibility exception.
    c. Once reviewed by the DIO, in order for the GMEC to consider an eligibility exception, the following documentation must be provided to the GME office.
        1) Documentation received related to prior training, final evaluations of this training, and a written attestation from the program director and residency selection committee as to the applicant's exceptional qualifications.
        2) Proof of eligibility for a limited license from the Alabama Board of Medical Examiners in accordance with Alabama Board of Medical Examiners Administrative Code Chapter 54-x-3 Certificate of Qualifications.
        3) A letter of support from the Department Chair (unless the chair is also the program director).
        4) Verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification.
        5) Visa status review and written approval by the University of South Alabama Office of Immigration.
8. Trainee Transfers
    a. The ACGME states that trainees are considered as transferring trainees when moving from one program to another within the same or different sponsoring institution.
    b. The term ‘transfer trainee’ and the responsibility of the two program directors noted below do not apply to a trainee who has successfully completed a residency and then is accepted into a subsequent residency program.
    c. Internal Trainee Transfer (See below for "external" and "internal preliminary to categorical program" trainee transfer procedures.)
        1) Any trainee, who requests to transfer to a GME Program of another clinical department within USAH, must notify the Institutional Ombudsperson, as soon as possible. This will allow the request to remain confidential.
        2) The Ombudsperson will notify the DIO of the request.
        3) The DIO will then discuss the matter with the program director whose program the trainee has requested to transfer into.
        4) If a position is available, the trainee’s current program director will be notified of the request allowing time to make adjustments to the GME Program’s trainee complement, such as offering an additional slot in the Match.
        5) Any related funding approvals will be addressed by the DIO with the Dean of the College of Medicine and Vice President for Medical Affairs before moving forward.
        6) Provided the transfer is mutually agreeable to all parties and any necessary funding has been approved, the following information, either in written or electronic format, must be provided by the trainee’s current program director for approval by the receiving program director

a) Evaluations – rotational and Milestones;
b) Rotations completed;
c) Procedural/operative experience; and,
d) Final competency-based performance evaluation.

7) Provided the receiving program director is satisfied with the trainee's progress and wants to offer them a spot in their program, the DIO is notified, and the transfer is added to the next GMEC agenda for discussion/approval including approval of any necessary complement increase.
8) All transfer documents must be maintained in the trainee's record in New Innovations.

d. External (Outside) Transfer

1) These procedures apply when a trainee is moving from one program to another from a different sponsoring institution, and when entering a PGY-2 program requiring a preliminary year from an outside institution, even if the trainee was simultaneously accepted into the preliminary PGY-1 program and the PGY-2 program as part of the match (e.g., accepted to both programs right out of medical school).
2) Prior to accepting a transferring trainee from outside USAH, the program director must clear the trainee for employment/training by contacting the GME office and providing the trainee's name and contact information.
3) The transferring trainee will then be required to complete a background release.
4) The applicant will also be required to complete pre-employment health work including a urine drug screen.
5) Documentation required from the trainee's current program director prior to offering the transferring trainee a position includes:
   a) Evaluations - rotational and Milestones,
   b) Rotations completed,
   c) Procedural/operative experience, and
   d) Most recent Milestone evaluation
6) Provided the above performance evaluation documents are satisfactory, the program director may offer the trainee a position pending:
   a) Results of the trainee's background check,
   b) Successful completion of all pre-employment health screening including a urine drug screen, and
   c) If applicable, verification that the trainee does not have a previous commitment to the National Residency Match Program (NRMP) or verification that the trainee has received a waiver from the NRMP releasing them from any previous match commitment.
   d) A Verification of Training and Milestones Evaluation must be received upon the trainee's matriculation into the receiving program.
   e) All transfer documents must be maintained in the trainee's record in either paper or electronic format.

e. Internal Preliminary Year Transfer

1) When trainees are simultaneously accepted into a preliminary PGY-1 GME Program and a categorical PGY-2 GME Program that are both at USAH, the categorical program director must obtain the following information in either written or electronic format from the preliminary program director prior to accepting the preliminary trainee into the categorical program:
    a) Evaluations- rotational and Milestones,
    b) Rotations completed,
    c) Procedural/operative experience, and
    d) Final competency-based performance evaluation either in written or electronic form.
    e) All transfer documents must be maintained in the trainee's record in New Innovations.

9. Physical Exam
    a. All newly appointed trainees must complete a health nurse screening with referral to a physician if indicated within 30 days of the date of appointment.
10. USMLE/COMLEX Examination
    a. All trainees must comply with the requirements for passing USMLE Steps 2 and 3 or COMLEX Levels 2 and 3 as outlined in the University of South Alabama GME Policies and Procedures Manual.
11. Alabama Medical License
    a. All trainees must comply with the requirements for obtaining a restricted (limited) or unrestricted Alabama license to practice medicine as outlined in the University of South Alabama Health GME Policies and Procedures Manual.
12. Alabama Controlled Substance Certificate/DEA Number
    a. All trainees must comply with the requirements for obtaining an Alabama Controlled Substance Certificate/DEA Number as outlined in the University of South Alabama Policies and Procedures Manual.

B. Trainee Selection

1. GME Programs must have a policy in place to ensure that the following requirements of USAH and the ACGME for all applicants selected for an interview are met.
2. GME Program applicants must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, including stipends, benefits, vacation, leaves of absence, professional liability coverage, disability insurance accessible to trainees and health insurance accessible to trainees and their eligible dependents, either in effect at the time of the interview or that will be in effect at the time of the applicant's eventual appointment.
3. GME Programs should select from among eligible applicants on the basis of criteria such as educational preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity.
4. GME Programs must not discriminate with regards to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status.

5. The program director, in accordance with program specific policies and procedures, reviews residency applications and personal interviews are granted to those applicants thought to possess the most appropriate qualifications, as determined by guidelines established by the program.
6. In selecting from qualified applicants, it is strongly suggested that GME Programs participate in an organized matching program when such is available for the specialty.
    a. Programs who recruit US medical school seniors must participate in the National Resident Matching Program (NRMP).
    b. The program director is responsible for verifying the eligibility of all candidates under serious consideration prior to the submission of rank order lists or other offer of a residency position.
7. When a foreign national resident is being considered, the program director or their designee must contact the University of South Alabama Office of Immigration to ensure that the immigration status/visa is acceptable PRIOR to placing them on the program's rank order list. (See Appendix A for contact information)
8. An offer for residency training is extended directly to the applicant by the program director or their designee, through a letter of offer.
9. Immediately following receipt of the results of The Match or the acceptance of an offer for residency training, the program director or the program coordinator is responsible for notifying the GME office of all candidates accepted and providing a copy of the following:
    a. Copy of medical school diploma,
    b. Documentation of any previous residency training,
    c. Copy of Alabama medical license (when available), and
    d. Copy of ECFMG certificate.

C. Trainee Agreement of Appointment (Contract)

1. USAH and program directors must ensure that trainees are provided with a written agreement of appointment/contract outlining the terms and conditions of their appointment upon entry into the GME Program.
2. USAH will monitor the implementation of terms and conditions of appointment by program directors and ensure that these conditions of appointment are responsive to the health and well-being of trainees.
3. USAH will ensure that program directors inform their trainees of and adhere to established educational and clinical practices, policies, and procedures in all sites to which trainees are assigned.
4. The “Postgraduate Training Agreement of Appointment” must be signed by the trainee, program director, and USAH contract officer.
5. The trainee contract must directly contain or provide a reference to the following items:
    a. Trainee responsibilities;

b. Duration of appointment;
c. Financial support for trainees;
d. Conditions for reappointment and promotion to a subsequent PGY level;
e. Grievance (appeal) and due process;
f. Professional liability coverage, including a summary of pertinent information regarding coverage;
g. Health insurance benefits for trainees and their eligible dependents;
h. Disability insurance for trainees;
i. Vacation and leave(s) of absence for trainees compliant with applicable laws;
j. Timely notice of the effect of leave(s) of absence on the ability of trainee to satisfy requirements for program completion;
k. Information related to eligibility for specialty board examinations; and,
l. Institutional policies and procedures regarding trainee clinical and educational work hours and moonlighting.

D. Conditions for Reappointment

1. Non-renewal of Contract for the Next Academic Year
   a. In the event a trainee's postgraduate training agreement of appointment will not be renewed, a written notice of intent must be provided no later than four (4) months prior to the end of the trainee's current agreement.
   b. However, if the primary reason for the non-renewal occurs within the four (4) months prior to the end of the agreement, the GME Program will provide the trainee with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement.
2. Renewal of Contract without Promotion (Extension of Training)
   a. In the event a trainee's training will be extended into the next academic year, the program director must provide the trainee a written notice of intent no later than four (4) months prior to the end of the trainee's current agreement.
   b. However, if the primary reason for the non-promotion occurs within the four (4) months prior to the end of the agreement, the program director will provide the trainee a written notice of intent not to promote with as much time as the circumstances will reasonably allow, prior to the end of the agreement.
   c. The trainee will remain at their current stipend level until the promotion is granted.

E. Promotion / Advancement of Trainees

1. The promotion/advancement of a trainee from one postgraduate level to another in a GME Program occurs following the satisfactory completion of each 12-month period of graduate medical education.
2. Trainees are promoted based on the recommendation of the program director in the context of acceptable milestones evaluations augmented by other evaluation methods and with input by their program's Clinical Competency Committee.

3. A list of names of trainees and their eligibility for promotion will be approved by the GMEC annually in April or May. This list will subsequently be presented at the USAH CW and UH Medical Executive Committee meetings for review and concurrence.

F. Completion of Residency Training: Final Evaluation and Verification of Training

1. Final Evaluation
    a. The program director must provide a final competency-based evaluation for each trainee upon completion of the program. The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure trainees are able to engage in autonomous practice upon completion of the program.
    b. The final evaluation must:
        1) Become part of the trainee's permanent record maintained by the program, and must be accessible for review by the trainee in accordance with institutional and program policy;
        2) Verify that the trainee has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice;
        3) Consider recommendations from the Clinical Competency Committee; and,
        4) Be shared with the trainee upon completion of the program. (Core)
2. Verification of Training
    a. The program director shall use the GME Final Verification of Training (VGMET) Form for documentation and submit the form to the GME office where it will be maintained in the institution's permanent records.
    b. USAH shall issue a certificate of training to each trainee completing a GME Program leading to certification by the American Board of Medical Specialties.
    c. It is the responsibility of the program director to certify a trainee as having satisfied the training requirements of a GME Program and as being eligible to sit for the certifying examination of the specialty.
    d. USAH shall issue a certificate of training to each trainee serving as chief resident during their final year of residency.

G. Maintenance of GME Program Training Records

1. Individual GME programs are to maintain educational records on each individual trainee, summary documentation of the recruitment process, and policy and procedure documents to be in compliance with policies of the University of South Alabama, including The Records Disposition Authority Policy; the laws of the state of Alabama, including the Public Universities of Alabama Functional Analysis & Records Disposition Authority and the Health Care Authorities Records Disposition Authority; the Accreditation Council for Graduate Medical Education requirements including the Common Program Requirements, and the laws of the United States of America, including Equal Employment Opportunity Commission (EEOC) regulations.
2. Individual GME programs are responsible for maintaining and retaining documents relevant to ACGME specialty- and subspecialty-specific requirements.

3. For the purposes of record retention in GME Programs at the University of South Alabama policy, the following terms are defined:
    a. The Performance Assessment, henceforth Assessment, serves the function of formative feedback as defined by the ACGME.
    b. These should be completed at least once during a rotation and at completion of the rotation and "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", and document progressive trainee performance improvement appropriate to educational level.
    c. Programs should use multiple assessment tools, such as:
        1) BLS/ACLS/PALS/ATLS;
        2) Case/procedure logs, including complications;
        3) Completion of institutional safety modules;
        4) Completion of knowledge-based modules;
        5) Conference attendance log;
        6) Critical incidents reporting and feedback;
        7) Direct observation and feedback;
        8) End-of-rotation global assessment;
        9) End-of-year, in-training, or other medical knowledge examinations;
        10) Objective structured clinical examinations (OSCEs);
        11) Peer assessments;
        12) Procedural competency checklist;
        13) Professionalism mini-evaluation exercise (P-MEX);
        14) Self-assessment and reflections/portfolio;
        15) Simulation exercise; and/or
        16) Timeliness in completing institutional and program requirements.
    d. Semiannual Review
        1) The program must provide each trainee with documented semiannual review of performance with feedback, henceforth Review.
        2) The Review should at least include the following:
            a) Reported ACGME Milestones,
            b) Case or procedure logs;
            c) Aggregated Assessment data and feedback with details provided as needed; and,
            d) An Individualized Learning Plan (ILP) for trainees to capitalize on their strengths and identify areas for growth or a performance improvement plan for trainees failing to progress according to institutional policies and procedures.
    e. Final Evaluation
        1) The program director must provide a final evaluation for each trainee upon completion of the program, henceforth Final Evaluation, to become part of the trainee's education file maintained by the program.

2) This evaluation must:
    a) be accessible for review by the trainee in a reasonable period of time, but not more than 30 days after receipt of a request;
    b) document the trainee's performance during the final period of education; and,
    c) verify that the trainee has demonstrated sufficient competence to enter the autonomous practice of medicine.

f. Final Verification of Training (VGMET)

1) The program director must provide a VGMET to become part of the trainee's education file maintained by the program.

2) This verification:
    a) is not provided directly to the trainee, but is used to verify training to outside agencies;
    b) must be available in a reasonable period of time, but not more than 30 days after completion of training program;
    c) must verify the training dates;
    d) must verify the trainee has demonstrated sufficient competence to enter the autonomous practice of medicine.

4. Permanent records are kept forever. These include lists of graduates, policy and procedure manuals and handbooks, and accreditation records, such as letters and notices of accreditation status.
    a. Trainee education files include the trainee residency applications and supporting documents, ECFMG certification, evaluations, all probationary records, case and procedure logs, any documents supporting board eligibility and/or certification, a copy of the certificate of training and copies of final verifications of training.
5. The trainee's file may be addended to include information available after graduation, such as board certification results reported after completion of the program or post-graduate education experiences obtained within the program, department, or institution, such as a mini-fellowship, chief residency, or research program/fellowship.
6. The trainee's education file should be maintained in a dedicated section of the trainee's record until completion of training and retained for 75 years thereafter.
7. Temporary records are retained until completion of training and creation of the Final Evaluation and Verification of Training, including Assessments and documentation of successful remediation.
    a. These documents should be maintained in a separate section of the trainee's record from permanent records.
    b. Any temporary records that include financial data, personnel records, or sensitive information must be shredded for disposal.
8. Records must be maintained in a secure manner with access available only to individuals who are authorized to view the records. Records maintained within New Innovations are considered to be in a secure location, based on the level of privileges authorized by the GME program director.

9. When records are stored external to New Innovations or University servers, a duplicate copy should be maintained in a remote, secure location and protected from environmental and other potential harm; specifically, duplicate copies of records stored in physical form should be maintained in an unattached building.
10. E-mail systems facilitate both internal and external business communications on a day-to-day basis for GME programs. Messages contained on email systems are kept for a limited period. Therefore, email systems should not be considered, or used as, an information archival or storage system and should be considered temporary records.
11. Programs must make a trainee's educational records available for review by the trainee within 30 days of a request by the trainee.
12. Trainees must be notified annually of their right to review their records.
13. Digital records must be maintained on retrievable media platforms.
    a. Digital records may be kept in New Innovations or on University servers.
    b. Records maintained on media external to New Innovations or University servers must be kept in a secure (locked) location.
    c. E-mail, spreadsheet, word processed, and other electronic documents, files, and databases must be retained for the same period as their paper equivalents.

H. Addressing Residency Altering Disasters and Substantial Disruptions in Patient Care or Education

1. USAH is committed to assisting in reconstituting and restructuring trainees' educational experiences as quickly as possible after a disaster. A disaster is defined by the ACGME as "an event or set of events causing significant alteration to the residency experience of one or more residency programs. Hurricane Katrina is an example of a disaster."
2. The institutional disaster plan may also be implemented in the setting of a "local extreme emergent situation" which is defined by the ACGME as "a local event (such as a hospital declared disaster for an epidemic) that affects trainee education or the work environment but does not rise to the level of an ACGME-declared disaster."
3. The ultimate goal of disaster planning efforts is to provide safe patient care and to support the well-being of trainees, faculty members, program and institutional leadership, and their families.
4. Preparation
    a. Trainees are referred to disaster preparedness resources, specifically hurricane preparedness resources at the time of orientation, and are instructed to plan for their immediate family at that time before a disaster occurs.
    b. Plans for families should cover a minimum of four (4) days and should include water, food, medications, cash, important papers, childcare, known shelters and destination sites, and emergency contact numbers to include a third-party contact known to both the trainee and their family.
    c. Trainees are instructed to familiarize themselves with the University Hospital and USACW Emergency Operation Plans located on the USAH website.

d. Due to limited resources, USAH will be unable to accommodate family members (or pets) of trainees.

e. Community based shelters are available for family members and information to access them is provided frequently through local media outlets during the period leading up to the storm.

f. Information about any pet friendly shelters that may be available will also be disseminated through local media outlets.

g. The GME office staff and DIO will maintain contact information for program directors and coordinators, hospital administration and USACOM leadership off site as back- up for access during and following an emergency.

5. Policy and Procedure

a. Department chairs and the DIO are updated by hospital administration throughout all phases of a disaster event and provide instructions to their individual departments.

b. Trainees are to follow departmental instructions as well as departmental disaster policies and procedures and maintain communication with their supervisors as directed.

c. Trainees must be available to return to work after a disaster on the USAH designated "return to work date", unless there are mitigating circumstances approved by the GME Program.

d. Should a trainee refuse to return to work when instructed, they will be subject to disciplinary action as outlined in the GME Policies and Procedures Manual.

e. Supervision policies must be followed by the departments in assigning tasks to trainees during times of disaster.

f. The 80-hour education and work hour requirement must be maintained during a disaster.

g. Trainees must not be expected to perform in any situation outside of the scope of their individual license.

h. Supervising physicians should also monitor the trainees for signs of sleep deprivation and fatigue and adjust schedules accordingly to mitigate these circumstances should they arise, in an effort to ensure patient safety.

i. GME Programs must operate within the guidelines set forth in the ACGME Institutional, Common and specialty/subspecialty specific Program Requirements during a disaster or local extreme emergent situation according to ACGME guidelines during the event.

j. Should a disaster affect the institution by causing significant alterations in the residency training experience of one or more GME Programs, the DIO and/or GMEC will enact the following plan as soon as is feasible:

1) The DIO, associate DIO, GME office representative or other designated individual will make an initial damage assessment based on feedback from the program directors in order to determine the immediate impact on each GME Program and any affected participating sites and the time frame in which the GME Programs anticipate initial progress toward recovery.

2) The DIO or designee will work with the GME Programs and USAH in an effort to assess the impact of the disaster on clinical and hospital operations.

3) The DIO or designee will facilitate an initial post-disaster meeting with available members of the GMEC in order to formulate short-term and long-term plans for moving forward to ensure the integrity of the trainees' educational experience.
4) Specific subjects to be addressed will include:
    a) Safety issues for patients, trainees, faculty members and staff,
    b) Adequacy of faculty members for trainee supervision and patient safety, and
    c) Adequacy of GME Program resources and the physical plant including the electronic health record (EHR), availability of patient testing and treatment services, effectiveness of communication systems, effect on patient volume along with any other issues raised by the GMEC members.
5) The DIO or designee will contact the ACGME to provide an initial status report in follow-up to the GMEC meeting and will maintain regular contact with the GMEC and ACGME for planning purposes should the need to restructure any of the GME Programs as a result of the disaster become evident.
6) The preceding steps will also be followed in the event of a local extreme emergent situation. However, directives for contacting the ACGME in the instance of a disaster versus a local extreme emergent situation differ. These steps are outlined later in this policy and will be followed accordingly.

k. Should the GMEC determine that USAH or any individual GME Program(s) will not be able to rebound from the disaster in an acceptable time frame in order to ensure a satisfactory working and learning environment for the trainees, and depending on the time frame anticipated for recovery, USAH and GME Program(s) will:
    1) Attempt to temporarily relocate trainees to already established participating sites within the local area,
    2) Temporarily transfer trainees to another GME Program, or
    3) Assist trainees in managing permanent transfers should that become necessary.
    4) Should trainees be temporarily transferred to a GME Program at an already established participating site, USAH will continue to pay trainee salary and benefits as long as funds remain available.
    5) Should trainees be temporarily transferred to a GME Program at another institution, USAH will continue to pay trainee salary and benefits at the USA stipend level as long as funds are available, although an effort to negotiate financial support from the institution to which the trainees have temporarily transferred will be pursued. Similarly, the institution will provide assistance for continuation of professional liability coverage.
    6) Should trainees permanently transfer to a GME Program at another institution, USAH will no longer pay their salary and benefits.
    7) These salary and benefit guidelines would also apply should USAH be the recipient of trainees transferring from another institution affected by a disaster. Under such circumstances, that institution would be expected to pay any transferring trainees' salaries and benefits until which time the trainees were permanently transferred to a USAH GME Program.

l. At all times, the trainees will be kept as up to date as possible regarding the anticipated time frame for initial and long-term recovery of USAH and its GME Programs and the date anticipated for resuming support of residency training programs.

m. As much notice as possible will be provided should a GME Program(s) or USAH determine they can no longer support graduate medical education.

6. ACGME Policies and Procedures to be followed during an ACGME declared disaster:
   a. ACGME Declaration of a Disaster
      1) When warranted, the ACGME Chief Executive Officer, with consultation of the ACGME Executive Committee and the Chair of the Institutional Review Committee, will make a declaration of a disaster.
      2) A notice of such will be posted on the ACGME website with information relating to ACGME response to the disaster.
   b. Trainee Transfers and Program Reconfiguration
      1) Insofar as a program/institution cannot provide at least an adequate educational experience for each of its trainees because of a disaster, it must:
         a) Arrange temporary transfers to other programs/institutions until such time as the GME Program can provide an adequate educational experience for each of its trainees, or
         b) Assist the trainees in permanent transfers to other programs/institutions, i.e., enrolling in other ACGME-accredited programs in which they can continue their education.
   c. If more than one program/institution is available for temporary or permanent transfer of a particular trainee, the preferences of each trainee must be considered by the transferring program/institution.
   d. Programs must make the keep/transfer decision expeditiously so as to maximize the likelihood that each trainee will complete the year in a timely fashion.
   e. Within ten (10) days after the declaration of a disaster (see above), the designated institutional official of each sponsoring institution with one or more disaster-affected programs (or another institutionally designated person if the institution determines that the designated institutional official is unavailable) will contact the ACGME to discuss due dates that the ACGME will establish for the programs:
      1) To submit program reconfigurations to the ACGME, and
      2) To inform each program's trainees of trainee transfer decisions.
   f. The due dates for submission shall be no later than thirty (30) days after the disaster unless other due dates are approved by ACGME.
   g. If within the ten (10) days, the ACGME has not received communication from the designated institutional official(s), ACGME will attempt to establish contact with the designated institutional official(s) to determine the severity of the disaster, its impact on residency training, and next steps.

7. ACGME Website
   a. The ACGME will provide, and periodically update, information relating to the disaster on its website (www.ACGME.org).
   b. Communication with ACGME from Disaster Affected Institutions/Programs
      1) On its website, the ACGME will provide phone numbers and email addresses for emergency and other communication with the ACGME from disaster affected institutions and programs.

2) In general, Designated Institutional Officials should call or email the Institutional Review Committee Executive Director with information and/or request for information.
3) Program directors should call or email the appropriate Review Committee Executive Director with information and/or request for information.
4) Trainees should call or email the appropriate Review Committee Executive Director with information and/or request for information.
5) On its website, the ACGME will provide instructions for changing trainee email information on the ACGME Web Accreditation Data System.

8. Institutions Offering to Accept Transfers
   a. Institutions offering to accept temporary or permanent transfers from programs affected by a disaster must complete a form found on the ACGME website. Upon request, the ACGME will give information from the form to affected programs and trainees. Subject to authorization by an offering institution, the ACGME will post information from the form on its website.
   b. The ACGME will expedite the processing of requests for increases in trainee complement from non-disaster affected programs to accommodate trainee transfers from disaster affected programs. The Residency Review Committees will expeditiously review applications and make and communicate decisions.
9. Changes in Participating Sites and Trainee Complement
   a. The ACGME will establish a fast-track process for reviewing (and approving or not approving) submissions by programs relating to program changes to address disaster effects, including, without limitation:
      1) The addition or deletion of a participating site,
      2) Change in the format of the educational program, and
      3) Change in the approved trainee complement.
10. Temporary Trainee Transfer
   a. At the outset of a temporary trainee transfer, a program must inform each transferred trainee of the minimum duration and the estimated actual duration of their temporary transfer and continue to keep each trainee informed of such durations.
   b. If a program decides that a temporary transfer will continue to and/or through the end of a residency year, the transferred trainee must be informed.
11. Site Visits
   a. Once information concerning a disaster-affected program's condition is received, the ACGME may determine that one or more site visits is required.
   b. Prior to the visits, the designated institutional official(s) will receive notification of the information that will be required.
   c. This information, as well as information received by the ACGME during these site visits, may be used for accreditation purposes.
   d. Site visits that were scheduled prior to a disaster may be postponed.
12. ACGME Policies and Procedures to be followed during a Local Extreme Emergent Situation

a. Program director's first point of contact for answers to questions regarding a local extreme emergent situation is the GME office/DIO.

b. The DIO should contact the Executive Director, Institutional Review Committee (ED-IRC) via telephone only if an extreme emergent situation causes serious, extended disruption to trainee assignments, educational infrastructure or clinical operations that might affect USAH or any of its GME Programs' ability to conduct trainee education in substantial compliance with ACGME Institutional, Common, and specialty/subspecialty-specific Program Requirements.

c. On behalf of the USAH, the DIO will provide information to the Executive Director of the Institutional Review Committee (ED-IRC) regarding the extreme emergent situation and the status of the educational environment for its accredited programs resulting from the emergency.

d. Given the complexity of some events, the ED-IRC may request that the DIO submit a written description of the disruptions at the institution and details regarding activities the institution has undertaken in response.

e. Additional updates to this information may be requested based on the duration of the event.

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

g. Upon receipt of this confirmation by the DIO, program directors may contact their respective EDs of their Review Committees, if necessary, to discuss any specialty/subspecialty-specific concerns regarding interruptions to trainee education or effect on educational environment.

h. Program directors are expected to follow their institutional disaster policies regarding communication processes to update the DIO on the results of conversations with EDs-RCs regarding any specialty/subspecialty-specific issue.

i. DIOs are expected to notify the ED-IRC when the institutional extreme emergent situation has been resolved.

I. Closures and Reductions of Programs or Institutions

1. USAH complies with the ACGME's requirements for closures and reductions of residency programs or institutions.
2. USAH will inform the GME Committee, the DIO, and the trainees in writing, as soon as possible, of when it intends to reduce the size or close one or more programs, or when USAH intends to close.
3. Upon notification from USAH, the GMEC will begin to oversee all processes related to the reduction and/or closure.
4. USAH will make every effort to allow those trainees already in the GME Program to complete their education. Should circumstances prevent this, the program director and institution will assist the trainee in enrolling in an ACGME accredited program in which they can continue their education.

J. Presence of Other Learners

1. The presence of other learners (including but not limited to, residents from other specialties, fellows, Ph.D. students and nurse practitioners) in the program must not interfere with the appointed trainees' education. The program director must report the presence of other learners to the DIO, GMEC and as further specified by the program's RC.

K. Availability of Resources

1. USAH and its residency programs ensure availability of the following resources, as specified in the program specific requirements:
    a. Availability of adequate resources for trainee education.
    b. Ready access to specialty/subspecialty-specific and other appropriate reference material, in print or electronic format, to include electronic medical literature.
    c. Databases with search capabilities are available at the Biomedical Library or their website.

L. Vendor Interaction

1. Each department shall establish a policy that meets the departmental educational needs and is in compliance with the USAH Institutional policy as follows:
2. Principles
    a. For purposes of this policy, "vendors" shall include pharmaceutical, biomedical devices, equipment, and other health-related entities.
    b. The admission of vendors or service providers to USAH areas will be monitored and must be pre-approved by the GME Programs' leadership.
    c. Conflicts of interest for physicians generated by pharmaceutical and other health-related industry marketing activities should be resolved consistent with obligations to patient care and medical education.
    d. Faculty members and trainees must commit themselves to intellectual rigor and objectivity in all transmittals of medical information.
    e. The primary mission of USAH residency training programs is to prepare physicians-in-training to deliver patient-focused, competent, evidence-based, and responsible clinical care.
    f. Physicians in training must:
        1) Acquire basic and advanced knowledge of pharmacotherapeutics,
        2) Demonstrate the ability to critically evaluate continuously developing therapeutic information from academic and commercial sources, and
        3) Recognize various commonly employed marketing strategies intended to influence physician practice.
    g. Pharmaceutical detailing must not inappropriately bias physician practice.
3. Guidelines
    a. Faculty Members

1) Faculty members should model behavior consistent with ethical guidelines developed by responsible professional organizations (AMA, ACGME) regarding relationships between physicians and industry.
2) Faculty members comprise any, and all physicians and non-physician instructors engaged in teaching trainees.
3) Regardless of venue or sponsorship, faculty members must present only objective and balanced materials, consistent with established norms of the ACGME and AMA.
4) Faculty members must disclose to peers and trainees relevant financial or other relationships between faculty members and industry that might constitute a conflict of interest, when involved in pharmaceutical or other vendor-sponsored programs, consistent with USA policies and procedures, including but not limited to USA Conflict of Commitment policies.

b. Trainees

1) Trainees may not attend detailing lunches off campus or at ambulatory sites during work hours, unless a faculty member physician is present during the program.
2) Trainees may not engage in any detailing activities (including computer-based detailing) either on campus or off campus, for which they receive gifts or payments.
3) Trainees may not receive payments for participation in lectures or detailing programs including those described as “peer groups’, “advisory boards”, “dinner lectures”, and the like.
4) Trainees may attend social events associated with educational activities under the following circumstances:
   a) The value of the event to the physician is de minimis,
   b) The event facilitates discussion among attendees or between attendees and faculty members, and
   c) The educational portion of the event accounts for a substantial majority of the total time accounted for by the educational activities and social events together.

4. Vendors

a. Admission of vendors to USAH areas is preapproved and monitored.
b. Repair or service representatives requiring access to the buildings on a recurring basis are excluded from this policy and are badged and monitored through Facilities Management.
c. Vendors are expected to contact the department head/attending physician for an appointment through Facilities Management.
d. Vendors seeking contact with hospital departments and/or the physician staff are required to wear the kiosk generated authorization badge at all times.
e. Kiosks at University Hospital are located in the OR, main hospital lobby and cath lab. At USACW, kiosks are located in the main hospital lobby and the OR.
f. Vendors are expected to sign out in the vendor tracking system.
g. Vendors may not loiter within the hospitals or clinics for the purpose of contacting physicians or other health care providers.
h. Vendors may not engage in any detailing, promotional, or educational activities on the inpatient floors.

i. Any representative found in a patient care area will be removed, and repeat offenders will be denied access to USAH.

j. Vendors may not, at any time, promote or offer professionally non-relevant activities, such as raffles, sweepstakes, contests, and tickets to cultural or sporting events.

k. Vendors may meet with the chief of service or designee by appointment.

l. Vendors may provide lunch meals and leave promotional materials, only with prior authorization by the chief of service or designee.

m. Vendors may attend but may not participate in any educational programs.

n. Vendors may not offer scholarship, grants, or funds directly to any trainee.

5. Vendor/Industry Support of Educational Conferences

   a. Vendors may recommend and sponsor a physician guest speaker for an educational conference, as long as:

      1) A faculty member approves the speaker and topic,
      2) There is full disclosure of the speaker's conflicts of interest, and
      3) At least one attending physician is present to moderate/respond to content.
      4) Vendors does not address the attendees (in this setting).
      5) These criteria are consistent with standards of the ACGME.

   b. Presentations by company-sponsored physicians must be objective, fair, and balanced, and be based on available research data. Drugs should be referred to by their generic names.

   c. Funds offered by vendors for trainee educational activities, including scholarship or support for attendance at professional conferences, must be given directly to a program director or USAH, not the trainees. Faculty members must retain full educational discretion over the use of such funds.

6. Presentation by Vendors

   a. Presentations by vendors may have specific value in terms of assisting faculty member(s) in educating trainees in the analysis of promotional material and in recognizing marketing techniques.

   b. Presentations by vendors attended by trainees in either inpatient or outpatient settings, must conform to the following:

      1) All presentations by vendors must be organized and directed by the chief of service or designee;
      2) Attendees must include at least one physician faculty member;
      3) Vendors must make promotional materials to be used during the presentation available to the faculty member preceptor prior to the meeting in a time frame acceptable to the preceptor;
      4) A faculty member should be prepared to discuss the promoted material in an objective and evidence-based fashion or assign this responsibility to a trainee.
      5) This preparation may include critical review of the promotional material, presentation of additional or refuting studies, referencing the promoted information with consensus panel statements, position paper, etc.; and,

6) The vendor may remain for the discussion portion of the meeting at the discretion of the physician faculty member in attendance.

7. Gifts
   a. Consistent with the AMA's Code of Medical Ethics "Gifts to Physicians from Industry", gifts from pharmaceutical companies and medical device manufacturers must be limited to gifts with patient benefit, educational value, and be of insubstantial monetary value.
   b. Gifts of minimal value related to physician's work are also permitted (e.g., pens, notepads).
   c. Trainees may not accept gifts unrelated to professional activities.
   d. Trainees/faculty members may not:
      1) Solicit or receive personal gifts from vendors;
      2) Allow vendors to conduct contests, drawings, or raffles or other activities that lead to personal gifts;
      3) Display gifts or promotional materials that advertise specific branded products in patient care waiting areas; or
      4) Trainees/faculty members may receive competitive awards and scholarship funded by a vendor's company if all control of recipient selection rests with an independent professional organization.
8. Product Samples
   a. Medications and other product sampling are promotional activities and should be limited among the hospital's clinical departments and faculty member's practices.
   b. Sample products may be helpful to patients who have financial difficulty in obtaining needed medications.
   c. However, prescribing and distributing branded medications solely because of gratis availability is inappropriate.
   d. The physician (or designee) responsible for a clinical department or faculty member practice determines the specific medication or product samples to be accepted for distribution.
   e. It may be acceptable to distribute a specific branded medication sample to treat a condition provided:
      1) The quality of care to the patient is in no way compromised by selection of the medication (e.g., efficacy, risk profile, compliance, or cost); and
      2) Physicians may not accept from vendors conditions of face-to-face interaction to procure product samples.

M. Trainees with Disabilities

1. Program directors with trainees having special needs or disabilities will afford reasonable accommodation in accordance with the Americans with Disabilities Act.
2. Contact University of South Alabama Human Resources for more information. https://www.southalabama.edu/departments/financialaffairs/hr/benefits-questions.html

IV. FINANCIAL SUPPORT AND BENEFITS

A. Allocated Residency Positions

1. Any request for residency positions in excess of the allocated number must be reviewed and approved by the GMEC with final approval by the Dean of USACOM / Vice President for Medical Affairs. The following policies are to be followed by program directors in the allocation of residency positions:
    a. The program director may not appoint more trainees than approved by the Review Committee, unless otherwise stated in the specialty/subspecialty-specific requirements.
    b. The program director must have adequate educational resources to support the number of trainees appointed to the program.
    c. The number of hospital-funded trainees in each program will not exceed the maximum number of positions allocated to the program by USAH.
    d. No trainee or program may bill in the trainee's name for any professional service provided by the trainee within the scope of the residency program.

B. Salaries

1. Salaries for each postgraduate year are based on the budget of USAH, with review, comment, and approval by the GMEC.
2. Periodic analysis of national and regional trends is performed, and trainee salaries adjusted in accordance with USAH policy to ensure salaries are competitive with those in the region.
3. Following review by the GMEC and final approval by the Vice-President for USAH, the GME Programs are notified of the coming academic year's salaries.
4. The following policies have been established and should be used as guidelines by program directors in determining the salary level for a trainee:
    a. Trainees in all programs at like levels of training must be paid in accordance with the salary set by USAH for the postgraduate year of training.
    b. Trainees are paid bi-weekly and on Friday.
    c. No trainee may be paid less than or in excess of the base salary set by USAH for the postgraduate year of training.

C. Meals

1. Reimbursement of $5.00 for one evening meal for each in-house overnight call and in-house night float rotation or shift may be requested using the Housestaff "Meal Reimbursement Form".
2. Those funds will be added to the trainee's regular paycheck. All in-house overnight call and in-house night float rotation or shift meals must be verified by the Chief trainee on the service and will not be paid until verified.

3. Requests for meal reimbursement must be received by the Housestaff Office within 8 (eight) weeks of completing the in-house overnight call or in-house night float rotation or shift assignment.

D. Fringe Benefits

1. A comprehensive benefits program is provided for trainees enrolled in GME Programs.
2. Fringe benefits are funded by USAH or other sources of salary support and provide trainees with health and dental insurance, life insurance, disability insurance, and professional liability insurance.
3. Benefits for incoming trainees and their eligible family members are effective on their program start date, provided enrollment applications for insurance are completed within 30 days of their employment date.
4. Health and Dental Insurance Plans
    a. USAH offers two insurance plan options for trainees, both of which include health, dental, and pharmacy benefits. Employees may choose to enroll in either of these two plans and are provided with a summary of the benefit plans to assist in the decision-making process.
    b. Premiums are paid one month in advance, and coverage is typically carried through the last day of the month following the month in which a trainee leaves USAH employment, provided that both health care premium deductions were made in the month before departure.
    c. Additional information can be found on the GME website at https://www.southalabama.edu/colleges/com/gme/salary.html
5. Vision Insurance
    a. Eligible employees can voluntarily elect to enroll in vision insurance with VSP. VSP vision insurance provides coverage and savings on the cost of an annual eye exam, prescription eyewear and lenses, contact lenses, and other eye-related services. The vision plan is built around the VSP provider network, who have higher benefits at a lower cost to the member. The employee pays the full premium for this benefit.
6. Short Term Disability Insurance
    a. USAH provides at no cost to eligible employees short-term disability insurance.
    b. After a 7-day period, benefits are paid at 60% of the employee's total weekly earnings, up to a maximum of $1,000 per week for a covered disability.
    c. Benefits are payable up to 12 weeks, as long as the employee remains unable to work due to a covered disability.
7. Long Term Disability Insurance
    a. The University provides at no cost to the eligible employee long term disability insurance.
    b. A trainee who is unable to return to work due to a medical reason may apply for long-term disability benefits under The Standard.

c. After a 90-day period of disability, 60% of the employee's base monthly salary will be paid for permanent or temporary total disability up to a maximum benefit of $10,000 a month.

d. Trainees who are unable to work due to a medical reason should contact the Housestaff Office to file a long-term disability claim.

8. Life Insurance

a. The University provides at no cost to benefit-eligible employees a group term life insurance plan, based on annual base salary.

b. Additionally, eligible dependents receive a $5,000 term life insurance policy also free of charge.

c. Additional life insurance can also be purchased for the trainee and their eligible dependents.

9. Retirement

a. The University of South Alabama 403(b) Plan

1) USAH provides a defined contribution plan which enables employees to use pre-tax income to contribute to their retirement. Participation is voluntary. The plan currently matches dollar for dollar up to 5% of earnings, up to an annual employer contribution allowed by the IRC Section 401(a)(17) of $16,500. This plan allows eligible employees to invest in fixed and variable annuities and mutual funds in a tax-deferred account.

2) Employees will be fully vested in 3 years when completing 3 years of service.

3) USA HealthCare Management, LLC, also offers a 403(b) supplemental plan that allows eligible employees to invest in fixed and variable annuities and mutual funds. Eligible employees may contribute up to $22,500 ($30,000 if over the age of 50) annually combined between the matching and the supplemental plan.

b. The University of South Alabama 457(b) Plan

1) 457(b) plans allow eligible employees to defer receipt of a portion of their salary until some later date, usually at retirement or termination of employment.

2) Contributions are made on a pre-tax basis and accumulate tax-free until withdrawal.

3) Eligible employees may also contribute post-tax contributions to the Roth 457(b).

E. Professional Liability Insurance

1. Professional liability insurance is provided through the University of South Alabama Professional Liability Trust Fund.
2. It is an occurrence-type policy which, by definition, provides "tail coverage" that includes legal defense and protection against awards within policy limits from claims reported or filed after the completion of the program if the alleged acts or omissions of the trainee are within the scope of the program.
3. The Office of Risk Management and Insurance assists in answering any questions related to professional liability insurance coverage. (See Appendix A for contact information).

4. The Office of Risk Management and Insurance requests immediate notification of their office of any potential liability issue, patient complication or receipt of a subpoena or summons.

F. Vacation, Sick Leave and Holiday, and Parental/Caregiver/Personal Leave Bank

1. The following is a summary of leave policies established by USAH, which generally apply to all trainee(s), except as modified by the policies established by the individual GME Programs:
   a. Vacation
      1) Upon employment and with each anniversary, each trainee is granted four (4) weeks [twenty (20) days] paid vacation leave per twelve (12) month year.
      2) For vacation purposes, each week excludes weekends, and is five (5) days.
      3) Vacation is scheduled at the discretion of the program director or their designee and must be approved in advance.
      4) Pay – Vacation may be applied to all types of leave below if needed. Trainees are not paid for unused vacation time and it is not cumulative.
   b. Sick Leave
      1) Upon employment and with each anniversary, each trainee is granted twelve (12) days paid sick leave per twelve (12) month year.
      2) Sick leave may be used when a trainee is unable to perform work duties due to:
         a) illness or injury;
         b) a member of a household that has been quarantined because of the presence of a contagious disease; or,
         c) required care for a member of the immediate family who is ill (not to exceed three (3) days.) Immediate family is defined to include the following: spouse, mother, father, sister, brother, son, daughter, mother-in-law, and father-in-law. Exceptions to the definition of immediate family members must be approved by the program director.
      3) The program may request a doctor's excuse for sick leave especially for absences longer than three (3) days. USAH reserves the right to have a trainee examined by a physician of its choice in cases where abuse of sick leave is suspected. Abuse of sick leave benefits is grounds for disciplinary action.
      4) Pay - Sick time must be utilized prior to going into unpaid status, if available. Trainees are not paid for unused sick time and it is not cumulative.
   c. Holidays
      1) Holidays are scheduled at the discretion of the program director. Official USAH holidays are not automatically observed as time off for trainees. If the trainee is scheduled to be off for a USAH holiday, they will not be charged a vacation day unless it is included in a week of their vacation leave.
   d. Parental/Caregiver/Personal Leave Bank

1) Beginning on the first day of employment, trainees are provided with up to six (6) weeks of parental/caregiver/personal leave at 100% of pay once during their training program. This leave will run concurrently with other leaves of absence and time off that the trainee may qualify for such as Family Medical Leave or Personal/Medical Leave. The requirements for the use of this GME leave are as follows:
    a) The parental/caregiver/personal leave bank may be used one time during the trainee's program. Once the leave time is used, it exhausts and does not renew.
    b) The parental/caregiver/personal leave bank leave can be taken intermittently or consecutively. If leave is taken intermittently, leave must be taken in at least one-week increments. The program director, program coordinator, and GME office must be made aware of intermittent leave plans.
    c) Trainees must use one week (5 days) of vacation or sick time at the start of the leave period
        (1) Vacation/sick time only needs to be used one time if taken intermittently.
2) The parental/caregiver/personal leave bank can be taken for the following reasons:
    a) The birth of a child and to bond with the newborn child within one year of birth.
    b) The placement with the trainee of a child for adoption or foster care and to bond with the newly placed child within one year of placement.
    c) A serious health condition that makes the trainee unable to perform the functions of their job.
    d) To care for the trainee's spouse, child, or parent who has a serious health condition.

G. Leave of Absence

1. Leaves of absence are defined as approved time away from residency duties, other than regularly scheduled days off as reflected in a rotation schedule.
2. All leave is scheduled with prior approval by the program director except for family emergencies or unexpected illnesses. All trainee leaves of absence anticipated to last more than two (2) consecutive weeks must be reported to the GME office as soon as the program is aware of the leave of absence request.
3. Trainees should consult with their program director to understand how leave may impact their progression towards their specialty board and program completion.
4. Only leaves greater than two (2) weeks will be considered reportable for licensing/credentialing purposes.
5. Types of leave are as follows:
    a. FAMILY AND MEDICAL LEAVE ACT (FMLA)
        1) Trainees will be granted Family Medical Leave (FML) as required by applicable law and consistent with the USA FMLA Policy. FML is only available to employees who have been employed by USAH for at least twelve (12) months.
        2) FML provides eligible trainees up to twelve (12) weeks of unpaid, job-protected leave per 12-month period for the following situations:
            a) Birth of a child, and to care for the newborn child;
            b) Placement of a child with the employee for adoption or foster care;

c) Care for the employee's spouse, child*, or parent with a serious health condition; (*child is defined as a biological, adopted or foster child, a stepchild, a legal ward or a child of a person standing in loco parentis, who is under 18; or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FML is to commence);

d) A serious health condition that makes the employee unable to perform the functions of the employee's job;

e) A qualifying exigency as defined by the Department of Labor arising out of the fact that the spouse, son, daughter, or parent (the "service member") of the employee is on covered active duty or has been notified of an impending call to order to covered active duty;

f) To care for a spouse, son, daughter, parent or next of kin (the "service member") who is a current member or veteran of the Armed Forces or National Guard or Reserves and who has an illness or injury incurred in the line of duty.

3) Further information about FMLA can be found at: https://www.southalabama.edu/departments/financialaffairs/hr/fmla.html

b. NON- FML AND PERSONAL LEAVE

1) Trainees who do not meet the FMLA eligibility requirements may take a personal or medical leave of absence.

2) Further information about personal leave can be found at: https://www.southalabama.edu/departments/financialaffairs/hr/absence.html.

c. GME ADMINISTRATIVE LEAVE

1) Administrative Leave is a general leave status, initiated by the program director, in consultation with the DIO, or initiated by the DIO. Examples of when a trainee may be placed on administrative leave include but are not limited to an internal review or investigation or for an investigation of an external event involving the trainee, such as arrest.

2) Pay – Administrative Leave is paid

3) Further information about GME Administrative Leave can be found under the disciplinary actions section of the GME Policy and Procedure Manual.

d. MILITARY DUTY LEAVE

1) Trainees will be granted military leave as required by applicable law and consistent with the USA Staff Employee Handbook. Please contact the GME office for specific questions about such leave.

e. OTHER LEAVE

1) BEREAVEMENT LEAVE

a) Trainees shall submit requests for bereavement leave to their program director, who may grant up to five (5) days off per PGY year for the funeral of immediate family members. Immediate family is defined to include the following: spouse, mother, father, sister, brother, son, daughter, mother-in-law, and father-in-law. Exceptions to the definition of immediate family members must be approved by the program director.

b) Pay - Trainees are provided with three (3) days of paid bereavement per PGY year. If a trainee requests and is granted more than three (3) days of bereavement leave, the trainee may use their sick or vacation leave time.

2) JURY DUTY
   a) Trainees will be granted leave for jury duty as required by applicable law and consistent with the USA Staff Employment Handbook. Please contact the GME office for specific questions about such leave.

3) PROFESSIONAL DEVELOPMENT
   a) At the program director's discretion, trainees may or may not be charged vacation for attending professional and continuing education meetings as participants, presenters, or as designated representatives of their departments for residency councils or other national appointments.

4) EMPLOYMENT RELATED LEAVE
   a) Paid leave will be granted for trainees to take examination(s) or attend an interview required for medical licensure in the state of Alabama.
   b) At the program director's discretion, trainees may or may not be charged vacation for career related activities, e.g. to take the board certification exam, attend employment interviews, etc.

6. BENEFITS WHILE ON LEAVE
   a. Trainees on medical leave MUST obtain a Return to Work/Physician Release form and return it to the GME office BEFORE the trainee may return to work.
   b. If the trainee is released with restrictions that affect their duties, the trainee should contact the GME office. If the restrictions may necessitate an accommodation, the trainee should contact Human Resources and make the GME office aware of the request for accommodation.

7. RESPONSIBILITY OF TRAINING PROGRAM
   a. Each individual GME program is responsible for understanding the requirements of their Review Committee and Specialty Board to advise trainees of any impact to their board eligibility, program extension or completion. Programs must provide their trainees with a written policy created in compliance with its Specialty Board, Review Committee, and individual program requirements. This policy will state the effect of leaves of absence with regards to satisfying the criteria for completion of the training program.
   b. Trainees' request for time away to which they are eligible must be honored by the training program.
   c. The program is responsible for being in contact with the GME Office once the program is made aware of a leave of absence request.

8. RESPONSIBILITY OF TRAINEE
   a. Prior to leave
      1) The trainee is responsible for communicating as soon as possible with their program and the GME Office regarding potential leave, duration, and timing.
      2) The trainee must initiate a request for leave of absence by submitting the GME leave of absence form to the GME Office.
      3) The trainee is responsible for communicating with their program and the GME office if their leave dates change from what was initially decided prior to their leave.

b. Returning from leave
    1) Trainees on medical leave MUST obtain a Return to Work/Physician Release form and return it to the GME office BEFORE the trainee may return to work.
    2) If the trainee is released with restrictions that affect their duties, the trainee should contact the GME office. If the restrictions may necessitate accommodations, the trainee should contact Human Resources and make the GME office aware of the request for accommodation.

9. LEAVE AND COMPLETION OF RESIDENCY
    a. Trainees can access information related to eligibility requirements for their specialty board.

V. TRAINEE RESPONSIBILITIES AND CONDITIONS OF APPOINTMENT

Note: To the extent that there is a conflict between the USA GME Institutional Policies and Procedures and policies and procedures developed by specific GME programs (except for programs' leave policies), the Institutional GME Policies and Procedures shall control.

A. Compliance with Institutional Policies and Procedures

1. Guidelines have been established by USA and USAH to ensure the safety, happiness and wellbeing of patients, visitors, students, trainees, and employees, and to ensure the productivity of each individual within USA and USAH.
2. Trainees are required to comply with the GME Policies and Procedures in their entirety, USA Drug Free Workplace Policy, the USAH Drug and Alcohol Testing Policy, and General Policies of USA and USAH, except as specifically modified by the GMEC.
3. All USAH standards and policies are available through the USAH Employee Hub at https://usahealthemployeehub.com/ on the Benefits and Wellness tab.
4. In addition, the University of South Alabama's Sexual and other forms of harassment policies are provided in this manual.
5. All trainees are provided with a copy of the GME Policies and Procedures Manual each year and are expected to read and become familiar with USA GME policies and procedures and sign an attestation of having done so.
6. Violation of such policies will subject trainees to disciplinary action of a non-academic type.
7. As a condition of promotion/advancement, and completion of training, trainees are responsible for completing all mandatory education required by the Sponsoring Institution (i.e., compliance training, IHI modules, etc.).

B. Physical Examination, Pre-Employment Drug Screen, and Immunizations

1. Physical Examination
    a. All newly appointed trainees must complete a health nurse screening with referral to a physician if indicated within 30 days of the date of appointment.
2. Drug and Alcohol Policy
    a. Pre-employment Drug Screen

1) Each trainee who is accepted for employment by USAH will be required, as a condition of appointment/employment, to submit to a pre-employment drug screen test.
2) Trainees who test positive will be required to accept a referral by the program director to the USA Employee Assistance Program for evaluation.
3) The program director shall also notify the DIO. A trainee who has a positive drug screen will not be permitted employment until the evaluation and any subsequent referrals for treatment have been completed.
4) Trainees are subject to the provisions set forth in the USAH Drug and Alcohol Policy found at https://www.southalabama.edu/departments/financialaffairs/hr/resources/hrdrugpolicy.pdf and are subject to drug testing when:
   a) There is reasonable cause to suspect the trainee is in violation of this policy;
   b) The trainee has been involved in a job site accident or incident which resulted, or might have resulted, in serious bodily injury or property loss or damage;
   c) The trainee is selected for random testing in order to monitor and ensure compliance with this policy.
5) The program director or Hospital Administration will contact the USAUH or USACW Personnel Manager to request testing of trainees under the conditions listed above.

3. Immunizations
   a. Tuberculosis Testing: All new incoming trainees are required to have a QuantiFERON gold TB test upon employment. Should a trainee be exposed to TB during subsequent training at the institution, repeat testing will be performed.
   b. Measles/Mumps/Rubella: Documentation of previous immunization must be shown at the time of starting the residency.
   c. Tetanus Toxoid: A tetanus toxoid booster will be given to all trainees who have not received a booster within the last ten years.
   d. Hepatitis B: Trainees considered to be at high risk for exposure to Hepatitis B will be offered a three-dose vaccine regimen at no cost to the trainee.
   e. Varicella: All trainees who have not had chickenpox (varicella zoster virus) will be tested for the presence of varicella antibodies. Trainees who are seronegative must receive the recommended two-dose series of varicella vaccine at no cost to the trainee.
   f. Influenza: All trainees employed by or rotating at a USAH facility must be vaccinated against influenza by December 1st of each year.
   g. COVID-19: per USAH policy.
   h. Trainees may obtain vaccinations, at no charge, through the hospital's health nurse office. Availability of vaccinations will be announced.
   i. These records will be maintained in the trainee's file by the Employee Health Nurse.

C. Identification Badges

1. Newly appointed trainees will have identification badges issued to them during orientation.
2. This identification badge should be worn prominently at all times while on duty.

D. Orientation for New Trainees

1. Newly appointed trainees are expected to attend orientation.
2. Orientation for new trainees is designed to facilitate each trainee's entry into the USAH system, provide education on policies and procedures, and expedite the completion of all required paperwork.
3. Trainees unable to attend orientation are required to notify their program coordinator and program director and report to the GME office for processing and instructions for completion of the required paperwork.

E. Postgraduate Training Agreement of Appointment (Trainee Contract)

1. A "Postgraduate Training Agreement of Appointment" must be signed by the trainee, program director and contract officer for USAH, upon entry into a USA GME Program and when promoted to the next PGY level.
2. The original agreement must be maintained in the GME office as part of USAH permanent record.

F. Leaving the Residency

1. Any trainee who plans to resign from their current residency at USAH, for any reason, should notify their departmental program director and chair in writing as soon as possible, but no less than thirty (30) days prior to the effective date of resignation.
2. The program director or the program coordinator must notify the DIO and the GME office of the resignation.
3. The program director must also provide timely verification (within 30 days) of residency education including a final evaluation and verification of training for trainees who leave the program prior to completion.

G. Institutionally Required Certifications

1. Trainees are required to obtain and maintain certifications as determined by individual GME programs such as BLS, ACLS, ATLS, PALS, and NRP;
2. Individual programs are responsible for this oversight according to their program's policies and procedures.

H. United States Medical Licensing Examinations (USMLE)/ Comprehensive Osteopathic Medical Licensing Exam (COMLEX)

1. USMLE Step 2/COMLEX Level 2
    a. All trainees with M.D. or D.O. degrees, regardless of postgraduate year, must take and receive a passing score on the Clinical Knowledge part of USMLE Step 2 (for M.D.s) or COMLEX Level 2 (for D.O.s) by the completion of their third month after entering a residency training program at USAH.

b. For example, if a trainee begins the PG year on July 1st, the deadline for successful completion of the applicable exam is September 30th of the same year.

2. USMLE Step 3/COMLEX Level 3

a. All trainees with M.D. or D.O. degrees must take and receive a passing score for USMLE Step 3/COMLEX Level 3 as soon as possible after beginning their PGY-2 year, but at the latest by the completion of the 6th month of postgraduate year two (taking and passing the exam by October 10 will avoid the necessity of paying for both a limited and a full license in the same calendar year).

1) The trainee must submit the report to the Program Coordinator to be uploaded in New Innovations.

b. Notwithstanding the foregoing, licensure requirements for trainees transferring into USAH will be determined as part of the transfer process. Refer to www.USMLE.org for eligibility requirements to take USMLE Step 3.

3. Oversight and Disciplinary Action

a. Individual GME programs will be primarily responsible for monitoring the compliance of their trainees with this policy.

b. As additional oversight, the GME office will request a status report from the GME Programs in September for trainees needing to pass USMLE Step 2/COMLEX Level 2 as outlined above.

c. The names of trainees who have been unsuccessful will be referred to the GME office / DIO.

d. The GME office will request a status report from the GME Programs in October for trainees needing to pass USMLE Step 3/COMLEX Level 3 as outlined above. The names of trainees who have been unsuccessful will be referred to the GME office/DIO.

e. Failure to meet these requirements will result in the trainee being reported to the GMEC to be addressed on a case-by-case basis.

f. Any trainee that receives a fine or other adverse action from the Board must immediately report it to the Program.

1) Upon notification from the trainee, the Program must notify the GME office.

g. Failure to successfully navigate their medical licensing exams by completion of the 6th month of postgraduate year two may result in dismissal from the GME Program.

h. This disciplinary action is not grievable and cannot be appealed by the trainee.

I. Licensure

1. Limited Alabama Medical License

a. All trainees, whether U.S. or International Graduates, who are not eligible for an unrestricted Alabama medical license must obtain a limited medical license to be obtained by their first day of employ.

2. Unrestricted Alabama Medical License

a. All trainees must apply for and obtain an unrestricted Alabama license to practice medicine when they meet the requirements stipulated by the Alabama Board of Medical Examiners.

b. Trainees who transfer into a GME program off cycle must apply for and obtain an unrestricted Alabama license to practice medicine at the time they meet requirements stipulated by the Alabama Board of Medical Examiners.

3. Licensure Reimbursement
   a. USAH will reimburse trainees for the cost of licensure once annually.
   b. Late fees or other penalties will not be reimbursed.
4. Oversight and Disciplinary Action
   a. Individual GME programs will be primarily responsible for monitoring the compliance of their trainees with this policy.
   b. As additional oversight, the GME office will monitor for licensure compliance.
   c. All trainees will be required to demonstrate to their GME programs and the GME office that they have obtained and maintained a medical license (unrestricted or limited) with the Alabama Board of Medical Examiners according to the policies and procedures outlined above.
   d. Noncompliant trainees will be reported to the GMEC and addressed on a case-by-case basis. This disciplinary action is not grievable and cannot be appealed by the trainee.

J. Alabama Controlled Substance Certificate (ACSC) and Drug Enforcement Administration Certificate (DEA) (See moonlighting policy for specifics related to trainees engaging in moonlighting)

1. USA Hospitals and Clinics
   a. Trainees will apply for a fee exempt DEA through the Housestaff office once licensure is obtained. A fee exempt DEA can ONLY be used within the USAH System.
   b. Any trainee required by their program to prescribe controlled substances will be required to have an Alabama medical license, limited or unrestricted, a DEA registration and an Alabama Controlled Substance Certificate.
   c. Trainees will not be able to write prescriptions for controlled substances until these have been obtained.
   d. Once obtained, trainees must maintain a current ACSC and DEA registration for the remainder of their GME training.
   e. Trainees must only use the individual DEA and ACSC numbers assigned to them.
   f. Use of another physician's numbers will be grounds for termination.
2. ACSC and DEA Reimbursement
   a. USAH will reimburse trainees for the cost of the ACSC once annually.
   b. Late fees or other penalties will not be reimbursed.
   c. Trainees are eligible for fee waivers for federal DEA certificates to use within their training program; therefore, the cost of DEA certificates is not reimbursed.
3. Oversight and Disciplinary Action
   a. Individual programs will be primarily responsible for monitoring the compliance of their trainees with this policy.

b. As additional oversight, the GME office will monitor ACSC and DEA certificate compliance in January of each year, and copies of current ACSC and DEA certificates must be provided to the GME office prior to contract renewal for the next academic year.

c. The GME office/DIO will monitor for trainees not in compliance with obtaining or maintaining their ACSC/DEA certificates.

d. Noncompliant trainees will be reported to the GMEC and addressed on a case-by-case basis.

e. This disciplinary action is not grievable and cannot be appealed by the trainee.

4. Trainees in training programs where controlled substances are not prescribed will not be required to obtain a DEA registration or ACSC. However, they must obtain a limited or unrestricted Alabama medical license as outlined above.
5. As with all GME Programs, trainees may not prescribe or order-controlled substances without DEA and ACSC certificates.

K. Educational and Work Hours

1. All GME Programs are required to incorporate the ACGME and USA GME Policies and Procedures on educational and work hours into their individual program's policy and procedure manual.
2. Trainees will be required to follow their GME Program's policy on educational and work hours.
3. USA GME Educational and Work Hours Policies are outlined in Section IX of this manual.

L. Moonlighting

1. Trainees may undertake moonlighting activities only in accordance with USA GME Policies and Procedures and individual program specific written policies and procedures.
2. Moonlighting is not required by USAH. The USA GME Moonlighting Policies and Procedures are found in section IX of this manual.

M. Participation in Educational and Professional Activities

1. Trainees are expected to develop a personal program of learning to foster continued professional growth with guidance from the teaching staff that leads to measurable achievement of educational and professional outcomes as outlined in the Six Core Competencies below:
   a. Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;
   b. Medical Knowledge that demonstrates knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care;

c. Practice-based Learning and Improvement that demonstrates the ability to investigate and evaluate their care of patients, appraise and assimilate scientific evidence, and continuously improve patient care based on constant self-evaluation and life-long learning;

d. Interpersonal and Communication Skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;

e. Professionalism that demonstrates a commitment to carrying out professional responsibilities and an adherence to ethical principles; and

f. Systems-based Practice that demonstrates an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

2. Participation in the educational and scholarly activities of their GME Programs and, as required, assume responsibility for teaching and supervision of trainees and students;
3. Participation on appropriate committees and councils whose actions affect trainee education and/or patient care;
4. Participation in educational programs offered by USAH and GME programs; and
5. Submission of confidential written evaluations of the faculty members and the educational experience to the program director, at least annually.

N. Trainee Duties

1. Trainees must demonstrate an understanding and acceptance of their personal role in the following areas:
   a. Assurance of the safety and welfare of patients entrusted to their care;
   b. Provision of patient and family-centered care;
   c. Assurance of their fitness for duty;
   d. Management of their time before, during, and after clinical assignments;
   e. Recognition of the symptoms of burnout, depression, substance abuse, and fatigue in themselves and others and knowledge of how to seek appropriate care for themselves and assist those experiencing these conditions;
   f. Alert the program director or other designated personnel or programs when they are concerned that another trainee or faculty member may be displaying signs of burnout, depression, substance abuse, fatigue, suicidal ideation, or potential for violence;
   g. Attention to lifelong learning;
   h. Monitoring of patient care performance improvement indicators; and,
   i. Honest and accurate reporting of educational and work hours, patient outcomes, and clinical experiences.
2. Completion of all assigned learning activities/modules required by the USA GME office, USAH and the individual residency programs by the expected deadlines.
3. The trainee staff shall adhere to the current USAH Bylaws and Medical Staff Rules and Regulations as applicable and any subsequent amendments approved by the

Medical Executive Committee, USAH Executive Committee, and the Board of Trustees.

4. Trainee staff shall adhere to all current applicable policies promulgated by the Graduate Medical Education Committee and any subsequent amendments.
5. Trainee staff shall also adhere to current USAH Policies and Procedures, USA GME Policies and Procedures, and any subsequent amendments approved by Hospital Administration, the Medical Executive Committee, the USAH Executive Committee, or the Chief Executive Officer.

O. Work Related Communication

1. Work-related communication and updates will be distributed using the official USAH email account. Personal email accounts will not be used for this purpose. Trainees must regularly check their USAH email account and keep up to date with all work-related communication.

P. Dress Code

1. Professional appearance is important.
2. Trainees at USAH are expected to maintain high standards of professional appearance at all participating sites and educational functions.
3. Trainees must be neat, clean, and dressed in a manner that is appropriate for the practice of medicine.
4. Identification badges are to be worn prominently at all times when on duty.
5. Additional dress codes may be defined for trainees working in specific departments or clinical areas.

Q. Electronic, Digital, and Internet Communications, Including Social Networking and User-Created Web Content

1. Background
    a. The relationship between the healthcare provider and the patient is based on a sacred bond of trust and respect. Within the protection of that relationship, those seeking healing present themselves, yielding a vulnerable portion of themselves with the expectation of trust. To quote Hippocrates, “All that may come to my knowledge in the exercise of my profession or in daily commerce, which ought not to be spread abroad, I will keep secret and will never reveal.”
    b. Within the assurance of trust, the principles of confidentiality and privacy thrive. The ability of the patient to confide in their healthcare providers allows the providers to gather personal health information and thereby render diagnoses and therapies. The healthcare provider is entrusted to act in the best interests of their patient and to protect the personal health information provided to them in the process of assessing, diagnosing, and healing. The patient should expect their healthcare providers to share information with others on a legitimate “need to know” basis. Without this confidence the patient may not be forthright with vital personal information necessary for the healing professions. Without patient authorization, disclosure of this protected health

information is a breach of the confidence that patients have in their healthcare providers and the providers' associates and weakens all healthcare professions.

c. Within the pledge of respect, the healer exerts authority and provides guidance to the infirmed. Blurring boundaries between the healthcare provider and the patient diminishes the provider's integrity, authority and both parties' respect for the other. Loss of professional standing may render healthcare providers unable to fulfill their professional responsibilities.

d. Upon these principles of trust and respect, policies and guidelines for handling patient relationships and personal health information are based.

2. Purpose and Scope

a. Acknowledging the benefits to patients when healthcare providers are readily accessible, healthcare providers must consider protection of confidential information, loss of personal interactions and the possibility of misunderstanding of communications when interacting with patients via non-verbal mechanisms.

b. Inappropriate use of communication tools, such as posting patient personal health information or patient photographs/videos on social media sites, blogs, or discussion boards can violate federal, state, and/or local laws, resulting in the posting healthcare provider facing the possibilities of civil liability, employment related discipline including job loss, disciplinary actions by licensing and credentialing authorities, and criminal investigations and sanctions.

c. The ever-evolving world of communication tools, and in particular the area of the digital, electronic, and internet communication platforms, represents a challenge to individuals and groups to be engaged and relevant in their community while maintaining professional standards of comport.

d. With the advent of social media outlets and advancing capabilities of mobile devices, employees, faculty, trainees, students, staff, and associates (henceforth "healthcare providers") must be cognizant and respectful of patient privacy and confidentiality as protected by the Health Information Portability and Accountability Act of 1996, as amended from time to time (collectively referred to as HIPAA).

e. The purpose of this policy is to ensure the proper and uniform use of digital and electronic communication tools in the University of South Alabama (USA) healthcare, education, and associated settings to reduce the risk of inappropriate or unlawful disclosures of protected health information (PHI).

f. It is the intent of this policy statement to establish procedures and provide guidelines for the professional use of digital, electronic and internet communication tools.

g. This policy addresses activities that (1) affiliate or identify a healthcare provider with USA or any members of its organized healthcare arrangements (OHCA) as delineated in the privacy notice, (2) use USA-provided communication tools, including but not limited to web pages, text messaging, email correspondence, and current or future social media websites, or (3) appear to represent the interests of USA. This policy is not intended to impact activities that do not represent USA and are purely related to personal matters not involving patients, including legally protected free speech.

h. This policy statement applies to the following:

1) Activities that would fall under the jurisdiction of HIPAA, such as handling of PHI by USA healthcare providers via digital, electronic, and internet communication tools, including remote access into USA medical records of PHI.
2) Digital and electronic communications between healthcare providers in the process of carrying out their professional responsibilities.
3) Activities on electronic media and user-created web content.
4) Common communication platforms and web content include email, text and instant messaging, cell phones, tablets, and other mobile devices, blogs and journaling, internet posts and comments, and social media networks, including, but not limited to, Doximity, Facebook, LinkedIn, Twitter, and YouTube.

3. Policy
   a. Protected Health Information
      1) With very limited exceptions and only as authorized by the HIPAA Compliance Office, identifiable PHI, including identifiable case descriptions, must never be published, on the internet or otherwise, without the patient's expressed and documented permission.
      2) This applies even if no one other than a patient is able to identify themself from the posted information.
      3) Healthcare providers must adhere to all HIPAA principles, including the reporting of HIPAA violations. PHI should be accessed and transmitted only in accordance with USA HIPAA privacy and security policies.
   b. Representation of USA or USAH
      1) Unauthorized use of institutional information or logos as in creation of any social media site that is branded to represent USAH, and authorization must be obtained from USAH Marketing and Communications.
      2) Only authorized individuals are permitted to represent USAH online.
      3) USAH websites and edits to existing content should be sent to the appropriate marketing contact for each division, department/section /office.
      4) Individuals given access to edit content directly must adhere to all policies of both USAH Marketing and Communications and USA Web Services.
      5) Among other requirements, official posts must respect copyright, fair use, and financial disclosure laws.
      6) Posting of institutional phone numbers, email addresses, web addresses, photographs or videos to the internet must be done in accordance with USA policy.
   c. Communication Using E-mail, Texting, and Instant Messaging
      1) Secure platforms for communicating PHI by healthcare providers are USA provided Microsoft Exchange/Outlook, and secure portal communication systems (e.g., Cerner).
      2) USA healthcare providers are fully responsible for their communications whether on USA-owned or personally owned communication devices.
      3) Digital communication tools may supplement, but not replace, face-to-face interaction.

4) Text messaging and email communication with a patient requires that a HIPAA-compliant authorization signed by the patient has been scanned into the patient's electronic health record.

5) Publicly available email (Hotmail, Gmail, Yahoo, etc.), texting, and instant messaging systems are not secure, do not guarantee confidential communication, and cannot be used for communicating PHI among providers.

6) Furthermore, healthcare providers cannot be certain that no other party has access to the patient's communications.

d. Offering Medical Advice

1) It is never appropriate to provide medical advice on a social networking site.

2) Interactions between patients and healthcare providers should occur within an established healthcare relationship.

3) Initial assessment of a patient's condition and development of a care plan must be performed in an appropriate clinical setting.

e. Privacy Settings

1) Healthcare providers should consider setting privacy at the highest level on all social networking sites.

2) This policy is not meant to discourage the use of innovative technologies, but to provide guidance and heighten the awareness of healthcare providers at USAH to the potential risks and consequences.

f. Violations of this or any USA computer or information privacy policies or laws, including, but not limited to, those regarding student and patient information, may lead to disciplinary action, up to and including termination and/or legal action.

4. Procedures

a. USAH recognizes the rapidly changing landscape of communication tools.

b. Healthcare providers will adhere to professional standards in their use of digital, electronic, and internet communication tools by acknowledging and observing the following:

c. USAH institutional resources are provided to healthcare providers for the primary purpose of timely completion of their educational and clinical/work duties, including the access and transmission of PHI.

d. Personal use of USAH resources should not interfere with these duties.

e. USAH healthcare providers should not expect privacy when using institutional computers.

f. Privacy and confidentiality between the healthcare provider and the patient are of the utmost importance. All healthcare providers have an obligation to maintain their personal access authorization through their supervisory personnel/leadership.

g. Be aware that photographs taken in the healthcare environment may contain PHI, including the presence of patients in the background or foreground of the photograph.

h. Remote access into any USAH system containing PHI should be performed in a secure environment.

i. Remote access into any USAH medical record system in public venues or via open Wi-Fi connections should not be considered secure or HIPAA compliant. Passwords to USAH medical record systems should not be stored in an unprotected repository.

j. All material published on the internet via email, social media, or otherwise, should be considered public and permanent; published information cannot be recovered.

k. Be aware that your relationship to USAH can be discovered on the internet without including a specific reference to your USAH affiliation in any specific post.

l. Healthcare providers must consider the content to be posted and the message it sends about them, their profession, and USAH. USAH reserves the right to request that certain subjects be avoided and that individuals withdraw certain posts as well as remove inappropriate comments.

m. The healthcare provider is owner of and responsible for the content of their own internet and social media blogs/posts, pictures, etc., including but not limited to any legal liability incurred (defamation, harassment, obscenity, libel, slander, privacy issues regarding students or patients, etc.).

n. Misrepresentation of professional credentials or failure to reveal conflicts of interest via electronic, digital, or internet platforms may result in disciplinary action by USAH or credentialing authorities

o. The tone and content of all USAH related electronic communications should remain professional.

p. Respect among healthcare providers must occur in a multidisciplinary environment.

q. Healthcare providers should use separate personal and professional social networking accounts. For personal activity, the use of a non-USAH email address as your primary means of contact is encouraged.

r. Do not post any material that is obscene, pornographic, defamatory, libelous, or unlawfully threatening to another person or any other entity.

s. Healthcare providers are discouraged from interacting with any current or former patient on any social networking site or checking patient profiles on social networking sites.

t. Only reputable sites and sources should be used as medical education resources, including for patient education. Any referral made by a USAH healthcare provider represents a tacit endorsement of that site by our institution.

u. USAH provides Microsoft Teams as a HIPPA compliant platform for document sharing, real time communication, and collaborative projects with other USAH employees. No other internet repository accounts shall be used for these purposes.

v. HIPPA compliant patient list application options include Kolkin SOS and PowerChart Touch.

Note: Refer to the IT Service Desk 251.445.9123 for support in using Microsoft Teams, Kolkin SOS and PowerChart Touch.

w. Personal calls should not be initiated and/or received in patient care areas, public service areas, within view of patients or visitors. Ring tones and alerts should be set to vibrate or silent mode.

x. Wireless headsets may not be used.

y. The use of personal entertainment devices (e.g., cell phone entertainment features, cell phone texting, employee personal laptop, etc.) are not allowed in patient care areas, public service areas, or within view of patients or visitors unless being used for USA business.

z. Devices must not produce electromagnetic interference (EMI) with biomedical equipment.

aa. Healthcare providers will be provided with training in the use of electronic, digital, and internet communication platforms by their department. This training must be documented.

VI. TRAINEE RESOURCES AND THE LEARNING AND WORKING ENVIRONMENT

A. Confidential Reporting

1. The sponsoring institution and its program directors are responsible for ensuring that trainees are provided with a learning and working environment in which they may confidentially raise and resolve issues without fear of intimidation or retaliation.
2. Each program must have written policies and procedures addressing this requirement specific for their programs.

B. Sponsoring Institution Mechanisms

1. Ombudsperson
   a. The GME Institutional Administrator acts as Ombudsperson to the trainees.
   b. The Ombudsperson is available to all trainees.
   c. This is an independent, informal, and confidential resource to assist with problem solving and conflict resolution.
   d. The Ombudsperson is available to hear complaints in a neutral and confidential setting and will help to sort out and identify options for resolving these concerns.
   e. Walk-ins are welcome; however, appointments are recommended to ensure availability.
   f. Any trainee may contact the Ombudsperson voluntarily. Identities of those utilizing the office will not be disclosed.
   g. The only exceptions to this policy will be those circumstances in which the Ombudsperson believes there is an imminent threat of serious harm or when the individual has given express permission to reveal their identity. Use of the Ombudsperson does not preclude engaging in a more formal resolution to a problem.
   h. If an individual is interested in pursuing a more formal remedy to a problem, the Ombudsperson may assist by helping make the appropriate referrals, if requested to do so. The office does not accept notice of any kind on behalf of USA.
   i. When an individual presents a problem, the Ombudsperson will listen carefully and help to sort out the issues.
   j. If appropriate, the Ombudsperson will explain relevant USA policies or procedures and make referrals.

k. The Ombudsperson also is available to engage others in informal discussions regarding a given situation.

l. If given permission, the Ombudsperson is available to gather information, consult with others, or mediate disputes that may arise.

m. Any trainee may contact the Ombudsperson with a concern or problem.

n. These may include issues of discrimination, work environment conflicts, interpersonal relationships, sexual harassment, and intimidation, dealing with change or other related concerns.

2. Housestaff Council
   a. Trainees may report concerns to any member of the Housestaff Council, composed of chief residents and fellow representative for discussion by the full Housestaff Council at its monthly meetings.
3. Anonymous Reporting to the GME office/DIO
   a. Any trainee may also raise issues in a confidential manner without fear of intimidation by calling the DIO or GME office or reporting via an anonymous e-mail account accessible on the USA GME webpage under the "Residents and Fellows" tab.
4. Anonymous Reporting outside the GME office/DIO
   a. Trainees may report anonymously using the University of South Alabama Ethics and Compliance Hotline: https://secure.ethicspoint.com/domain/media/en/gui/60474/
   b. Trainees may report anonymously directly to the ACGME on their website: https://www.acgme.org/

C. Ancillary Support Services and Systems

1. USAH is committed to the provision of necessary support services to develop healthcare delivery systems that minimize trainee work that is extraneous to the GME Programs' educational goals and objectives and to ensure that the trainees' educational experience is not compromised by excessive reliance on trainees to fulfill non-physician service obligations.
2. Other support services provided for trainees include, but are not limited to, provision of white lab coats and scrubs, on-call quarters, free parking, free and discounted meals, trainee lounges with computer access, clinical librarian to assist with scholarly activity, free round trip cab service for trainees too fatigued to safely return home after work, free counseling services, lactation rooms with refrigeration and 24-hour security for trainee safety.
3. Patient Support Services: Peripheral intravenous access placement, phlebotomy services provided by the clinical laboratory, and messenger and transporter services are provided to the trainees in a manner appropriate to and consistent with educational objectives and quality patient care.
4. Laboratory, Pathology, and Radiology Services: Clinical laboratory, anatomic pathology and radiology services are provided to support timely and quality patient care.
5. Medical Records: A comprehensive electronic health record that documents the course of each patient's illness and care is available throughout the Health system

and supports quality patient care, trainee education, quality assurance activities, and provides a resource for scholarly activity.

6. Dictation is available via the Dragon system.
7. Food Services:
    a. Hospital Cafeterias: Hospital cafeterias are located on the second floor of USAUH and first floor at USACW.
    b. USAUH and USACW will provide meals to trainees.
    c. To not have the amount considered taxable income (IRS Code, Section 119) the meals will be “in-kind” (goods, services and transactions not including money).
    d. To receive the free meal, trainees must present their USAH employee badge.
    e. If an additional meal is required during a trainee’s shift, it may be purchased at a 25% discount using the USAH employee badge.
8. Call Rooms:
    a. USAH provides sleep/rest facilities that are available to trainees and are safe, quiet, clean, and private with proximity for safe patient care. USAH assigns each GME Program rooms with a sufficient number of beds for the number and gender of trainees on call.
    b. Any GME Program requiring additional call rooms should direct this request to the Housestaff Office.
    c. Repairs or maintenance work needed in the call rooms should be reported to the Housestaff Office.
    d. Cleanliness of call rooms is maintained by the Housekeeping Department.
9. USA Bookstore is located at the Student Center on the USA main campus. Trainees receive a 10% discount on selected items with proper identification.
10. Laundry: Laundry is the responsibility of the trainee.
11. Mileage Reimbursement: Mileage between healthcare facilities (for work-related reasons) is reimbursable. Travel reimbursement forms should be filed within sixty (60) days. USAH reserves the right not to honor travel reimbursement requests after that time. Contact the GME office for proper forms. (See Appendix A for contact information.)
12. Moving/Relocation Allowance: Trainees relocating to Mobile are allowed a one-way moving allowance of $2.00 per mile with a cap of $1,200.00. Mileage should be turned into the GME office for reimbursement.
13. Reference Materials
    a. The USA Biomedical Library provides access to the library's eBook and online journal collection. It also serves as a centralized entry point into the library's numerous research tools and databases including Access Medicine, Access Pediatrics, Access Surgery, BMJ Best Practice, Clinical Key, the Cochrane Library, McGraw Hill First Aid Test Prep, PubMed, Up-to-date and other authoritative and full text tools only available through the library's paid subscriptions.

b. If the Biomedical Library does not subscribe to or own the book or journal article needed, up to 20 free articles/books per month may be requested through Interlibrary Loan/Document Delivery.

c. This link (https://www.southalabama.edu/departments/biomedicallibrary/ask.html) also provides easy access to reference librarians via e-mail, chat, text, or telephone.

d. Any Health Systems employee who currently has a USAOnline or JagMail password should be able to login remotely to library resources using the same information.

e. However, if you do not have a USAOnline or JagMail account, you can get a JagNet password by going to https://www.southalabama.edu/services/jagnet/jagnetforhealth.html

f. Clista Clanton (cclanton@southalabama.edu) is the assigned clinical librarian for each GME Program and can assist in securing program specific educational resources, providing instruction on library resources, and consulting on other information needs.

14. Parking
    a. Trainees are assigned parking and issued parking decals.
    b. Parking is free.
    c. Every effort is made to place the trainees in parking facilities in close proximity to the hospital.
15. Loan Deferments: The Housestaff Office staff can assist with the filing of paperwork necessary for the deferment of loans.
16. Uniforms
    a. White Coats
        1) Up to three (3) white coats, depending on your specialty, are provided at the beginning of the first year of training.
        2) One (1) white coat is provided in each subsequent year of training.
    b. Scrubs
        1) Scrubs are issued by the GME office.
        2) Tops and bottoms must be the same color and style.
        3) Hospital scrubs worn while on rounds or on call will require a white lab coat while in areas other than the OR, specialty areas, certain areas of Radiology, Labor and Delivery or the Emergency Department.
        4) Hospital scrubs are specifically provided for staff working in high-risk areas of blood and body fluid exposure including the operating rooms.
        5) Physicians and students who work in direct patient care areas may wear hospital scrubs if their own clothes have been heavily soiled in the line of duty or in keeping with departmental guidelines.
        6) Scrubs, if soiled, should be changed.
        7) Trainees are responsible for laundering their own scrubs and having them available when needed.
        8) All head and shoe covers and OR masks should be removed prior to leaving the operating room and invasive laboratory areas.

17. Requests for reasonable accommodations under the Americans with Disabilities Act See Appendix A for contact information for making requests.
18. Well-being Resources
    a. USA EMPLOYEE ASSISTANCE PROGRAM
        1) The USA Employee Assistance Program (EAP) offers free, confidential support services for USA benefits eligible employees and members of their immediate household.
        2) A licensed counselor is available to help trainees identify, understand, and resolve work-related and personal issues to assist employees in achieving a successful work/life integration.
        3) Services include individual, couples and family counseling, educational and stress management programs, and access to other helpful resources.
        4) The USA EAP services include a counselor who specializes in marriage and family counseling, alcohol and other drug dependency aftercare, critical incident stress management, caregiver issues, employee assistance, career counseling, mindfulness and more.
        5) Counseling sessions are designed to help identify and resolve problems related, but not limited to:
            a) Relationship or family problems, work or home related stress, international medical graduates who may experience "culture shock", depression/mood swings/anxiety, grief/loss/loneliness, alcohol and other drug dependency, work-life balance, LGBTQ issues, chronic illness support, communication problems, and smoking cessation.
            b) For more information, email Fletcher Eaton at gfeaton@health.southalabama.edu or call 251.410.7664. You can also visit https://www.southalabama.edu/departments/financialaffairs/hr/eap/.
19. JagFit@South wellbeing program and app for the entire University of South Alabama community:
    a. JagFit@South was created with a focused approach to elevate health and well-being for the University community. The program encourages participants to "Move Your Body, Fuel Smart, Stress Less and Live Healthy" with a goal for participants to "Live, Learn, Feel and Engage." https://www.southalabama.edu/programs/jagfit@south/
    b. The information and resources available in each element are designed to positively impact participants' personal well-being and happiness while helping them reach their full potential.
    c. JagFit Gym at USAH Children's and Women's Hospital free of charge.
    d. Discounted membership to the University of South Alabama Recreation Center.
20. Clean and private lactation facilities with clean and safe refrigeration resources for the storage of breast milk with proximity appropriate for safe patient care are available at USAH Children's and Women's Hospital, University Hospital, Strada Patient Care Center and USA Mitchell Cancer Institute.
21. Free notary service provided by the GME office.

22. Well-being resources available on the USA GME Webpage Wellness Resources tab https://www.southalabama.edu/colleges/com/gme/ including access to the National Suicide Prevention Lifeline, self-screening tools and links to other resources.
23. Free 2-way cab account for trainees who may be too fatigued to safely return home after work https://www.southalabama.edu/colleges/com/gme/

D. Other Learners

1. Programs must ensure that the presence of other learners and other care providers, including, but not limited to, medical students, trainees from other programs, subspecialty fellows, and advance practice providers, not negatively impact the appointed trainees' clinical and educational learning experiences.
2. Program directors must report circumstances to the DIO and GMEC when the presence of other learners has interfered with the trainees' education.
3. Prior notification of an external trainee must be provided to and approved by the GME office.
4. External trainees must follow appropriate policies for outside learners.

E. Trainee Safety

1. The Accreditation Council for Graduate Medical Education (ACGME) mandates that sponsoring institutions assure a safe working environment for their trainees.
2. USAH Security Department
   a. USA is responsible for the safety and protection of staff, students and visitors and the prevention of crime on all USA campuses. Security personnel are present on hospital grounds, as well as parking facilities and on-call areas.
   b. Emergencies may be reported, or assistance requested by calling Security:
      1) University Hospital 251.471.7195 or 251.471.7525
      2) Children's and Women's Hospital 251.415.1135
   c. An escort to the parking lots can be requested at any time by calling these numbers.
3. Needle sticks and Other Occupational Exposure to Blood-borne Pathogens
   a. Provide stabilizing, preliminary care to the exposure or injury.
   b. Immediately notify supervisor/manager.
   c. If during business hours notify Employee Health Nurse (EHN) or designee at 251.410.7629.
   d. If after regular hours, weekends, and holidays contact the Clinical Administrator/Nursing Supervisor at the respective hospital:
      1) USAUH - 251.471.7000
      2) USACW: 251.460.1000
   e. Exposures or injuries occurring at USAH Ambulatory setting will be evaluated per USAH policy.
   f. Complete the follow-up procedures found on the USAH Intranet Stat tab.

g. Complete an RL6.

h. Trainees rotating at participating sites that are not in the USAH system will follow the policies and procedures at those sites.

VII. RESIDENCY PROGRAM PERSONNEL AND FACULTY MEMBER DEVELOPMENT

A. Program Directors

1. There must be one faculty member appointed as program director, with authority and accountability for the operation of the overall program, including compliance with all applicable program requirements.
2. Selection
   a. The individual department chair will appoint a program director for the program.
   b. The chair may appoint themself as program director or as further specified by the ACGME.
   c. The department chair must confirm that the program director meets all RC requirements for appointment as program director prior to the appointment.
   d. A letter of appointment from the Department Chair and a copy of the appointee's CV should be submitted to the GME office for GMEC review.
   e. For combined residency programs (e.g., combined Internal Medicine-Pediatrics) the department chairs of all applicable departments will collaboratively appoint a program director and ensure they meet all requirements.
   f. The GMEC will review the qualifications of the program director.
   g. After review and approval, the chair of the GMEC will appoint a mentor from the GMEC to the newly appointed program director to assist with any questions they may have.
   h. The DIO will then submit the program director information via ACGME ADS for approval by the RC. Final approval of the program director resides with the RC.
   i. Upon notification of program director approval by the RC, the program director will receive a confirmation e-mail from the ACGME with further instruction.
3. Qualifications
   a. Each program director must obtain and maintain the following qualifications:
      1) Requisite specialty expertise and at least 3 years of documented educational and/or administrative experience, or qualifications acceptable to the RC;
      2) Current certification by the specialty board in the discipline of the program, or specialty qualifications that are acceptable to the RC;
      3) Licensure to practice medicine in the state where the institution that sponsors the program is located and an appointment in good standing to the medical staff of an institution participating in the program;
      4) Ongoing clinical activity;
      5) Salary support and protected time to effectively carry out educational, administrative and leadership responsibilities as described in the institutional, common, and specialty/subspecialty specific program requirements; and

6) The program director must continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. The minimum term of the program director appointment should be the duration of the program plus one year (IRC may specify further).

4. Responsibilities

a. In addition to any specialty-specific requirements outlined in the relevant program requirements and ACGME Manual of Policies and Procedures, the program director has the responsibility, authority, and accountability for administration of the overall program.

b. Responsibilities of the program director include, but are not limited to, the following:

1) Serves as a role model of professionalism;

2) Designs and conducts the program in a fashion consistent with the needs of the community, mission of USAH, and the mission of the program;

3) Oversees and ensures the quality of didactic and clinical education in all sites that participate in the program;

4) Develops and oversees a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education;

5) Authority to approve and remove program faculty members for participation in the residency program at all sites;

6) Removal of trainees from supervising interactions and/or learning environments that do not meet the standards of the program;

7) Submission of accurate and complete information required and requested by the DIO, GMEC and ACGME;

8) Completion of annual updates of the program and trainee records through the ACGME Accreditation Data System (ADS);

9) Obtains prior approval of the GMEC and RC for changes in the program that may significantly alter the educational experience of the trainees including, but not limited to, the addition or deletion of major participating institutions, change in the approved trainee complement, or change in the format of the educational program;

10) Provides applicants who are offered an interview, with information related to the applicant's eligibility for the relevant specialty board examination;

11) Provides a learning and working environment in which trainees have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner;

12) Ensures implementation of fair policies and procedures, as established by USAH GME, to address trainee grievances (appeals) and due process including when action is taken, to suspend or dismiss, or not to promote or renew the appointment of a trainee in compliance with the Institutional Requirements and Common Program Requirements;

13) Ensures implementation of policies and procedures, as established by USAH, to address employment and non-discrimination;

14) Monitors trainee stress, fatigue, sleep deprivation, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction;

15) Along with faculty, be sensitive to the need for timely provision of confidential counseling and psychological support services to trainees;
16) Recognizes situations that demand excessive service or that consistently produce undesirable stress on trainees and evaluate and modify them;
17) Adopts fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning such as strategic napping or other measures;
18) Develops and implements the academic and clinical program of trainee education by preparing and implementing a written statement outlining the competency-based educational goals and objectives of the program, with respect to knowledge, skills, and other attributes of the trainees for each major assignment and each level of the program;
19) Distributes educational goals and objectives to trainees and faculty;
20) Ensures trainees review educational goals and objectives prior to starting rotation;
21) Provides trainees with direct experience in progressive responsibility for patient management;
22) Prepares and implements a comprehensive, well-organized, and effective curriculum, both academic and clinical, that includes the presentation of core specialty knowledge supplemented by the addition of current information;
23) Ensures that trainees are provided with effective educational experiences that lead to measurable achievement of educational outcomes in the ACGME competences as outlined in the Common and specialty/subspecialty-specific Program Requirements;
24) Establishes and maintains an environment of inquiry and scholarship, including an active research component within the program, and ensures participation by trainees and faculty, as defined in Section IV.D of the ACGME Common Program Requirements;
25) Prepares written, program-specific criteria and processes for the selection, promotion, transfer, dismissal, and verification of trainees;
26) Ensures the program's criteria are in compliance with the ACGME Institutional Requirements, Common Program Requirements, relevant specialty-specific Program Requirements, and USA GME policies and procedures;
27) Develops and implements policies and procedures for trainee supervision at all participating institutions that are in compliance with Section II.A.4 and VI.D of the ACGME Common Program Requirements, relevant specialty-specific Program Requirements, and policies and procedures of USA GME and participating institutions;
28) Develops and implements formal written policies and procedures governing trainee clinical and educational work hours including moonlighting that are in compliance with Sections II and VI of the ACGME Common Program Requirements, relevant specialty-specific Program Requirements, and USA GME policies and procedures;
29) Develops and implements policies and procedures for the evaluation of trainees, faculty, and the program that are in compliance with Sections II and V of the Common Program Requirements, relevant specialty-specific Program Requirements, and USA GME policies and procedures;

30) Develops and implements policies and procedures for the learning and work environment that are in compliance with Sections II and VI of the Common Program Requirements, relevant specialty-specific Program Requirements, and USA GME policies and procedures (see Section VIII – Trainee Learning and Working Environment);

31) Develops and implements policies and procedures for transitions of care that are in compliance with Section VI of the ACGME Common Program Requirements, relevant specialty-specific Program Requirements, and USA GME policies and procedures;

32) Prepares the Annual Program Evaluation;

33) Prepares program information for CLER site visits;

34) Documents and provides verification of a trainee's completion of the program for all graduating trainees or departure from the program for trainees not completing the program within 30 days of a request; and,

35) Plans and monitors annual faculty development as educators; in QI and patient safety; in faculty fostering their own and their trainees' well-being; and in patient care based on their practice-based learning and improvement efforts.

B. Teaching Faculty

1. Program teaching faculty are appointed based on recommendation by the program director, division director and department chair.
2. All faculty are approved by the Dean of USACOM / Vice President for Medical Affairs during the hiring process.
3. The program director has authority to approve and remove program faculty from participating in teaching in the residency program.
4. The teaching faculty should include members of the medical staff at each hospital participating in the educational activities of the program.
5. At each participating site, there must be a sufficient number of faculty members with competence to instruct in ACGME Program Requirements.
6. All teaching faculty should possess the following qualifications:
   a. Be role models of professionalism;
   b. Demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care, and a strong interest in the education of trainees;
   c. Requisite specialty expertise as well as documented educational and administrative abilities and experience in their field;
   d. Current certification in the specialty by the applicable American Board of Medical Specialties (ABMS), American Osteopathic Board or possess qualifications judged by the RC to be acceptable;
   e. Licensure to practice medicine in the state where their participating site is located and appointment in good standing to the medical staff of an institution participating in the program;
   f. Devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities, including the timely evaluation of the trainees they supervise;

g. Support the goals and objectives of the program, demonstrate competence in both clinical care and teaching abilities, and participate in the scholarly activities of the program, including but not limited to, organized clinical discussions, rounds, journal clubs, and conferences;

h. Pursue faculty development designed to enhance their skills at least annually in education, quality improvement and patient safety, eliminating health inequities, well-being, and in patient care based on their practice-based learning and improvement efforts; and

i. Non-physician faculty members must be approved by the program director and have appropriate qualifications in their field and an appointment in good standing to the medical staff of an institution participating in the program.

C. Core Faculty

1. Core Faculty is defined by the ACGME as having a significant role in the education and supervision of trainees and must devote a significant portion of their entire effort to trainee education and/or administration.
2. Core faculty must teach, evaluate, and provide formative feedback to trainees.
3. Core Faculty are designated by the program director and must complete the annual ACGME Faculty Survey.
4. Review Committees, as outlined in the specialty/subspecialty-specific Program Requirements are required to specify the minimum number of core faculty and/or the core faculty-trainee ratio.
5. Review Committees may further specify either:
   a. Requirements regarding dedicated time and support for core faculty members' non-clinical responsibilities related to trainee education, or
   b. Requirements regarding the role and responsibilities of core faculty members inclusive of both clinical and non-clinical activities and the corresponding time commitment required to meet those responsibilities.

D. Associate Program Directors

1. As outlined in the specialty/subspecialty-specific Program Requirements, Review Committees may specify requirements for associate program directors.

E. Program Coordinators

1. There must be a program coordinator.
2. At a minimum, the program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration according to the ACGME requirements .
3. The Review Committee may further specify.

F. ACGME Competencies

1. ACGME-accredited programs must require that their trainees obtain competence in the six areas listed below to the level expected of a new practitioner who is ready to enter the independent practice of medicine. Programs must define the specific knowledge, skills, behaviors, and attitudes required and provide educational experiences as needed in order for their trainees to demonstrate the following:
    a. Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
    b. Medical knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
    c. Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
    d. Interpersonal and communication skills that result in effective information exchange and collaboration with patients, their families, and other health professionals including learning to communicate with patients and their families in partnership to assess their care goals and end-of-life goals.
    e. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population, as well as the ability to recognize and develop a plan for one's own personal and professional well-being.
    f. Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

G. Scholarly Activities

1. The program director and faculty are responsible for establishing and maintaining an environment of inquiry and scholarship and an active research component within each program that is consistent with each program's mission and aims.
2. Programs must advance trainees' knowledge and practice of the scholarly approach to evidence-based patient care. This may be accomplished by:
    a. Asking meaningful questions to stimulate trainees to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan.
    b. Challenging the evidence that the trainees use to reach their medical decisions so that they understand the benefits and limits of the medical literature.
    c. Improving trainee learning by encouraging them to teach using a scholarly approach.
3. Among their scholarly activity, programs must demonstrate accomplishments of scholarship in at least three of the following domains:
    a. Research in basic science, education, translational science, patient care, or population health;
    b. Peer-reviewed grants;

c. Quality improvement and/or patient safety initiatives;

d. Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports;

e. Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials;

f. Contribution to professional committees, educational organizations, or editorial boards;

g. Innovations in education; and/or,

h. Active participation of the teaching faculty in clinical discussions, rounds, journal club, and research conferences in a manner that promotes a spirit of inquiry and scholarship; offering of guidance and technical support (e.g., research design, statistical analysis) for trainees involved in research, and provision of support for trainees participating in appropriate scholarly activities.

4. The program, in partnership with the sponsoring institution must ensure that adequate resources for scholarly activities for faculty and trainees are available, including sufficient laboratory space, equipment, computer services for data analysis, and statistical consultation services.

VIII. EDUCATIONAL PROGRAM

A. Curriculum Components

1. All GME Programs must provide their trainees with an educational curriculum as outlined in the Common and specialty/subspecialty specific Program Requirements, including competence in the Core Competencies for Graduate Medical Education listed below to the level expected of a new practitioner entering the unsupervised practice of medicine.
2. The program's curriculum must contain, at a minimum, the following educational components:
   a. Overall educational goals and objectives for the program which must be distributed to the trainees and faculty members annually;
   b. Regularly scheduled didactic sessions;
   c. Job descriptions of trainee responsibilities by PGY level for patient care, progressive responsibility for patient management, and supervision of trainees over the length of the program; and,
   d. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to trainees and faculty members, in either written or electronic form, annually.
   e. Programs must require that trainees review this information prior to the start of each rotation and have a monitoring system in place to ensure compliance.
   f. The following ACGME Competencies must be integrated into the program's curriculum:
      1) Patient Care

a) Trainees must be able to provide patient care that is patient and family centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health;

2) Medical Knowledge
   a) Trainees must be able to demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care;
3) Practice-based Learning and Improvement
   a) Trainees 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 life-long learning.
   b) Trainees are expected to develop skills and habits to be able to meet the following goals:
      (1) Identify strengths, deficiencies, and limits in one's knowledge and expertise;
      (2) Set learning and improvement goals;
      (3) Identify and perform appropriate learning activities;
      (4) Systematically analyze practice using quality improvement methods, including activities aimed at reducing healthcare disparities, and implement changes with the goal of practice improvement;
      (5) Incorporate formative evaluation feedback into daily practice;
      (6) Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; and,
      (7) Participate in the education of patients, families, students, trainees, and other health professionals.
4) Interpersonal and Communication Skills
   a) Trainees must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.
   b) Trainees are expected to:
      (1) Communicate effectively with patients and patient's families, and the public, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patent;
      (2) Communicate effectively with physicians, other health professionals, and health related agencies;
      (3) Work effectively as a member or leader of a health care team or other professional group;
      (4) Act in a consultative role to other physicians and health professionals; and
      (5) Maintain comprehensive, timely, and accurate healthcare records.
5) Professionalism
   a) Trainees must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.
   b) Trainees are expected to demonstrate:
      (1) Compassion, integrity, and respect for others;
      (2) Responsiveness to patient needs that supersedes self-interest;
      (3) Cultural humility;
      (4) Respect for patient privacy and autonomy;
      (5) Accountability to patients, society and the profession; and

(6) Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

6) Systems-based Practice
   a) Trainees must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.
   b) Trainees are expected to:
      (1) Work effectively in various health care delivery settings and systems relevant to their clinical specialty;
      (2) Coordinate patient care within the health care system relevant to their clinical specialty;
      (3) Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
      (4) Advocate for quality patient care and optimal patient care systems; and
      (5) Use tools and techniques that promote patient safety and disclosure of patient safety event, real or simulated.

3. Each GME program is also responsible for ensuring that any additional specialty/subspecialty-specific requirements by their individual RC are incorporated into the curriculum.

IX. THE LEARNING AND WORKING ENVIRONMENT

A. Professionalism and Personal Responsibility

1. Along with USAH, the program director is responsible for:
   a. Educating trainees and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients;
   b. As a commitment to professionalism, all trainees and faculty are required to sign an acknowledgement of having read and become familiar with the USA COM "Compact between Teachers and Trainees in Medicine and Biomedical Sciences";
   c. Trainees and faculty must annually complete required institutional training on fatigue recognition and mitigation and other required institutional and program-specific educational assignments;
   d. Promoting patient safety and trainee well-being in a supportive educational environment;
   e. Foster appreciation for the privilege of caring for patients;
   f. Ensuring trainees are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs;
   g. Structuring the learning objectives of the program to be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events;
   h. The learning objectives of the program must be accomplished without excessive reliance on trainees to fulfill non-physician obligations and ensure manageable patient care responsibilities;

i. Trainees must be provided with protected time to participate in core didactic activities;

j. Providing a culture of professionalism that supports patient safety and personal responsibility;

k. Providing a professional, equitable, respectful, and civil clinical working and learning environment that is psychologically safe and free from mistreatment, abuse, or coercion of students, trainees, faculty, and staff; and

l. A process should be in place for education of trainees and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.

2. Trainees and faculty may report concerns confidentially through RL6 or the USA GME anonymous email account under the "Residents" tab on the USA GME website home page.
3. The clinical working and learning environments are monitored through the ACGME Resident and Faculty Surveys and CLER visits.
4. Trainees and faculty members must demonstrate an understanding of their personal role in the following:
    a. Safety and welfare of patients entrusted to their care, including their professional responsibility to report the full range of patient safety events including near misses, sentinel events, unsafe conditions, events without harm, unexpected deteriorations, and known complications of procedures;
    b. Provision of patient- and family-centered care;
    c. Assurance of their fitness for work;
    d. Management of their time before, during, and after clinical assignments;
    e. Recognition of impairment, including illness, fatigue, depression, burnout, substance abuse and suicidal ideation in themselves, their peers, and other members of the health care team and know how to seek help;
    f. Commitment to lifelong learning;
    g. The monitoring of their patient care performance improvement indicators;
    h. Reporting of clinical and educational work hours, patient outcomes and clinical experience data; and
    i. Demonstrating responsiveness to patient needs that supersedes self-interests. 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.
5. The programs and sponsoring institution must provide systems for education in and monitoring of professional responsibilities including scholarly pursuits and accurate completion of required documentation by trainees.
    a. Education and Monitoring of Scholarly Pursuits
        1) A full-time clinical librarian is available to assist the GME Programs in securing program specific educational resources, providing instruction on library resources, and consulting on other information needs.
        2) Scholarship is a component of each program's curriculum.

3) The USA GME office and GMEC monitor scholarly pursuits by review of ADS updates, program citations and areas for improvement/concerning trends on letters of notification and via the USA College of Medicine Annual Report.

b. Education and Monitoring of Required Documentation by Trainees

1) USAH provides mandatory trainee education on compliance and other topics via Health Stream, the institution's online learning system, which is monitored by the programs with oversight by the GME office.

c. Monitoring of Required Documentation by Trainees

1) The GME Office, in partnership with the programs, monitors trainee administrative tasks including but not limited to timely logging of work hours and the completion of required institutional GME learning modules.

2) The USAH Medical Records Department monitors trainees' EHR documentation and notifies the program director of trainees with delinquent medical records.

B. Well-Being

1. In partnership with the Sponsoring Institution, programs have the same responsibility to address well-being as they do to evaluate other aspects of trainee competence. This responsibility must include:
   a. 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 trainee well-being;
   c. Evaluating workplace safety data and addressing the safety of the trainees and faculty members;
   d. Policies that encourage optimal trainee and faculty member well-being to include the opportunity to attend medical, mental health, and dental care appointments, etc. including those scheduled during their work hours; and
   e. Educating faculty members and trainees to identify the symptoms of fatigue, burnout, depression, substance abuse, suicidal ideation, or potential for violence in themselves and others and how to seek appropriate care.
2. The GME office provides trainees and faculty with educational resources available on the USA GME home page, required annually, instructing how to recognize the forms of impairment listed above. https://www.southalabama.edu/colleges/com/gme/
3. Trainees and faculty are informed about resources, including free mental health assessment, counseling, and treatment, available through the USA Employee Assistance Program (EAP) and how to contact the EAP for help. https://www.southalabama.edu/colleges/com/gme/
4. A link to the National Suicide Prevention Hotline is available on the USA GME home page by clicking on the Well-being Resources tab for 24/7 access. https://www.southalabama.edu/colleges/com/gme/

5. Links to self-screening tools for the various forms of impairment are available by clicking on the Well-being tab on the USA GME home page. https://www.southalabama.edu/colleges/com/gme/
6. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a trainee may be unable to perform their patient care responsibilities.
7. These policies must be implemented without fear of negative consequences for the trainee who is unable to provide the clinical work;
8. Trainees and faculty members must alert the program director or other designated personnel when they are concerned that another trainee, faculty member or health care worker may be demonstrating the potential for violence; and,
9. The institution provides online training for scenarios such as active shooter.

C. Patient Safety and Quality Improvement

1. Patient Safety
   a. Culture of Safety
      1) The program, its faculty, and trainees must actively participate in patient safety systems and contribute to a culture of safety.
      2) The program must have a structure that promotes safe, interprofessional, team-based care.
   b. Education on Patient Safety
      1) Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques.
   c. Patient Safety Events
      1) Trainees, faculty members, and other clinical staff members must:
         a) Know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site;
         b) Know how to report patient safety events, including near misses, at the clinical site;
         c) Be provided with summary information of their institution's patient safety reports;
   d. Trainees and faculty members are instructed on how to report patient safety events in the institution's RL6 reporting system software.
   e. Institutional patient safety data are shared at least annually with the USAH Housestaff Council and the GME Committee.
   f. Trainees must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.
   g. Trainee Education and Experience in Disclosure of Adverse Events
      1) All trainees must receive training in how to disclose adverse events to patients and families.

2) Trainees should have the opportunity to participate in the disclosure of patient events, real or simulated.

2. Quality Improvement
   a. Education in Quality Improvement
      1) Trainees must receive training and experience in quality improvement processes, including an understanding of health care disparities.
      2) All trainees in ACGME accredited programs and their core faculty are required to complete the following Institute for Healthcare Open School modules on quality improvement:
         a) QI 101: Introduction to Healthcare Improvement
         b) QI 102: How to Improve with the Model for Improvement
         c) QI 103: Testing and Measuring Change with PDSA Cycles
      3) Certificates of completion are maintained by the housestaff office.
      4) The GME office provides quarterly oversight for compliance.
   b. Quality Metrics
      1) Trainees and faculty members must receive data on quality metrics and benchmarks related to their patient populations.
      2) Each program is responsible for providing this information according to their specialty specific practices.
   c. Engagement in Quality Improvement Activities
      1) Trainees must have the opportunity to participate in interprofessional quality improvement activities which should include activities aimed at reducing health care disparities.

D. Supervision and Accountability

1. This policy will establish the minimum requirements for trainee supervision in programs in the USAH System and at programs' participating sites.
2. Other hospitals and individual programs may have additional trainee supervision requirements that trainees will need to follow.
3. Each program director must ensure, monitor, and document adequate supervision of trainees at all times.
   a. There must be program-specific policies and guidelines for trainee supervision and progressive levels of responsibility for each year that are distributed to all trainees and teaching faculty.
   b. The clinical responsibilities for each trainee must be based on PGY-level, patient safety, trainee education, severity and complexity of patient illness/condition and available support services.
   c. Programs' written policies and procedures shall include the role, responsibilities, and patient care activities of trainees in the programs by PGY level.
   d. The policies and procedures shall include mechanisms by which the trainees' supervisors and program directors make decisions about each trainee's progressive responsibilities and independence in specific patient care activities.

e. A list of approved procedures by year of training must also be documented.

4. Attending/Supervising Physician Responsibilities:
   a. Supervision may be exercised through a variety of methods.
   b. For many aspects of patient care, the supervising physician may be a more advanced trainee.
   c. Other portions of care provided by the resident 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.
   d. Some activities require the physical presence of the supervising faculty member.
   e. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.
   f. Residents are supervised by the assigned service attending or appropriate supervisor.
   g. A complete medical history and physical examination must be performed and documented in the patient's medical record and the resident's note co-signed within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by USAH to perform histories and physicals.
   h. The primary attending physician's involvement in a patient's care must be at least daily as evidenced by the attending's medical record entry note.
   i. The primary attending physician will ensure that all discharge diagnoses are accurate and can be coded.
   j. Documentation should reflect the primary attending physician's involvement in discharge planning.
   k. The primary attending is responsible for ensuring the medical record is complete.

5. Supervision Requirements
   a. The program director must ensure that the teaching staff at all participating institutions and clinical sites provide appropriate supervision of residents that is consistent with proper patient care and the educational needs of the residents.
   b. Each patient must have an identifiable, appropriately credentialed, and privileged attending physician (or licensed independent practitioner as specified by the applicable RC who is ultimately responsible for that patient's care at all clinical sites utilized for the education of residents.
      1) This information should be available to residents, faculty members, other members of the health care team, and patients.
      2) Residents and faculty members should inform patients of their respective roles in each patient's care.
   c. Faculty attending and call schedules must be structured to provide residents with continuous supervision and consultation.
   d. Residents and other health care personnel must be provided with rapid, reliable systems for communicating with supervising faculty.

e. To ensure oversight of resident supervision and graded authority and responsibility, the program must define the levels of supervision that is in accordance with their RC and use the following classification of supervision:

   1) Direct Supervision:
      a) The supervising physician is physically present with the resident during the key portions of the patient interaction. PGY-1 residents must initially be supervised directly only in this fashion.
      b) "Physically present" is defined as follows:
         (1) The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.
         (2) Review Committees will describe the conditions under which PGY-2 trainees progress to be supervised indirectly.
         (3) The supervising physician and/or patient is not physically present with the trainee and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. (The Review Committee may further specify.)
   2) Indirect Supervision: The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the trainee 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.

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

g. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

   1) The program director is responsible for defining the levels of responsibilities for each year of training through written job descriptions of the types of clinical activities residents may perform and/or teach.
   2) The level of responsibility granted to a resident is determined by the program director and/or supervising teaching faculty and must be based on documented evaluation of the resident clinical experience, judgment, knowledge, technical skill, and the needs of the patient.
   3) 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.

h. The program director must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members (escalation of care policy).

i. Residents must be aware of their limitations and may not attempt to provide clinical services or perform procedures for which they are not trained.

j. PGY-1 residents should be supervised at all times either by direct supervision or indirect supervision with direct supervision immediately available.

k. Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available.

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

m. Fatigue Mitigation: The program director is responsible for ensuring that all teaching faculty and residents are educated to recognize the signs of fatigue and for implementing policies and procedures to prevent and counteract the potential negative effects.

1) Faculty members and residents must be educated to recognize the signs of fatigue and sleep deprivation; alertness management and fatigue mitigation processes; and to adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning such as naps or back-up call schedules.

2) A process must be developed to ensure continuity of patient care in the event that a resident may be unable to perform their patient care duties.

6. Attending Notification Policy

a. This policy applies to all GME programs and sets minimal standards to guide residents with a set of clinical conditions that requires immediate attending notification.

b. Each program will provide their policy to the GME office on their staff attending notification (escalation) that contains minimal circumstances in which the attending must be notified specific to their programs. Programs' policies must contain the following minimal elements:

1) Escalation of Care

a) Any urgent patient situation should be discussed immediately with the supervising attending.

2) Examples include:

a) Any time there is an unexpected deterioration in patient's medical condition;

b) Patient is in need of invasive operative procedures;

c) Instances where patient's code status is in question and faculty intervention is needed;

d) A patient is transferred to or from a more acute care setting (floor to ICU and vice versa);

e) A patient's condition changes requiring a medical emergency team activation;

f) Any other clinical concern whereby the intern or the resident feels uncertain of the appropriate clinical plan; and

g) In the event of a patient death.

3) Timeliness of Attending Notification

a) It is expected that the resident will notify the attending as soon as possible after an incident has occurred.

b) Notification of the attending should not delay the provision of appropriate and urgent care to the patient.

c) If, despite the best efforts, the resident cannot reach the assigned attending, then they should notify the program director, medical director of the service or the chair of the department for guidance.

7. Bedside Procedures
    a. The purpose of this policy is to provide guidance for residents on when to notify the attending or higher supervisor trainee when performing bedside invasive procedures.
        1) This policy applies to all bedside procedures performed by GME trainees on patients seen at USAH Hospitals and clinics.
        2) Surgical procedures performed by GME trainees on patients in the operating rooms are not covered by this policy.
        3) Refer to institutional policies governing the OR.
    b. Attending/Supervising Physician Responsibilities:
        1) During performance of bedside procedures supervision is direct supervision, indirect supervision, or oversight according to the specialty/subspecialty specific program requirements, the program's trainee supervision policies and procedures and as determined by the program director and/or supervising teaching faculty.
        2) The attending/supervising physician reviews the evaluation and plan with the trainee.
        3) The attending/supervising physician oversees all clinical decisions, the attending/supervising physician or their designee is available for the performance of the procedure according to the level of supervision appropriate for the trainee to ensure patient safety and an optimal educational experience.
    c. Trainee Responsibilities (for being supervised)
        1) Trainees are responsible for evaluation of the patients, discussion of the patient with the responsible attending/supervising physician, contributing to development of the plan, and participating in the bedside procedures.
        2) As trainees increase in experience, they will have increased autonomy and need less assistance in performing bedside procedures and contribute more significantly to development of the plans. In all situations, the attending/supervising physician is responsible for all patient care decisions and will be available to the trainee according to the level of supervision appropriate for the trainee.
    d. Bed Side Procedures and Level of Training
        1) PGY 1 Resident: Direct supervision by upper-level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity (this number can vary by training program).
        2) PGY 2 and Higher Resident: Direct supervision by peer upper-level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity, (this number can vary by training program).
    e. Performance of Procedure
        1) PGY1 trainees performing a bedside procedure should discuss the clinical appropriateness of the procedure with the senior resident, fellow or attending.
        2) PGY2 and higher GME trainees should discuss the clinical appropriateness of a bedside procedure with the fellow or attending as needed.
        3) This discussion must be documented in the EHR.

4) The attending physician is responsible for determining the appropriate level of supervision required for performing a bedside procedure, the appropriate indication for the procedures, discussion of risk-benefit with trainees and patients (as necessary), assessing the risk of the procedure, determining the qualification of the trainee performing the procedure and providing adequate support to the trainee performing the procedure.

5) It is expected that a trainee shall inform the faculty member or upper-level trainee when they do not feel capable of performing a bedside procedure.

6) The trainee performing a procedure should make sure that there is adequate backup (such as senior resident, fellow, attending, interventional services, surgical services) before performing the procedure.

E. Clinical Responsibilities, Teamwork and Transitions of Care

1. Clinical Responsibilities
   a. The clinical responsibilities of each trainee must be based on PGY level, patient safety, trainee ability, severity and complexity of patient illness/condition, and available support services.
2. Teamwork
   a. Trainees must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system.
   b. The Review Committee may specify further.
3. Transitions of Care
   a. A responsibility of the Institution that sponsors Graduate Medical Education in partnership with its programs is to ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety (Common Program Requirement VI.B.3). The ACGME has charged the institution and the programs with designing clinical assignments to optimize the transitions in patient care, including their safety, frequency, and structure (CPR VI.E.3), ensuring that trainees are competent in communicating with team members in the hand-off process (CPR VI.E.3.c), and maintaining and communicating schedules of attending physicians and trainees currently responsible for each patient's care. Each program must ensure continuity of patient care, consistent with the program's policies and procedures in the event that a trainee may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.
   b. This policy applies to all graduate medical education training programs sponsored by USAH.
   c. Definitions
      1) Transitions of Care (Patient Hand-offs) constitute the transfer of information, authority, and responsibility during transitions in care across the continuum for the purpose of ensuring the continuity and safety of the patient's care.

2) Hand-off communication is a real time, active process of passing patient-specific information from one caregiver to another, generally conducted face-to-face, or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care.

3) Hand-offs should occur at a fixed time and place each day and use a standard verbal or written template.

4) The circumstances for transitions of care may include scheduled and unscheduled changes of assignments, at the conclusion and the commencement of assigned duty periods or call, when the patient is transferred to another site or another team of providers (e.g., transfer within in-patient settings and out-patient settings), and when it is in the best interest of the patient to transfer the care to another qualified or rested provider (e.g., clinical experience and education hours or fatigue).

   a) Each training program will be responsible for developing a formal policy for patient hand-offs/transitions of care. This policy must be distributed to all trainees and faculty.

   b) Hand-off communication entails direct communication between the off-going provider/team member currently caring for the patient and the upcoming provider/team taking over the care of the patient; face-to-face and phone-to-phone are two such methods of direct communication.

   c) It is highly recommended that trainees and faculty identify a quiet area to give report that is conducive to transferring information with few interruptions. NOTE: email and text are not acceptable forms of direct communication for Patient Hand-offs.

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

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

   f) Providers will afford each other the opportunity to ask or answer questions and read or repeat back information as needed.

d. The patient will be informed of any transfer of care or responsibility, when possible.

e. The effectiveness of the program's hand-off process will be monitored through direct observation of trainee performance. The program will review hand-off effectiveness at least annually as part of the annual program evaluation.

f. Minimal Elements of a Template

1) Each residency training program that provides in-patient care is responsible for creating/utilizing a patient checklist template. At a minimum, key elements of this template should include, but are not limited to:

   a) Patient information (name, age, room number, medical id number, important elements of medical history, allergies, resuscitation status, family contacts);

   b) Current condition and care plan (pertinent diagnoses, diet, activity, planned operations, significant events during previous shift, current medications);

   c) Active issues (pending laboratory tests, x-rays, discharge or communication with consultant, changes in medication, overnight care issues, "to-do" list);

   d) Contingency plans (if/then statements);

   e) Synthesis of information ("read-back" by receiver to verify);

f) Opportunity to ask questions and review historical information;
g) Name and contact number of responsible trainee and attending physician; and
h) Name and contact number of resident/fellow/attending physician for back up.

F. Clinical Experience and Education (Including Clinical and Educational Work Hours)

1. Clinical experience and education is defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, clinical work done from home including using an electronic health record and taking calls at home, time spent in the hospital after being called in to provide patient care, and scheduled academic activities such as conferences.
2. Clinical educational and work hours do not include reading done in preparation for the following day's cases, studying, and research done from home.
3. Purpose
    a. In compliance with the ACGME Institutional and Common Program Requirements, it is the goal of USAH to provide trainees with a sound academic and clinical education.
    b. The following Clinical Experience and Education Policies are applicable to every trainee in all GME training programs.
4. Policy
    a. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on trainees to fulfill service obligations.
    b. Didactic and clinical education must have priority in the allotment of trainees' time and energies.
    c. Clinical work and education assignments must recognize that faculty and trainees collectively have responsibility for the safety and welfare of patients.
    d. The ACGME Common Program Requirements require the following:
        1) Program Director Responsibilities
            a) Implement policies and procedures governing trainee clinical and educational work hours in compliance with their specialty/subspecialty-specific Program Requirements, the Common Program Requirements, and Institutional requirements.
            b) Program directors must provide copies of their policies to the GME office that include the following:
                (1) Mechanisms used by the program to monitor honest and accurate reporting of trainee clinical and educational work hours that ensure trainees log their work hours in NI by a specific day;
                (2) How the program monitors work hours, according to USA GME institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
                (3) How the program monitors the demands of at-home call and adjusts schedules as necessary to mitigate excessive service demands and/or fatigue, if applicable;
                (4) How the program monitors fatigue;

(5) How the program adjusts schedules as necessary to mitigate excessive service demands and/or fatigue;
(6) How the program monitors the need for and ensures the provision of back-up support systems when patient care responsibilities are unusually difficult or prolonged;
(7) Whether the program allows moonlighting. If moonlighting is allowed, the policy must comply with and reference the USA GME Institutional Policy on Moonlighting; and,
(8) Whether the program allows call trading, and if so, document how the GME Program oversees this to ensure compliance with clinical and educational hour requirements.

c) Distribute these policies and procedures to the trainees and faculty.

e. Educate trainees and faculty concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

f. Encourage trainees to use fatigue mitigation strategies in the context of patient care responsibilities.

5. Trainee Clinical Experience and Education

a. Programs, in partnership with the Sponsoring Institution, must design an effective program structure that is configured to provide trainees with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

b. 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.

c. Clinical work done from home includes using the electronic health record and taking calls from home. It does not include reading done in preparation for the following day's cases, studying, and research done from home.

d. Mandatory Time Free of Clinical Work and Education

1) The program must design an effective program and structure that is configured to provide trainees with educational opportunities, as well as reasonable opportunities, for rest and personal well-being.

2) Trainees should have eight hours off between scheduled clinical work and education periods.

3) There may be circumstances when trainees 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 one-day-off-in-seven requirements.

4) Trainees must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

5) Trainees 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.

e. Maximum Clinical Work and Education Period Length

1) Clinical and educational work periods for trainees must not exceed twenty-four hours of continuous scheduled clinical assignments.
2) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or trainee education. Additional patient care responsibilities must not be assigned to a trainee during this time.

f. Clinical and Educational Work Hour Exceptions
1) In rare circumstances, after handing off all other responsibilities, a trainee, 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 a patient or family; or
c) To attend unique educational events.
2) These additional hours of care or education must be counted toward the 80-hour weekly limit.

g. In-House Night Float
1) Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.
2) Programs should be familiar with specialty/subspecialty-specific requirements for the maximum number of consecutive weeks of night float and maximum number of months of night float per year.

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

i. At-Home Call
1) Time spent on patient care activities by trainees on at-home call must count towards the 80-hour maximum weekly limit.
2) 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.
3) Trainees are permitted to return to the hospital while on at-home call to provide direct care for new or established patients.
4) These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.
5) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each trainee.

G. Oversight and Monitoring of Clinical and Educational Work Hours (work hours)

1. New Innovations: The GME Committee has mandated that all trainees log their work hours using the Graduate Medical Education Software New Innovations (NI).

a. Trainees are responsible for accurately reporting work hours, including time spent moonlighting in accordance with their individual GME program and USA GME institutional policies and procedures.

b. It is the responsibility of each GME program to ensure trainee compliance with work hour logging in NI. The GME office and GMEC will provide oversight of work hour monitoring as follows:

1) The program coordinator will monitor work hours weekly to ensure trainees are logging and approving their work hours.

2) The program coordinator will notify the trainee(s) who are non-compliant in logging their work hours (for the prior month) on the 7th of each month or by the following business day if the 7th falls on a weekend or holiday.
Note: June work hours, run in July, must be completed on earlier dates due to the Children's Hospitals Graduate Medical Education (CHGME) Payment Program. These deadlines are mandated by the government and unchangeable.

3) The trainee(s) will have until the 21st of the month to come into compliance with logging their work hours,

4) The GME office will run a report at this 2-week mark. Program coordinators and program directors will be notified of non-compliant trainees in their programs who have been placed on leave without pay. These trainees will remain on leave without pay every day until all work hours have been logged.

c. On the 7th of each month, or the following day if the 7th falls on a holiday or weekend, the GME office will generate a monthly report listing work hour violations for each program from the prior month.

1) The program director will present any work hour violations listed on the final compliance report to the GMEC.

2. ACGME Resident and Faculty Surveys: Trainees in all core specialty GME Programs, regardless of size, and subspecialty GME Programs with four (4) or more fellows are surveyed by the ACGME every year.

a. A section of the survey assesses educational and work hour compliance.

b. Results are available to the program and DIO for programs with four (4) or more trainees with a 70% or greater response rate.

3. Anonymous Reporting: Any trainee may report violations of any educational and work hour requirement through procedures established by each GME Program and/or by reporting to the DIO, USAH Ombudsperson, GME office (including anonymous reporting via an e-mail account on the USA GME web page) or the ACGME reporting mechanisms on the ACGME website.

4. Monitoring Process

a. Evidence of non-compliance discovered in the aforementioned, as determined by the GMEC, will prompt review by the GMEC as follows:

1) Any deficiencies identified through monitoring the above processes are presented by the program director to the GMEC in order to solicit suggestions and feedback from the committee.

2) Based on this feedback, the program director devises a written plan of action and monitoring plan for presentation at the following month's GMEC meeting.
3) The GMEC reviews, modifies as necessary, and approves the GME Program's action plan by majority vote.
4) Outcome data, based on the implemented plan, are collected during the course of the next three months.
5) The program director provides a written follow-up report to the GMEC summarizing the results from monitoring and indicating whether the plan of action corrected the deficiencies.

b. GMEC Special Review: Non-compliance with work hours may prompt a focused or full GMEC Special Review.

H. Requests for Approval of Clinical and Educational Work Hours Exceptions

1. The GMEC will evaluate an individual GME Program's request for a maximum 10% increase in the eighty (80)-hour limit to trainee educational and work hours. Such a request must be based on a sound educational rationale.
   a. In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures.
   b. The GMEC will review and, upon acceptance, formally endorse the request for an exception.
   c. This endorsement will be indicated by a letter to the GME Program signed by the DIO.
   d. The following written procedures and criteria for endorsing requests for an exception to the educational and work hour limits must be met:
      1) Eligibility Criteria
         a) USAH must have a Favorable Status from its most recent review by the ACGME Institutional Review Committee.
         b) The GME Program requesting the exception to educational and work hours must be accredited in good standing, i.e., without a warning or a proposed or confirmed adverse action.
      2) Required Documentation
         a) It will be the GME Program's responsibility to show that the exception is necessary for educational reasons. The proposal presented to the GMEC must include the following:
            (1) Patient Safety: Information that describes how the GME Program and USAH will monitor, evaluate, and ensure patient safety with extended work hours.
            (2) Educational Rationale: A sound educational rationale should be described in relation to the GME Program's stated goals and objectives for assignments, rotations, and level(s) of training for which the increase is requested. This shall include required case experiences if applicable and reasonable efforts to limit activities that do not contribute to enhancing trainee education. Blanket exceptions for the entire GME Program will be considered the exception, not the rule.
            (3) Moonlighting Policy: Specific moonlighting policies for the periods in question must be included.

(4) Call Schedules: Trainee call schedules during the times specified for the exception must be provided.
(5) Faculty Member Monitoring: Documented evidence of faculty development activities regarding the effects of trainee fatigue and sleep deprivation must be provided.

I. Moonlighting

1. Definitions (from ACGME Glossary of Terms):
   a. Moonlighting: Voluntary, compensated, medically related work performed beyond a trainee's clinical experience and education hours and additional to the work required for successful completion of the program.
   b. External Moonlighting: Voluntary, compensated, medically related work performed outside the site where the trainee is in training and any of its related participating sites.
   c. Internal Moonlighting: Voluntary, compensated, medically related work performed within the site where the trainee is in training or at any of its related participating sites.
      1) Internal moonlighting may occur with faculty supervision or without faculty supervision. In the circumstance of internal moonlighting without faculty supervision, the trainee is performing in the role of a licensed independent practitioner.
2. Background and Rationale
   a. Moonlighting activities must not distract trainees from their primary responsibilities including their own educational activities and the management of patients charged to their care. The ACGME Common Program Requirements governing moonlighting include the following:
      1) CPR VI.F.5.a) Moonlighting must not interfere with the ability of the trainee to achieve the goals and objectives of the educational program and must not interfere with the trainee's fitness for work nor compromise patient safety.
      2) CPR VI.F.5.b) Time spent by trainees in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour maximum weekly limit.
      3) CPR VI.F.5.c) PGY1 residents are not permitted to moonlight.
3. General Policies
   a. Each GME program must have a written policy on moonlighting that is approved by the DIO.
      1) This policy should include specific circumstances under which moonlighting activities are allowed and the procedure for requesting program director approval.
      2) Programs and departments may have policies that are more restrictive than the institutional policy including not allowing for moonlighting to occur.
      3) Each program's policy regarding moonlighting activities must be well-publicized to its graduate medical trainees (e.g., handout materials; signed attestation to the program's handbook).
   b. The institution's moonlighting request form must be used to document permission to moonlight and must become a part of the trainee's file.

c. The privilege of moonlighting shall be contingent upon the trainee consistently demonstrating professionalism by staying up to date with the completion of assigned educational modules required by the institution, GME office and their program and maintaining up to date USAH medical records.

d. The trainee must also be in good standing within their program.

e. Trainees in programs, such as pathology and radiology, where controlled substances are not prescribed, are not required to obtain a DEA number or ACSC.

f. The program director must closely and regularly monitor moonlighting activities to ensure compliance.

    1) To ensure program director monitoring of moonlighting activity, the program director must submit a copy of any approved requests for moonlighting forms to the GME office.

    2) The GME office will periodically audit program compliance with institutional moonlighting policies and procedures and ensure trainees are logging their moonlighting hours in New Innovations.

g. Out of state moonlighting is permissible if approved by the program director. The program director has authority not to allow out of state moonlighting for their training program.

h. The program director is responsible for monitoring fatigue for all graduate medical trainees participating in all moonlighting activities. The trainees' performance must be monitored for the effect of these activities and adverse effects may lead to withdrawal of permission to moonlight.

i. Time spent by trainees in moonlighting must be counted towards the 80 hours maximum weekly limit averaged over a 4-week period. All work hours inclusive of moonlighting must be logged in New Innovations according to the USAH GME educational and work hour logging requirements.

j. PGY-1 residents are not permitted to moonlight.

k. Trainees must not be required to moonlight.

l. J-1 visa holders are not permitted to moonlight.

m. Moonlighting must not incur legal liability or risk to USAH or its affiliates.

n. In view of the serious legal implications of graduate medical trainees engaging in unauthorized moonlighting activities, noncompliance with the USAH GME Moonlighting Policy may result in certain penalties or disciplinary action, up to and including dismissal from the GME training program.

o. Specific penalties or disciplinary action will be determined by the appropriate program director or DIO.

p. Similarly, trainees moonlighting during work hours at USAH when they are on an assigned rotation and trainees who fail to log their moonlighting hours into New Innovations will also be subject to disciplinary action, up to and including dismissal from the program.

q. It is the responsibility of the institution (or department if moonlighting and functioning under supervision) hiring the trainee to moonlight to ensure appropriate credentialing

and licensure are in place, adequate liability coverage is provided, and that the trainee has the appropriate training and skills to carry out assigned duties.

r. Graduate medical trainees and the hiring institution must be responsible for obtaining clinical privileges at the site where the moonlighting activity occurs.

s. For International Medical Graduates and Foreign National Graduates from a Medical School in the U.S, all conditions and requirements included in this section of the USA GME Policy and Procedure Manual apply.

1) International graduates on J-1 visas are not permitted to moonlight.

2) The University of South Alabama, Office of Immigration, will consider other nonimmigrant visa types on a case-by-case basis.

4. Moonlighting and Functioning as a Licensed Independent Practitioner Without Supervision within the USAH System

Note: Applicable for trainees or fellows who have not completed a prior residency and are board-eligible or certified in that specialty.

a. Trainees participating in moonlighting activities independently must have an unrestricted full license to practice medicine in the State of Alabama.

b. Trainees are issued a fee exempt DEA upon the beginning of their residency. A fee exempt DEA can ONLY be used within the USAH System.

c. Trainee moonlighters approved through the medical staff credentialing and privileging process to provide professional services as an independent practitioner within USAH outside of their training programs will receive a “Professional Staff Appointment”, and are subject to all the requirements, responsibilities and rules outlined in the USAH Medical Staff Bylaws when working as a moonlighter.

d. In this capacity, they are not under direct GME/program director supervision, but instead are under the supervision of the appropriate service chief.

5. Moonlighting and Functioning Under Supervision within the USAH System

a. Trainees participating in moonlighting activities under attending supervision must have an unrestricted full license or limited license to practice medicine in the State of Alabama, a current Alabama Controlled Substance Certificate (ACSC), and a personal DEA certificate.

b. Trainees moonlighting and functioning as an independent practitioner (not supervised) are required to go through the credentialing process.

c. At USAH, trainees who are ineligible for an unrestricted full license in Alabama may moonlight with a limited license only when working within the scope of their training program and under attending supervision.

6. Moonlighting and Functioning as a Licensed Independent Practitioner Outside USAH

a. Trainees participating in moonlighting activities independently must have an unrestricted full license to practice medicine in the State of Alabama or the state in which the moonlighting is to occur.

b. If the hiring institution requires a federal DEA for credentialing, it is the responsibility of the trainee to purchase their own DEA. Their fee exempt DEA cannot be used for external moonlighting.

c. The trainee will not be reimbursed through the GME office for their personal DEA certificate.

7. Professional Liability Insurance
   a. Medical malpractice coverage by the USA Professional Liability Trust Fund (PLTF) will be provided only for moonlighting activities within USAH that have been approved by the program director for trainees participating in the activity and the department chair for the department employing the trainee to moonlight.
   b. Moonlighting outside of USAH is not covered by the USA Professional Liability Trust Fund.
   c. Trainees who moonlight at other sites are responsible for obtaining their own malpractice insurance at their own expense.
8. Moonlighting Request and Approval Procedure
   a. Preliminary approval of this process should be started within the program.
   b. This process should not be started until all required licenses, ACSC and personal fee-paid DEA as applicable are obtained and certificates are uploaded into New Innovations.
   c. All trainees who are seeking approval for participation in moonlighting activities must be aware of their program-specific and USA institutional GME moonlighting policies.
      1) Step 1. Obtain approval from the program director.
         a) The trainee must complete all applicable sections of the USAH GME moonlighting request form and present it to their program director for approval and signature.
         b) Visa holders, other than J1 visa holders must also obtain approval and signature from the University of South Alabama, Office of Immigration.
      2) Step 2. Once the form is signed by the program director, it is submitted to the GME office for DIO approval.
      3) Step 3. The DIO will review, approve (if deemed acceptable by the DIO), and sign the form, which will be uploaded into New Innovations. The PD and trainee will be notified by the GME office of the DIO's final approval.
      4) Step 4. After approval of the program director and DIO, obtain appropriate credentialing at the moonlighting site as applicable according to their requirements.
      5) Step 5. Ensure appropriate professional liability insurance is in place.
         a) For trainees moonlighting at an entity not participating in the USA PTLF (NON-USA Covered Facility), it is the responsibility of the institution hiring the trainee to moonlight to ensure that adequate liability coverage is provided.
         b) The USA PLTF does not provide professional liability coverage for moonlighting activities at institutions that are not covered entities under the USA PLTF.
         c) Trainees moonlighting at an entity participating in the USA PLTF (USA Covered Facility) do not have to obtain additional professional liability coverage.
      6) Step 6. All moonlighting hours (internal and external) without exception must be logged into New Innovations.
9. GME Oversight of Work Hours and Moonlighting
   a. Random audits of programs that allow moonlighting will be conducted by the GME office throughout the academic year.

b. Individual program moonlighting policies must be submitted and approved by the DIO.

c. An annual assessment and report of moonlighting activities will be included in the Annual Program Evaluation.

d. The DIO will conduct a focused special review of the program if any of the following situations arise:

1) "New or Extended Citation" or "Area for Improvement/Concerning Trend" is issued on a program's annual accreditation letter from the ACGME regarding work and educational hours,

2) ACGME Resident Survey data suggests potential issues regarding work and educational hours, or

3) A concern is raised through the GME office confidential email account or other confidential reporting means.

J. Evaluations of Trainees, Faculty, and Program

1. The program director must develop and implement program-specific policies and procedures for evaluating trainee performance, the performance of faculty, and the educational effectiveness of the program.
2. Such policies and procedures must include methods for utilizing the results of evaluations to improve trainee performance, gauge the effectiveness of the teaching faculty and the quality of education provided by the program.
3. Trainee Evaluation
   a. Each trainee's performance must be evaluated throughout the training program, the results of evaluations communicated to each trainee, and the results of evaluations used to improve trainee performance.

   b. Each program's evaluation procedures must include evaluation tools and methods that produce an accurate assessment of each trainee's competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

   c. Each program must establish procedures for providing regular and timely feedback to trainees regarding their performance.

   d. The following policies apply to all programs and trainees:

      1) Supervising faculty must directly observe, evaluate, and frequently provide feedback on performance during each rotation or similar educational assignment.

      2) The program director, or their designee, must maintain a record of each trainee's evaluations, and the results of evaluations must be made available to each trainee.

      3) A trainee evaluation must be documented at the completion of each assignment and must address the trainee's strengths and areas for improvement.
         a) For block rotations of greater than three months in duration, evaluation must be documented at least every three months.
         b) Longitudinal experiences in the context of other clinical responsibilities such as continuity clinic, must be evaluated at least every three months and at completion of the experience.

4) The program must have a policy for trainees to review their evaluations and program record in the presence of the program director, or their designee.
5) The program director must provide an objective performance evaluation based on the Competencies and use multiple evaluators e.g., faculty members, peers, patients, self, other professional staff, etc.
6) The program must provide information to the CCC for its synthesis of progressive trainee performance and progression toward unsupervised practice.
7) The program director or designee, with input from the CCC, must prepare a documented semiannual evaluation of each trainee's performance, including progress along the specialty-specific milestones and communicate this evaluation to the trainee in a timely manner.
8) The program director, with input from the CCC, must assist trainees in developing individualized learning plans to capitalize on their strengths and areas for growth as they move toward autonomous practice; and develop plans for trainees failing to progress following institutional policies and procedures.
9) At least annually there must be a final evaluation of each trainee that includes their readiness to progress to the next year of the program, if applicable.

e. Final Evaluation

1) The program director must prepare a final, written evaluation for each trainee upon completion of the program using the USA GME Final Evaluation of Trainee template in New Innovations.
2) The specialty-specific Milestones, and when applicable, the specialty-specific Case Logs, must be used as tools to ensure trainees are able to engage in autonomous practice upon completion of training.
3) The final evaluation must:
   a) Become part of the trainee's permanent record maintained in the program file and must be accessible for review by the trainee in accordance with institutional policy.
   b) Verify that the trainee has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.
   c) Consider recommendations from the Clinical Competency Committee.
   d) Be shared with the trainee upon completion of the program.
   e) The final evaluation is NOT intended to be shared outside the program or USAH.

f. Verification of Training (VGMET)

1) The program director must complete a Verification of Graduate Medical Education Training (VGMET) form (available in NI) for each program graduate as well as for all trainees who do not complete the residency program.
2) The verification of training form must be maintained in the trainee's permanent file in the residency program and a copy provided to the GME office for the trainee's permanent institutional record.
3) The program director must document verification of training of an individual's completion for all graduating trainees within 30 days of completion of the program.

4. Clinical Competency Committee (CCC)

a. Each program must develop a written policy governing their CCC based upon ACGME Common Program Requirements and USA GME Policies and Procedures. (The program may not defer to the USA GME Policy to substitute for their individual program policy.)

b. The program director (PD) must appoint the members of the CCC.

   1) At a minimum, the CCC must include three (3) members of the program faculty, at least one of whom must be a core faculty member. A group size of five (5) to seven (7) members and no more than ten (10) is recommended for optimal committee functioning.

   2) Additional members must be faculty from the same program or other programs (e.g., from a fellowship's core program or other related disciplines or settings for which the learner has substantial exposure and/or provides substantial consultation) or other health professionals who have extensive contact and experience with the program's trainees (e.g., nurses, physician assistants, nurse practitioners, social workers, etc.)

   3) Chief residents who have completed core residency programs in their specialty may be members of the CCC.

   4) Chiefs who are trainees within the training program cannot serve on the CCC.

   5) The program coordinator may administratively attend CCC meetings to take minutes, etc., at the discretion of the PD but may not be a member for the CCC.

   6) The committee chair should:
      a) Be an individual who will best solicit broad input regarding trainee performance and ensure all voices are heard;
      b) Be the Milestones expert;
      c) Encourage a confidential working environment and open communication from all members;
      d) Use best practices in effective group processes, such as ensuring the CCC members develop a "shared mental model" of trainee competencies, Milestones and performance; understand their roles and responsibilities on the committee; and understand how the CCC operates to assess trainee performance;
      e) Work with the PD to develop a plan for professional development of CCC members related to the basics of good assessment tools in use by the program; and,
      f) Make certain the program coordinator or a designated member maintains documentation and meeting minutes.

   7) There is no mandatory rule regarding PD participation in the CCC.
      a) They can be chair, member, or observer, or not attend at all.
      b) Some program directors find it very useful to have another faculty member chair the CCC so they can function better as the trainee advocate and mentor, avoid the perception that the CCC judgments are "only" those of the PD.
      c) Ultimately, however, the ACGME's intent is that the PD has the final decision for determining a trainee's milestones acquisition, as they have the authority for summative decisions relative to trainee promotion and graduation.

d) However, if the CCC functions effectively, it is expected that it would be a rare occurrence for a PD to overrule the CCC consensus on Milestone evaluations, especially since the Milestones are primarily for formative purposes.

c. The CCC must:

1) Review all trainee evaluations at least semi-annually;
2) Determine each trainee's progress on achievement of the specialty-specific Milestones;
3) Advise the PD regarding each trainee's progress, including suggestions for the development of the trainee's individualized learning plans;
4) Advise the PD on trainees with academic deficiencies by suggesting learning plans for improvement and advising the PD in matters of disciplinary action such as probation and dismissal in accordance with USA GME Policies and Procedures; and
5) Review their program's CCC policy annually and update it accordingly.

5. Faculty Evaluation

a. The program director must ensure that evaluation of the teaching faculty is performed in accordance with the ACGME Common Program Requirements and specialty-specific Program Requirements.

b. The performance of the teaching faculty must be evaluated by the program no less than annually.

c. Faculty members must receive feedback at least annually.

d. The evaluations should include a review of 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.

e. Annual written anonymous evaluations by trainees must be included in this process.

f. Results of evaluations should be incorporated into program-wide faculty development plans.

6. Annual Program Evaluation (APE)

a. The goal of the APE process is to improve the quality of the program and the quality of its trainees' future clinical care.

1) This is achieved by assessing components of program quality, identifying areas for improvement, and developing action plans to improve the quality of the program.
2) All ACGME accredited programs sponsored by USAH must abide by the ACGME requirements for the program's continuous improvement process.
3) The Program Evaluation Committee (PEC) is central in developing the APE and Plan of Action (POA), but the program director has ultimate responsibility for the program's quality and continuous improvement processes.

b. Program Evaluation Committee (PEC) and Annual Program Evaluation (APE)

1) To achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvements in the APE.
2) The PD must appoint the PEC to conduct and document the APE as part of the program's continuous improvement processes.

3) The PEC must be composed of at least 2 program faculty members, at least one of whom is a core faculty member, and at least one trainee from the program.
4) PEC responsibilities must include:
   a) Review of the program's mission and aims, strengths, areas for improvement and threats;
   b) Guiding ongoing program improvement, including development of new goals, based upon outcomes; and
   c) Review of the current educational environment to identify strengths, challenges, opportunities, and threats related to the program's mission and aims.
5) The PEC should utilize outcome parameters and other data sources to assess the program's quality and progress toward achievement of its goals and aims.
6) The PEC should use metrics that reflect the goals that the program has set for itself.
7) The PEC should consider the following data sources and support documents in its assessment of the program:
   a) Educational and clinical curriculum;
   b) Outcomes from prior Annual Program Evaluations and Plans of Action;
   c) ACGME letters of notification, including citations, areas for improvement, and comments;
   d) Quality and safety of patient care including at least annual monitoring of patient hand-offs/transitions of care through direct supervision according to program policies and procedures;
   e) Work hours and moonlighting compliance with program and institutional policies and procedures and outcomes of oversight and monitoring.
   f) Aggregate trainee and faculty:
      (1) Well-being
      (2) Recruitment and retention
      (3) Workforce diversity
      (4) Engagement in quality improvement and patient safety
      (5) Scholarly activity
      (6) ACGME Resident and Faculty Surveys
      (7) Written anonymous internal evaluations of the program
   g) Aggregate trainee
      (1) Achievement of the Milestones
      (2) In-training examinations (where applicable)
      (3) Board pass certification rates; and
      (4) Graduate performance
   h) Aggregate faculty
      (1) Evaluation; and,
      (2) Professional development.
8) Assessment of the Educational Program
   a) GME Programs must develop methods to evaluate the effectiveness of the educational program and, based on these evaluations, update the curriculum annually.
   b) Some assessment methods and time frames in which to solicit feedback include, but are not limited to, the following:

(1) Lecture Evaluations: Written or electronic evaluations, distributed after lectures, allow tabulated results to be shared with the lecturer;
(2) Confidential Rotation Evaluation: Evaluations completed by the trainees at the completion of each rotation/assignment;
(3) Semiannual Trainee Evaluations: This type of evaluation allows programs to hear from all trainees about their impressions of their educational experience biannually in a formal sit-down session;
(4) Program Completion Evaluation: An exit questionnaire or exit interview with trainees completing the program to assess their overall training experience; and/or,
(5) Postgraduate Surveys: A short postgraduate survey can be sent to former trainees one year after they graduate which provides feedback of current issues young physicians are encountering in practice, which allows programs to adjust their curriculum, accordingly. This may also provide more forthright responses than current trainees give a program.

c) The APE/POA must
(1) Be distributed to and discussed with the members of the teaching faculty and the trainees; and,
(2) Be submitted to the DIO.

9) Annual Program Evaluation Documentation
a) All programs will use a SCOT (strengths, challenges, opportunities, and threats) analysis for creation of their APE and POA with data sources and support documents attached as appendices to the APE/POA.
b) The APE report and plan of action are submitted to the GME office/DIO on the appropriate forms specified for the APE/POA.
c) Data sources and support documents should be made available to the GME office upon request.
d) APE Plan of Action
(1) The program's POA considers the program's strengths and opportunities to address its challenges and threats. The program should prioritize its challenges and threats identified through the APE process and establish a plan to address the issue(s);
(2) Plans should include goals, specific interventions, or initiatives to achieve the goals, the date instituted, the responsible team leader, outcome measures to be used in assessing successful achievement of the goals, and a timeline for each of the goals using the USA GME Annual Program Evaluation Follow-up Spreadsheet (available on NI);

7. Creation of a New GME Training Program
a. Purpose
1) Creation of new training programs may be necessary to fulfill the educational and clinical missions of USAH.
2) The purpose of this policy is to ensure that the process for creation of new GME training programs is handled in a fair, equitable and timely manner.
b. Policy

1) A request for a new GME training program should be anticipated more than a full year before the program is to begin to allow time for GMEC and USAH procedures and for submission of all necessary documentation needed for program approval by the RC since this occurs periodically at various times during the year.
2) Requests for new fellowship programs should be anticipated at least two full years before they are to begin.
3) All training programs must seek accreditation from the ACGME.
4) If accreditation is not available from the ACGME in a specialty or subspecialty, the program must seek equivalent accreditation if available through another accreditation authority.
5) A training program that does not seek appropriate accreditation will not be sponsored by USAH.
6) The GMEC provides vetting for all new GME programs.
7) GMEC approval is required for all new GME programs prior to submitting the proposal to the Dean of USACOM/Vice President for Medical Affairs.
8) The Dean of USACOM/Vice President for Medical Affairs makes the final decision for approval of sponsorship of a new GME program.
9) Review of all applications and approval of the DIO is required prior to submission of the application for accreditation.

c. Procedure

1) The chair of the department proposing the program and the potential program director meet with the DIO and GME Accreditation Specialist to review the University, GMEC and ACGME requirements that would affect the proposed program.
2) The chair and program director would need to address major accreditation requirements before the program is presented to the GMEC.
3) The GMEC will not consider a program that cannot meet accreditation requirements.
4) The chair and program director will present a written proposal to the GMEC for the new GME program.
5) To allow for distribution to the GMEC membership, the proposal will need to be submitted to the GME office in digital MS Word format at least 2 weeks prior to the next scheduled GMEC meeting.
6) At a minimum, information in this proposal will include the following:
    a) The educational rationale for the proposed program, including the program's mission and aims and how these align with the mission of USAH.
    b) The structure of the program including:
        (1) Length of training
        (2) Number of trainees
        (3) Eligibility requirements of trainees (training prerequisites)
        (4) Selection process for trainees (NRMP, or other specialty match)
        (5) Program curriculum, including a didactic curriculum and a block schedule diagram.
        (6) Trainee clinical schedules, including call schedules
        (7) Review of sufficient patient/case volume

(8) Use of simulation training experiences

7) The impact on clinical services, including impact on the following:
   a) Core faculty physicians' ability to perform their clinical duties;
   b) Reputation of USAH, locally, regionally, and nationally;
   c) Other training programs in USAH with particular attention to trainees in other GME programs, and medical students in the USA College of Medicine.
8) Fellowship programs must have a letter of support from the program director of the core residency.
9) Letters of support from the program directors most likely to be impacted by the program are expected.
10) The following program staff must be identified:
   a) Program director,
   b) Faculty complement,
   c) Program coordinator,
11) Description of any requirements that will need to be outsourced and a viable plan to do so, i.e., if USAH does not provide clinical services to fulfill a required experience, the trainee(s) will need to go to another institution to obtain this training.
12) An estimation of cost and the source of funding to cover program expenses, such as:
   a) Trainee salaries, benefits, malpractice, etc.
   b) Program director's and coordinator's salary support
   c) Potential increases in faculty complement and/or GME staffing
   d) Cost of outsourcing clinical rotations or other training
   e) Program expenses such as ACGME, NRMP, New Innovations, and other fees
   f) Workspace for the program staff and trainee(s), including office space, classroom(s), call room(s).
13) A timeline to be used to guide the process from application to full accreditation. If requesting that the program is to be accredited by an agency other than the ACGME, a copy of the agency requirements must be included with the proposal.
14) The program director must present at the GMEC when the proposal is considered. Attendance by the department chair is expected.
15) Approval of the proposal by the GMEC does not imply financial commitment to the program.
16) Upon receiving the approval of the GMEC, the proposal will go to the Dean of USACOM/Vice President for Medical Affairs, who makes the final decision of institutional support and commitment to the program.
17) Upon receiving approval by the Dean of USACOM/Vice President for Medical Affairs, the application process will be initiated with guidance from the DIO and GME office.
18) Again, review of all applications and approval of the DIO is required prior to submission of the application for accreditation.

K. Advancing Innovation in Residency Education (AIRE)

1. Since responsible innovation and experimentation are essential to improving professional education, faculty members and trainee participation in experimental projects at the USAH must be supported by sound educational principles.

2. Trainees' participation in projects that deviate from the Institutional, Common, and/or specialty/subspecialty-specific Program Requirements requires approval from the GMEC prior to submission to the ACGME and/or respective Review Committee.
3. Program directors must adhere to the procedures of the ACGME. These are available in the ACGME Manual on Policies and Procedures under "Advancing Innovation in Residency Education".
4. USAH and the program director are mutually responsible for monitoring the quality of education offered to trainees for the duration of the project, and the trainees are expected to conduct themselves according to the standards and practices which are commonly accepted within the scientific community.
5. Any allegation of scientific misconduct by a trainee will be handled by the USA College of Medicine using the University of South Alabama Procedures for Investigating and Reporting Scientific Misconduct.

L. Institutional Commitment of Education and Resources for Critical Care Programs

1. Purpose
    a. The purpose of this policy is to ensure that the educational training experience for the USA GME Critical Care Programs including the Pulmonary Disease and Critical Care Fellowship and the Surgical Critical Care Fellowship have adequate educational resources and cooperation of multiple disciplines involved in these programs.
2. Monitoring and compliance
    a. Each critical care program director is assigned the primary responsibility for organizing the educational program for each critical care trainee and ensuring cooperation among all involved disciplines in accordance with ACGME Institutional, Common Program Requirements and subspecialty-specific Program Requirements.
    b. USAH is committed to providing the necessary administrative, educational and clinical resources to all GME programs including multidisciplinary critical care programs.
    c. If difficulties in the distribution of resources committed to critical care training programs are identified or conflicts among program participants arise, the Associate Dean for Graduate Medical Education will meet with members of the program involved to assess the issues and to recommend corrective action. The findings will be reported to the GMEC.

X. TRAINEE PHYSICIAN IMPAIRMENT

A. Background

1. Physical or mental health conditions that interfere with a physician's ability to engage safely in professional activities can put patients at risk, compromise professional relationships, and undermine trust in medicine.
2. While protecting patients' well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care. Physician health is essential to quality patient care.

3. USA GME strives to create an environment to assist trainees and faculty in maintaining well-being and in proactively addressing any health condition that could potentially affect their health, well-being, and performance.
4. For the purposes of this policy and procedure, which applies to all trainees participating in GME programs at USAH, a health condition is defined as including (but not limited to) any physical health, mental health, substance use/abuse, or behavioral condition that has the potential to adversely affect the practice of medicine and/or impair the trainee's performance in the program.

    Examples of conditions that may cause impairment include, but are not limited to:

    a. Substance abuse or dependence due to drugs or alcohol
    b. Mood disorders such as major depression with or without suicidal ideation and attempt
    c. Anxiety disorders (PTSD, OCD, phobias)
    d. Sleep disorders
    e. Stress and "burnout"
    f. Behavioral changes from medical conditions, such as poorly controlled diabetes or thyroid irregularities
    g. Traumatic brain injury
    h. Chronic non-malignant pain
    i. Neurodegenerative disorders such as multiple sclerosis

B. Responsibilities of the Program Director, Faculty Members and Trainees

1. Program directors and faculty members must monitor trainees for the signs of impairment, particularly those related to burnout, depression, suicidal ideation, substance abuse and behavioral disorders.
2. Trainees and faculty members should have a mechanism to alert the program director or other designated personnel or programs when they are concerned that another trainee or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.
3. Trainees and faculty members must be educated on how to recognize symptoms of these forms of impairment in themselves and how to seek appropriate care as required under ACGME guidelines to "monitor stress, including mental or emotional conditions inhibiting performance or learning, and drug or alcohol related dysfunction."
4. Situations that demand excessive service or that consistently produce undesirable stress on trainees should be evaluated and modified.
5. Faculty development resources are available from the GME office.

C. Procedures

1. Program directors and faculty members should be sensitive to the needs of the trainee for timely provision of confidential counseling and psychological support services.

2. The Hospital does not assume a punitive role in cases of impairment but recognizes the importance of identifying and facilitating the treatment of any trainee who is incapable of meeting their responsibilities because of impairment.
3. When health conditions that affect a trainee's ability to practice medicine safely are known or suspected, the program director, and in their absence, the associate program director, any responsible faculty member, or the department chair should act quickly to perform a discreet investigation and plan a workplace intervention and plan of action.
4. This must be done in collaboration with and oversight by the Associate Dean for Graduate Medical Education (or in their absence the Associate DIO) by contacting the Dean as soon as possible for any trainee who has shown signs or symptoms of impairment.
5. If the investigation determines that there is sufficient evidence of impairment, the program director will intervene with the trainee, present the concerns and evidence reported, and determine if diagnostic testing is indicated. (See USAH Drug and Alcohol Testing Policy and Procedures pertaining to USAH employees in Policy Stat on the USAH Intranet)
6. If the trainee accepts the results of the investigation, the program director will work with the trainee to develop a plan of action for appropriate counseling, treatment and/or rehabilitation.
7. The program director shall facilitate referral of the trainee in accordance with the plan of action developed. The program director should work with the trainee to monitor the rehabilitation process and act as an advocate for the trainee with medical and teaching staff, other trainees, and state review boards.
8. If a trainee does not accept the demonstration of impairment and accept the plan of action, the program director shall have the option to dismiss the trainee from the GME program. The trainee has the right to appeal this action.
9. All paid and unpaid leave taken by the trainee will be in accordance with Annual Leave policies. During any period of unpaid leave, the trainee must make arrangements for the payment of premiums for continuance of benefits, including health insurance. The trainee is responsible for the cost of counseling, treatment, and rehabilitation exceeding the limits of coverage provided under the trainee's health insurance.
10. The Associate Dean for Graduate Medical Education must be kept informed via written reports on the results of the intervention, the plan for treatment and/or rehabilitation, the inclusive dates of the leave of absence, the dates of any leave planned as unpaid leave, and the arrangements made for continuance of benefits during unpaid leave.
11. All records concerning an impaired trainee will be treated with strict confidentiality, in accordance with existing state and federal laws.

D. Resources

1. USA Employee Assistance Program
    a. Website: https://www.southalabama.edu/departments/financialaffairs/hr/eap/

b. The USA Employee Assistance Program (EAP) offers free, confidential support services for USA benefits eligible employees and members of their immediate household.

c. The USA EAP services include a counselor that specializes in marriage and family counseling, alcohol and other drug dependency aftercare, critical incident stress management, caregiver issues, employee assistance, career counseling, mindfulness and more.

d. Counseling sessions are designed to help identify and resolve problems related, but not limited to: Relationship or family problems, work or home related stress, international medical graduates who may be experiencing "culture shock", depression /mood swings /anxiety, grief/ loss/ loneliness, alcohol and other drug dependency, work-life balance, LGBTQ issues, chronic illness support, communication problems, and smoking cessation.

1) For more information, email Fletcher Eaton at gfeaton@health.southalabama.edu or call 251.410.7664. You can also visit https://www.southalabama.edu/departments/financialaffairs/hr/eap/.

2. Spiritual Care Services

a. This department has a certified chaplain and offers support to people of diverse faiths.

b. Support includes critical incident stress management, stress reduction, reflections and encouragement and spiritual and emotional support.

c. For information or support contact Chaplain Kim Crawford-Meeks at kcrawfordmeeks@health.southalabama.edu or 251.445.9015.

3. Alabama Professionals Health Program https://alabamaphp.weebly.com/referrals.html

a. The Alabama Professionals Health Program was established and is authorized by the Alabama Board of Medical Examiners.

b. The purpose of the program is to encourage early referral of medical professionals (including practicing physicians, trainees, medical students, and physician's assistants) who have problems that could lead to impairment. The program is confidential and non-punitive.

c. The goal is to provide a clinical mechanism to obtain appropriate assistance prior to having significant impairment that could damage the professional's career or harm patients.

d. Confidential consultation and support services are available for, but not limited to the following:

1) Chemical dependence or abuse,
2) Mental illness (stress, anxiety, depression, etc.),
3) Personality disorders,
4) Disruptive behaviors, and
5) Sexual boundaries.

XI. LEARNING SUPPORT PLANS AND DISCIPLINARY ACTIONS

A. Background and Levels of Action

1. Background

This section details the University of South Alabama Health (USAH) Graduate Medical Education (GME) policy for trainees who encounter academic, technical, and/or professionalism difficulties achieving the knowledge, skills, and attitudes of an independent practitioner. Such problems are to be specifically identified in one or more of the domains of the Accreditation Council for Graduate Medical Education (ACGME) core competencies using appropriate evaluation tools and processes. Letter templates are provided for the actions referred to throughout this section and may be found in New Innovations (NI) under Administration > File Manager > Guidelines, Forms and Templates > Disciplinary Actions.

2. Levels of Action
   a. Program Level Learning Support Actions (Not Appealable, Non-Reportable)
      1) Letter of Warning
      2) Learning Support Plan
   b. Formal Disciplinary Actions (Appealable, Reportable)
      1) Probation
      2) Renewal of Contract without Promotion (Extension of Training)
      3) Non-Renewal of Contract
      4) Dismissal
   c. Administrative Leave
      1) Procedural Administrative Leave (Not Appealable, Reportable)
      2) Performance-Based Administrative Leave (Appealable, Reportable)

B. Program Level Learning Support Actions (Not Appealable, Non-Reportable)

Program Level Learning Support Actions are usually undertaken before Formal Disciplinary Action is considered, as the violations and/or deficiencies have not risen to the level of formal discipline. However, in some circumstances, the violations and/or deficiencies may be so acute and significant that more definitive action is needed when first identified. Particularly when misconduct is involved, a single event may trigger the need for Formal Disciplinary Action without warning or prior Program Level Learning Support Actions. The Clinical Competency Committee (CCC) advises the Program Director (PD) during this process and makes a recommendation to the PD as to the appropriate action to take. However, the final decision is the responsibility of the PD. All CCC discussions must be documented in the CCC minutes.

1. Letter of Warning

The PD may issue a Letter of Warning when an event has occurred that does not meet program standards in one or more of the core competencies defined by the ACGME (template available in NI). This status is not appealable and will not be reported to outside agencies (e.g., ACGME, boards, training verifications).

Violations or deficiencies may also result in additional consequences, in the PD's sole discretion, such as loss of moonlighting privileges, rescheduling of missed clinical experiences, or other appropriate actions relative to the concern.

The Letter of Warning must include:

a. The recognized deficiencies based on the core competencies defined by the ACGME.

b. The specific corrective actions that must be taken by the trainee to correct the problem(s).

c. The consequences of noncompliance, or unsuccessful correction or recurrence of the initial problem(s).

The trainee file should include documentation of the meeting at which the PD discussed the Letter of Warning with the trainee: the Letter of Warning signed and dated by the parties, and documentation of the outcome. If the trainee refuses to sign the Letter of Warning, the date will commence from the date the Letter of Warning is signed by the PD (witness attestation form available in NI). Recurrent issues may result in progression to a Learning Support Plan or Formal Disciplinary Action such as probation. If the trainee has successfully complied with the Letter of Warning and there are no further concerns in training, the documentation will be removed from the trainee's file upon successful completion of the program.

2. Learning Support Plan (LSP)

LSPs are used as a program-level tool to provide a notice of deficiencies, a written constructive plan to correct the deficiencies in a trainee's performance or behavior, and the markers that will be utilized to assess performance in the areas of deficiency. When the deficiency is recognized, the PD, with input from the CCC, should develop a written LSP to strengthen the trainee's performance deficiencies that may cause disruption to the trainee's progression or continuation in the program (template available in NI). The department chair and the Designated Institutional Official (DIO) should be notified of the need for an LSP for the trainee. This action is not appealable.

All moonlighting privileges will be suspended while in this status. Suitability for promotion while on an LSP should be considered by the PD, with input from the CCC.

The LSP must include:

a. The recognized deficiencies based on the core competencies defined by the ACGME.

b. The length of time provided for the trainee to correct the problem(s), not to exceed six (6) months.

c. A statement that moonlighting privileges will be suspended while in this status.

d. The specific corrective actions that must be taken by the trainee to correct the problem(s).

e. The faculty mentor assigned to work with the trainee during the review period and the interval at which the mentor will provide written progress reports to the PD.

f. The specific markers that will be used by the PD and CCC to determine whether the problem(s) has been corrected.

g. The consequences of noncompliance, or unsuccessful correction or recurrence of the initial problem(s).

The trainee file should include documentation of the meeting at which the PD discussed the LSP with the trainee: the LSP signed and dated by the parties, and documentation of the outcome. If the trainee refuses to sign the letter, the date will commence from the date the letter is signed by the PD (witness attestation form available in NI).

Trainees unsuccessful in meeting the conditions of their LSP may face additional Program Level Learning Support Actions and/or Formal Disciplinary Action. If a trainee has successfully

completed the LSP and there are no further concerns in training, the documentation will be removed from the trainee's file upon successful completion of the program.

C. Formal Disciplinary Actions (Appealable, Reportable)

Probation, Renewal of Contract without Promotion, Non-Renewal of Contract, and Dismissal are Formal Disciplinary Actions. They may be the first step in addressing a deficiency, or they may be the culmination of prior attempts at performance improvement.

A trainee cannot be promoted to the next level of training while on a Formal Disciplinary Action, and all moonlighting privileges will be suspended for the duration of the action.

The trainee file should include documentation of the meeting at which the PD discussed the Formal Disciplinary Action with the trainee: the letter of Formal Disciplinary Action signed and dated by the parties, the action plan and expectations, and documentation that the trainee was advised of the appeals process. If the trainee refuses to sign the letter, the date will commence from the date the letter is signed by the PD (witness attestation form available in NI).

The trainee file should include documentation of the outcome: successful compliance or consequences of failing to correct the deficiencies. This documentation will remain part of the trainee's file and be reported on training verifications upon program completion.

1. Procedural Steps for Formal Disciplinary Actions

(Probation, Renewal of Contract without Promotion, Non-Renewal of Contract, Dismissal):

The trainee will be notified in writing by the PD that he or she is being considered for Formal Disciplinary Action (templates available in NI). The trainee will be informed that he or she may submit documentation/information in writing to the PD and CCC chair for consideration and may appear before the CCC to discuss the information. The CCC meeting will be scheduled no sooner than ten (10) business days from the date of Notification of Consideration for Formal Disciplinary Action. All CCC discussions must be documented in the CCC minutes. The notification letter should be signed and dated by the parties. If the trainee refuses to sign the letter, the date will commence from the date the letter is signed by the PD (witness attestation form available in NI).

The PD shall decide whether to move forward with Formal Disciplinary Action after considering all information and the recommendations of the CCC.

Trainee will be notified in writing (templates available in NI) of decision to place on disciplinary action within ten (10) days from the CCC meeting that was scheduled to address the potential disciplinary action.

The Notification of Formal Disciplinary Action letter must include the following elements:

a. The specific problem(s) to be addressed in the context of the ACGME core competencies.
b. The defined length of time during which the trainee must correct the deficiency.
c. A statement that moonlighting privileges will be suspended while in this status.
d. The specific corrective actions that must be taken to correct the deficiency.
e. The specific markers that will be used to determine if the deficiency has been corrected.

f. The consequences of noncompliance or unsuccessful correction of the deficiency or recurrence of the initial problem after correction of the deficiency.

g. The faculty mentor assigned to work with the trainee during the disciplinary period, the interval at which the trainee will schedule and meet with the mentor, and the interval at which the mentor will provide written progress reports to the PD.

h. The notice of the trainee's right to appeal the action according to the Appeal Procedure for Formal Disciplinary Actions in the USA GME Policy and Procedure Manual.

The Notification of Formal Disciplinary Action letter must be submitted to the DIO for review and approval. The DIO will advise the PD through all stages of the Formal Disciplinary Action process.

Following approval by the DIO, the PD shall meet with the trainee to review the Notification of Formal Disciplinary Action letter and notify the trainee of the appeal process governing this action. Both parties shall sign and date the letter. If the trainee refuses to sign the letter, the date will commence from the date the letter is signed by the PD (witness attestation form available in NI).

Based on the trainee's compliance or non-compliance with the disciplinary plan, the program shall evaluate success (or lack of success) in correcting the deficiency and determine the disposition of the action. See specific actions for disposition options.

2. Probation

Probation may be used for trainees who experience a serious lapse in complying with the policies and procedures of the program, USA GME, or USAH or for other serious misconduct and/or performance problems and may result in an extension of training.

Reasons for Probation may include, but are not limited to:

a. Failure to successfully correct deficiencies outlined in a Letter of Warning or LSP or recurrence of those deficiencies.

b. Failure to meet performance standards of an individual rotation.

c. Ongoing, documented failure to meet performance standards of the program in any of the core competencies defined by the ACGME.

d. Ongoing, documented failure to comply with the policies and procedures of the GME Committee (GMEC), USAH, or any of the major participating institutions.

e. Misconduct that infringes upon the principles and guidelines of the GME program.

f. Ongoing, documented failure to complete medical records in a timely and appropriate manner.

g. Professional misconduct, unethical behavior, or disruptive behavior considered significant enough to raise issues as to the trainee's fitness to participate in the educational program.

If probation follows unsuccessful prior attempts at improvement such as an LSP, clear documentation of failure to achieve the goals and objectives outlined therein must be shown. If the misconduct is considered serious enough, it may trigger probation without the trainee having been subject to prior Program Level LSP action.

Probation is typically the final step before dismissal occurs. However, dismissal before the probationary period ends may occur if there is further deterioration in performance or additional deficiencies are identified.

If probation is successfully completed, time spent on probation will be counted toward completion of program requirements. If not successfully completed, time spent on probation may or may not be counted toward program requirements, as determined at the PD's discretion with approval of the DIO.

When considering probation, the PD shall follow the procedural steps outlined above for Formal Disciplinary Actions.

Based on the trainee's compliance or non-compliance with the Probation plan, the program shall evaluate success (or lack of success) in correcting the deficiency and the disposition may be one of the following:

a. Continued probation for a specified time, generally not to exceed an additional six (6) months, with possible extension of training. (If probation continues, the prior procedural steps must be repeated with a new Letter of Notification.)

h. Removed from probation.

i. Dismissed from the program or placed on another Formal Disciplinary Action. (Due process procedures for any Formal Disciplinary Action must be utilized.)

3. Renewal of Contract without Promotion (Extension of Training)

Renewal of Contract without Promotion (Extension of Training) may be used when the trainee has not been able to clearly demonstrate the knowledge, skill, or behaviors required to advance to the next level of training and responsibility. Clear documentation of failure to achieve the goals and objectives outlined by the GME program is essential. This action results in a failure to advance to the next PGY level of education but does not imply termination of all association with USAH, and employment is maintained at the current PGY level.

When considering Renewal of Contract without Promotion (Extension of Training), the PD shall follow the procedural steps outlined above for Formal Disciplinary Actions. The notification letter must also include the impact of the additional period of training on board eligibility requirements.

Trainee will be notified in writing (template available in NI) of the decision to place the trainee on Formal Disciplinary Action of Renewal of Contract without Promotion (Extension of Training) no later than four (4) months prior to the conclusion of the academic year or with as much notice as the circumstances reasonably allow.

Based on the trainee's compliance or non-compliance with the Renewal of Contract without Promotion plan, the program shall evaluate success (or lack of success) in correcting the deficiency and the disposition may be one of the following:

a. Continued Renewal of Contract without Promotion with possible extension of training for a specified time generally not to exceed an additional six (6) months. (If continuation of this action is required, the prior steps must be repeated with a new Letter of Notification.)

b. Promotion to the next academic year upon successful remediation.

c. Dismissal from the program. (Dismissal procedures must be implemented, including a new Letter of Notification.)

4. Non-Renewal of Contract

Non-Renewal of Contract results in termination of association with USAH at the end of the current contract period. Clear documentation of failure to achieve the goals and objectives outlined by the GME program is essential, and a record of counseling and attempts at remediation are required.

When considering Non-Renewal of Contract, the PD shall follow the procedural steps outlined above for Formal Disciplinary Actions. The notification letter must also include the credit, if any, for the academic year in question that will be given to the trainee at the discretion of the PD, with approval from the DIO. Recognition of the credit will be determined by the certifying Board.

Trainee will be notified in writing (template available in NI) of the decision to place the trainee on Formal Disciplinary Action of Non-Renewal of Contract no later than four (4) months prior to the conclusion of the academic year or with as much notice as the circumstances reasonably allow.

5. Dismissal

Dismissal involves immediate and permanent removal of the trainee from the GME program for failing to maintain academic and/or other professional standards required to progress in or complete the program. Dismissal is usually preceded by sufficient notice to the trainee that there are significant deficiencies in knowledge, performance, or behaviors. Previous Formal Disciplinary Actions are considered such notice. However, there is no requirement that there be preceding Formal Disciplinary Action before being dismissed. In some circumstances, the deficiencies may be so acute and significant as to warrant more definitive action when first identified. Dismissal can occur at any time.

Reasons for Dismissal may include, but are not limited to:

a. Failure to meet requirements of probation.
b. Failure to meet the performance standards of any rotation, misconduct that infringes on the principles and guidelines of the GME program, failure to comply with the policies and procedures of the GMEC, USAH, or any other of the major participating institutions which is considered serious enough that continued participation in the program is felt to be a danger to patients, the trainee, or others.
c. Documented failure to complete medical records in a timely and appropriate manner or alteration of medical records.
d. Professional misconduct or unethical behavior considered significant enough to raise issues as to a trainee's fitness to participate in the GME program.
e. Illegal, unethical, or immoral conduct.
f. Inability to pass the requisite examinations for licensure to practice medicine in the State of Alabama according to the policies of the GMEC.
g. Misrepresentation of information in the residency appointment application.

When considering Dismissal, the PD shall follow the procedural steps outlined above for Formal Disciplinary Actions. The notification letter must also include the credit, if any, for the academic

year in question that will be given to the trainee at the discretion of the PD, with approval from the DIO, and the date the dismissal will be effective. Recognition of the credit will be determined by the certifying Board.

D. Appeal Procedure for Formal Disciplinary Actions

A trainee has the right to appeal a Formal Disciplinary Action issued by their PD before a hearing of a Special Review Committee (SRC) appointed by the Dean of the Frederick P. Whiddon College of Medicine (Whiddon COM), who will ascertain whether the Formal Disciplinary Action should be upheld. The SRC will consist of at least three (3) faculty members appointed by the Dean of the Whiddon COM from three (3) different specialties that have accredited GME programs at USAH and are in good standing with the ACGME.

The appointed members must have substantial experience in residency training and be senior members of their respective departments. Appointed members must be from a different department than that of the trainee. Every appeal will have its own SRC that will be disbanded at the conclusion of the appeal process.

The trainee may obtain legal counsel or other assistance in preparing for the hearing; however, the trainee cannot be represented by legal counsel during the hearing. Neither the trainee nor the PD will have legal counsel present at the hearing.

Specifics of the hearing process are at the discretion of the SRC and the SRC chair. For example, the SRC may adjust the timeline, determine whether the trainee may be present when the PD presents (the trainee has the opportunity to be present when the case is made by the PD, but if disruptive the trainee may be removed), or determine when they have received enough information from either the trainee or the program to reach a decision. The hearing is contemplated not to be an adversarial process, but rather, a process for gathering information. The GME office will facilitate the appeal process by scheduling meetings, reserving rooms, ensuring transfer of appropriate documentation, and other administrative support.

Audio and/or video recording of the hearing is not allowed. A recording secretary shall keep notes to assist the SRC in preparing its report. The parties may take notes during the hearing.

The trainee file should include documentation of the outcome of the appeal: SRC decision for action upheld or SRC decision for action not upheld. This documentation will remain part of the trainee's file and be reported on training verifications upon program completion.

Procedural Steps for an Appeal of Formal Disciplinary Action:

a. Trainee must make an appeal in writing to the Dean of Whiddon COM within ten (10) business days of the trainee's receipt of written notification of Formal Disciplinary Action. This date will commence from the date of the trainee's signature on the written notification of Formal Disciplinary Action letter. If the trainee refuses to sign the letter, the date will commence from the date the letter is signed by the PD (witness attestation form available in NI).
b. The Dean of Whiddon COM will appoint a three-member SRC to hear the case within five (5) business days of receipt of the trainee's appeal. The SRC will meet to determine specifics of the hearing process within ten (10) business days of appointment by the Dean of Whiddon COM.

c. The SRC will send a notification letter to the trainee and PD within three (3) business days of its initial meeting. This letter will specify the particulars of the timeline and hearing process. The hearing date shall be no sooner than ten (10) days after receipt of the letter by the trainee.

d. All information to be presented by the trainee and the PD shall be provided to the SRC in advance of the hearing but no later than five (5) business days before the scheduled hearing date. All parties shall copy the DIO and GME Administrator on all correspondence. No additional information may be presented at the hearing that was not submitted by the stated deadline.

e. The SRC chair will forward all information from the trainee to the PD and all information from the PD to the trainee prior to the hearing but no later than three (3) business days after receipt. The SRC shall copy the DIO and GME Administrator on all correspondence. The GME Administrator will ensure that documents are sent to the parties in a timely manner.

f. The SRC will hold a hearing allowing both parties to present their case. The SRC will reach a decision based on the evidence from the parties within three (3) business days of the hearing. This decision is the final appeal available to trainees within USAH.

g. The SRC will transmit its decision in writing to the Dean of Whiddon COM within three (3) business days of the hearing, and the Dean of Whiddon COM will then notify the trainee and PD of the SRC's decision within three (3) business days of his/her notification of the SRC's determination.

h. The GME office may provide administrative support to the SRC, but the SRC will determine the particulars of the SRC proceedings and final outcome.

E. Administrative Leave (Reportable)

Should a trainee violate any applicable general or personnel policies set forth in the Policy and Procedure manuals of USAH, the trainee will be notified by the GME Institutional Administrator via USAH email of the specific violation, including information pertaining to the violation. The Staff Grievance and Appeals Process set forth in the Staff Employee Handbook is not applicable to trainees.

The trainee file should include documentation of the outcome. This documentation will remain part of the trainee's file and be reported on training verifications upon program completion.

There are two types of Administrative Leave: Procedural and Performance-Based.

Procedural Administrative Leave is usually for first-time or minor administrative infractions, such as non-compliance with proof of required vaccinations or non-compliance with logging work hours. This Administrative Leave is unpaid, and the trainee will remain on leave without pay until the violation is remediated. The duration of the leave will be a minimum of 24 hours. This leave is not eligible for appeal.

Performance-Based Administrative Leave is for serious violations of policy, including, but not limited to, conduct that may have jeopardized or could jeopardize patient safety, serious ethical violations, arrests, and other matters. Any party may report a concern of this nature regarding a trainee to the GME office. When the GME office becomes aware of the alleged violation, information regarding the violation will be sent to the DIO, the appropriate PD, and the Chair of

the trainee's department, which will then be investigated. At the discretion of the PD, the trainee may be removed from clinical duties immediately and for the duration of the leave. Non-clinical duties may be assigned during the investigative process at the program's discretion and if allowable by specialty-specific rules of the ACGME and certifying Board. The trainee may be placed on Performance-Based Administrative Leave with pay for no longer than thirty (30) calendar days. Upon being removed from clinical duties and placed on Performance-Based Administrative Leave, the trainee shall be provided with a Notification of Leave letter, which is to be signed by the PD and the trainee. If the trainee refuses to sign the letter, the date of the notification, and the beginning of the administrative leave, will commence from the date the letter is signed by the PD (witness attestation form available in NI).

Duration of leave may be extended at the discretion of the DIO or based on outside determinations, including, but not limited to, Alabama Licensure Board, medical evaluations, and court decisions regarding criminal behavior, among other things.

All moonlighting privileges will be suspended while on Performance-Based Administrative Leave.

Upon the investigation's conclusion, the trainee may receive Notification of Consideration of Formal Disciplinary Action, up to and including dismissal. If Formal Disciplinary Action is determined, the Procedural Steps for Formal Disciplinary Action shall be followed.

Reported violations found to be without merit will not be reportable, and documentation of the Notification of Leave will be removed from the trainee's file upon successful completion of the program.

XII. SEXUAL HARASSMENT OR HARASSMENT BASED ON ANY OTHER PROTECTED STATUS

A. Definition of Harassment

1. Harassment is defined as unwelcome conduct, whether verbal, physical, or visual, that is based upon a person's identity(ies), including race, color, national origin, sex, pregnancy, sexual orientation, gender identity, gender expression, religion, age, genetic information, disability, or protected veteran status or any other applicable legally protected basis.

B. Harassment Policy

1. USA will not tolerate harassing conduct that affects tangible job or education benefits, that interferes unreasonably with an individual's work or academic performance, or that creates an intimidating, hostile, demeaning, or offensive working or learning environment.
2. To avoid actual or apparent conflict of interest, coercion, favoritism, or bias, USA personnel may not participate in the evaluation of any other employee or student with whom such personnel have or have had an amorous relationship.
3. Any employee who believes that they are, or have been, the subject of harassment based on any protected status, or is aware of such conduct, should report such conduct immediately as outlined below.

4. It is against USA policy to retaliate against an employee for reporting a complaint of harassment or participating in an investigation.
5. A violation of the USA harassment policy can lead to disciplinary action, up to and including termination.
6. A complaint relating to sexual harassment may be filed with the Title IX Coordinator, a Title IX Deputy Coordinator, USA Security, or your program leadership.
7. The complaint should be filed within one hundred eighty (180) days of the most recent act.
8. A thorough investigation will be conducted, and appropriate action taken.
9. All University employees and USAH employees have a duty to report sexual misconduct that they observe or otherwise learn about.
10. A complaint of harassment based on any other protected status or any questions relating to the USA's policy on unlawful harassment or discrimination should be directed to Human Resources.
11. The non-discrimination policy can be found at the bottom of the Human Resources webpage: www.southalabama.edu/departments/financialaffairs/hr/
12. USA will make reasonable efforts consistent with enforcement of this policy and with the law to protect the privacy of the individuals involved and to ensure that the complainant and the accused are treated fairly.
13. Once reported, information about individual complaints and their disposition is considered confidential and will be shared only on a business need-to-know basis.
14. This harassment policy, however, shall not be used to bring frivolous or malicious complaints. If USA determines a complaint has been made in bad faith, disciplinary action up to and including termination may be taken against the person bringing the complaint.
15. Additional information is available via the following links:
    a. USA Title IX Information, including directory of Title IX Coordinator and Deputy Coordinators: https://www.southalabama.edu/departments/studentaffairs/titlenine/
    b. University of South Alabama Sexual Misconduct Policy and Complaint Resolution Procedures: https://www.southalabama.edu/departments/studentaffairs/titlenine/
    c. **NOTE**: In the event a conflict of interest arises with the above-named coordinator or any of the deputy coordinators, the case will be managed by that coordinator's supervisor.

XIII. VISITING TRAINEE POLICY AND PROCEDURE

A. Responsibilities Related to Visiting Trainees

1. During the elective rotation, the visiting trainee will be required to uphold the professional standards established by federal, state, and local laws, regulations stipulated by the Joint Commission and ACGME and the policies of the USA, USAH, USAH GME and the GME Program hosting the elective.

2. USAH will be responsible for the accreditation, planning, programming, and administration of its GME Programs, as well as the selection, assignment, and supervision of visiting trainees participating in electives in a GME Program.

B. Visiting Trainee Elective

1. A trainee must be currently enrolled in an ACGME- or AOA-accredited residency program to participate in patient care under the supervision of the USAH faculty member as part of an elective rotation.
2. The program coordinator provides the “University of South Alabama Graduate Medical Education Application for Visiting Resident Elective" form (available under “Administration" then "File Manager" then "Forms and Templates" in New Innovations) to the requesting trainee. The requesting trainee completes the sections of the form pertinent to them and returns the form to the program coordinator. The program coordinator/program director completes their sections of the form and submits the form to the Housestaff Office. The Housestaff Office reviews the form and notifies the program of initial approval and that they may proceed with onboarding the trainee for the elective.
3. The trainee must provide the requested documents listed on the form to the program coordinator four (4) weeks prior to beginning the rotation.
4. Risk Management
    a. The visiting trainee must provide proof of liability insurance coverage for any elective experience.
    b. If liability coverage is provided by the visiting trainee’s home program, a certificate of liability coverage must be provided to the University of South Alabama Office of Risk Management and the USAH Residency Coordinator.
    c. In some cases, the home program does not extend liability coverage outside its institution.
    d. When this happens, the trainee must provide their own liability coverage.
    e. If the trainee qualifies, liability coverage may be purchased by the trainee from the University of South Alabama Office of Risk Management.
    f. The availability and cost of liability coverage can be determined by contacting the Housestaff Office upon receipt of the application to participate in an elective at USAH.
5. HIPAA Compliance
    a. All visiting trainees must have completed HIPAA compliance training.
    b. If this has already been accomplished at the trainee’s home institution within the past year, they must provide this documentation and sign a HIPAA Confidential Agreement available from the USAH Residency program coordinator.
    c. If the individual has not completed HIPAA compliance training, once an approved visiting trainee elective application is provided to the USAH Residency Coordinator, a request will be sent to Computer Information Systems and the visiting trainee will be provided with the appropriate access to complete HIPAA compliance training.
6. Computer Access

a. Visiting trainees requiring access to the electronic health record (EHR) will be provided access to the computer systems. The Housestaff Office will submit the required form prior to the visiting trainee's arrival.

7. Final Visiting Trainee Rotation Approval
    a. Once all the required documents have been reviewed and approved by the Residency Program and Housestaff Office staff, the USAH GME Program may notify the visiting trainee regarding approval of the elective and establish a start date for the rotation. The Residency Coordinator must also notify the Housestaff office of the start date.

C. Second Look Visit for Program Applicants

1. USAH provides residency program applicants a short (1-2 day) observership for individuals who have interviewed at one of the programs and are interested in a "second look" visit.
2. These visits are arranged by the individual programs in conjunction with the USAH Office for Community engagement.
3. The program coordinator works with the program applicant to make these arrangements and ensure appropriate documentation is in place prior to the second look visit.

Appendix A: Contact List

Name	Contact Information	Address/Website
Alabama Professional Health Program (APHP)	334-954-2596 800-239-6272 334-954-2593 staff@alabamaphp.org	http://www.alabamaphp.org/
Biomedical Library ***Main Campus*** **Clista Clanton** *Clinical Librarian*	Email: medlib@southalabama.edu (Research) 251-460-7043 (Circulation Desk) cclanton@southalabama.edu 251-414-8210	5791 USA Drive North Mobile, AL 36688 www.southalabama.edu/departments/biomedicallibrary/
Graduate Medical Education and Housestaff Office **Judy Blair-Elortegui, MD (DIO)** *Designated Institutional Official* **Danielle Haynes** *Institutional Administrator* **Amari Armour** **Kimberly Bonner** **Stacey Hartman** **Leah Musgrove**	251-471-7206 251-471-7875 jblair@health.southalabama.edu daniellehaynes@health.southalabama.edu aarmour@health.southalabama.edu kbonner@health.southalabama.edu shartman@health.southalabama.edu lmusgrove@health.southalabama.edu	University Hospital, Mastin 212 2451 University Hospital Drive Mobile, AL 36617 www.southalabama.edu/colleges/com/gme
Human Resources Departments	www.southalabama.edu/hr/index.html	
University of South Alabama Campus USA Health System	251-460-6133 251-415-1604	hrmaincampus@southalabama.edu hrhealth@southalabama.edu
Office of Immigration **Arrin Hines**, *Manager*	251-460-6050 arrinhines@southalabama.edu	390 Student Center Circle Meisler Hall, Suite 2200 Mobile, AL 36688 https://www.southalabama.edu/departments/immigration/
Office of Marketing and Communications **Marie Katz** *Interim Associate Vice President of Marketing and Communication*	251-470-1671 251-415-8633 mkatz@health.southalabama.edu	251 Cox Street CWEB Ste. 1015 Mobile, AL 36604

Name	Contact Information	Address/Website
Office of Risk Management **Connie Cook** *Director of Risk Management and Insurance* **Cassie Roote** *Risk Manager*	251-460-6232 251-460-6074 cgcook@southalabama.edu croote@southalabama.edu	CSAB 216, 5795 USA Drive North Mobile, AL 36688 www.southalabama.edu/departments/financialaffairs/riskmanagement/
ADA information **USA Human Resources** **Yamayra Betler**	251-460-6133 https://www.southalabama.edu/departments/financialaffairs/hr/benefits-questions.html	USA Main Campus USA Technology & Research Park, Bldg. III, Suite 2200 650 Clinic Drive Mobile, AL 36688
Personnel Managers **Andrea Rosler** *Chief Human Resources Officer*	251-415-1635 arosler@health.southalabama.edu	210 Cox Street Mobile, AL 36604 (Adjacent to C&W Hospital)
Reimbursement **Kimberly Lambeth** **Melissa Cannedy** **Debra Sibley-Randall**	251-434-3836 251-434-3836 251-434-3836	UHOP 4th Floor 3929-1 Airport Blvd. Mobile, AL 36688
USA Title IX Office **Dr. Deidra Byas** *Title IX Coordinator* **For Staff, Administrators & Resident Physicians** **Dr. Franklin Trimm** *Deputy Title IX Coordinator for the College of Medicine, and USAH Faculty and Staff Physicians*	251-461-1538 titleix@southalabama.edu 251-460-6641 rftrimm@southalabama.edu	USA Student Center, Room 116 Mobile, AL 36688 USA College of Medicine Bldg. https://www.southalabama.edu/colleges/com/administration/diversity/
Security **USA** **UH** **USA CW** **USA MCI**	police@southalabama.edu 251-460-6312 Campus Police 251-471-7195 or 251-471-7525 251-415-1135 251-665-8000	Main Office at USA 290 Jaguar Blvd. Mobile, AL 36688

APPENDIX B: American Boards of Medical Specialties Resources

Specialty Board	Website
American Board of Medical Specialties	www.abms.org
Emergency Medicine	www.abem.org/public
Family Medicine (Includes Sports Medicine subspecialty)	www.theabfm.org
Internal Medicine (Includes Cardiology, Gastroenterology, Hematology/Oncology and Pulmonary subspecialties)	www.abim.org
Neurology (Includes Clinical Neurophysiology subspecialty)	www.abpn.com
Obstetrics and Gynecology (Includes Gynecology/Oncology)	www.abog.org
Orthopedic Surgery	www.abos.org
Pathology	www.abpath.org
Pediatrics	www.abp.org
Psychiatry (Includes Child & Adolescent Psychology and Addiction Medicine)	www.abpn.com
Radiology	www.theabr.org
Surgery (Includes Surgical Critical Care and Urology)	www.absurgery.org
Urology	https://www.auanet.org/