Contents
Statement of Values ...................................................................................................................................... 3
Statement of Institutional Philosophy and Commitment ............................................................................. 3
Equal Opportunity and Non-Discrimination .................................................................................................. 5
Harassment/Workplace Violence: ................................................................................................................ 5
Medical Learners ........................................................................................................................................... 5
Medical Student Teaching .......................................................................................................................... 10
Information Technology and Systems Access ............................................................................................. 10
Continuation of GME Support in the Event of a Disaster ........................................................................... 11
Academic Integrity ...................................................................................................................................... 12
Restrictive Covenants/Non-compete Clauses ............................................................................................. 12
Ethical Conflicts in Care Management ........................................................................................................ 12
Malpractice ................................................................................................................................................. 13
Disability Benefits ....................................................................................................................................... 13
Protecting Patient Privacy ........................................................................................................................... 14
Resident Eligibility and Selection Policy ...................................................................................................... 14
Non-Academic Requirements for Appointment, Reappointment and Retention ...................................... 17
Accommodation for Residents/Fellows with Disabilities .......................................................................... 19
Resident Transfers ...................................................................................................................................... 20
Employee Benefits and Perks ....................................................................................................................... 21
Paid Time Off, Funeral Leave, Military Duty, and Program Specific Policies .............................................. 24
Leaves of Absence ....................................................................................................................................... 26
Continuing Medical Education (Including Travel, Meetings and Books) .................................................... 27
Off-Site “Away” Elective Rotations ............................................................................................................. 29
Global Health Rotation Program .................................................................................................................. 32
Resident Promotion, Evaluation and Contract Renewal ............................................................................... 35
Due Process Procedures for Concerns, Performance Problems and Offenses: Correction, Discipline, Suspension and Termination ........................................................................................................ 38
Resident Council ......................................................................................................................................... 45
Supervision of Residents ............................................................................................................................ 46
Statement of Values

The Community Health Network (CHNw) Department of Academic Affairs (and its educational and research programs) support the PRIIDE values of the Network.

**Patients First**...prioritizing patients’ and families’ needs  
**Relationships**...working together inclusively with coworkers and teams  
**Integrity**...demonstrating truth-telling and transparency in word and action  
**Innovation**...being creative and open to new ideas  
**Dedication**...serving as an accountable steward of resources  
**Excellence**...exemplifying commitment to high quality and safe patient care

All learners (students, residents, and fellows), faculty and staff will employ these values during their educational experience. This handbook, which includes network policies, procedures and guidelines, is intended to support the best patient care, highest quality education, and strongest experience of personal and professional development of each person and program. We align with network policies whenever possible.

Our philosophy of education is that learners are to be treated with collegial respect, included in decision making related to their education, and supported with care and concern for their well-being and that of the patients we serve.

We promise you an educational environment that is respectful, that allows you to work to be the best physician you can be, and supports you physically, emotionally, cognitively and spiritually in your growth.

We expect learners to demonstrate these values as they work with patients, families, colleagues and the community during training.

Statement of Institutional Philosophy and Commitment

Community Health Network (network) through its Department of Academic Affairs is committed to providing graduate medical education that facilitates professional, ethical and personal development in
accordance with ACGME, AOA, and CPME standards, both at the institutional and specialty board levels required of independent physicians. We offer graduate medical education (GME) as a way to train the workforce of the future in the “Community Way”: high quality patient care and safety systems integration and teamwork.

Graduate Medical Education is under the network leadership of the Senior Institutional Executive (SIE), Bryan Mills, President and CEO, the Chief Academic Officer and Designated Institutional Official (DIO) Kathy Zoppi, PhD (ACGME), and the Network Graduate Medical Education Committee (GMEC). The specific structure of the ACGME, AOA and CPME program leadership is dictated by the standards and structures applicable to each program. GMEC is organized under GME requirements for all specialties and programs.

Specific membership of the GMEC is defined in the “Graduate Medical Education Committee (GMEC)” section (see table of contents for page) of this Handbook. Resident representation to GMEC and on the Resident Council is one means for residents to ensure the network is meeting high educational and patient care standards.

Community Health Network is committed to providing the necessary educational, financial and human resources to ensure the effective implementation and support of its programs to comply with all ACGME, CPME and AOA institutional, common, and program specific requirements.

Such commitment includes financial support and protected time for the GME Office, residency program directors, faculty, and program coordinators to carry out their educational and administrative responsibilities to the institution and their respective programs; adequate space, communication resources, technology programs and support; and access to appropriate reference material and electronic databases.

Community Health Network is committed through its GMEC and GME offices to ensure that each program provides effective educational experiences for its GME trainees that lead to measurable achievement of educational outcomes in the ACGME, CPME and AOA competencies.

Community Health Network has developed and approved institutional level policies for its GME programs and assumes the responsibility to monitor the compliance with all such policies.

Specific and continuing oversight of compliance is provided by Community Health Network, GMEC, DIO, and program directors. Additional policies which are applicable to all Network employees are found in Network Human Resources Policies and policies of affiliated hospitals.

The GMEC provides oversight of all training programs through each individual program’s annual program review, the periodic internal review of the program and necessary follow up, and annual review
of corrective actions of site visit citations. The specific methodology of and action and response to such reviews is in accord with the specific requirements of ACGME and AOA standards.

Unless program requirements, policies, and procedures are distinguished by ACGME, CPME or AOA designation, all requirements apply to all programs. The term “practice of medicine” includes the practice of all CHNw residency program specialties. Where program requirements differ, the specific of the ACGME, CPME, or AOA standards are reflected in the applicable portion of this Handbook and are adopted as part of the Community Health Network Graduate Medical Education policies and procedures. Further, the term ‘Resident’ is intended to represent all medical education trainees to include Resident and Fellows (both employed and visiting) throughout this handbook.

**Equal Opportunity and Non-Discrimination**

Community Health Network will seek and employ qualified individuals in all positions and in all departments; provide equal opportunity for advancement of employees; and administer these and all other matters concerned with employment in a manner which will not discriminate against any person in accordance with Title VII of the Civil Rights Act of 1964 (i.e. age, race, color, disability, religion, gender or national origin) and the Americans with Disability Act as amended.

In accordance with Community Health Network’s values, all employees will be treated with dignity, respect and courtesy. To this end, and to provide a productive work environment, Community prohibits all forms of discrimination, including but not limited to: harassment on the basis of race, gender, ethnic background, age, religion, disability, or sexual orientation.

**Harassment/Workplace Violence:**

All employees have the right to work in an environment free from all forms of discrimination and conduct which can be considered harassing, threatening, hostile, intimidating, coercive, or disruptive, including sexual harassment. Community supports a zero tolerance towards acts of harassment, workplace threats and workplace violence.

**Medical Learners**

The purpose of this policy is to define and clarify the Community Health Network medical learner parameters. It governs our placement and on-boarding of Community residents and fellows, medical students, visiting medical residents and fellows, and medical observers within Community, and all
affiliated hospital and practice locations. It is the policy of the Community Health Network (Community), and its Office of Academic Affairs (OAA) to assure high quality education for learners and the highest possible service for our patients. These principles guide all learner requirements, including on-boarding activities, as well as legal and regulatory compliance.

Definitions:

Medical Student: Student currently enrolled in an accredited Medical School which is sanctioned by the LCME (Liaison Committee on Medical Education) or COCA (Commission on Osteopathic College Accreditation), and whose graduates are eligible for licensure in Indiana according to the Indiana Board of physician licensure.

Medical Observer: This is an experience (also referred to as ‘shadowing’) that does not exceed 16 hours in length and is intended to provide exposure to learners in a health care environment allowing them to determine level of interest in health care careers.

Affiliated Locations: Clinical sites of care which include employed physicians as well as those which are not employed, but the physicians are on the Community Medical Staff.

Graduate Medical Education (GME): Education provided to employed medical residents and fellows. Community has multiple residency and fellowship programs.

Undergraduate Medical Education (UGME): Education provided to enrolled/registered Medical Students.

Visiting Medical Residents and Fellows: When an external accredited program requests a rotation or clinical experience for a learner, the GME program may offer reciprocity for that learner for a brief period of time, dependent on specialty and preceptor availability.

Visiting Physician Observer: Physicians who are not licensed in the US who wish to observe in a patient care setting must go through the medical staff office for permission to observe in any patient care setting.

Learner Priority:
Due to limits associated with preceptor availability, learners are prioritized as follows:

1. Employed GME trainees (residents and fellows)
2. Marian University College of Osteopathic Medicine students
3. Indiana University School of Medicine students
4. Auditioning medical students (residency program applicants for that year only)
5. Lake Erie College of Osteopathic Medicine students

Based on additional availability, additional prioritization as follows:

6. Indiana University School of Medicine visiting residents
7. Other Indiana visiting residents
8. Other medical students (not listed above)
9. Observers for short-term observation (<16 hours)
10. Longer-term observers as requested by Community Medical Staff (may not exceed 30 days)
11. International observers not currently in training programs are allowed by special arrangement (approval by Chief Academic Officer and Director of Medical Staff Services) only, and must meet specific legal, health, and immigration expectations prior to approval.

In order to better serve the needs of our learners and teaching preceptors, annual planning schedules will be prepared. The schedule will incorporate deadlines for rotations and other activities for increased efficiency for prioritized learners. This includes deadlines for resident rotation requests and system entry (New Innovations) as well. Those involved with learner groups must adhere to these deadlines. Additional learners (for other medical schools, observers, etc.) will be accommodated after we have met the needs of the priority groups.

Learner Requirements:

- All learners must be registered (submission of completed application) with the OAA at least 45 calendar days prior to the start of their educational experience. (Applications may be requested by emailing smcnew@ecommunity.com)
- The OAA must approve all educational experiences at least 45 days in advance of the start of the experience. Approval is subject to the availability of appropriate preceptors, placement of affiliation agreement, and all other applicable criteria as defined by the OAA.
- A fully executed Affiliation Agreement must be current and on file at the school and with Community Legal Department before students can begin their educational experience.
- For patient safety, all Learners are required to complete an application and proof of immunizations and flu shot, as well as general good health. All required documentation must be submitted to the OAA in advance of approval.
- Learners will adhere to the highest level of professionalism in service to our patients including our Community Standards of Behavior. This includes adhering to all network Appearance policies.
- Learners will be required to provide evidence of citizenship or eligibility to be in the United States (green card is acceptable).
- Learners must provide verifiable written evidence of enrollment in a bona fide educational program associated with the request for educational experience (except for Observers). This school program may not be solely be matriculated via on-line.
- Learners enrolled in a current program will need to supply evidence of malpractice coverage for the student and approval for the rotation requested.
Some Learners are required to complete training in EMR (electronic medical record) use, HIPAA, infection control, and any other requirements (as deemed appropriate by the OAA) prior to placement in any clinical environment (Residents, and long-term students).

If a learner is taking a rotation for credit, the learner must obtain written agreement from their preceptor to complete evaluations in a timely manner as part of the experience approval of the learner by the OAA. This information must accompany the application.

Procedure:
A. The Learner must initiate contact with the AAO to begin the approval process for the experience. This is done via email to the AAO office (smcnew@ecommunity.com). An application (and all corresponding health screenings and forms) must also be completed and submitted as part of the registration process (Students taking a rotation for credit must include written agreement from their preceptor as part of their application.)

B. Learners may have experiences in both network ‘employed’ and network ‘affiliated’ clinical sites. Both employed and affiliated site management must adhere to the requirements of this policy to include all on-boarding, appropriate training, and adherence to all network policies.

C. Learners must obtain approval from the OAA prior to beginning an experience. This approval is typically communicated via email.

D. Please see grid below regarding important information regarding the type of learner involved and EPIC Care Connect Access:

<table>
<thead>
<tr>
<th>Learner Type</th>
<th>Notes in EMR</th>
<th>Admits to Hospital</th>
<th>Orders</th>
<th>Charge Capture</th>
<th>Hospital Privileges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Service Provider</td>
<td>Billing Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident</td>
<td>Yes (with co-sign/attestation)</td>
<td>Y*</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Fellow: Non-accredited program</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Fellow: Accredited program</td>
<td>Yes (with co-sign/attestation)</td>
<td>Y*</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Visiting:</td>
<td>1st year Medical Student</td>
<td>2nd year Medical Student</td>
<td>3rd year Medical Student</td>
<td>4th year Medical Student</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Fellow: Non-accredited program</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Fellow: Accredited program</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Resident</td>
<td>Yes (with co-sign/attestation)</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>1st year Medical Student</td>
<td>Read Only</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>2nd year Medical Student</td>
<td>Read Only</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>3rd year Medical Student</td>
<td>Limited***</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>4th year Medical student</td>
<td>Limited***</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

* May technically admit, but requires attending physician to sign the Admit Order. Residents may not act as an attending physician.

** Has approval to train, but not a member of the Medical Staff

*** Able to practice entering notes in ‘student area’ of EMR but does not become official part of the patient medical record.
Medical Student Teaching

Assuming a role in the clinical teaching of early learners is an expectation of training, and residents are expected to develop their teaching ability during the course of residency. Residency programs are to provide guidance in the development of these teaching skills. Medical students should provide feedback regarding teaching capability to foster improvement of teaching methods and approaches. Residents who require additional support/guidance are encouraged to ask for assistance from their program faculty or the Office of Academic Affairs.

Residents are not expected to provide oversight to the structure and particulars of medical student rotations. The Office of Academic Affairs will direct scheduling of medical student clerkship experiences. Medical students will be afforded adequate space, technology, scrubs, sleep areas, parking, and meals by their medical school and/or Community Health Network. Residents are NOT asked to assist in providing resources in the aforementioned areas. If a resident has any questions about expectations of students and teachers, the Office of Academic Affairs can provide information and assistance.

Information Technology and Systems Access

Adherence to the Community Health Network information privacy and security policies is required in the use of the electronic medical record (CareConnect; EPIC). Employee user IDs and passwords may not be shared with others, and individuals are prohibited from using/working under another individual’s ID/password. Failing to preserve the unique user identification/password undermines the integrity of the clinical documentation and communication, and the privacy and confidentiality of the patient information. Violation of this policy, whether an attending physician, fellow, or resident, may result in disciplinary action, including termination.
Continuation of GME Support in the Event of a Disaster

Purpose: The ACGME requires that every sponsoring institution have a written plan to address administrative support for each of its ACGME-accredited programs and residents/fellows in the event of a disaster or interruption in patient care. The policy should include information about assistance for continuation of salary, benefits, and resident/fellow assignments. This policy applies to all ACGME and AOA programs.

Definition of Disaster: An event or set of events causing significant alteration to the residency/fellowship educational experience in one or more residency/fellowship programs.

Policy: If, because of a disaster, an adequate educational experience cannot be provided for each resident/fellow, Community Health Network through its Graduate Medical Education Program will:

1. Arrange temporary transfers to other programs/institutions if deemed necessary. Temporary transfers will continue until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows. Residents/fellows who temporarily transfer to other institutions remain Community Health Network employees and receive pay and benefits from Community Health Network. Receiving institutions are responsible for requesting temporary complement increases from the respective ACGME-Review Committee (RC) and specialty board(s).

2. Inform each transferred resident/fellow of the minimum duration of his/her temporary transfer, and continue to keep each resident/fellow informed of the minimum duration. If and when a program decides that a temporary transfer will continue to and/or through the end of a residency/fellowship year, it must so inform each such transferred resident/fellow.

3. Cooperate in and facilitate permanent transfers to other programs/institutions if deemed necessary. Programs/institutions will make the transfer decision expeditiously so as to maximize the likelihood that each resident/fellow will timely complete the resident/fellow year.

Procedures: The Designated Institutional Official (DIO) will call or email the ACGME Institutional Review Committee Executive Director or the AOA with information and/or requests for information. Similarly, the program directors will contact the appropriate Residency Review Committee Executive Director with information and/or requests for information. The GMEC will meet as soon as possible following disaster declaration. The committee will determine whether existing programs can continue with or without restructuring and whether temporary transfers of residents to another institution will be necessary. If the disaster is expected to cause a serious or extended disruption of resident/fellow assignments that may affect programs’ abilities to be in compliance with ACGME requirements (program, common, institutional), the DIO or designee will contact the ACGME to initiate an action plan for the programs involved, to submit program reconfigurations, and to inform each program’s residents/fellows of transfer decisions. This should be done within 10 days after declaration of a disaster.
Residents/fellows should call or email the appropriate Residency Review Committee Executive Director with information and/or requests for information.

The due dates for submission to the ACGME shall be no later than thirty days after the disaster unless other due dates are approved by ACGME.

**Academic Integrity**

Community Health Network residents and fellows are expected to maintain a high level of academic integrity in their scholarly activities. Academic misconduct is a direct violation of professionalism. Academic misconduct includes, but is not limited to, acts such as fabrication, falsification, plagiarism, and cheating. Individuals who assist others in academic misconduct are also in violation of the principle of academic integrity. Residents and fellows who engage in academic misconduct are subject to disciplinary action.

**Restrictive Covenants/Non-compete Clauses**

Community Health Network fully supports the ACGME policy which prohibits the inclusion of any restrictive covenants or non-compete clauses for residents or fellows. Neither the Sponsoring Institution nor any of our ACGME-accredited programs will require a resident or fellow to sign a non-competition guarantee or restrictive covenant. Residents and fellows must immediately report to the Office of Academic Affairs about any Community Health Network residency/fellowship-related documents that contain language which could be construed as non-compete or restrictive covenant language.

Residents can elect to inform select patients where they will be practicing after graduation, but it is the assumption that most patients will continue treatment within the training program. Graduating residents should not solicit patients to join their new practice with letters/mailings/emails or any other correspondence.

**Ethical Conflicts in Care Management**

In a complex health care system, there is the potential for conflicts to arise. When caring for patients evokes a difference in values amongst patients and family members, providers, or internal to the physician, chaplaincy or an ethics consultation (via the Bioethics or Organizational Ethics Committee) can provide assistance. These services are to help the patient, family or treatment team in their
decision making based on values and legal principles. A consultation may be requested by contacting the Office of Academic Affairs or a Program Director.

For additional information, please see InComm Patient Rights Conflicts in Care Management:

InComm>Learn>Policies/Procedures/Plans>Patient Rights>07 Conflicts in Care Management

For additional information about Chaplaincy:

InComm>Services>Chaplaincy Services>Ethical Decision Making

Malpractice

All Community Health Network employed physicians are provided professional liability coverage for the scope of duties outlined in the employment contract. The coverage does NOT include activities which are voluntary in the community (unless requested by the Program Director in advance) or moonlighting activities outside of Community Health Network facilities. All physicians share in the limits of liability with the hospital. The professional liability coverage is a ‘claims made’ policy and the current limits of liability set forth in the Indiana Medical Malpractice Act (Ind. Code § 36-18 et seq.) are $250,000 for each incident with an accumulative aggregate of $7.5 million. Under the current limits, the Community Health Network policy will pay up to the $250,000 and then the State of Indiana Patient Compensation Fund will pay any amount over $250,000 up to $1,000,000. The coverage limits and maximum liability cap set forth in the Indiana Medical Malpractice may be amended from time to time.

When a Community Health Network employed physician is terminated from the Professional Liability Policy, tail coverage/extended reporting period will be provided. The termination date from the policy is the date that coverage ends. For any services provided after that date, Community Health Network will not cover. The tail coverage is in place to allow for any claims that may not have been reported as of the termination date/graduation.

Disability Benefits

Community Health Network provides disability insurance benefits for residents and fellows effective upon date of hire. Coverage is automatic, and no enrollment is required. Please reference the CHNw ABC Employee Benefits Planner for additional details.
Protecting Patient Privacy

Laptops issued to you at the start of training will be yours to keep upon successful completion of Residency, and are the property of Community Health Network during your training. Use of this or a phone or pager is a serious responsibility for patient data. HIPAA and privacy issues require diligence and the protection of system passwords. Report any losses immediately. Encrypt all emails or pages with PHI by putting “secure:” in the subject line of the e-mail (the colon must be included in order to encrypt the e-mail). Limit the transport of patient-related information from site to site; keep patient care information at the site where the patient seeks care. If your laptop is stolen or missing, contact your program director immediately.

Resident Eligibility and Selection Policy

All residents within the Community Health Network Programs must possess the following characteristics and meet the following criteria for consideration for appointment and hiring.

If additional criteria are required for specialty programs, that will be noted in the specialty program documents.

I. Eligibility:

A. Applicants with one of the following educational qualifications are eligible for appointment:

1. Graduates of medical schools in the United States and Canada accredited by the LCME.
2. Graduates of COCA accredited colleges of osteopathic medicine in the United States
3. Graduates of colleges of podiatric medicine accredited by the CPME
4. Graduates of medical schools outside the United States and Canada who hold current and valid ECFMG certification.
5. Graduates of medical schools outside the United States who have completed a “Fifth Pathway” program provided by an LCME-accredited medical school.
6. All applicants must be qualified for approval of an Indiana license, based on the criteria current at the time of hire.

B. Applicants must have passed USMLE Parts I, II, preferably on the first attempt. More than three attempts on any one part disqualify the applicant from licensure in the State of Indiana and application consideration. USMLE Clinical Skills passing grade is strongly preferred.

C. COMLEX is an acceptable substitute for osteopathic applicants.

D. NBPME is an acceptable substitute for podiatric applicants.
E. Applicants must be legally authorized to work in the United States without sponsorship.
F. Applicants must have at least one year of direct patient clinical care experience in the United States. Research, volunteer work, or observerships do not qualify. Patient care clinical experience must be on-the-job or rotational experience.
G. Applicants must have graduated from medical school, college of osteopathic medicine or college of podiatric medicine, within five years of application.
H. Applicants must provide three letters of recommendation with the author’s name, phone number, and address listed. References may be checked and appointment is contingent on acceptable recommendations.
I. Appointments are contingent on verification of credentials and other information required by Indiana state law. Appointments are also contingent on the completion of a criminal history check. Community Health Network Human Resources has established a confidential background check process that consists of two parts: 1.) completion of a self-disclosure questionnaire, and 2.) consent to perform a criminal history background check and check of sex and violent offender registry; both occurring prior to the beginning of training. Exclusions established by Community Health Network or the Graduate Medical Education Committee will result in withdrawal of an offer of appointment.
J. Applicants with prior medical education experience or military training must meet the criteria outlined in postdoctoral training standards of ACGME, CPME or AOA as applicable admission and advanced standing or credit.
K. Osteopathic trainees in AOA programs must remain members in good standing of the AOA throughout their training program, as a current requirement of the AOA.

II. Selection:
All network GME Residency Programs participate in the national matching programs (National Residency Matching Program (NRMP) the AOA IRRP or equivalent) and only accept applications through the Electronic Residency Application Service (ERAS) or CASPR/CRIP. No contracts may be offered outside these mechanisms except for transferring residents. See “Resident Transfers.”
A. Selection is based on a thorough evaluation of the information provided in the ERAS application, interview day evaluations by faculty and residents, and other contact (both formal and informal). Selection takes into account an applicant’s academic credentials, communication skills, preparedness to enter the residency program, personal qualities such as motivation and integrity and the non-academic criteria specified as part of these policies and network standards of behavior and values. Each program will set criteria for the specific needs of its specialty and curriculum goals.
B. Community Health Network GME Residency and Fellowship Programs pride themselves on their diversity and do not discriminate with regard to sex, race, age, religion, color, creed, ancestry, marital status, national origin, sexual orientation (including gender
identity), disability, status as a protected veteran or any applicable legally protected
status.

C. Selection decisions are made by the program director with input from both residents
and faculty, and with review and approval of the DIO.

III. Prior to Beginning of Program:

A. At the time of hire, each applicant must complete an I-9 form pursuant to the
present appropriate documents to establish identity and eligibility for employment in
the United States.

B. Prior to the beginning of training, each house staff member must pass a physical
examination administered by employee health and must complete and return the
Immunization Verification form to employee health. Any missing vaccinations must be
completed prior to the beginning of training and are available through employee health
at no cost. Although not required, Hepatitis B vaccine is strongly recommended and is
available without cost through one of our CHNw Work-Site Care Clinic locations. CHNw
also requires flu immunization for all employees on a seasonal/annual basis.

C. Residents must complete mandatory orientation and education to prepare them for
administrative, academic and clinical expectations for participation in the Graduate
Medical Education Programs. This orientation and education will be at Network and
specialty program levels and may include multiple assigned learning modules. The
orientation and education may also be site specific and include specific material
developed by the medical staff (for example by-laws). Orientation will include a formal
orientation to the administrative and professional organization of the program, facilities
available in the laboratories, nursing, social services, risk management, patient safety,
sleep deprivation and management, quality assessment, dietetics, record room and
pharmacy. Fellows must complete similar orientation designed by their program.

D. Residents and fellows are responsible for reading the resident policies and procedures
manual for all residencies and fellowships, as well as the program specific policies in
their entirety. Each resident and fellow is fully responsible for being knowledgeable
about and complying with the contents of all applicable policies and procedures.
Residents and fellows are also expected to familiarize themselves with Community
Health Network and Community Physician Network policies, which are found on
InComm/Learn/Policies and Procedures. Residents and fellows are expected to review
the Medical Staff Constitution, by laws and policies, for each facility at which they are
trained. These materials can be accessed through Network libraries.

E. In addition, residents and fellows must review, and when necessary, complete the
following training and forms before beginning training:

1. Health/Dental/Life/Retirement Enrollment and Benefit Forms
2. OSHA-Universal Precautions
3. Conflict of Interest
Non-Academic Requirements for Appointment, Reappointment and Retention

Non-academic requirements refer to those physical, cognitive and behavioral attributes required for satisfactory completion of all aspects of the curriculum and development of those personal and professional attributes required for resident/fellow certification and the independent practice of medicine. These areas include communication, intellectual capacity (conceptual, integrative, problem solving and diagnosis), motor, sensory, behavioral, social, and emotional aspects of the performance of a physician. These are attributes required of the resident/fellow and use of a third party for fulfillment is not adequate.

In accordance with the Americans with Disabilities Act (ADA) of 1990, the ADAAA, and the Rehabilitation Act of 1974, Community Health Network and its GME programs provide reasonable accommodations to qualified individuals with a disability.

The Graduate Medical Education Committee (GMEC) has specified the following non-academic criteria ("technical standards") that all residents/fellows are expected to meet in order to participate in the medical education program and the practice of medicine. As appropriate, individual training programs may add more specific standards to these criteria.

**Observation:** The resident/fellow must be able to participate actively in all demonstrations and laboratory exercises in the basic medical sciences and to assess and comprehend the condition of all patients assigned to him or her for examination, diagnosis, and treatment. Such observation and information acquisition usually requires the functional use of visual, auditory, and somatic sensation.

**Communication:** The resident/fellow must be able to communicate effectively and sensitively with patients in order to elicit information; describe changes in mood, activity, and posture; assess non-verbal communications; and effectively and efficiently transmit information to patients, fellow house staff, students, faculty, staff, and all members of the health care team.

Communication must be in a patient centered manner, exhibiting sensitivity to social and cultural differences. Communication extends to the work with colleagues, faculty and team members, in both patient care and educational settings. Communication skills include speaking, reading, and writing, as well as the observation skills described above.
**Motor:** The resident/fellow must have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers; be able to perform basic laboratory tests; possess all skills necessary to carry out diagnostic procedures; and be able to execute motor movements reasonably required to provide general care and emergency treatment to patients. In addition, the resident must have adequate physical energy and stamina to carry out taxing duties over long periods of time.

**Intellectual-Conceptual, Integrative, and Quantitative Abilities:** The resident/fellow must be able to measure, calculate reason, analyze, and synthesize. Problem solving, the critical skill demanded of physicians, requires all of these intellectual abilities. The resident/fellow must be able to comprehend three-dimensional relationships and to understand the spatial relationships of structures. The resident/fellow must have the capacity to perform these problem-solving skills in a timely manner.

The resident/fellow must be able to comprehend and learn factual knowledge from readings, didactic presentations, gather information independently, analyze and synthesize learned information and apply information to clinical situations. Residents must develop habits of lifelong learning.

Residents/fellows must be able to develop sound clinical judgment and exhibit well-integrated knowledge about the diagnosis, treatment and prevention of illness within their scope of practice.

They must be comfortable with uncertainty and ambiguity, and seek advice from others when appropriate.

**Behavioral and Social Attributes:** The resident/fellow must possess the emotional health, maturity and stability required for full utilization of his or her intellectual abilities, the exercise of good judgment, the prompt completion of all responsibilities attendant to the diagnosis and care of patients, and the development of mature, sensitive, and effective relationships with patients and others. Residents/fellows must also be able to tolerate taxing workloads, function effectively under stress, adapt to a changing environment, display flexibility, and learn to function in the face of uncertainties inherent in the clinical problems of many patients.

Compassion, integrity, empathy, concern for others, commitment, responsibility, tolerance and motivation are personal qualities that each resident/fellow should possess.

The resident must demonstrate skills of self-management, both intellectual and emotional, which enable him/her to seek help when needed for patient care, effective learning, coping with the stresses of medical practice, or social/ethical aspects of the clinical care environment.

The resident/fellow must be able to interact productively, cooperatively and in a collegial manner with individuals of differing personalities and backgrounds and contribute to providing care as a team member.
Residents/fellows must be capable of empathetic response to individuals in many circumstances and be sensitive to social and cultural differences. They must be able to exhibit an ethic of professionalism, including the ability to place other’s needs and points of view above their own.

All residents, fellows, and teaching faculty are additionally expected to comply with the network expectations regarding Standards of Behavior.

Accommodation for Residents/Fellows with Disabilities

The Americans with Disabilities Act (ADA) of 1990 requires Community Health Network to provide certain kinds of reasonable accommodation to qualified residents/fellows, when necessary to provide an equal learning opportunity. Under the law, “reasonable” must be individually determined after an individual requests accommodation.

The purpose of this policy is to outline the process whereby a resident/fellow in a Graduate Medical Education Program may request accommodation for disability. The graduate medical education division and programs follow the accommodation and disability policies established by Human Resources except as specified in this policy. A request for accommodation may be made at any time during residency/fellowship training. In order for the resident/fellow to receive maximum benefit from his/her residency/fellowship training time, requests for accommodation should be made before the beginning of the program or as early as possible after an event which may affect the resident/fellow’s ability to meet the non-academic qualifications. A request should not be made after the fact or in response to a negative evaluation or action taken by the training program.

To qualify for an accommodation, the resident/fellow must identify him/herself to the program director, declare the disability in writing and request a reasonable accommodation. The program director and necessary institutional staff will coordinate with the resident/fellow to determine whether the requested accommodation would be effective, reasonable, and enable the resident/fellow to perform the essential functions of the position and achieve the essential educational goals and program objectives, or make a good faith effort to negotiate another accommodation. The notification of this accommodation will be communicated to the Designated Institutional Official and the GME office. The accommodation must be within standards set by the AOA, CPME, or ACGME/ Resident Review Committee (RC) and approved by the Specialty Board as applicable. Accommodations for fellows must be declared and approved by the appropriate program director and where required by the specialty board.

All medical-related information will be kept confidential and maintained separately from other resident records. However, the program ACGME-RC, AOA specialty board, supervisors and managers may be advised of information necessary to make the determinations they are required to make in connection with a request for an accommodation. First aid and safety personnel may be informed, in accordance
with applicable laws, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADA may also be provided relevant information as requested.

Once an individual has been approved by the residency program and the program ACGME-RC or AOA specialty board for specific accommodations and has subsequently received those accommodations, that individual will be held to the same essential performance standards as other trainees. Focus should be on the trainee’s performance in all evaluations. Written evaluations should not mention disabilities or accommodations for disabilities in any way. Community Health Network does not notify potential residency/fellowship programs or other employers about an individual’s disabilities without specific permission from the trainee.

Resident Transfers

The Community Health Network program director must obtain either written or electronic verification of previous education experience or a summative competency-based performance evaluation from the previous program director to consider accepting a resident with existing Graduate Medical Education training into an advanced position (i.e. beyond the normal entry level in the program). The program director must communicate to the applicant that this information will be sought from the previous program as part of the application/transfer process.

Verification of previous educational experiences includes the following:

- A list of rotations completed
- Evaluations of various educational experiences
- Procedural/operative experiences

The summative evaluation includes an assessment of the following:

- Clinical judgment
- Medical knowledge
- Performance on standardized tests
- Clinical skills, including history-taking, physical examination and procedural skills
- Personal skills, including interaction and communication with patients; ability to work cooperatively with colleagues and subordinates; and professional conduct and ethical behavior
- Reasons for departure from previous program, if relevant
- Any activities related to licensure, impairment, or other issues which might affect the applicant’s ability to perform duties as a trainee.

The program director must maintain a record of this verification and summative evaluation as part of the applicant’s file, as well as, in the resident’s evaluation file if the resident is appointed to the
program. A copy of the verification and evaluation must also be sent to the Graduate Medical Education office with all other required documentation when requesting a letter of appointment for the individual.

The program director will make personal contact with the previous program director and/or other individuals able to evaluate a resident's/fellow's performance and level of residency education training. The program director will document that discussion as part of the application process.

All components of this policy will also apply to any trainee requesting transfer to a Community Health Network training program who has lost a position due to the closure of a sponsoring institution or training program, reduction of residency positions, or loss of accreditation by an institution or training program.

Decisions on transfer and/or advanced standing/credit will be made by the faculty and specific program director, with consultation with the DIO or AOA DME. A written record of all decisions and the reasons for such decisions will be kept in the applicant’s file.

Employee Benefits and Perks

Employee Benefits, salary expectations, and time off are specifically outlined in the contract appendix for each trainee. The GMEC annually reviews benefits and salaries for approval for the subsequent academic year (July-June).

Some specialty programs may allow ‘start’ bonuses, moving allowances or other incentives. When offered, these will be noted in the exhibit attached to the resident contract.

**Paid Time Off/Paid Time Away:** Each residency will determine time off based on its program and specialty requirements. In general, all residents receive a minimum of 21 days of Paid Time Away, and additional days may be allowed for board examinations, USMLE and employment interviews. Each residency program will state these policies in writing in specialty specific documents.

**Professional Seminars and Fees:** Continuing education and travel is a privilege extended to residents and fellows. Community Health Network GME programs will reimburse for off-campus educational seminars in accordance with the network travel policy. All residents/fellows are encouraged to participate in educational opportunities. See Program Director for additional information.

Programs may choose to support resident licensure, membership in professional organization, or attendance to present at professional meetings, at the discretion of the program director and financial approval by GMEC.
Program Specific Benefits: Nothing in this policy shall be construed as limiting benefits within a specific program so long as those benefits are not inconsistent with CHNw or GME policy.

Meals: All meals during working hours are provided to residents/fellows at no charge.

Overnight meals: Meals will be provided in call rooms when cafeteria food is unavailable for residents on call.

Call rooms: Appropriately equipped call rooms with private rest areas, toilets, showers and computer and records accessibility are available at each duty location requiring overnight call.

Health Insurance: Residents/fellows are eligible for the same health insurance benefits available to other Network employees, which includes choices from several plans. Plans include prescription, dental, and vision options. Coverage is available under a family plan which includes spouses, eligible dependents and domestic partners.

Mental Health and Counseling: Residents/fellows may participate in Community Health Network mental health and counseling services through the Network Employee Assistance Program (EAP). The Network EAP provides confidential services at no cost to the employee. In addition, the program and any trainee may access the Indiana State Medical Association (ISMA) services for physician impairment (physical, chemical dependency or mental health issues) as needed.

Life Insurance: Residents/fellows are eligible for the same group life insurance as Network employees at employee rates, after a period of eligibility is established.

Accidental Death and Dismemberment (ADD) Insurance: Residents/fellows are eligible for the same ADD benefits as Network employees.

Travel Insurance: The Network provides, without cost to the resident/fellow, a travel accident policy providing accidental death and dismemberment benefits in the amount of $50,000 while traveling on official program business.

Public Liability: The Network provides, without cost to the resident/fellow, a public liability policy. Ask the Human Resources representative working with the GME programs for details.

Retirement Plan: Residents/fellows are eligible to participate in the Network retirement plan. Ask the HR representative working with GME programs for details. A period of eligibility is required.
Lab Coats: Long lab coats with names are furnished to each resident/fellow at the beginning of the residency/fellowship program. Lab coats may be laundered through hospital/Network laundries.

Parking: The Network provides a parking permit without charge to the resident/fellow. In most instances, parking is without charge to the public and designed lots/spots are reserved for physicians.

Safety: Safety of all employees, patients, families and guests is of paramount importance to Community Health Network and appropriate security personnel and procedures are in place to protect persons on all Community Health Network properties. Similar personnel and procedures are in place at all affiliated hospitals. Additional safety and security resources and information are available from program directors and the GME Office.

Health and Fitness Facilities and Programs: Residents/fellows are eligible to participate in all health facilities and programs that are available to other Network employees, at no cost. The purpose of this is to ensure consistent personal self-care, and also be in a position to provide experience and provide testimony when caring for patients who might benefit from increased fitness.

Domestic Partner Benefits: Specific benefits are available to same and opposite sex qualifying domestic partners and their eligible children. Because of the complexity of domestic partnership benefits and tax implications, please contact HR and carefully review the information HR policies in the CHNw ABC Employee Benefits Planner.

Open Enrollment at Time of Hire: Community provides employee benefits to all and requires active enrollment by each new hire in accordance with applicable enrollment procedures and deadlines.

Annual Open Enrollment: Each November the network holds Open Enrollment for all employees. Each employee is responsible for monitoring email and US Mail to ensure enrollment or desired changes occur during the defined enrollment period.

IT Support: Each resident/fellow is provided with specific technologies, which may include a laptop computer, tablet, and pager, to support his/her educational program. Support for these technologies is available 24/7/365. In addition, the resident/fellow will participate in Community Care Connect, an advanced IT system which brings all treatments and tests, and all records of a patient within Community Health Network into a continuum of care with an inclusive medical record available to each resident as part of his/her care and treatment of the patient. Residents are encouraged to protect their personal privacy and patient data safety by using the technology offered by the program rather than personal devices.
Paid Time Off, Funeral Leave, Military Duty, and Program Specific Policies

**Paid Time off (PTO) or also called Paid Time Away (PTA):**

Taking regular paid time off is encouraged for the purpose of increasing the personal well-being of the house staff member. This institutional level Paid Time-Off (PTO) Policy follows ACGME, AOA, and CPME requirements. Individual programs must develop program specific PTO and leave policies that are consistent with this policy and with the program specific ACGME-RC or specialty board requirements. All residency/fellowship program directors must work together to create as much consistency across programs as is possible. The program specific policies must be approved by the DIO, DME for AOA, and submitted to GMEC for review and approval. This policy is applied in tandem with the Network employee PTA policies, and specifically follows and adopts for GME programs the Network FMLA and other Leave of Absence policies.

Generally residents are permitted 21 paid days per academic year (July-June). Additional days are allowed for taking Board, USMLE, NBME/COMPLEX or AOA equivalent exams. Residents in their final year are allowed 3 additional days for interviewing. These time allowances are subject to ACGME-RC, AOA and specialty program requirements in each year.

Paid time off includes time off for vacation, illness, business, personal or other leaves not listed with special provisions below.

Additional time may be allowed for residents and fellows for program required or approved educational seminars and conferences. At the program director’s discretion and with DIO approval, the additional time may be considered part of training time and expenses may be paid in accord with Network and program travel policies.

Approval must be obtained from the program director or designee in advance. All ACGME, AOA and RC/specialty board requirements must still be observed. Days not approved by the program director or designee do not carry over.

No payment will be made for unused paid time off at the completion of training. Programs may place limits on the times of the year when paid time off can be taken.

If the number of days away from the training program when all time off is added together exceeds program guidelines, the program director or designee and resident/fellow must design make up time within make up time guidelines in order to meet ACGME/AOA/CPME and program standards.
Timing of paid time off for personal days, interview days, meeting times, or holidays or reasons other than necessary medical appointments will be at the discretion of the program director or designee and may be affected by the resident’s or fellow’s assignments and specialty Board certification requirements.

Time off and holiday assignments may be affected by agreements with hosts (department or hospital systems) for off-service, off-site, or away experiences.

The program director or designee may deny requested time off to remediate documented deficiencies or as part of a disciplinary plan.

In the case of a stated hospital or regional emergency, urgent professional responsibilities may cancel previously arranged paid time off.

**Funeral Leave**
Residents/fellows are eligible for funeral leave in accordance with Network policies (up to 3 business days or 24 hours) for the death of an immediate family member defined as spouse, children, parents, brothers, sisters, grandparents and in-law and step relatives of the same degree), subject to ACGME-RC, AOA and specialty board requirements, and approval of the program director or designee.

**Military Duty**

*Short Tours of Military Duty:* A house staff member will receive military time off in accord with applicable laws and Network policies. Written military orders must be submitted to the program director as soon as possible to allow for revision of schedules. The resident/fellow must make-up time, which exceeds program specific requirements.

*Extended Active Military Duty:* A house staff member inducted to active military duty through Selective Service, voluntary enlistment, or called through membership in the National Guard or military reserves will be granted leave without pay. Community Health Network will continue to pay its portion of provided and elected benefits for an eligible domestic partner, spouse and eligible dependents for 30 days after the employee leaves the training program. The fellow/resident may continue participating in the Community Health Network sponsored medical, dental and vision plans for up to 24 months following the beginning of the employee’s leave of absence for military duty in accord with Network policies. To continue coverage, the house staff member must pay the total monthly premium for that continuation coverage period. A military leave of absence may extend up to five years. This five year period may be extended in accordance with the requirements of federal law. Upon return from military leave of absence the house staff member will be reinstated at the PG year level appropriate to the training program provided that the house staff member meets all conditions for eligibility as they then exist. Community Health Network will make reasonable efforts to assist a returning service member to meet the applicable eligibility requirements as required by federal law. Military leaves may result in
extension of training periods or repeat of training based on the requirements of individual specialty boards and program as they are at the time of reinstatement or at the discretion of the DIO, program DME and program director in the best interests of the program and patients.

**Program Specific Policies**

Each program will develop a written policy for leaves consistent with ACGME-RC/specialty board requirements and will advise trainees of the effect a leave may have on completing the residency program based on specialty RC/specialty and ACGME/AOA/CPME requirements. These policies will be developed by the Program director and appropriate DME and reviewed by the DIO.

**Leaves of Absence**

Community Health Network has developed a Leave of Absence Policy which can be viewed on InComm>Departments>Learn>CHNw Policies>Human Resources>Leaves of Absence. This GME policy merges Network policy and the needs of the Graduate Medical Education programs. These policies must be read together, with GME specific requirements applicable to GME house staff members superseding Network HR policies when in conflict.

For eligible house staff (1 year of employment and worked at least 1250 hours), Community Health Network GME programs provides family and medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA). FMLA leave is outlined in Community Health Network’s “Leaves of Absence” policy referenced above. The Human Resources representative assigned to the GME programs is available to discuss and advise about FMLA and other leave in detail.

Generally, full-time house staff not eligible for FMLA leave may be granted up to six weeks leave for bona fide events including (but not limited to) parental leave and sick leave. The Network director of academic affairs or appropriate DME and program director will determine what constitutes a bona fide leave, and will consider the written recommendation(s) of the physician(s) caring for the resident or the resident’s immediate family member. The network HR team will work with each individual when requesting such leave to provide a means for continuation of benefits.

All requests for leave must be made in writing to the program director at least thirty days in advance, or as soon as reasonably practicable. In addition, all requests for leaves of absence require the final approval of the Network director of academic affairs. Any available paid time off will run concurrently with such leave with the exception of 5 (one work week) business days which will be held for use after the leave of absence.

In the event that the resident wishes to take a longer amount of time off (according to eligibility defined above) beyond the allotted paid time off available under the program, requests for exceptions may be
made through the Program Director. These additional days off would be unpaid (unless disability still applies) and would result in the extension of residency. In this instance, and depending on the time during the academic year, the program director will determine if the resident in required to hold back 5 paid days for later use after the conclusion of the leave of absence.

Further, residents requiring a leave of absence must contact the network Leave Team to obtain and complete appropriate leave paperwork. The resident must comply with all network leave policies and procedures.

The resident should notify the program director and those responsible for the scheduling of rotations and call as soon as the need for a leave of absence is confirmed. The resident should be expected to make up or trade call assignments before or after their time of leave so their total residency call amount remains consistent with what other residents in the program are assigned. Electives can be completed around the time of the maternity leave return date if authorized by the program director. The standards of goals and objectives along with clinical obligations will remain the same for all residents.

Make-up time:
For a leave of absence that extends beyond the maximum time off allowed by the specialty Board, the program director or designee will calculate a new date of graduation, once the leave has occurred, and determine how long the resident should extend residency. The number of days missed (that were not covered by PTO) will be added to the final day of residency, day for day, to determine the new graduation date.

Any make-up time that is required will be scheduled with an effort to best accommodate the needs of the resident/fellow, and make-up time or a specific schedule cannot be guaranteed. When make-up time is available, the resident/fellow ordinarily will be required to make-up the absent time in excess of the maximum allowed by the specialty Board at the end of the academic year in which the absence occurred. Additional time may be required as make-up time for portions of modules or rotations started but not completed. This make-up time will necessarily delay the beginning of each of the resident or fellow's subsequent academic years by an amount equal to the make-up time. In effect, the resident’s senior year or fellow’s last year of training will extend beyond June 30 (or the expected conclusion of the program for mid cycle trainees) by an amount equal to the make-up time. Any required make-up time will be paid and all employee benefits provided.

Continuing Medical Education (Including Travel, Meetings and Books)

Residents are allowed 5 working days each contract/academic year for approved CME, and the resident may be reimbursed for costs of approved CME including costs of meetings, travel, books and other CME expenses up to a specified amount in each contract, and must be used within the academic year (July-
June). This money must be utilized during the contract year. It cannot be carried over to the following year. Funds will be prorated by the program director if a resident is off cycle.

Definitions:

1. CME days are any day in which half or more of the day is spent participating in a CME event approved for CME by an acceptable accreditation body to the Program Director.
2. CME events are 5 days provided per academic year in the resident or faculty contract, where the resident or faculty can choose what activity they attend and where it is located with Program Director approval.
3. Travel days are the day before or the day after the CME event when the employee must travel during normal working hours to get to the meeting location.
4. Events which faculty or residents attend but the purpose is to learn/present for Community Health Network (examples include: Conf. on Practice Improvement, Residency Program Solutions, STFM spring meeting and Program Director’s Workshop) should follow similar rules.

CME Travel Policy Procedure:

1. All CME activities requires prior Program Director approval. Requests should be made well in advance but no less than one (1) month in advance.
2. CME meetings and/or travel which occurs on weekends are usually not made up by giving alternative days off elsewhere.
3. For meetings starting at noon or after, travel including flights, should be the morning of the meeting.
4. For meetings starting before noon, travel should be the afternoon or evening before usually leaving after 1 pm.
5. For meetings ending before 5 pm, travel back home should be in the afternoon/evening of the day the meeting ends.
6. For meetings ending after 5 pm, travel back should be late that evening or the following morning so you could return to work by 1 pm.
7. Hotel rooms, cars, and food will be paid for only for the above times frames. Any expenses which occur outside the above times would be at the employee’s personal expense, not Community Health Networks.
8. A maximum of 5 days of any type (PTO, CME or combined) may be taken off of any rotation by a resident. Exceptions may be considered and approved by the Program Director in advance.
9. Flights may be taken earlier or later than the above as long as they are not more expensive. If adding additional personal travel into a CME activity, any additional expenses, including higher cost of airfare, hotel or food, will be at the expense of the participant. Any additional days missed will require a PTA be used.
10. Travel for CME is generally limited to the continental United States. In the event a resident identifies a strong CME opportunity outside of these parameters, Program Director review and approval in required.
11. Any questions regarding this policy should be directed to the Program Director and should be clarified before booking hotels or travel.
A log is kept of all CME expenses for each resident/fellow by the program director. The specific CME program, meeting or seminar and any travel and related expenses must be approved well in advance. Such requests for approval must be made in writing at least 1 month before the final registration date and 2 months before the program and must include a program brochure and a statement detailing how the CME will enhance the resident or fellow’s training. Expense reimbursement will occur in accordance with the network travel policy.

Books:
Minor expenditures such as journal subscriptions, society memberships, books and CD/DVD which will enhance or support training do not need pre-approval and will be reimbursed from receipts and log entries up to the maximum allowable. Books may be purchased at a discount through Network purchasing agreements. For additional information contact the Network Medical Library team.

The program director has complete discretion to approve or deny requests for CME attendance and all travel and related expenses. The Program Director will keep in mind Community Health Network and its GME program’s support for research, scholarly and educational activities.

Guidelines for booking travel:
The Residency Program Coordinator or Administrative Assistant/Secretary for each program makes all travel arrangements for residents and fellows.

- All travel and associated costs (meals, hotel, transportation, etc.) must be in compliance with the Network Travel Policy and guidelines specific to the Office of Academic Affairs.
- Prior to initiating travel, you must go to the Residency Coordinator to initiate.

Lack of prior approval will result in delayed or denied reimbursement.

Off-Site “Away” Elective Rotations
Residents and fellows may desire to take an elective rotation at an outside institution within the state of Indiana, another state within the United States or abroad. Such away elective rotations should have as its primary goal an educational focus that cannot be obtained within Community Health Network. During the elective rotation Community Health Network will continue to pay the resident’s or fellow’s salary, benefits, and malpractice insurance as currently provided (for rotations within Indiana). All other associated expenses (housing, meals, travel, etc.) will be the responsibility of the resident/fellow.

Malpractice insurance differs depending on where the rotation is:
- Within Indiana: Coverage would be the same as a rotation within Community Health Network.
• Outside of Indiana (but still within the US): Coverage is both expensive and difficult to obtain so that may limit a resident’s ability to obtain approval for the rotation. Sometimes the location of the rotation might be willing to provide malpractice insurance. Coverage details must be in writing before the rotation can begin.
• Outside the US: Malpractice coverage is never provided.
• Additional malpractice insurance beyond the current coverage will not be provided by Community Health Network. (You may be able to get this from the place you are going if needed).

Requirements and Process:
1. The request for an “Away Rotation” must be reviewed and approved by the applicant’s Program director. All requests must be received by the Program director at least 2 months (see below for out of state rotations) before the beginning of the rotation to be considered for approval. Some programs may require more advanced notice. In that case, the specific program requirements will take precedence.
2. No more than two elective away months may be taken per year per resident/fellow during their training period.

Types of Away rotations:
1. **Off-site rotations within Indiana** may be allowed for educational activities not available locally. The proposed rotation must be approved by the Program Director.

   In addition to all of the above, these rotations require:
   a. Written curriculum complete with goals and objectives that support both the educational benefit and the need for off-site learning during the rotation.
   b. Preceptor who would be willing and appropriately credentialed to provide supervision of the resident during off-site rotation.
   c. Paperwork must be submitted a minimum of two (2) months in advance (or per program guidelines if longer) in order to procure legal agreement between Community Health Network and the host site as well as malpractice coverage (Program Letter of Agreement: which is available from the Program Coordinator). Some programs may require more advanced notice. In that case, the specific program requirements will take precedence.
   d. Once the above steps are complete, the resident shall then arrange for coverage of clinic duties and call, and trade with other residents so all duties are covered.
   e. A time-away request must be completed and submitted.

2. **International rotations** may be taken but Malpractice coverage is not provided by Community Health Network. Additionally, residents are required to present the names and email addresses of primary supervisor and travel documents including proof of evacuation insurance to your Advisor to receive initial rotation approval. It must be then approved by the Program Director.
In addition to all of the above, these rotations require:

a. Written curriculum, complete with goals and objectives that support both the educational benefit and the need for off-site learning during the rotation.
b. Preceptor who would be willing and appropriately credentialed to provide supervision of the resident during off-site rotation.
c. Paperwork must be submitted at least two (2) or more months in advance in order to procure a legal agreement between Community Health Network and the host site (Program Letter of Agreement: which is available from the Program Coordinator). Some programs may require more advance notice. In that case, the specific program requirements will take precedence.
d. Once the above steps are complete, the resident shall then arrange for coverage of clinic duties (desktop coverage) and call trades with other residents so all duties are covered.
e. A time-away request must be completed and submitted.
f. Elective rotations to countries either on the U.S. State Department’s Travel Warning list [link] or those with U.S. Treasury Office of Foreign Assets Control restrictions will not be permitted. [link]
g. Failure to do all the above may result in inability to participate in international experiences.
h. A copy of a current passport must be submitted.

3. **Off-site rotations outside Indiana but within the US** are more difficult because the Malpractice coverage is expensive and difficult to obtain. Consequently, off-site rotations will only be considered in unusual circumstances. Please discuss any rotation well in advance including the rationale and justification of the rotation with your Advisor and Program Director.

It can take six months (6) or more to arrange and get the required documentation in place. If malpractice cannot be obtained, then the rotation will not be approved.

In addition to all of the above, these rotations require:

a. Written curriculum, complete with goals and objectives that support both the educational benefit and the need for off-site learning during the rotation.
b. Preceptor who would be willing and appropriately credentialed to provide supervision of the resident during off-site rotation.
c. Paperwork must be submitted at least six (6) or more months in advance in order to procure a legal agreement between Community Health Network and the host site as well as malpractice coverage (Program Letter of Agreement which is available from the Program Coordinator or some places will require an Master Affiliation agreement which must come from legal and can take months go get approved.)
d. Once the above steps are complete, the resident shall then arrange for coverage of clinic duties (desktop coverage) and call trades with other residents so all duties are covered.
e. A time-away form must be completed and submitted.
f. Medical license: Medical licensure is done on a state-by-state basis. If the away rotation is out-of-state, it is the responsibility of the trainee to understand and follow the applicable
Global Health Rotation Program

The opportunity to study medicine and provide medical care in a foreign country is reserved for residents in good standing (i.e. not on a Performance Improvement Plan or Corrective Action). The intent of this opportunity is to support the cause of those who lack the resources for a reasonable quality of life and at the same time learn the practice of medicine in a milieu of limited technology and financial resources. The outcome should consist of a better understanding of the problems of providing health care in an underserved area; an understanding of how to provide medical care with limited resources; and an understanding of how the culture plays a role in providing health care. Similar education must not be able to be obtained locally here in Indiana.

It is not recommended that residents who have lived in foreign countries return to the same country for this international experience. We would encourage you to consider a new experience in a different country.

PROCEDURE

1. Residents in good standing can approach their program director about participating in a global health elective. If given the approval to proceed through the application process, the Community Health Network Global Health Elective Application may then be filled out. As part of the application, the resident must develop learning objectives for the rotation, see #7 for some sample learning objectives.

2. The completed Community Health Network Global Health Elective Application would then be forwarded to the GME Global Health Committee to vet the application to ensure safety, appropriateness for the trainee, and to ensure a quality educational experience with appropriate supervision. No presumptive arrangements should be made such as purchasing plane tickets until this trip has been approved.

3. You will be notified immediately upon approval. Air ticket costs should have been investigated preceding request to travel and should be bought as soon possible after approval to acquire the best possible price. It is required for you to purchase medical evacuation insurance.

4. Residents may use their CME money to be reimbursed for the cost of their travel and lodging, with appropriate receipts, after completion of their experience.

5. A program letter of agreement (PLA) must be completed with the preceptor in country. As part of the application, residents must provide the name and address or working e-mail of the
preceptor. If the PLA cannot be completed prior to the rotation, the resident will be responsible to have the preceptor complete the PLA and resident evaluation form and return these to the GME office upon return. Without the PLA, educational credit cannot be granted for the rotation. A PLA is not required if the rotation is being supervised by a Community Health Network physician.

6. Upon return, all residents will be expected to:
   1. Complete a rotation evaluation in New Innovations
   2. Return the Preceptor’s evaluation of the resident’s performance and attendance
   3. Write a 1-2 page reflection of their experience and submit to their Program Director
   4. Present to their residency or other GME venue a PPT presentation of their experience in accordance with their program director’s preference.

7. **Additional Information for International Rotations**

   A. It is the resident’s responsibility to make all contacts and arrangements, including the securing of personal travel insurance. The GME Global Health Committee is glad to be a resource if you want suggestions on possible rotations. Please remember we have our group global health elective that is an option for all Community Health Network residents.

   B. Begin planning early. Research sites and make contacts at least 3-6 months in advance. Carefully evaluate each site for working and living conditions, consider rainy and dry seasons, extreme heat or cold conditions, running water, toilets, beds, air conditioning etc. or lack thereof.

   C. Only consider sites where you speak the language, or where interpreter services are readily available.

   D. You must have an identifiable preceptor prior to departure for the purpose of education, supervision and evaluation. Clarify your role for the rotation – will you be providing clinical services, teaching, or some other services? Make sure that your training is adequate to meet expectations.

   E. Determine if you will be taking anyone with you, and make sure that person, and the site coordinator, are ok with your plans.

   F. Research the costs and if too expensive for your budget, ask the sponsoring organization about alternatives. In some instances it might be appropriate to ask family members, your community or other organizations to help support your medical work abroad.

   G. Confirm that your site is open to US citizens and is safe. Make sure that your passport is active and if not it can takes up to 3 months for processing. Applications and processing are handled by the US Post Office. Most countries require the expiration date of your passport to be greater than 6 months from your date of entry in country.
H. Check the CDC web site, www.cdc.gov/travel, to determine which immunizations are necessary.

I. Confirm that your travel dates line up with elective time in your academic calendar.

J. Sample Learning Objectives:
   1. Experience and understand how to practice medicine with limited resources.
   2. Experience and understand how poverty affects a person’s health.
   3. Experience and understand how native cultural beliefs influence health care delivery to a given population.
   4. Experience and become familiar with local diseases not commonly found in the United States (malaria, parasites, malnutrition).
   i. Experience and become familiar with how common diseases in the United States are treated similarly or different in the local health care system (diabetes, asthma, osteoarthritis).
   5. Improve medical and conversational foreign language skills (where appropriate).
   6. Understand the proper use of malaria prophylaxis, recognizing endemic areas of the world and the implications of drug resistance patterns.
   7. Be able to counsel travelers regarding staying healthy while traveling including prophylactic medications based on their itinerary.
   8. Know the physiologic effects of malnutrition and understand the deficiencies unique to the region visited.
   9. Understand the pathophysiology, clinical presentations and management of Mycobacterium tuberculosis.
   10. Understand the mechanisms of HIV transmission and the implications for a country without sophisticated community health services or availability of highly effective antiretroviral therapy.
   11. Practice cost effective health care and resource allocation.
   12. Advocate for quality patient care and assist patients in dealing with the health care system of a developing country.
   13. Productively and cooperatively participate in a multidisciplinary approach to patient management in a developing country.
   14. Work cooperatively as a team member with multi-disciplinary team and support staff in the affiliated hospital, its outpatient offices and any travel clinic volunteers.
   15. Understand the impact of public health infrastructure (e.g. sanitation, pollution, education, immunizations, nutritional resources, etc.) in the role of health care delivery.
   16. Understand the impact of government policies in health care delivery.
Resident Promotion, Evaluation and Contract Renewal

Within each program, each resident must meet the requirements and professional obligations of each PGY level as outlined here, in the ACGME, CPME, or AOA competencies, in specifics outlined in the Common program requirements and the specialty requirements of individual review boards for that program before promotion to the next level and graduation from the program.

Entering year one:
Please refer to “Resident Eligibility and Selection Policy” for criteria that must be met in order to enter as a resident into a Community Health Network residency program.
Signing a contract for services with Community Health Network and additional specific health, training and administrative requirements may be required before beginning the residency. Additional requirements will be available at the time of recruitment and when changes to the program are subsequently made, at the time of contract negotiation and signing.

Promotion from year to year:
In order to successfully advance from year to year, each resident must meet the following criteria and demonstrate appropriate competence in the following areas:

- Patient Care
- Medical Knowledge
- Practice-Based Learning & Improvement
- Professionalism
- Interpersonal and Communication Skills
- Systems-Based Practice
- For residents in osteopathic recognition tracks or who desire to practice manual medicine after graduation, the application of skills of manual medicine.
- Complete all required educational experiences and longitudinal learning
- Attend and participate in assigned hospital and medical committee meetings
- Receive passing evaluations on all learning modules; if fails any portion, must repeat that portion, with passing evaluations prior to advancement
- Be assessed by the core faculty as ready to perform duties of the next year
- Fulfill all obligations and duties specified in the contract for employment
- Abide by all medical records policies and network employee policies
- Abide by all standards of behaviors of the network
- Participate in scholarly activities as prescribed by the specialty program
- Complete all specific competencies and procedures required by the specific Board for the specialty program
- Complete evaluations of the rotations and faculty as required by the ACGME or AOA
• Pass USMLE Step III, or equivalent (COMLEX Step III, Part 3 APLME) according to timeline specified by each program.

For successful graduation from the program:

In order to successfully advance to graduation from the program or further study, the terminal year resident must meet all of the above and additionally:

• Hold a permanent medical license in order to apply and sit for the program appropriate specialty boards
• Complete all specific competencies and procedures required by the specific Board for the specialty program. Complete evaluations of the learning modules and faculty as required by ACGME or AOA and the network.
• Complete all required patient care duties and charting.

Each program will provide its trainees with information relating to eligibility for certification by the relevant certifying Board.

Resident Evaluation Process:

Formal resident evaluations will be made in accordance with ACGME, CPME, and AOA standards as set out in the Common Program Requirements. Additional informal evaluations may be made by the program director whenever he/she feels necessary.

Each program must develop specific written methods of assessment and evaluation of the trainee. Formal evaluations will take two forms: formative and summative.

Formative evaluations:

1. The faculty will evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

2. The program will:
   a. Provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
   b. Use multiple evaluators (e.g., faculty, peers, patients, patients’ families, self, ancillary staff, and other professional staff);
   c. Document progressive resident performance improvement appropriate to educational level; and,
   d. Provide each resident with documented semi-annual evaluation of performance with feedback.
3. The evaluations of resident performance will be accessible for review by the resident, on request and with an appointment in the Office of Academic Affairs.

**Summative (final) Evaluation**

The program director will provide a summative evaluation for each resident upon completion of the program. This evaluation will become part of the resident’s permanent record maintained by Community Health Network, and will be accessible for review by the resident on request and with an appointment in the GME office.

This evaluation will document the resident's performance during the final period of education, and verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

**Non-Promotion**

Residents will be appointed for the term or terms and conditions set out in their contract. Also, they will be promoted in accordance with the provisions of their contract as set out in Network and CHI policies, the GME Handbook, and in accordance with any ACGME or specialty program requirement.

In instances where the term of a resident’s contract will not be extended or when a resident will not be promoted to the next level of training the program, the Program Director or designee will provide the resident with a written notice of intent no later than four (4) months prior to the end of the resident’s current contract specifying in writing the reason(s) for not extending the term of the current contract or non-promotion. If the primary reason for not extending the term or non-promotion occurs within the four (4) months prior to the end of the contract, the program will provide the resident with as much written notice of intent not to extend the term or not to promote as circumstances will reasonably allow, prior to the end of the contract.

The program director has decision-making responsibility in resident promotion and contract extension but seeks input from multiple sources, including residency faculty, chief residents, and other parties when arriving at promotion decisions. Promotion review includes evaluation reviews.

A resident, who is not promoted or whose contract term is not extended for academic and performance reasons stated in the letter from the program, may appeal the program director’s decision. Reference the Due Process appeal policy below.
Due Process Procedures for Concerns, Performance Problems and Offenses: Correction, Discipline, Suspension and Termination

The purpose of this policy is to identify the procedure for handling house staff member performance problems and offenses relating to corrective action plans and disciplinary actions with Community Health Network house staff members.

The duties, privileges, authority and responsibilities of residents are governed by their contract, the policies in the GME Handbook (as amended from time to time, by specific written authorization or delegation by the DIO with approval by the GMEC) and by the rules, regulations, policies and procedures of the Medical Staffs and Hospitals. In all matters, the house staff member must act within Network PRIIDE values. This policy is supplemental to the guidelines of Community Health Network (Network) and Community Hospitals of Indiana (CHI) policies concerning employee discipline and replaces Network and CHI policies with respect to actions and processes specifically described here. The Network and CHI policies delineating and describing the concerns process, classification of offenses, discipline and due process procedures apply to situations not specifically covered by this policy. Those policies may be found on InComm, under departments by clicking Human Resources.

Depending on circumstances, the below procedures may be utilized when a house staff member fails to meet the expectations of a program. The program is not required to follow a progressive system of discipline. Serious deficiencies and/or misconduct may warrant action up to and including termination as a first offense, regardless of whether less formal actions have been taken in the past. Programs are to review the house staff member’s past performance as well as the current performance problem on an individual basis to determine level of intervention needed for the given situation.

A. **Structured Feedback:**

In accordance with ACGME common program requirements, all programs must provide objective assessment 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. Programs must use multiple evaluators, document progressive resident performance improvement appropriate to educational level, and provide each resident with documented semiannual evaluation of performance with feedback.

Additionally, the Clinical Competency Committee will review resident performance on a semiannual basis, and they will advise the program director regarding resident progress, including promotion, remediation, and dismissal.
House staff members in Non-ACGME programs must provide objective assessments in accordance with their respective program requirements.

If the program director determines that routine structured feedback is not leading to the necessary improvement, or if the program director determines the problem is significant enough to warrant more formal action than routine feedback, the program director can proceed with formal actions as indicated by the situation.

B. **Oral Counseling:**
Formal oral counseling consists of a verbal conference between the program director/designee, faculty members (as appropriate), persons designated by the program director/designee with relevant information/involvement (as needed), and the house staff member. The program director/designee will specifically state the performance problem, and the house staff member will be given the opportunity to present his/her point of view. The program director/designee and house staff member will attempt to resolve the performance issues. A record of this session will be made by the program director/designee. A Performance Improvement Plan may be implemented depending on circumstances.

C. **Performance Improvement Plan**
A Performance Improvement Plan (PIP) is a plan of remediation designed to improve a house staff member’s proficiency in one or more ACGME Core Competencies. A PIP is NOT considered a Corrective Action or formal disciplinary action; rather, a PIP is an educational tool to correct areas of unsatisfactory performance by a house staff member. Therefore, a house staff member may not appeal a PIP pursuant to the Due Process procedure outlined for Corrective Actions below. A PIP does not trigger a report to any outside agencies, but it may be reported if an outside agency specifically inquires whether a PIP has ever been issued to a house office member.

A PIP worksheet (Example below) outlining specific deficiencies will be provided to the house staff member by the program director/designee. The worksheet will also include plan for improvement and monitoring. The PIP is to be signed by the program director/designee and house staff member.
## PERFORMANCE IMPROVEMENT PLAN WORKSHEET

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characterization of the lapse or performance improvement needed</td>
<td>Use Competencies to characterize</td>
<td></td>
</tr>
<tr>
<td>GOAL(s)</td>
<td>Describe in terms of specific milestone(s) and competency(ies)</td>
<td></td>
</tr>
<tr>
<td>Requirements: Educate</td>
<td>If needed, activity(ies) for learner to study about expected behavior change, why it is important, what behaviors define success</td>
<td></td>
</tr>
<tr>
<td>Requirements: Behavior/Performance Change</td>
<td><strong>SMART objectives:</strong> Specific, Measureable, Achievable, Realistic, Time</td>
<td></td>
</tr>
<tr>
<td>Requirements: Monitoring</td>
<td>Who, frequency, expectations for f/u meetings</td>
<td></td>
</tr>
<tr>
<td>Consequences for incomplete success/relapse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Resident
Name: ______________________________
Date: __________________

Resident
Signature: ______________________________
Date: ________________

Program
Director/Designee: ______________________________
Date: ________________
D. Corrective Action: Written Counseling
Corrective Action is a written notice of a performance problem or violation of policy. A Written Counseling is a formal document (Example below) outlining a performance problem or violation of policy. The Written Counseling notice will be prepared by the program director/designee on the Corrective Action form, and it will include the specific performance problem(s), concerns, or deficiencies; identify a corrective action plan; outline expected timeframe for improvement; inform house staff member of potential outcome if performance does not improve. The notice must be signed by the house staff member, acknowledging receipt of the document. The house staff member has the option to appeal the Corrective Action (see section H. Appeal Process for Disciplinary Action /Suspension /Termination):

The program director or designee will consult frequently, and no less than once every four weeks with appropriate individuals (e.g. appropriate faculty, residents, attending physicians) to monitor the house staff member’s performance. Written reports of progress will be generated. The reports will be discussed with the house staff member no less than every four weeks, and these reports will be kept in the house staff member’s file and also forwarded to the DIO. The general timeframe for improvement is 90 days (timeframe can be amended by the program director/designee dependent on the situation). At the end of the expected timeframe for improvement, the house staff member may be determined to have:

1. Inadequately completed the Corrective Action Plan to the program director/designee’s satisfaction. The house staff member will be informed of the status and next steps to be taken. Any additional actions imposed will follow the designated procedures for the disciplinary action initiated.
2. Made substantial improvement, but additional time is needed for further correction. In this case, the Corrective Action Plan may be extended up to 30 days to address residual deficits. The house staff member will be informed of the extension of the Corrective Action period and what deficits need to be remedied during this period of extension.
3. Adequately completed the plan to the program director/designee’s satisfaction. The Corrective Action period is terminated. Corrected performance is expected to be maintained.

E. Corrective Action: Probation (Final Notice)
Probation is a formal notification to the resident that there are serious identified areas of unsatisfactory performance that will require immediate remediation and/or improvement, or the resident will not be permitted to continue in the program. Probation notice will be prepared by the program director/designee on the Corrective Action form, and it will include the specific performance problem(s), concerns, or deficiencies; identify a corrective action plan; outline expected timeframe for improvement; inform house staff member of potential outcome if performance does not improve. The notice must be signed by the house staff member, acknowledging receipt of the document. The house staff member has the option to appeal the Corrective Action (see section H. Appeal Process for Disciplinary Action /Suspension /Termination):
If the house staff member’s performance deficiencies are not resolved during the period of probation to the satisfaction of the program director, or the house staff member refuses the probationary period and plan, the house staff member’s training may be terminated by the DIO on the written recommendation of the program director and in consultation with Human Resources (HR). The house staff member will be given a copy of such recommendation and a written notice of discharge/termination of training. At that time, the house staff member will follow all Network HR procedures.

RESIDENT CORRECTIVE ACTION FORM

☐ Written Counseling  ☐ Probation (Final Notice)

Resident Name: ___________________________________ Employee ID: _______________
Dept/Location: ____________________________________
PGY: ___________       Date: _______________

1. The resident is not meeting the Residency Program’s expectations in the following area(s):
   - ☐ Patient Care and Procedural Skills
   - ☐ Medical Knowledge
   - ☐ Practice-based Learning and Improvement
   - ☐ Interpersonal and Communication Skills
   - ☐ Professionalism
   - ☐ Systems-based Practice
   - ☐ Other (please specify):

2. Cite specific examples/incidents (including dates):
3. List/describe previous corrective actions (including dates):

4. Outline the expected behavior, performance standard, or policy/procedure to be followed and how or why it is to be performed as described:

5. List the corrective action steps to address the identified problem(s). Include how the program can assist the resident AND what the resident will commit to doing to remedy the problem(s):

6. What is the expected timeframe for improvement?

7. If performance does not improve, the next step will be:

It is the intent of the Residency Program to support the resident to reach a satisfactory performance level. The resident will be assigned Dr. ____________ as a faculty mentor during the period of corrective action. While the faculty member will provide coaching and support to the resident, it is the resident’s responsibility to correct the identified deficiencies.

RESIDENT COMMENTS:

Resident: I have read and received a copy of the Corrective Action. My signature indicates receipt of this document, not necessarily agreement. I understand that failure to meet performance expectations as outlined above may result in further disciplinary action, up to and including termination.

________________________________________  _____________________________
Program Director/Designee Name Printed   Resident Name Printed

_________________________________________  _______________________________
Program Director/Designee Name Signature  Resident Name Signature
F. **Suspension**
Whenever a house staff member's conduct or activities, in the opinion of the DIO/designee, based on his/her personal knowledge or information presented, may cause a threat of injury or damage to the health or safety of patients, employees, other persons in the hospital, or to him/herself unless prompt remedial action is taken, or if it appears reasonable to believe that the house staff member has failed to observe all laws or principles of medical ethics of the profession in such a manner as to impose a threat to patient care or the high ethical standards expected of members of the house staff, the DIO/designee may suspend all or any part of the house staff member's duties and privileges at such time and for such duration as outlined and documented by the DIO/designee. The DIO/designee has absolute discretion in such circumstances with respect to the terms of the suspension. Suspension may precede termination or remediation. The suspension will be reported in writing to the program director, the affected house staff member and Network Human Resources. The house staff member has the right to appeal the summary suspension (see section H. Appeal Process for Disciplinary Action /Suspension /Termination).

G. **Revocation or Termination of Appointment**
The appointment of a member of the house staff may be revoked or terminated prior to the end of a current term of appointment for failure to abide by the terms and conditions of appointment and contract, the rules and regulations, PRIIDE Values, Standards of Behavior, and policies and procedures of the hospitals and the Medical Staffs, the GME Handbook, or for activities or professional conduct considered to be disruptive to the operations of the hospitals, to the quality of patient care, or the teaching programs.

In such cases, a recommendation for revocation or termination of appointment will be made by the program director to the DIO. The DIO or designee will consult with Network Human Resources in accordance with Network policies and practices associated with termination of employment. The house staff member will be advised of the revocation or termination of his/her appointment in writing, stating the reasons for such action. The house staff member may appeal his/her termination within five (5) days of the date of the written notice following the same as outlined in section H. Appeal Process for Disciplinary Action /Suspension /Termination.

H. **Appeal Process for Disciplinary Action/Suspension/Termination/Non-Renewal/Non-Promotion:**

Within 5 business days of receipt of a Corrective Action Form/Notice of Suspension/Notice of Revocation or Termination, the house staff member may appeal such notice in writing and provide any additional information about factors which may be contributing to his/her performance. The house staff member is to give this appeal to the DIO or program director/designee.

Within the next 10 business days from receipt of the house staff member’s appeal, the DIO/designee, program director/designee, and house staff member will meet. Information is to
be gathered from appropriate faculty, chief house staff members and others with information as may be designated by either the house staff member or program director/designee with respect to the identified performance problems and the house staff member’s response. At this time, the DIO/designee can appoint, at his or her discretion, an ad hoc committee composed of a subset of identified GMEC members for further review and recommendation. Within 15 business days from the DIO/designee, program director/designee, and house staff member meeting, the DIO/designee will notify the house staff member and the program director of his/her decision in writing with a clear statement of facts and the reasons for their decision. The decision of the DIO/designee is final.

If a termination or suspension is reversed, the house staff member will be re-instated in the residency program and offered make up time for the time lost from the program during the appeal. Pay will be re-instated retroactive to the date of termination.

**Resident Council**

The DIO shall facilitate the creation of a Resident Council, membership of which will include all house staff, with a peer elected representative from each program serving a one-year term as a leadership body. From that group, all residents will elect a president and secretary. Monthly meetings (at a minimum) will be held, at which time any resident may bring matters of concern to the group for discussion. The institution will support meetings with venue, food and minutes. Written minutes will be kept for all meetings. See **Bylaws of the Resident Council** for more information about how the council conducts business.

In all cases, when a specific concern is discussed, the names of the residents participating in the discussion and process will be confidential and not shared with anyone outside of the Resident Council. If concerns affect a specific residency or program as a whole or at the request of a single resident expressing a concern, the president will write a letter of concern to the DIO and Chairman of the GMEC without disclosing the name of any resident. The DIO will then review the concern with the program director. If any action is deemed appropriate by the DIO, the DIO or program director at the direction of the DIO will take such action. In all instances the DIO will advise the Resident Council president of the response undertaken. The DIO will report the concern and response to GMEC as part of the standing agenda report at each meeting. The GMEC may will approve or direct further action by the DIO.

All reports of concerns shall protect the confidentiality of the resident and the Resident Council concern process may be used by any house staff member without fear of retaliation of any form. Retaliation in any form is specifically prohibited and may result in action by the program director, DIO, GMEC chairman up to and including termination of the retaliating individual(s). Nothing in this policy shall be construed as limiting the member’s right to access formal legal processes (i.e. EEOC).
The Resident Council “concern process” is not a substitute for formal concerns or grievances which affect a single student, but rather a forum in which house staff may exchange information, experiences and discuss issues affecting more than one resident/fellow. It may be used by a single resident with resident specific concerns to maintain confidentiality and as a supplemental or alternative procedure to the process outlined in the Due Process policy.

Supervision of Residents

Residency is an essential dimension of the transformation along the continuum of medical education of the graduate medical student to the independent practitioner. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

This specialty education of physicians to practice independently is experiential and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence.

Supervision in the setting of Graduate Medical Education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Community Health Network ultimately and through its Graduate Medical Education programs has the responsibility of assuring such care through appropriate supervision. As an institution, Community Health Network has established the following guidelines for all residency programs, recognizing that specialty programs may have additional supervision policies. These guidelines come directly from the ACGME Common Program Requirements, but provide guidance for all programs including AOA and CPME.

A. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician or licensed independent practitioner as approved by each Review Committee who is ultimately responsible for that patient’s care.

   1. This information should be available to residents, faculty members, and patients.
   2. Residents and faculty members should inform patients of their respective roles in each patient’s care.

B. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.
Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

C. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

1. Direct Supervision: the supervising physician is physically present with the resident and patient.
2. Indirect Supervision:
   a. With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision.
   b. With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.
3. Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

D. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

1. The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
2. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
3. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

E. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.
1. Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
   a. PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 resident’s progress to be supervised indirectly, with direct supervision available.]
   b. All decisions to advance independence should be made by program faculty and identified in writing in evaluation files and criteria.

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

G. Faculty and other preceptors should be aware of the restrictions of billing for medical visits when residents are the providers and supervision is indirect. If a resident has a billing question faculty or preceptors cannot answer, the resident should contact the practice administrator or program director for clarity.

Resident Clinical Duties

The following description of resident responsibilities is applicable to all Community Health Network GME residency programs. Additional responsibilities of each specialty program are noted in that program’s documents and available on the ACGME website.

Statement of Resident Responsibilities

Patient care responsibilities assigned to residents will be commensurate with their level of training, according to ACGME Special Requirements for training programs, the specific training program and the judgment of the program director, faculty where appropriate, and the attending physician. The goal of these supervision and responsibility guidelines is to always assure patient safety and high quality of care and education. These responsibilities may include:

- Where appropriate, formulate a plan of care based on a thorough assessment of the patient's history, current condition, and needs
- Write orders for the implementation of the plan of care
- Coordinate consultations with physicians and other members of the multi-disciplinary health team
- Facilitate communication(s) regarding the plan of care with the patient, family, attending physician(s), and any other involved member(s) of the health team
- Perform and/or assist in procedures according to the level of delegation appropriate to the resident's experience and ability
Communications: Expectations and Policies on use of Communication Tools

Each resident is provided with technology appropriate to support his or her responsibilities and enhance communication. This technology may include a laptop computer, pager and/or other wireless devices (smart phone). The following outlines the GME and Network policies on expectations and acceptable and restricted uses.
Mail and Address Changes

Each program has its own arrangements for resident mail. Each resident should check with the department or Chief Resident as to where to pick up mail. Personal mail is to be delivered to your home address. Community Health Network Graduate Medical Education and its programs communicate with residents through both the U.S. Postal Service and the individual’s official Network email account. Therefore, it is important for residents to update their information as soon as they have any changes in their mailing address.

An email or fax should be sent to the program director for forwarding to the Graduate Medical Education office with the full name, phone number, and new address listed. The resident should notify the Indiana Professional Licensing Agency (IPLA) any change in the home address. Updates to the address and phone number can be made on the medical license as part of the on-line renewal process. If changes need to be made after an individual has renewed their license, an email or fax should be sent to IPLA. Email: pla3@pla.IN.gov; Fax: 317-233-4236. Changes of address must also be reported to the Human Resources Department.

E-Mail

Within Community Health Network and its Graduate Medical Education programs, there is an increasing need for fast and efficient communication with current residents in order to conduct official business. Residents tend to communicate extensively through electronic mail. Each resident is issued a Network ID and email account for use throughout the time the resident is in training. Accordingly, email is an available mechanism for formal communication by the GME office, program directors and faculty with residents. The domain for residents’ emails is ecommunity.com. Official communications will be sent to residents’ official Network email addresses. If a resident or fellow chooses to forward his/her mail to another email address (AOL, Hotmail, departmental server, etc.), the resident’s or fellow’s CHNw email address remains the official destination for official Network and program correspondence.

Email shall be considered an appropriate mechanism for official communication by Community Health Network and its Graduate Medical Education programs unless otherwise prohibited by law. Community Health Network Graduate Medical Education and its programs reserve the right to send official communications to residents by email with the full expectation that residents and fellows will receive email and read these emails daily on work days. Residents must ensure that there is sufficient space in their accounts to allow for email to be delivered. Residents have the responsibility to recognize that certain communications may be time-critical. Residents will not be held responsible for an interruption in their ability to access a message if system malfunctions or other system-related problems prevent timely delivery of, or access to, that message (e.g., power outages or email system viruses).

Residents and fellows are expected to follow appropriate email etiquette when communicating with faculty, staff, and peers. Users are subject to all Network and hospital policies concerning information technology, including without limitation policies on use and misuse of information technology resources.
Inappropriate use of email may be grounds for disciplinary action up to and including dismissal. Based on HIPAA regulations, Community’s Corporate Compliance Department strongly recommends that Protected Health Information (PHI) not be sent via email. Residents are instructed to consult with the program director and review Network policies before sending any PHI via email.

Medical professionals share experiences and information with others in the medical community through web logs (blogs). When medical professionals choose to blog about their experiences, it must be understood that any information that might identify patients, faculty, staff, residents or students and their health conditions shall not be used or disclosed. Refer to the related network Social Media Policy for more details.

Residents and fellows may not share with or transfer to others their Network accounts including network IDs, passwords, or other access codes that allow them to gain access to Network information technology resources.

Community Health Network technology resources may not be used in a manner that violates the law, for private commercial activities that are not approved by the Network, for personal private gain, or for political campaigning and similar activities that are inconsistent with the Network’s tax-exempt status.

**Course Related Use of Email**

The program director and faculty may assume that a resident’s official Network email is a valid mechanism for communicating with that resident. This policy will ensure that all residents will be able to comply with program requirements communicated to them by email.

**Communication Technology Policies**

Each resident must review and comply with Network technology policies, specifically:

- Policy ADM F 003B: Communication Devices in Community Health Network facilities. Use of wireless cellular phones and two way radios
- Policy ADM C 005 Instructions for completing the new electronic DP39 (request for access to Community Health Network)
- Policy ADM C 008 Electronic Mail Usage Guidelines
- Policy ADM C 0013 Information Systems Acceptable Use Policy
- Policy ADM C 015 Internet Security Policy
- Policy ADM C 023 Personal Electronic Device Acceptable Use Policy
- Policy ADM C 023A Personal technology
- Policy IS 010 Mobile Device Acceptable Use Policy
An index to Network policies can be found at InComm/Learn/Policies and Procedures. Each resident is responsible for regularly checking for policies and updates of network policies.

Charting and Documentation

Our residency and fellowship programs align with Community Physician Network, Jane Pauley and CHNw medical staff standards for timeliness of charting, medical record documentation, and response to patient care needs for resident, fellow, faculty and other clinical providers.

- Closing patient encounters in office setting (within 48 hours/2 business days)

- Responding to phone notes, refills, (within 1 business day), MyChart messages (within 1 business day) and notifying patients of lab, imaging and other test results (within 2 business days)

- Patient form completion (within 5 business days)

- Completion of H&P, progress notes (same day/real time as close to rounding time as possible) and discharge summaries in hospital (within 72 hours of discharge)

Residents are not subject to monetary fines for delays in inpatient charting that the rest of the medical staff are held; however, delays in inpatient charting can result in disciplinary actions from the program depending on the frequency and severity of the delays. Faculty are subject to fines as described in medical staff bylaws.

Clinical site leaders at each clinical residency site will run reports twice per week of “open encounters” past 3 business days. This report will be shared with all providers and leadership at the clinical site. It will include the date of the oldest open encounter for each provider on the report.

Encounters open over 3 business days will need to be closed ASAP. Encounters open past 5 business days (or 1 week) will receive a formal warning from their advisor (for residents) or supervisor (for faculty). For encounters open past 10 business days (or 2 weeks), the resident or faculty member will be pulled from duties and charged PTA until charts are complete.

Repeated appearance on the open encounter lists at any clinical site can trigger due process measures including oral counseling, performance improvement plans, probation.

Exceptions to this policy require the approval of Academic Affairs Leadership.
Resident Work Hours

Resident work hours are carefully planned and constructed within the ACGME/AOA/CPME standards and guidelines to achieve a balance among education, service, patient safety and resident well-being. Each program must develop specific written policies which conform to these guidelines and any specialty specific ACGME/AOA/CPME guidelines. All programs must ensure that ACGME/AOA/CPME standards are maintained and that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. The structure of duty hours and on call responsibilities focus on the safety, needs and well-being of the patient; continuity of care; and the needs of the resident. In providing such care in stressful and demanding environments, the overriding policy is that faculty must monitor resident performance; and residents must recognize signs of fatigue, stress and burnout in themselves and each other, even when duty falls within allowable standards.

A. Supervision

All patient care is supervised by faculty in accordance with the ACGME/AOA/CPME standards and Faculty Call Schedule. Any questions or problems that may arise should be directed to the faculty on call, chief resident or program director in accordance with specific program policies.

B. Clinical Experience and Education

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 all call activities, and scheduled academic activities such as conferences. Clinical experience and education hours do not include reading and preparation time spent away from the clinical site.

2. The objective of on-call activities is to provide residents with continuity of patient care experiences throughout their clinical work and education period. In-house call is defined as those hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

3. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. 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 resident education. Additional patient care responsibilities must not be assigned to a resident during this time.

4. The clinical responsibilities for each resident is based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services.
Clinical and educational work hours are limited to no more than 80 hours per week, averaged over a four-week period. This time period includes clinic, rotation, on call and moonlighting experiences. The program director with review and the approval of the DIO/DME may petition a specific Review Committee to grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale. The ‘hour exception’ policy from the ACGME Manual of Policies and Procedures is to be followed when the program director is preparing a request for an exception.

5. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. These additional hours of care or education will be counted toward the 80-hours weekly limit.

6. In unusual circumstances, a resident on his/her own initiative may remain beyond the scheduled duty period to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must: appropriately hand over the care of all other patients to the team responsible for their continuing care; and, document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. The program director will review each occurrence of additional service, and track both individual resident and program-wide episodes of additional duty.

7. Residents should be scheduled for a minimum of one day in seven free from all educational and clinical responsibilities, averaged over a four-week period. At home call cannot be assigned on these free days.

8. Residents will have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the clinical site with fewer than either hours free of clinical experience and education. This must occur within the context of the 80-hours and the one-day-off-in-seven requirements.

9. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

10. Residents must be scheduled for in-house call no more frequently then every third night, averaged over a four-week period.
11. At home call is not subject to the every third night rule. However, when the resident is handling patient care activity, time spent is counted towards the weekly limit, and will not violate the requirement for one-day-in-seven free of clinical work when averaged over four weeks. Call must not be assigned so frequently as to interfere with other program and training responsibilities and the resident’s necessary rest and reasonable personal time. Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient care must be included in the 80-hour weekly limit.

C. Accountability

Each resident is expected to have read and to comply with these policies, as well as, the required education about fatigue management and sleep deprivation. Resident duty schedules and call schedules are made with these policies in mind. Duty hours must be entered and signed off by each resident on a weekly basis through the New Innovations Residency Management Suite. The program director and GME director will regularly review duty hour logs in New Innovations as required by ACGME/AOA standards. Violations of duty hour policies will be reviewed by the program director and actions will be taken to correct the violations as required by the ACGME standards.

Moonlighting is discouraged by the network residency programs, given that residency is a full time obligation. In the event a resident would like to pursue moonlighting, the resident must request a form from his/her program director. The form must be completed and the proposed moonlighting approved in writing prior to commencing the moonlighting activity. (See Moonlighting)

Time Away for Medical Appointments

Programs will support residents in attending medical, dental and mental health appointments, including those during work hours. The options for residents when time away from residency duties is needed for medical care are outlined below:

a) PTA can be requested and taken in half-day increments for health-related appointments

b) When possible, occasional allowance for appointments during Tuesday afternoon didactics (without the use of PTA) is permissible with advanced notice to program. The resident should request the need to miss didactic time to the Program Administrator or Coordinator and their advisor by email as far in advance as possible.

c) If appointment not able to be completed via (a) or (b), appointments during first or last hour of morning or afternoon assignment can be approved (without the use of PTA) as long as >75% of scheduled clinical time/activities for the day are completed, otherwise ½ day PTA will need to
be utilized. Request to be made to Program Administrator or Coordinator in advance, and resident is required to inform scheduled preceptor/staffer or clinical supervisor (if seeing patients in FMP) of their absence. If more than two hours is needed, exceptions (without the use of PTA) may be requested through the Program Director.

d) In the case of multiple anticipated absences from work, FMLA may need to be utilized for residents who have been employed for > 1 year. (Standard CHNw HR policies apply and resident needs to work with HR contact and/or the Leave Team)

e) Scheduled absences during non-PTA eligible rotations should generally be avoided. Should medical necessity arise, contact your Advisor, Program Director and Program Administrator or Coordinator and absences will be evaluated on a case-by-case basis.

Fitness and Fatigue Mitigation

The Graduate Medical Education Committee (GMEC) and DIO or designee must:

a. Educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

b. Educate all faculty members and residents in alertness management and fatigue mitigation processes;

c. Adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning; program directors, faculty, or residents who recognize fatigue in a resident should provide appropriate options such as naps, back-up patient care coverage and/or safe transportation home (via taxi or Uber/Lyft, for which receipts would be reimbursed by the programs in any cases of fatigue);

d. Monitor fitness and fatigue reports and problems in individual programs and with the program director develop responsive changes.

e. Each program must develop a written back-up patient care system to ensure continuity of patient care in the event that a resident/fellow may be unable to perform her/her duties. (The program can use same back-up patient care system for fatigue as is used for illness).

f. Every resident will be required to review and document education around fatigue management and fitness policies and practices each year.

Moonlighting

The Graduate Medical Education Committee recognizes that additional medical experience, commonly referred to as “moonlighting” can offer educational value which may supplement that of the residency curriculum. Moonlighting is defined as any employment for compensation that is unrelated to your educational program at Community Health Network. Moonlighting is not a required aspect of residency
training. The GMEC supports moonlighting to the extent that it is conducted in an approved manner, and does not detract from residency education. Under the terms of Community Health Network’s professional liability policy, malpractice coverage for moonlighting is not provided and must be supplied by the individual moonlighting or the entity employing the resident.

Requirements before moonlighting include:

- Valid, unrestricted license to practice medicine in the State of Indiana (this is your own personal medical license, not the temporary license you can use for residency).
- Valid, unrestricted controlled substance registration (Indiana) and DEA registration (this is your own personal ones, not the temporary ones you can use for residency).
- PGY 2 or higher in good standing (not on an improvement plan, probation or deemed at risk by the program director).
- Approval by the Program Director for all moonlighting activities and locations.
- Moonlighting hours do count toward, and must not create a violation in the ACGME/AOA rule of 80 hours of work per week, averaged over four weeks. All moonlighting hours must be logged into New Innovations.
- Moonlighting must not adversely affect the resident’s home or professional life as determined by the Program Director and faculty.
- Moonlighting must not interfere with the resident’s regular duties and/or call availability.

Note that PGY-1 residents are not permitted to moonlight per the ACGME guidelines. Also, the regulations issued by the Indiana Medical Licensing Board limit the scope of practice of persons holding temporary medical permits. Specifically, the statute states:

“Persons issued a temporary medical permit ... shall not accept, receive, or otherwise be employed or engaged in any employment as physician unless approved by, or otherwise made a part or adjunct of, the applicant’s post-graduate medical education or training program.”

Under the guidelines established by the Indiana Health Professions Bureau, receipt of any compensation beyond the residency stipend provided by the hospital would be considered moonlighting.

Any PGY-2 or PGY-3 must adhere to the following while engaging in moonlighting:

- No moonlighting Monday through Friday 7am until 5:00pm unless on approved PTA
- No moonlighting during any scheduled call or weekend rounding duties
- No moonlighting during any required residency function
- Additionally, a moonlighting checklist form (obtained from program administration) must be filled out and signed by the Program Director stating they are aware, and approve of, the moonlighting. This must be signed before any moonlighting can occur. A separate form must be filled out and signed by the Program Director for each location in which the resident moonlights.

Any violations of the above REQUIREMENTS, including any Moonlighting activity that is deemed detrimental to the resident’s educational responsibility, may result in limitation of moonlighting, loss of PTA, residency probation, suspension, or termination.
Types of moonlighting:

- **External moonlighting**: moonlighting at a non-Community Health Network owned entity: e.g. Fairbanks hospital H and P’s, an immediate medical center not Community Health Network owned, ER work at a hospital not owned by Community Health Network.

- **Internal Moonlighting**: moonlighting at a Community Health Network owned site: e.g. all Med Checks, any ER work at a Community Health Network affiliated hospital, work at night in a Community Physician’s Network office.

- External moonlight is allowed as long as all criteria above are met and the resident has Program Director approval.

- Internal moonlight is only allowed at locations which have been approved for internal moonlighting at the “all program Program Director meeting” which is administrated by the DIO. Once the location is approved by this group and all criteria above are met including the resident’s Program Director approval, then internal moonlighting can occur at that/those location(s) only. Residents may not individually start internal moonlighting at a location which have not been approved by the Program Director committee.

**Drug-Free Workplace**

See Community Health Network policy below which applies to all employees, including residents:

**Statement of Purpose:**
This policy promotes Community Health Network as a drug-free and alcohol-free workplace and provides compliance with the Drug-Free Workplace Act of 1988.

**Policy:**
Community Health Network is committed to providing a safe work environment. Regardless of whether you show up for work as scheduled or are called in while on call, you may not report to work impaired by drugs or alcohol. If you must use prescribed or over-the-counter medication, you must consult with your physician to determine whether such use may impair your ability to safely perform your job in a productive manner and, if so, you must report any such impairment to your direct supervisor before you begin work. Depending on the circumstances, you may be referred to Employee Occupational Health Services and/or to Human Resources to properly address your situation.

Community Health Network does not tolerate unsafe or unlawful activity. The unlawful or unauthorized manufacture, distribution, dispensation, possession, sale, or use of controlled substances on our premises, in our vehicles, or while you are engaged in any Community Health Network business
activities will not be tolerated and likely will result in termination of employment. You must notify Human Resources of any criminal conviction for drug-related activity occurring in the workplace as soon as possible, and in no case more than five (5) days after the conviction, so that we may notify federal contracting or granting agencies as required by law.

Please keep in mind that medications prescribed for another individual and medications that are not used in accordance with the prescription or product instructions shall be considered illegally used and likely will result in termination of employment.

**Procedure:**

If you appear to be impaired in your ability to perform your job duties, you may be temporarily removed from work and required to take a drug and/or alcohol test as a condition of continued employment. Observations that might result in temporarily removing you from work include, but are not limited to, the following (we understand that these behaviors do not necessarily mean that you are under the influence):

- **Walking:** Staggering, stumbling, swaying, unsteady, unable to walk.
- **Standing:** Holding on for support, swaying, staggering, unable to stand.
- **Speech:** Incoherent, rambling, shouting, slurred.
- **Demeanor:** Unusually excited or drowsy.
- **Actions:** Erratic, hostile, hyperactive, profane, threatening.
- **Eyes:** Bloodshot, closed, dilated, droopy, glassy, watery.
- **Face:** Flushed, pale, sweaty.
- **Appearance/Clothing:** Stains, unruly, having odor, partially dressed.
- **Breath:** Odor of alcohol or drugs.
- **Movements:** Hyperactive, jerky, nervous, slow.
- **Unusual pattern of absences**
- **Unusual change in attendance or performance**
- **Significant workplace accident**
- **Missing drugs**

The results of the test will be considered in determining an appropriate response to your situation. If you test positive for drug or alcohol use in violation of our policies (or if you admit to such use and forego testing) and you are professionally licensed, certified, or registered, we will notify the professional board and/or governmental authorities as required by law or as we otherwise deem appropriate.
To verify compliance with this policy, we may conduct a search of your person or property that you brought to work. You are expected to fully cooperate with any reasonable request for a search of your person or property. Failure to do so likely will result in disciplinary action, up to and including termination of employment.

We are proud of our culture of providing assistance to employees who ask for help before problems arise at work. If you need help, please ask. You may be able to get help on a confidential basis through our Employee Assistance Program, Leave of Absence policies, and/or other benefit plans. Please remember that it is important to ask for help before a problem adversely impacts safety or job performance because illegal or unsafe conduct at work will not be tolerated.

**Physician Impairment**

Community Health Network prohibits the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance on hospital premises or while conducting hospital business off hospital premises. Violations of this policy may result in immediate termination of Graduate Medical Education training.

Community Health Network expects and requires all residents/fellows to report to work on time and inappropriate mental and physical condition. It is the hospital’s intent and obligation to provide a drug-free, healthful, and secure environment for its patients, visitors and employees.

Community Health Network recognizes drug dependency as an illness and a major health problem. Community also recognizes drug usage as a potential health, safety, and security problem. Therefore, Community Health Network has contracted with the Indiana State Medical Association (ISMA) Physician Assistant Program (PAP), website http://www.ISMANet.org, to coordinate efforts in identifying and assisting residents/fellows and other physicians practicing at Community Health Network with illnesses impairing their ability to practice medicine. These illnesses may include chemical dependency, psychiatric illnesses, and/or physical illnesses. The partnership between Community Health Network and ISMA was created to assist in the identification, treatment, and rehabilitation of an impaired member of the medical staff, residents, and fellows.

The objective is to serve all physicians who provide care at Community Health Network be they faculty or resident physicians in the Graduate Medical Education programs. If intervention is deemed appropriate, it is undertaken in a confidential, positive, supportive manner, consistent with the laws of the State of Indiana, with the goals of recovery and rehabilitation foremost in mind.

**For-Cause Drug Testing of Residents and Fellows**
If any individual has a concern or question regarding a resident/fellow’s mental or physical condition due to supposed substance abuse, he or she should contact the program director or the DIO immediately and follow this up with written documentation of the event.

The program director has the authority to direct a “for cause” alcohol and drug screen. The program director should contact the Designated Institution Official (DIO) or his/her designee who will in turn, contact the ISMA PAP. A resident who declines a for cause screening may be suspended or placed on leave to be sure that patients or colleagues are not put at risk.

**Intervention**

Intervention offers a way to approach the impaired practitioner in a caring, nonjudgmental manner and request that the physician receive assistance for a suspected problem. To set up an intervention:

- ISMA PAP staff review the information and determine if it is adequate to reasonably conclude impairment exists. If more information is needed, the referral source may be asked to identify other concerned parties to provide additional details.
- A meeting is held with the impaired physician and an assessment is requested by a source approved by the ISMA PAP.
- While engaged in the assessment and treatment planning in the ISMA PAP, the trainee will not be terminated.

**Assessment/Treatment Referral**

Once an intervention has successfully occurred, the following usually represents the best interests of the physician and hospital:

- Formal enrollment in the ISMA PAP
- Agreement to immediately enter an approved assessment program and allow formal communication between the assessing agency and the ISMA PAP
- Agreement to follow all treatment recommendations resulting from the assessment recommendations
- Agreement that failure to comply with this plan violates the program agreement and may result in action on continuance of training, medical privileges, and/or medical licensure.

**Monitoring/Advocacy Services**

A key service offered by the ISMA PAP is the monitoring contract. A typical physician contract remains in effect for five years and may include monitoring the following:

- Attendance at 12-step support groups, where appropriate
- Random urine drug-screen testing, where appropriate
- Individual, family and/or group counseling, where appropriate
• Communication with all appropriate therapists and treating physicians
• Attendance at Caduceus meetings, a support group for health care professionals, where appropriate
• Regular meetings with the PAP-named physician monitor and/or staff
• Any other requirements deemed necessary to aid recovery.

As part of this contract, the physician allows regular communication with all necessary and appropriate program personnel. Additionally, regular progress compliance letters can be sent on behalf of the recovering physician, when consent is given.

Confidentiality
According to federal law and ISMA program policies, all participant information is confidential. The ISMA does not automatically refer a physician to the licensing board for a minor infraction of the contract. It is only after all attempts to work with a physician have failed that a referral is made to the appropriate board.

Work Environment
In addition to Community Health Network’s Policy on Harassment and Workplace Threats and Violence, the Community Health Network office of Graduate Medical Education and its GMEC have adopted the following guidelines for its medical education programs:

1. There may be situations where residents feel they are abused or sexually harassed in the medical education setting. Because the relationship between faculty and residents is hierarchical, it remains the ethical responsibility of the faculty to assure that residents are professionally mentored and respectfully treated.

2. Criticism of performance will be discussed in private with the resident.

3. Discussions about patient care with consulting medical staff with or among residents will be carried out in a civil tone and volume.

4. Shouting, cursing, name calling, or personal attacks have no place in any discussions.
5. When physically present in the hospitals, professional conversation and interactions are critical to patient care and to the functions of the hospitals and must be carried out civilly.

Any resident, attending physician, professional staff member or faculty member may report any such behavior to the program director, chairman of GMEC, the DIO or his designee or to a regional physician executive who will investigate and respond. The individual may also initiate the HR Policy “Harassment/Workplace Threats and Violence.”

**Concern Resolution (Grievances)**

The purpose of this policy is to identify the process in which resident can address concern(s) that arise during his/her training. It is the policy of the Community Health Network to have an identified procedure of how a house staff member can address his/her concern(s).

Retaliation against the house staff member for submitting a dispute through the concerns procedure is prohibited. Retaliation may result in action by the DIO up to and including termination of the retaliating individual(s).

This procedure may be used in conjunction with or in place of the confidential concern procedure outlined in “Resident Council” for all the above concerns.

Nothing in this policy shall be construed as limiting the house staff member’s right to access formal legal processes (i.e. EEOC).

This policy is supplemental to Community Health Network policies which provides the opportunity and mechanism to confidentially report concerns such as witnessed HIPAA violations or other violations of ethical standards or law.

**Definition:**

**Concern:** Any dispute or grievance about the house staff member’s conditions of work, faculty member, the specialty program in which he/she is matriculating, or the interpretation/application of any rule, regulation, contract, letter of appointment, practice or policy of Community Health Network or its affiliated hospitals. It does not include any individual performance problems, discipline, failure to promote, nonrenewal of appointment, or termination.

**Procedure:**

1. The house staff member shall promptly discuss the concern(s) with his/her program director.
2. If the matter is not satisfactorily resolved, or the house staff member is not comfortable speaking with the program director because the concern involves the program director, the house staff member may forward his/her written concern(s) to the DIO.
3. The DIO shall review the written concern, and he/she may, as deemed necessary, refer the concern to an appropriate body or person (e.g., Human Resources) for an advisory recommendation.

4. Following review of the written concern and advisory recommendation (if applicable), the DIO shall promptly render a final decision, including any related recommendations. A written record of the concern and decision will be kept in the Academic Affairs Office. The record will be confidential except as may be needed for further consideration (e.g., additional disciplinary actions or HR use).

5. The DIO will follow up on any recommendations which he/she has made.

Relationships with Colleagues

Community Health Network’s Graduate Medical education mission is promoted by professionalism in faculty/resident/staff relationships. Professionalism is fostered by an atmosphere of mutual trust and respect. Actions of residents that harm this atmosphere undermine professionalism and hinder fulfillment of the network’s educational mission. Trust and respect are diminished when those in positions of authority abuse or appear to abuse their power. Those who abuse their power in such a context violate their duty to the academic community.

Residents exercise power over other residents and staff whether in providing praise or criticism, evaluations, recommendations for their further studies or future employment, or conferring other benefits. All amorous or sexual relationships between residents or between residents and personnel staff are unacceptable when the resident has any professional responsibilities or relationship with or for the other. Such situations greatly increase the possibility that resident will abuse power and this abuse may lead to sexual exploitation. Voluntary consent by the other in such a relationship is suspect, given the fundamental asymmetric nature of the relationship.

Moreover, other residents and staff may be affected by such unprofessional behavior because it places the resident in a position to favor or advance one person’s interest at the expense of others and implicitly makes obtaining benefits contingent on amorous or sexual favors. Therefore, Community Health Network Graduate Medical Education Programs view such relationships as a violation of this policy if a resident engages in amorous or sexual relations with another resident or with staff for whom they have professional responsibility or relationship even when both parties have consented or appear to have consented to the relationship. Should a resident find him/herself in a supervisory relationship with someone he/she has already had a relationship with, he/she should notify his/her supervisor immediately and ask for reassignment.

Any concerned person may initiate complaints about alleged violations of this policy. Such complaints should be brought to the attention of the program director, DIO, or Chief Academic Officer, or SIE.
Sanctions appropriate to the offense will be applied by the DIO or program director. Possible sanctions may include, but are not limited to, reprimand, consideration in promotion decisions, termination of employment, and immediate dismissal.

Residents disciplined or terminated on grounds of violation of this policy shall have such rights as are provided by the Due Process policies.

**Professional Appearance Standards**

One of the hallmarks of professionalism is the pride that each individual brings to his or her job. Part of professionalism begins as we prepare for work and consider our professional role in service to each other, physicians, staff, patients and the public. Community Health Network Office of Academic Affairs has developed the following standards to apply to all participants in Community Health Network Graduate Medical Education programs.

1. Residents and fellows must dress appropriately, look professional, maintain a high level of personal hygiene and inspire confidence in the patients and families they serve. Accommodations may be requested on the basis of religious or other needs.

2. Residents and fellows must comply with the dress and hygiene codes established by the affiliated facility where they are rotating.

3. Program directors or designees may use a progressive enforcement procedure, including verbal counseling, removal from patient care or other professional activities to allow the trainee to comply with the policy. The Due Process policy may be applied if appearance standards are repeatedly violated.

4. Appropriate dress and appearance standards include (but may be expanded by a program to meet that program’s objectives):

   a. Hair will be maintained in a clean and neat appearance. If shoulder length or longer, hair must be contained in a neat fashion, preferably pulled back away from the face. It should not be a distraction to the resident, nor a risk for infection control.

   b. In the spirit of our excellent patient/family experience customer-focused care, scents will not be worn except those incorporated in mild deodorants, lotions, soaps, or hair products.
c. Fingernails will be clean and trimmed to a natural appearance. Per infection control policy and CDC guidelines, artificial nails will not be permitted. Nail polish colors will not be bright in nature; preferably pale or nude in shades.

d. Clothing must be clean, in acceptable condition, wrinkle free, and appropriately sized. Pants or scrub bottoms (as permitted by the individual program) will not drag on the floor; they will either touch the tops of the feet or mid heel on shoes. In ambulatory patient care settings, professional attire will not include wearing scrubs except for procedures.

e. Clothing must be worn in a professional manner, e.g. NO low neckline; NO exposed abdomens; NO exposed midriffs; NO exposed underwear of any kind; NO sleeveless tops or tank tops unless covered with a jacket or top; NO tight clingy clothing; NO hoodies; NO cover gowns except as required for patient care.

f. Skirts, dresses, and tops should be worn at length that is appropriate for the professional setting and which allows for reaching, bending, stooping, and sitting without exposing upper thigh, midriff or torso region. NO denim blue jeans. NO Capri pants. NO shorts permitted for any program activity (except as permitted by the program for example after hours social activities, council meetings, off hours informal residency only meetings). No T shirts or shirts with embellishments or advertising except shirts which identify Community Health Network.

g. Shoes should be clean and in good repair. Heels of moderate height or flat-soled shoes must be worn in consideration of employee and patient safety. Clogs, e.g. Crocs are acceptable without holes. NO sandals or open-toed shoes are permitted where direct patient care is provided or in patient care areas.

h. ID badges will be worn at all times, so that patients and staff can easily identify the person and role. The name badge should be clipped on the right shoulder area and always on the outer layer of clothing. Badges should be clean and presentable and nothing may be placed over the picture or the name of the employee. No stickers are to be on the badge.

i. Tasteful and understated piercings of alternative sites, (e.g. eye brow, nose, lip, or other than single ear piercing for traditional hoop or post earrings) is acceptable. Program directors have authority to determine if something does not meet standards. Tongue rings hamper verbal communication and are not an acceptable part of professional attire.
j. Large and highly visible tattoos are not considered part of professional attire and must be covered while in the workplace, including hospital, clinic, office, or other location while on program work or business. Small and/or tasteful tattoos (not on face) are acceptable. Program directors have authority to determine if tattoos must be covered during patient care.

k. Jewelry should be modest and minimal and in keeping with professional standards. To facilitate hand washing, rings, bracelets and watches should be minimal.

IT Support and Use Policy

Each resident is provided with specific technologies, which may include a laptop computer, smart phone and pager, to support the educational program. Support for these technologies is available 24/7/365. In addition, the resident will attend training for and utilize Community CareConnect, an advanced IT system (Electronic Medical Record or EMR). The EMR captures all treatments and tests, and all records of a patient within Community Health Network into a continuum of care with an inclusive medical record available to each resident as part of his/her care and treatment of the patient.

Additional information can be found in the following Network policies:

- Policy ADM F 003B: Communication devices in Community Health Network facilities. Use of wireless cellular phones and two way radios
- Policy ADM C 005 Instructions for completing the new electronic DP39 (request for access to Community Health Network)
- Policy ADM C 008 Electronic mail usage guidelines
- Policy ADM C 0013 Information systems acceptable use policy
- Policy ADM C 015 Internet security policy
- Policy ADM C 023 Personal electronic device acceptable use policy
- Policy ADM C 023A Personal technology
Library and Research Services

Community Health Network Library’s resources and services meet the health professionals need to:
- maintain and improve clinical competence;
- support patient care management decisions;
- support performance improvement;
- and support training program scholarly needs. The library provides a wide range of services and resources. These are organized into a seamless and integrated network consisting of a main library location at Community Hospital East; other libraries at satellite locations; and numerous electronic resources. The central service is staffed by Masters trained medical librarians who can assist with evidence based database training as well as literature searches, reference work, in-person and virtual requests, orientations, and interlibrary loan services. Rush and same day evidence-based information is provided for direct patient care requests and other urgent information needs.

Community Hospital East is the main library location for Community Health Network and is staffed Monday – Friday and is accessible 24/7 with swipe badge access. The main phone number is 317-355-3600. In addition to the main library location there are two satellite library locations at Community Hospital North and Community Hospital Anderson. These two locations have part-time staffing, two days a week. Calls not answered at these two locations are automatically routed to the main library phone. Community Westview Hospital has a small print collection of books and journals and computer workstations located in the Physicians’ Lounge. This location is not staffed by the librarians, but assistance is available by contacting the main library. Other questions, requests and comments can also be sent directly to library@ecommunity.com.

In addition to the physical locations and resources, the Community Health Network Library actively maintains an intranet website that is accessible to all clinicians at InComm>Learn>Library. The website provides evidence based resources, practice guidelines, electronic journals and databases. Included is access to Up-To-Date, Ovid databases, EBSCO databases, PsychInfo, Micromedix, Cochrane Library etc., as well as access to thousands of electronic journals.

Scholarly and Clinical Research Support Services

The Community Health Network research section of the Office of Academic Affairs helps clinicians link to needed grant and funding resources, and helps learners link to resources for scholarly activity.

Medical Education programs require that residents, fellows, and their faculty participate in active learning and scholarly activity. The active engagement in scholarly activity, whether a literature review,
presentation, or practical application of evidence, is essential to learning, critical thinking, safety, quality and practice improvement.

A resident planning to complete any presentation, study, or project must speak with the network Office of Research Administration.

The Research support services include:
1. Mentoring and guidance study design, questions, and planning of projects
2. Guidance on institutional review board submissions
3. Project development, management and execution support
4. Grant submission, management, compliance and evaluation
5. Statistical analysis support
   - All people who participate in research or scholarly activity will be required to learn basic skills, including Complete the research training program requirements, including the CITI Protection of Human Subject training
   - Presentation (oral or written) of findings appropriate to the organization.

All research requires an institutional review board submission to assure protection of human subjects. This includes educational research and surveys on patients. Although these types of studies may be exempt or expedited, people who want to lead such projects must follow the guidelines of their program and the IRB to assure protection of their data.

Residents are encouraged to participate in resident research competitions and symposia. The research support group may assist residents and fellows in preparation of these submissions.

Closure or Reduction Policy for Residency and Fellowship Programs

Purpose
The closure of sponsoring or participating institutions, training programs, or the reduction of residency/fellowship positions may occur for a number of reasons such as loss of program or institution accreditation or loss of patient revenue. While Community Health Network has no reason to believe such a program/institution closure or loss of accreditation will occur, it is Community Health Network’s responsibility to address these possibilities should they become a reality.

Policy
In case of a closure, reduction, or loss of accreditation, Community Health Network will make every effort to provide residents/fellows with treatment equal to that provided to other staff affected by the event.

Community Health Network will make every effort to allow those residents/fellows in the program to complete their education at a Community site. If possible, payment of stipends and benefits will continue to the conclusion of the current contract.

**Procedures**

Community Health Network will notify the Graduate Medical Education Committee (GMEC), the program directors, and the residents/fellows of a projected closing at as early a date as possible.

If any resident/fellow is displaced by loss of program accreditation or a reduction in the number of residents/fellows in a program, Community Health Network will assist the residents/fellows in enrolling in an ACGME or AOA-accredited program(s) in which they can continue their Graduate Medical Education.

Provision will be made for the proper disposition of residency education records, including appropriate notification to licensure and specialty boards.

Community Health Network will also inform residents/fellows of adverse accreditation actions taken by the Accreditation Council for Graduate Medical Education (ACGME) or AOA in a reasonable period of time after the action is taken.

The GMEC will supervise the implementation of this policy.

**Review and Approval of Documents Prior to Submission to the ACGME**

The DIO, or the Network Director of Academic Affairs, in the absence of the DIO, must review and cosign all program information forms and any correspondence or documents submitted to the ACGME by the program director that addresses the following issues:

- All applications for ACGME accreditation of new programs and subspecialties
- Changes in resident complement
- Major changes in program structure or length of training
- Additions and deletions of participating institutions used in a program
- Appointments of new program directors
- Progress reports requested by a Residency Review Committee
Responses to all proposed adverse actions
• Requests for an appeal of an adverse action
• Appeal presentations to a Board of Appeal or the ACGME
• Requests for increases or any change in resident duty hours
• Requests for “inactive status” or to reactivate a program
• Voluntary withdrawals of ACGME-accredited programs

The documents described above should be sent to the DIO for inclusion in the agenda of the next GMEC meeting. Program directors who are applying for accreditation of new programs must also be present at the GMEC meeting to describe the program and answer any questions the GMEC may have.

Upon approval by GMEC, the DIO will sign the document prior to sending it to the ACGME.

Resident Vendor Policy

The Network has a policy about vendors and relationships between providers and vendors.

As a Community Health Network resident, the GME programs want you to learn to consider the influence of pharmaceuticals and other vendors on your practice of medicine, and attend training about these relationships and inappropriate influences on patient care and health care costs.

The ACGME and the GME office oversight discourages use of pharmaceutical vendors in any educational setting. Each specialty training program will establish its own practices related to the presentations, access and support by vendors in educational sites.

Community Health Network Graduate Medical Education Program Relationships with Vendors

Statement of Purpose: The promotional and/or informational activities at Community Health Network and its subsidiaries and affiliates (to include Community Hospital East, Community Hospital North, Community Hospital South, Community Heart and Vascular Hospital, Community Westview Hospital, Community Hospital Anderson, Community Howard Regional Health, Community Home Health, and Community Surgery and Endoscopy Centers) by Vendor representatives are a privilege. Vendor representatives are expected to be aware of this policy, any additional guidelines, processes and protocol and follow them accordingly. This policy applies to both clinical and non-clinical work areas.

Certification does not obligate the Network to contract and/or perform services with Vendor.
**Policy** It is the policy of Community Health Network to ensure that all Vendor representatives abide by the Network Policies and Procedures that are applicable to Vendor representatives. Failure to abide by the policies is subject to the sanction(s) contained within.

**Procedures:**

1. Initial Registration/Certification
   
   All vendor representatives must be certified by the Network Purchasing Department prior to engaging in any promotional, informational activities (detailing), and the distribution and/or use of the Vendor’s products and services within the network. Certification consists of the following:
   
   - Registering as a Vendor with Vendormate and complying with all its requirements.
   - Attend a training session conducted by Network Purchasing staff.
   - Read and sign the “Declaration of Understanding and Compliance with Policies for Vendor Representatives”.

   Note: Certification is not transferable from one Vendor representative to another. Each Vendor representative must complete certification.

2. Identification Badge
   
   Vendor representatives will be provided with an identification badge upon completion of Vendor Certification as outlined in Section A. above. This badge must be worn at all times while on site at any network location.

3. Appointments
   
   Vendor representatives are not permitted to enter any network areas without a scheduled appointment.
   
   - The network staff members have the authority to schedule appointments at a location of their choice. In patient care areas, necessary steps to assure patient confidentiality and privacy are required. Vendor representatives may not go to any area to make an appointment. Network staff may be contacted for appointments by mail, e-mail, or telephone. Vendor representatives must leave the area immediately upon completion of an appointment.
   
   - All Clinical Staff, Physicians, Residents, Fellows and Medical Students may be contacted by appointment only. The Vendor representative must have a prior appointment with the specific clinical staff before proceeding to the department.
   
   - Vendor representatives making appointments with Pharmacy staff are required to follow Pharmacy’s “Guidelines for Pharmaceutical Sales Representatives” policy.
   
   - All Vendor representatives visiting The Community Heart & Vascular Hospital (CHVH) must follow the “Check-In Procedure for Vendors, Clergy and Contractors” policy and addendum.
All Vendor representatives conducting business at the request of Case Management must follow the “Vendor Liaisons: Standards for External Vendors Whose Referrals Are Received through Case Management” policy.

Loitering in the network corridors, cafeterias, and other areas in an attempt to facilitate a non-scheduled meeting with the network staff member is prohibited.

An appointment with one staff member does not grant permission to detail other staff within that department.

4. Access to Procedural Areas

- Vendor representatives may be present in the Operating Room, Cardiac Cath Labs, Radiology, Endoscopy, and other procedure areas only when specifically invited by a physician or member of that department’s management staff. Attendance must be prior arranged by department management staff.

- If requested by the physician or the department’s management staff, the Vendor representative may observe a procedure. HIPAA compliant authorization must be obtained from the patient prior to sharing any information. Hospital patient and/or medical staffs consent policies also must be followed. Attendance must be prior arranged by department management staff.

- Vendor representatives may request permission to observe a procedure from the physician and/or management staff. All HIPAA and consent policies must be followed. Attendance must be prior arranged by department management staff.

- Rationale for having access to these areas include, but may not be limited to:
  - Conducting training for new products/devices;
  - Technical consultation requested by the physician or management staff;
  - Introduction and/or trial of approved products/devices/instruments;
  - Research and field tests of unreleased products and devices.

- Vendor representatives are not permitted to operate any equipment or device. In an extreme situation, if requested by the physician, the Vendor representative may assist with problem solving.

- Vendor representatives are not permitted to touch a patient at any time.

- Vendor representatives are not permitted to introduce any product on a sterile field.

- Vendor representatives are not permitted to participate in any procedure, including “scrubbing in.”

- There is to be no photography of any kind in procedure areas.

- Vendor representatives who have voluntarily ceased employment with the Network within the last twelve (12) months are not permitted to be a Vendor representative for
the Network. Network Purchasing will determine a time frame for when/if a former employee may be permitted to service the Network in the future.

5. Meetings and Educational sessions
   • Attendance at Grand Rounds and departmental meetings is by invitation only.
   • Education sessions for new products and equipment shall be requested by and coordinated by network staff members only. Network Purchasing shall be notified of the purpose of the education session in order to communicate the opportunity throughout the network as appropriate.
   • Education sessions for non-formulary pharmaceuticals require permission from and attendance of a Pharmacy manager.

6. New and Off-contract products, equipment, and pharmaceuticals
   • All new and off-contract products and equipment must be introduced to the network through the Purchasing department.
   • New and off-contract products and equipment must be presented a minimum of three (3) business days prior to use.
   • Vendor representatives are required to complete a brief form detailing the product or equipment, and obtain the signature of the department management/designee prior to use. The New and Off-Contract Products and Equipment and/or the Vendor Implant and Endomechanical Request forms may be obtained from Network Purchasing. Electronic copies are also available.
   • Completed New and Off-Contract Products and Equipment and/or the Vendor Implant and Endomechanical Request forms must be forwarded to Purchasing by the Vendor representative within the minimum three (3) day period prior to use.
   • No purchase orders will be generated without the completion of the New and Off-Contract Products and Equipment and/or the Vendor Implant and Endomechanical Request forms.
   • New equipment must be reviewed and approved by Clinical Engineering prior to use.
   • All new and non-formulary pharmaceuticals must be reviewed and approved prior to use by a Pharmacy manager and/or their approval body.
   • Direct orders for any pharmaceutical may be accepted ONLY from a Pharmacy manager.
   • Any product, equipment, or pharmaceuticals not submitted through the proper authority and the processes listed above, will be considered a contribution to the network and the vendor will not be paid for the product.
   • Vendor representatives who habitually fail to introduce products, equipment, and pharmaceuticals through the proper authority will be subject to sanctions (see Violation of Policy section).

7. Trial Products and Pharmaceuticals
   • Trials of products and equipment must be approved and coordinated with P and department management.
• Trial pharmaceuticals must be approved by and delivered to a Pharmacy manager.
• Sample pharmaceuticals may be used in select outpatient settings only when requested by an attending physician and/or nurse practitioner. These samples must be registered with a Pharmacy manager prior to distribution.
• All products, equipment, and/or pharmaceuticals are subject to the same processes outlined in section “F” above.
• During a reasonable trial period, it is expected that all fees associated with the trial product be waived by the Vendor representative.
• A No Charge purchase order shall be generated by Network Purchasing prior to any products and/or equipment trials.

8. Invoicing and Bill Only Purchase Orders
• Invoices must be submitted in a timely manner.
• For products delivered by the Vendor representative for same day use, the invoice must be provided to the designated staff in the department where the product and/or equipment is used the same day. Contact the specific department’s manager to identify the required process.
• Network Purchasing is the only authority that can issue a Purchase Order for products and equipment.
• The department management is the only authority that can approve a Purchase Order. Physicians have no authority to request or approve purchase orders.
• Requests for Bill Only purchase orders must meet the following criteria:
  ➢ A complete invoice of products and/or equipment used must be signed by a member of the network clinical staff verifying the use of the items.
  ➢ This signed invoice must be provided to the designated department staff on the same day the products and/or equipment is used.
• Failure to follow the above processes in their entirety will result in the products and/or equipment being considered a contribution to the network and the vendor will not be paid for the product.
• Vendor representatives who habitually fail follow invoicing and bill only purchase order processes will be subject to sanctions (see Violation of Policy section).

9. Violation of Policies
The network’s “Vendor Visitation Policy” is to be followed in its entirety. In the event that a member of the network staff observes a Vendor representative in any network area without an approved Vendor Badge, the staff member should do the following:
• Ask the Vendor representative if he/she is aware of the “Vendor Visitation Policy.” (If not, they should be directed to the Network Purchasing Department at Community Hospital East located in Building 4, First floor, phone number is 317-355-5474.).
• Ask the Vendor representative for his/her name; request that they leave the area immediately.
• Notify the Network Purchasing Department (317-355-5474) with the Vendor representative’s information.

Failure to comply with the policy shall result in written notification detailing the nature of the violation:

1. First infraction – The Vendor representative, district manager and home office will receive a written notice of the violation from the Network Purchasing Department.
2. Second infraction – The Network Purchasing Department will suspend the Vendor representative’s privileges within the network for sixty (60) days.
3. Third infraction – The Network Purchasing Department will revoke the Vendor representative’s privileges for a period of twenty-four (24) months at which time; the Vendor representative’s district manager may contact the Vice President of Materials Management for reinstatement.

It is at the discretion of the network to determine which action(s) should be taken based on the severity of the infraction.

Immediate action, including an FDA report, will be taken if the infraction warrants such action.

**ACGME Guidance on Vendors:** Please refer to the ACGME website and to the posting entitled “Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME”

**Community Health Network policy** regarding Continuing Medical Education (CME)
CME Programs Supported Financially through Grants from Pharmaceutical Companies

**Statement of Purpose:**
To define the responsibilities of the Medical Education Department and the pharmaceutical companies when offering continuing medical education programs.

The leaders of CHNw Medical Education, will be responsible for the overall planning and implementation of CME programs. This responsibility includes the selection of speaker, topic, date of presentation and location. They will, with the assistance of the Program and Education Committee and other members of the medical staff, choose topics that demonstrate an educational need and opportunity. The ACCME and the ACGME have specific restrictions on pharmaceutical/industry sponsorship.

If a pharmaceutical company provides an educational grant for a program, acknowledgement will be given to that company in publications and announcements. If more than one pharmaceutical company provides educational grants, all companies will be listed in alphabetical order.
There are several options available for publicizing a program for which a pharmaceutical company is offering financial support:

1) Letters and/or formal invitations sent by pharmaceutical representative with prior approval of the Medical Education Department.
2) Letters and/or announcements sent by the Medical Education Department.
3) The pharmaceutical representatives may encourage attendance as they detail a physician. Pharmaceutical representatives are welcome to attend all CME offerings at Community Health Network but may not engage in sales activities while in the room where the educational activity takes place.

All educational activities must be free of commercial bias for or against any product. If an activity is concerned with commercial products, it must present objective information about the product, based on scientific methods generally accepted in the medical community.
The content of slides and reference materials must remain the ultimate responsibility of the faculty selected by the Medical Education Department.

Booth and display space for pharmaceutical companies may be available at all half or full day conferences at a cost to be determined by the planning committee responsible for the conference.

No promotional materials shall be displayed or distributed in the same room at any time during the educational activity. No promotional materials will be permitted at the one-hour conferences. Funds from a pharmaceutical company should be in the form of an educational grant made payable to the Medical Education Department of Community Health Network. The terms, conditions, and purposes of such grants must be documented by a signed agreement between the pharmaceutical company and Community Health Network. All financial support associated with a CME activity must be given with the full knowledge and approval of the Medical Education Department.

Community Health Network requires the disclosure of the existence of any relevant financial interest or other relationship a faculty member may have with the manufacturer(s) of any commercial product(s) discussed in an educational presentation. These relationships shall be disclosed to participants before the educational activity either in brochures, syllabi, exhibits or by the moderator of the educational activity.

Graduate Medical Education Committee (GMEC)

All residency and clinical fellowship programs under the sponsorship of Community Health Network are overseen by the Graduate Medical Education Committee (GMEC). The GMEC operates using the accreditation requirements of the ACGME, the AOA, the CPME, and other residency regulatory groups.
The GMEC works with the DIO (Designated Institutional Official) for the ACGME programs to set policies, offer oversight, and address quality and operations of GME programs. The following requirements are taken directly from the ACGME Institutional Requirements. The GMEC committee also serves as a proxy for the postgraduate training committee of the AOA in some meetings each year, so that coordination across the institution can be achieved.

Membership on GMEC
Voting membership on the committee includes the DIO, residents nominated by their peers, representative program directors, and quality improvement/safety representative from the network. The committee may also include other members of the faculty or other members who have specialty and/or supervisory experience which will enhance the GMEC in carrying out its responsibilities as determined by the DIO.

Meetings
The GMEC will meet at least quarterly and maintain written minutes. Meetings will be facilitated using Roberts’ Rules of Order, and will hold votes on issues of significance to the functioning of the GME enterprise.

Responsibilities
The GMEC will establish and implement policies and procedures regarding the quality of education and the work environment for the residents in all programs. These policies and procedures include:

1. Stipends, benefits, and position allocation: Annual review and recommendations to Community Health Network regarding resident stipends, benefits, and funding for resident positions.

2. Communication with program directors: The GMEC will:
   a. Ensure that communication mechanisms exist between the GMEC, the DIO, senior executives, and all program directors within the Network
   b. Ensure that program directors maintain effective communication mechanisms with the site directors at each participating site for their respective programs to maintain proper oversight at all clinical sites.

3. Resident duty hours - GMEC will:
   a. Develop and implement written policies and procedures regarding resident duty hours to ensure compliance with the Institutional, Common, and specialty/subspecialty-specific Program Requirements.
   b. Consider for approval requests from program directors prior to submission to an ACGME-RC for exceptions in the weekly limit on duty hours up to 10 percent or up to a
maximum of 88 hours in compliance with accreditation Policies and Procedures for duty hour exceptions.

4. Resident supervision: Monitor programs’ supervision of residents and ensure that supervision is consistent with:
   a. Provision of safe and effective patient care;
   b. Educational needs of residents;
   c. Progressive responsibility appropriate to residents’ level of education, competence, and experience; and,
   d. Other applicable Common and specialty/subspecialty-specific Program Requirements.

5. Communication with Medical Staff: Communication between leadership of the medical staff regarding the safety and quality of patient care that includes:
   a. The annual report to the OMS of each participating site;
   b. Description of resident participation in patient safety and quality of care education; and,
   c. The accreditation status of programs and any citations regarding patient care issues

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

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

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

9. Management of institutional accreditation: Review of Community Health Network’s ACGME and/or AOA letter of notification from the IRC and monitoring of action plans for correction of citations and areas of noncompliance.

10. Oversight of program changes: Review of the following for approval, prior to submission to the ACGME or AOA by program directors:
   a. All applications for accreditation of new programs;
   b. Changes in resident complement;
   c. Major changes in program structure or length of training;
   d. Additions and deletions of participating sites;
   e. Appointments of new program directors;
   f. Progress reports requested by any Review Committee;
   g. Responses to all proposed adverse actions;
   h. Requests for exceptions of resident duty hours;
   i. Voluntary withdrawal of program accreditation;
j. Requests for an appeal of an adverse action; and,
k. Appeal presentations to a Board of Appeal or the ACGME.
l. Special reviews of underperforming programs
m. Major changes to resources or financial support for programs

11. Experimentation and innovation: Oversight of all phases of educational experiments and innovations that may deviate from Institutional, Common, and specialty/subspecialty-specific Program Requirements, including:
   a. Approval prior to submission to the specialty accreditation Review Committee;
   b. Adherence to Procedures for “Approving Proposals for Experimentation or Innovative Projects” in ACGME Policies and Procedures; and or equivalent AOA processes
   c. Monitoring quality of education provided to residents for the duration of such a project.

12. Oversight of reductions and closures: Oversight of all processes related to reductions and/or closures of:
   a. Individual programs
   b. Major participating sites
   c. Community Health Network
   d. Any facilities affiliated with Community Health Network
   e. Dissolution of any affiliation agreement affecting the programs

CLER (Clinical Learning Environment Review)

The ACGME’s CLER program focuses on the graduate medical education learning environment and how it can deliver high quality, safe patient care and physicians, prepared to contribute to health system improvement over a lifetime of practice. Reviewers from the ACGME will conduct regular visits to evaluate our residency programs on the following six focus areas: Patient Safety, Health Care Quality, Transitions of Care, Supervision, Clinical and Education Hours Oversight (including fatigue management and mitigation), and Professionalism. The goals of the CLER program and those of Community are in alignment, and are paramount to the success of our programs. CLER visits will be announced to the institution approximately 1 week before and will include the network leadership, including the CEO, CNO, CMO (or designee), CFO, and our chief patient safety person. It will include rounding with residents and staff in office and hospital settings, with feedback to the organization, DIO, and leadership about how to improve the clinical learning environment.
Procedures and Guidelines for Annual review of the Residency/Fellowship Programs

As required by the ACGME and AOA Institutional Requirements, the Graduate Medical Education Committee (GMEC) has the responsibility for periodic review of all residencies and fellowships that are sponsored by Community Health Network.

As prescribed by the guidelines, this periodic review will assess each program’s:

1. Compliance with the Common, specialty/subspecialty-specific Program, and Institutional Requirements;
2. Educational objectives and effectiveness in meeting those objectives;
3. Educational and financial resources;
4. Effectiveness in addressing areas of non-compliance and concerns in previous accreditation letters of notification and previous internal reviews;
5. Effectiveness of educational outcomes in the general competencies;
6. Effectiveness in using evaluation tools and outcome measures to assess a resident’s level of competence in each of the general competencies; and,
7. Annual program improvement efforts in:
   a. Resident performance using aggregated resident data;
   b. Faculty development;
   c. Graduate performance including performance of program graduates on the certification examination; and,
   d. Program quality.

Process for Review

All residency and fellowship programs sponsored by Community Health Network will undergo a review by GMEC on an annual basis (The Annual Program Evaluation or APE). Annual updated reports will be required for all programs to GMEC on a rotating cycle in accordance with accreditation system changes.

Required Documents

All training programs are expected to adhere to the Institutional Requirements, Common Program Requirements, and relevant Program Specific Requirements which are available on the ACGME website http://www.acgme.org, AOA website http://www.osteopathic.org, and CPME website.
The residents will be expected to complete the Resident/Fellow Survey requested by the ACGME on ADS, as well as periodic program, faculty and GME evaluations available on the GME data management system.

**Annual Program and Annual Institutional Review**

The review will be conducted by a committee appointed by the GMEC membership, and include at a minimum a member of GMEC, a full-time faculty member from another program, a resident member from another program, and the GME DIO.

**Materials and data used in the review process will include the following:**

- ACGME Institutional Requirements, ACGME Common Program Requirements, AOA requirements, and RC Program Specific Requirements from the Essentials of Accredited Residency Programs, or comparable organization.
- Letters of accreditation from previous reviews and progress reports to the respective accrediting group.
- Reports from previous internal reviews of the program and the program director’s response including corrective actions.
- A completed program information form, evaluations, and summary data as requests.
- List of current house staff and their medical school of graduation.
- The Resident/Fellow Survey summary if any sent to the current house staff in the training program, any reports resident Council and the latest ACGME Resident and faculty Survey or other surveys (where applicable)
- Minutes of the program’s Graduate Medical Education Committee Meetings.
- Program letters of agreement and affiliation agreements.
- Resident files from each level of training (including past graduates for the most recent two years).
- Goals and objectives for each level of training and for each major rotation.
- Evaluations of residents, faculty, and program.
- Match results and Board scores.
- Policy on selection and advancement of residents.
- Policy on moonlighting and a summary of moonlighting activities approved by the program director.
- Written description of supervisory lines of responsibility for the care of patients.
- Policy on work hours, method of monitoring work hours, and on-call schedules.
- Policy concerning the effect of leaves of absence on satisfying the criteria for completion of the residency program.
- Rotation schedules.
- Financial records, including CAP allocations, clinical revenue and performance reports
- Scholarly activity of residents, faculty and program director
- Conference schedules.
- Milestone reports
Interviews with the program director, faculty, and peer-selected residents from each level of training and individuals outside the program deemed appropriate by the committee will be a major component of the internal review process.

Report
The Review Committee will prepare a draft report of its findings which will include a summary of the following:

- Assessment of the residency program’s compliance with the institutional requirements.
- Assessment of the residency program’s compliance with each of the program standards.
- Assessment of the educational objectives of the program.
- Assessment of the adequacy of available educational and financial resources to meet these objectives.
- Assessment of the effectiveness of the program in meeting its objectives.
- Assessment of the effectiveness of the program in addressing citations from previous ACGME letters of accreditation and previous internal reviews.
- Assessment of the effectiveness of the program curriculum, faculty, and clinical environment in defining the specific knowledge, skills, and attitudes required and in providing the educational experience for the residents/fellows to demonstrate competency in the six general areas.
- Assessment of the effectiveness of the program in using evaluation tools developed to assess a resident’s level of competence in milestones.
- Assessment of the program in using dependable outcome measures developed for each of the six general competencies.
- Assessment of the program in implementing a process that links educational outcomes with program improvement.
- A list of the areas of noncompliance or any concerns or comments from the and a list of recommendations which must be addressed by the program director.

GMEC Review and Follow-up
After the Review Committee has approved the draft report, the review report is sent to the program director. The program director will be expected to respond in writing to the Recommendations Sections of the report within a limited specified amount of time (typically thirty days). Once the program director’s response is received, the review report and the program director’s response will be presented at the next GMEC meeting. The GMEC representative serving on the Review Committee will make a brief presentation to GMEC emphasizing the program’s compliance with the ACGME Institutional and Program Requirements, as well as recommendations for improvement of the program if applicable.

The GMEC will discuss and review the report and the program director’s response. The GMEC may request additional information or follow-up action. The Review Committee will communicate the GMEC’s actions to the program director and DIO. This communication may include a requirement for
additional actions on the part of the program director as the DIO or designee of the DIO will follow up with the program director in three to six months to review the corrective actions implemented and make recommendations for further improvement. A report of action will be provided to the DIO and GMEC.

Organizational Structure and Responsibilities
Formulated by: Community Health Network (CHNW) Office of Academic Affairs (OAA)

Revised and Approved by: Graduate Medical Education Committee (GMEC)