Texas Institute for Graduate Medical Education and Research

Policy and Procedure Manual

October 19, 2022

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Responsibilities of the Designated Institutional Official (IR I.A.5.b), I.B.5.b), II.A, and II.B)

Effective Date: July 20, 2022
Origination Date: February 2016

POLICY STATEMENT

The Accreditation Council for Graduate Medical Education (ACGME) requires that institutions sponsoring graduate medical education (GME) programs be led by a Designated Institutional Official (DIO), who, in collaboration with the Graduate Medical Education Committee (GMEC), has the authority and responsibility for the oversight and administration of the Sponsoring Institution's GME programs, as well as for ensuring compliance with ACGME Requirements (Institutional, Common, and specialty/subspecialty-specific).

Responsibilities of the DIO include:

- approve program letters of agreement (PLAs) that govern the relationship between each program and each participating site providing a required assignment for residents/fellows in the program
- oversee submissions of the Annual Update for each program and the Sponsoring Institution to the ACGME
- after GMEC approval, oversee the submission of applications for ACGME accreditation and recognition, requests for voluntary withdrawal of accreditation and recognition, and requests for changes in residency and fellowship program complements
- annually submit a written executive summary of the Annual Institutional Review (AIR) to TIGMER's Governing Body. The written executive summary must include a summary of institutional performance on indicators for the AIR and action plans and performance monitoring procedures resulting from the AIR

Institutional GME Infrastructure and Operations

- engaging in professional development applicable to responsibilities as an educational leader
- ensuring sufficient salary support and resources are provided for effective GME administration

Program Administration

- ensuring financial support and protected time for the program directors to effectively carry out educational, administrative, and leadership responsibilities, as described in the ACGME standards
- ensuring support for core faculty members to ensure both effective supervision and quality resident/fellow education
- ensuring support for professional development applicable to program directors' and core faculty members' responsibilities as educational leaders
- ensuring support and time for the program coordinator(s) to effectively carry out responsibilities

- ensuring resources, including space, technology, and supplies, to provide effective support for each of its ACGME-accredited programs

Participation in the Institutional governance of GME programs

- Maintain current knowledge of and compliance with TIGMER GME Policies
- Maintain current knowledge of and compliance with ACGME standards
- Participate as a voting member in GMEC
- Cooperate promptly with requests by the various regulatory bodies for information, documentation, etc.
- Maintain accurate and complete institutional GME files in compliance with ACGME and with institutional records retention policies
- Lead institutional involvement with the National Resident Matching Program (NRMP) Match and other match processes, Electronic Residency Application Service (ERAS), Texas Medical Board, the Texas Osteopathic Medical Association, and other entities
- Ensure sufficient financial support and protected time to effectively carry out educational, administrative, and leadership responsibilities

Continuity of GME Oversight

To ensure appropriate continuity of management of institutional GME endeavors and oversight of GME programs:

- If the DIO is not available to provide oversight, represent the GME programs, sign documentation related to accreditation, or other functions, the role will be filled by the Director of Graduate Medical Education.

- In the absence of both the DIO and Director of Graduate Medical Education, a member of the GME Executive Committee may be designated to fill the role.

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https://www.acgme.org/globalassets/pdfs/faq/ir_faqs.pdf

DEFINITIONS

Designated Institutional Official (DIO): The individual in a Sponsoring Institution who has the authority and responsibility for all that institution's ACGME-accredited program.

RELATED INFORMATION

GMEC Oversight (IR I.B.4)

Effective Date: July 20, 2022
Origination Date: February 2016

POLICY STATEMENT

GMEC responsibilities include oversight of:

- ACGME accreditation and recognition statuses of the Sponsoring Institution and each of its ACGME-accredited programs
- the quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites
- the quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty-specific Program Requirements the ACGME-accredited programs' annual program evaluations and Self-Studies
- ACGME-accredited programs' implementation of institutional policies for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence, at least annually
- all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution
- the provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided.

GMEC responsibilities include review and approval of:

- institutional GME policies and procedures
- GMEC subcommittee actions that address required GMEC responsibilities
- annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits
- applications for ACGME accreditation of new programs requests for permanent changes in resident/fellow complement
- major changes in each of its ACGME-accredited programs' structure or duration of education, including any change in the designation of a program's primary clinical site
- additions and deletions of each of its ACGME-accredited programs' participating sites
- appointment of new program directors
- progress reports requested by a Review Committee
- responses to Clinical Learning Environment Review (CLER) reports
- requests for exceptions to clinical and educational work hour requirements
- voluntary withdrawal of ACGME program accreditation or recognition
- requests for appeal of an adverse action by a Review Committee
- appeal presentations to an ACGME Appeals Panel

- exceptionally qualified candidates for resident/fellow appointments who do not satisfy the Sponsoring Institution's resident/fellow eligibility policy and/or resident/fellow eligibility requirements in the Common Program Requirements

It is the policy of the GMEC to maintain oversight of training programs by ensuring that programs include at least the following policies for review by residents and faculty members:

- Recruitment, selection, eligibility, and appointment of residents/fellows
- Promotion or, for a single year program - a completion policy
- Grievance and due process
- Promotion, appointment renewal, and dismissal
- Graded responsibility and supervisory lines of responsibility for patient care
- Clinical and educational hours including moonlighting

Programs are permitted to develop additional policies with approval of the GMEC that might aid in education or further explain processes to the residents.

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Annual Institutional Review (IR I.B.5)

Effective Date: July 20, 2022
Origination Date: February 2016

POLICY STATEMENT

The Graduate Medical Education Committee (GMEC) will appoint members of the Institutional Review Subcommittee on an annual basis to review the performance indicators and prepare the Annual Institutional Review (AIR) report for the GMEC.

Performance Indicators
The AIR will include, but not be limited to, the following performance indicators:

- Results of the most recent institutional self-study visit
- Most recent ACGME institutional letter of notification
- Results of ACGME surveys of residents/fellows and core faculty.
- ACGME accreditation information, including accreditation and recognition statuses and citations
- Results of most recent Clinical Learning Environment Review (CLER)

REASON FOR POLICY

This policy is to establish a process for TIGMER and to identify institutional performance indicators for the AIR and reporting and monitoring processes.

PROCEDURES

Report to GMEC

- The AIR is submitted to the GMEC.
- Any performance indicator found by the GMEC to be out of compliance will be monitored by the GMEC for progress. The frequency of the reporting shall be determined by the DIO based upon the nature of the noncompliant item(s).
- Should any item(s) need monitoring, the GMEC may charge the Subcommittee to conduct additional document review, develop objectives and/or corrective action plan, review citation correction progress, and/or conduct appropriate mentoring.
    - Recommendations of the Subcommittee shall be reported to the full GMEC for approval.
- The GMEC may stipulate additional monitoring procedures for action plans resulting from the Subcommittee's review.

Report Dissemination

- In accordance with the ACGME Institutional Requirements (I.B.5.c.), the DIO must submit a written annual executive summary of the AIR to the TIGMER Board of Directors

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RELATED INFORMATION

GME Special Review (IR I.B.6)

Effective Date: July 20, 2022
Origination Date: April 2018

POLICY STATEMENT

The Graduate Medical Education Committee (GMEC) must demonstrate effective oversight of underperforming programs through a Special Review process. The Special Review process must include a protocol that:

1. Establishes a variety of criteria for identifying underperformance that includes:

    a) program accreditation statuses of Initial Accreditation with Warning, Continued Accreditation with Warning, and adverse accreditation statuses as described by ACGME policies
    b) multiple citations (new or extended)
    c) an annual program evaluation review with deviations from expected results noted in standard performance indicators, as well as from the evaluation process itself
    d) program attrition in faculty or resident/fellow
    e) ACGME Resident/Fellow or Faculty Survey results demonstrating a) significant downward category trends since last survey; b) results at or below 80% in any category for two consecutive periods; and/or, c) results that necessitate review dependent upon severity. failure to implement or document outcomes in Milestones or competencies
    f) failure to submit a complete an annual program evaluation to GME or address other institutional administrative issues
    g) Board pass rates that do not meet the ACGME specialty-specific standards
    h) major changes in the curriculum or participating sites
    i) insufficient scholarly activity of resident/fellow or faculty
    j) not meeting case log/clinical experience minimums
    k) Inability to demonstrate success in the CLER focus areas
    l) Any indication of noncompliance with ACGME Requirements or TIGMER policies

2. Results in a timely report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes, including timelines.

REASON FOR POLICY

To ensure excellence in the educational quality and demonstrate effective oversight and monitoring of underperforming programs through a Special Review process under the auspices of the GMEC.

PROCEDURES

When a program is deemed to have met the established criteria for an underperforming program, the DIO shall schedule a special review within 60 days of its identification. (Note: Focused Special Reviews related to a specific area may be scheduled.)

Special Review
Each special review shall be conducted by a panel including at least one member of the GMEC who shall serve as chair of the panel, one additional GMEC member, and one resident/fellow. Additional reviewers may be included on the panel as determined by the GMEC/DIO. Panel members shall be from within the sponsoring institution but shall not be from the program being reviewed. Administrators from outside the program may also be included.

The chair of the special review panel, in coordination with the GMEC/DIO shall identify the concerns to be reviewed. These concerns may range from those that encompass the entire operation of the program to single, specific areas of interest. Based on the specific area of interest, the program may be asked to provide information and documentation prior to the review for the panel to understand the identified concern.

Focused Reviews When a program is deemed to have met the established criteria of an underperforming program for a second consecutive year, GME will schedule a Focused Special Review or request a progress report within 60 days of its identification.

Materials to be used in the special review process may include:

- The ACGME Requirements in effect at the time of the review.
- Most recent ACGME letters of notification.
- Previous annual program evaluations and ADS Annual Updates.
- Reports from previous focused or special review of the program.
- Results from internal or external resident/fellow and faculty surveys.
- Evaluations of resident/fellow and faculty performance.
- Materials for the programs' Clinical Competency Committee or Program Evaluation Committee.
- Any other materials the special review committee considers necessary and appropriate.
- The special review panel may conduct interviews with the program director and key faculty members. If resident/fellows are interviewed, at least one peer-selected Resident/Fellow from each level of training in the program will be interviewed, and other individuals deemed appropriate by the panel.

Special Review Report
The special review panel shall submit a written report to the DIO and GMEC that includes, at a minimum, a description of the review process and the findings and recommendations of the panel. These shall include a description of the quality improvement goals, any corrective actions designed to address the identified concerns and the process for GMEC monitoring of outcomes. The GMEC/DIO may, at its discretion, choose to modify the special review report before accepting a final version.

Monitoring of Outcomes
The DIO/GMEC shall monitor outcomes of the special review process, including actions taken by the program and/or by the institution with special attention to areas of GMEC oversight that includes progress reports, data collection, and review of accreditation results, surveys, and/or annual program evaluations. The process and follow-up discussion(s) will be documented in

GMEC minutes.

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RELATED INFORMATION

Well-Being, Fatigue Mitigation, and Behavioral Health (IR II.B.7 and IV.I.1; CPR VI.D.)

Effective Date: August 17, 2022
Origination Date: February 2016

POLICY STATEMENT

Well-Being

- Self-care is an important component of professionalism for residents and faculty. It is also a skill that must be learned and nurtured in the context of other aspects of residency training. TIGMER programs have the same responsibility to address well-being as they do to evaluate other aspects of resident competence. This responsibility must include:
    - efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships;
    - attention to scheduling, work intensity, and work compression that impacts resident well-being;
    - evaluating workplace safety data and addressing the safety of resident and faculty members;
    - policies and programs that encourage optimal resident and faculty member well-being; and,
        - Resident must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.
    - attention to resident and faculty member burnout, depression, and substance abuse. TIGMER residency programs must educate faculty members and resident in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Resident and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. TIGMER programs must:
        - encourage resident and faculty members to alert the program director, chief residents, attending or faculty member when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence;

        - provide access to appropriate tools for self-screening (resident and faculty may access the ACGME Tools and Resources for Resident and Faculty Member Well-Being); and,

        - provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week (*See Behavioral Health Section below*).

- There are circumstances in which resident may be unable to attend work, including but not limited to fatigue, illness, and family emergencies.

    - All TIGMER programs must have a policy and procedure in place that ensure coverage of patient care in the event that a resident or fellow may be unable to perform their patient care responsibilities.

    - These policies must be implemented without fear of negative consequences for the resident or fellow who is unable to provide the clinical work.

Program Responsibilities

Each program must:

- Educate all faculty members, residents, and fellows (hereinafter referred to as "residents") to recognize signs of fatigue and sleep deprivation. This must be done annually as part of the residents' curriculum and faculty development.

- Educate all faculty members and residents about alertness management and fatigue mitigation processes.

- Encourage residents to use fatigue mitigation processes such as strategic napping or turnover of care via back-up schedules, to manage the potential negative consequences on patient care and learning.

- Ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care responsibilities due to fatigue.

- Educate residents and faculty members about their professional responsibilities as physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.

- Ensure that residents and faculty members demonstrate an understanding of their roles in the management of their time before, during, and after assignments; recognize impairment, including illness, fatigue, and substance abuse, in themselves, their peers; and other members of the health care team; and submit accurate clinical and educational work hour reports.

- Monitor the demands of at-home call and adjust schedules to mitigate fatigue when applicable.

Institutional Responsibilities

- Each program, in partnership with its sponsoring institution must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.

- The GME Office offers a fatigue mitigation transportation option to help ensure residents arrive home safely when fatigued after work.

    - Reimbursement is available to any resident that elects to use a transportation service (app-based or taxi) to arrive home instead of driving their own vehicle while fatigued, as well as to pick up their car or return to work the next day.

    - In order to monitor the quality of the GME learning and working environment, use of this service will be monitored.

Behavioral Health

A TIGMER Resident or Fellow who wishes to seek confidential counseling services for themselves and/or their immediate family have access to the Employee Assistance Program through LifeWorks – MetLife.

Call 1-888-319-7819 anytime, 24 hours a day, seven days a week or visit and enter the following: https://metlifeeap.lifeworks.com

username: metlifeeap
Password: eap

In emergencies, the resident or fellow is encouraged to use the Emergency Department at their nearest hospital. At the Resident and Fellow Orientation, the process and policy for support services are reviewed. Program directors are advised to emphasize the same at their program's individual orientation.

Residents and fellows may self-refer to the Texas Physician Health Program (TXPHP) by calling 512-305-7462 or by visiting their website at https://www.txphp.state.tx.us/.The TXPHP can confidentially direct the resident or fellow to resources to assist those affected by substance use disorders (SUD), physical illnesses and impairment, and/or psychiatric conditions.

During orientation and at least annually thereafter, the GME administration will review options for confidential counseling services for all residents/fellows.

REASON FOR POLICY

This policy is required in accordance with Accreditation Council for Graduate Medical Education (ACGME) standards for resident well-being and fatigue mitigation to ensure continuity of patient care, patient safety, and resident safety.

The Sponsoring Institution must ensure that residents/fellows are provided with access to confidential counseling and behavioral health services.

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RELATED INFORMATION

- Transitions of Care/Handoffs Policy
- Resident Utilization of Rideshare Apps
- Learner Disability Assessment and Behavioral Health Evaluation Policy

Learner Disability Assessment and Behavioral Health Evaluation

Effective Date: August 17, 2022
Origination Date: February 2016

POLICY STATEMENT

It is recognized that residents/fellows in our GME programs may benefit from having a learner disability assessment and/or a behavioral health evaluation. This may include an assessment for attention deficit hyperactivity disorder (ADHD).

The costs associated with learner disability assessments and behavioral health evaluations are the responsibility of the resident/fellow. Some forms of assessment may be covered by health insurance.

When not covered by health insurance:

- The program may choose to share in the cost of the assessments if they determine it is in the best interest of the resident/fellow and the program to do so.
- If the assessment or evaluation is a condition of the resident's/fellow's appointment, then the cost of the assessment or evaluation is the responsibility of the program.

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RELATED INFORMATION

Transitions of Care/Handoffs (IR III.B.3; CPR VI.E.3)

Effective Date: August 17, 2022
Origination Date: February 2016

POLICY STATEMENT

Individual programs must design schedules and clinical assignments to maximize the learning experience for residents as well as to ensure quality care and patient safety and adhere to general institutional policies concerning transitions of patient care. Examples of strategies which have successfully minimized transitions include day/night teams, staggering of intern/resident/attending switch times and/or days to maintain continuity, outpatient clinic "pods" or teams, etc. All training programs must design call and shift schedules to minimize transitions in patient care. Schedule overlaps should include time to allow for face-to face handoffs to ensure availability of information and an opportunity to clarify issues.

REASON FOR POLICY

To establish protocol and standards within the TIGMER residency and fellowship programs to ensure residents function in an environment that supports resident wellbeing, minimizes work compression, and adheres to the ACGME work hour limits, thus ensuring the quality and safety of patient care when transfer of responsibility occurs related to work hour limits, shift changes and other scheduled or unexpected circumstances. To ensure an environment that maximizes communication, including the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in each program and the larger health system.

PROCEDURES

The transition/hand-off process should involve face-to-face interaction with both verbal and written/computerized communication, with opportunity for the receiver of the information to ask questions or clarify specific issues. The hand-off process may be conducted by telephone conversation. The transition process should include, at a minimum, the following information in a standardized format that is universal across all services:

1. Identification of patient, including name, medical record number, and date of birth
2. Identification of admitting/primary/supervising physician and contact information
3. Diagnosis and current status/condition (level of acuity) of patient
4. Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, and anticipated procedures and actions to be taken
5. Outstanding tasks – what needs to be completed in immediate future
6. Outstanding laboratories/studies – what needs follow up during shift
7. Changes in patient condition that may occur requiring interventions or contingency plans

The following is a list of elements that should be common to all hand-offs:

1. The creation of “to-do” lists
2. The use of “if-then” statements
3. The ability and expectation for the receiver of information to ask questions
4. “Read-back” at the end of a patient hand-off
5. Setting of expectations for when it is essential to move the hand-off to the patient’s bedside

Each residency program must develop components ancillary to the institutional transition of care policy that integrate specifics from their specialty field. Programs are required to develop scheduling and transition/hand-off procedures to ensure that:

1. Residents comply with specialty specific/institutional work hour requirements
2. Faculty are scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents
3. All parties involved in a particular program and/or transition process have access to one another’s schedules and contact information. All call schedules should be available on department-specific password- protected websites and also with the hospital operators.
4. Patients are not inconvenienced or endangered in any way by frequent transitions in their care
5. All parties directly involved in the patient’s care before, during, and after the transition have opportunity for communication, consultation, and clarification of information
6. Safeguards exist for coverage when unexpected changes in patient care may occur due to circumstances such as resident illness, fatigue, or emergency
7. Programs provide an opportunity for residents to both give and receive feedback from each other or faculty physicians about their handoff skills

Each program must include the transition of care process in its curriculum.

Residents must demonstrate competency in performance of this task. There are numerous mechanisms through which a program might elect to determine the competency of residents/fellows in handoff skills and communication. These include:

1. Direct observation of a handoff session by a supervisory level clinician by a peer or by a more senior trainee
2. Evaluation of written handoff materials by clinician or by a peer or by a more senior trainee
3. Didactic sessions on communication skills including in-person lectures, web-based training, review of curricular materials and/or knowledge assessment
4. Assessment of handoff quality in terms of ability to predict overnight events
5. Assessment of adverse events and relationship to sign-out quality through:
    a. Survey
    b. Reporting hotline
    c. Chart review

Programs must develop and utilize a method of monitoring the transition of care process and update as necessary. Monitoring of handoffs by the program to ensure:

1. There is a standardized process in place that is routinely followed
2. There is a consistent opportunity for questions
3. The necessary materials are available to support the handoff (including, for instance, written

sign-out materials, access to electronic clinical information)
4. A setting free of interruptions is consistently available, for handoff processes that include face-to-face communication
5. Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines

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A handoff is defined as the communication of information to support the transfer of care and responsibility for a patient/group of patients from one provider to another. Transitions of care are necessary in the hospital setting for various reasons. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another. Transition of care occurs regularly under the following conditions:

1. Change in level of patient care, including inpatient admission from an outpatient procedure or diagnostic area or ER and transfer to or from a critical care unit.
2. Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas
3. Discharge, including discharge to home or another facility such as skilled nursing care
4. Change in provider or service change, including change of shift for nurses, resident sign-out, and rotation changes for residents.

RELATED INFORMATION

Professionalism – Code of Conduct (IR III.B.6; CPR IV.B.1.a) and VI.B)

Effective Date: July 20, 2022
Origination Date: August 2017

POLICY STATEMENT

Residents are responsible for demonstrating and abiding with the following professionalism principles and guidelines.

Physicians must develop habits of conduct that are perceived by patients and peers as signs of trust. Every physician must demonstrate sensitivity, compassion, integrity, respect, professionalism, and maintain patient confidentiality and privacy. A patient's dignity and respect must always be maintained. Under all circumstances, response to patient needs shall supersede self-interest.

REASON FOR POLICY

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A medical professional consistently transmits respect for patients by his/her performance, behavior, attitude, and appearance. Commitment to carrying out professional responsibilities and an adherence to ethical principles are reflected in the following expected behaviors:

Respect patient privacy and confidentiality
- Knock on the door before entering a patient's room.
- Appropriately drape a patient during an examination.
- Do not discuss patient information in public areas, including elevators and cafeterias.
- Keep noise levels low, especially when patients are sleeping.

Respect patient self-autonomy and the right of a patient and a family to be involved in care decisions.
- Identify yourself and your professional level to patients and staff.
- Wear name tags that clearly identify names and roles.
- Take time to ensure patient and family understanding and informed consent of medical decisions and progress.

Respect the sanctity of the healing relationship.
- Exhibit compassion, integrity, and respect for others.
- Ensure continuity of care when a patient is discharged from a hospital by documenting who will provide that care and informing the patient of how that caregiver can be reached.

- Respond promptly to phone messages and pages.
- Provide reliable coverage through colleagues when not available.
- Maintain and promote physician/patient boundaries.

Respect individual patient concerns and perceptions,
- Comply with accepted standards of dress as defined by each institution
- Arrive promptly for patient appointments.
- Remain sensitive and responsive to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

Respect the systems in place to improve quality and safety of patient care.
- Complete all mandated on-line tutorials and public health measure (e.g., TB skin testing) within designated timeframe.
- Report all adverse events within at timely fashion.
- Improve systems and quality of care through critical self-examinations of care.
- Respect for peers and co-workers.
- Respect for colleagues is demonstrated by maintaining effective communication.
- Inform primary care providers of patient's admission, the hospital content and discharge plans.
- Provide consulting physicians all data needed to provide a consultation.

Patient's records must be accurate and legible. Timely and accurate completion of medical records according to specific guidelines of the affiliated institution at which the resident is rotating is mandatory.
- Maintain legible and up-to date medical records, including dictating discharge summaries within approved hospital guidelines.
- Inform all members of the care team, including non-physician professionals, of patient plans and progress.
- Provide continue verbal and written communication to referring physicians.
- Provide all appropriate supervision needed for those one is supervising, by informing and involving supervising faculty of any changes in patient status, and by providing informed and safe handoffs to colleagues who provide patient coverage.

Respect for the residency program.
- Provide leadership in improving the residency program for future residents/fellows.
- Provide constructive criticism focused on potential solutions to problems.
- Do not make derogatory comments about the program or program faculty.
- Assist with the creation of new or improved educational experiences when possible.

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Resident Utilization of Rideshare Apps (IR III.B.7.d).(3); CPR VI.D.3)

Effective Date: July 20, 2022
Origination Date: May 2019

POLICY STATEMENT

This policy is to provide safe transportation options for residents who may feel or be impaired by fatigue, due to rotation shift length and/or intensity, with a safe option for getting home.

Reimbursement is available to any resident that elects to use a transportation service (app-based or taxi) to arrive home instead of driving their own vehicle while fatigued, as well as to pick up their car or return to work the next day.

To monitor the quality of the GME learning and working environment, use of this service will be monitored.

REASON FOR POLICY

To protect the safety and wellbeing of all TIGMER residents, as well as the safety of the communities in which we serve, this policy serves as an option to prevent a fatigued/impaired resident from having to drive home.

PROCEDURES

- Rideshare and/or taxicabs should only be utilized by a resident if they are too tired to drive home from a shift.
- When using UBER, residents should limit the car selection to UBER X.
- If a rotation offers transportation (i.e., shuttle or bus), the resident should utilize the offered services. Rideshare and/or taxicab fees will not be reimbursed if the resident opts out of the offered services.
- Residents should submit all appropriate receipts to their residency coordinator to process the reimbursement of rideshare and/or taxicab fees.
- Rideshare and/or taxi cabs should NOT be used by a resident if their car is being repaired or for any other personal reasons.
- The destination is to be limited to your home address and the rideshare should not include personal stops (for example, grocery store, fast food, etc.).

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Resident/Fellow Appointments (IR IV.B; CPR III.)

Effective Date: July 20, 2022
Origination Date: February 2016

POLICY STATEMENT

In accordance with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements, the Sponsoring Institution must have a policy for resident recruitment, selection, eligibility, and appointment.

Preconditions

In addition to meeting all qualifications for resident/fellow eligibility described below, prior to starting the program, the resident must:

1. possess a valid Physician In Training permit from the Texas Medical Board.
    a. The resident will not be permitted to begin the program under any circumstances until the appropriate license has been obtained.
    b. The State of Texas grants the medical license for the length of the program with an automatic extension of fourteen (14) days at the end of the program.

2. undergo a criminal background check and meet all the requirements of University policies related thereto.

3. be eligible for employment according to applicable law and University policy. In the event the Resident is not a U.S. citizen, the Resident must provide, upon request of the University, proof of eligibility to participate in the residency program prior to beginning training, as prescribed by applicable immigration law.

4. comply with University policy requiring an initial health evaluation and with all immunizations/vaccinations.

5. if a renewal of a previous Resident Agreement, meet all the conditions of probation or advancement that may have been imposed on the Resident.

Eligibility

Residents:
Prior to their program start date program applicants must provide their program with documentation of the following qualifications to be eligible for appointment:

1. Graduation from a medical school in the United States, Canada, or Puerto Rico accredited by the Liaison Committee on Medical Education (LCME), OR
2. Graduation from a college of osteopathic medicine in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA), OR

3. Graduation from a medical school outside the United States, Canada, or Puerto Rico with one of the following:
    a. A currently valid certificate from the ECFMG, OR
    b. An unrestricted license or residency permit to practice medicine in Texas
4. Passing scores on Steps 1 and 2 (Clinical Knowledge and Clinical Skills) of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).
5. For those residents/fellows entering a program after a Transitional or Preliminary Year (PGY-1), a written or electronic verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.

Fellows:
In addition to the previous five requirements, fellowship program applicants must also provide their program with documentation of the following qualifications to be eligible for appointment:

1. Graduation from an ACGME-accredited residency program (Residents who temporarily suspend their residency training to take a subspecialty fellowship position do not have to provide a completion certificate); and
2. A passing score on Step 3 of the USMLE or COMLEX; and
3. A written or electronic verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.

Recruitment and Selection

TIGMER and its ACGME-accredited programs engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents and fellows.

1. Programs select from among eligible applicants utilizing a holistic review process for review of applications, that is based on their educational preparedness, ability, aptitude, academic credentials, communication skills and personal qualities such as motivation and integrity.

2. TIGMER does not discriminate with regard to sex, race, color, creed, religion, national origin, age, marital status, disability, public assistance status, veteran's status or sexual orientation.

3. TIGMER participates in the National Residency Matching Program (NRMP). Each accredited residency/fellowship program that participates in the NRMP Match will abide by the rules and regulations of the NRMP. Those programs using other Match programs will abide by their rules and regulations. The program director is responsible for verifying the eligibility of all candidates under serious consideration prior to the submission of rank order lists or other offer of a residency position.

    4. An applicant invited to interview for a resident/fellow position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of their appointment.

5. Interviews are granted to those applicants thought to possess the most appropriate qualifications, as determined by guidelines established by the program.

Appointment

1. An offer for residency training is extended directly to the applicant by the program director or their designee, through a letter of offer following the completion of The Match.

2. The GME Office will ensure that residents/fellows are provided with a written agreement of appointment/contract outlining the terms and conditions of their appointment to a program. Immediately following receipt of the results of The Match or the acceptance of an offer for residency training, the program director is responsible for notifying the Graduate Medical Education Office of all candidates accepted and providing a copy of the following:

    - Copy of medical school diploma
    - Documentation of any previous graduate medical education training
    - Copy of ECFMG certificate, if applicable

Trainee Transfers

In accordance with the ACGME's Common Program Requirements prior to accepting a trainee from another residency or fellowship program the program director must obtain the following:

1. Written or electronic verification of previous educational experiences and a summative competency-based performance evaluation prior to the acceptance of the transferring resident.

2. Milestone evaluations upon matriculation.

3. Proof that they have passed the USMLE Step 3 or COMLEX for PGY-3 residents or higher.

REASON FOR POLICY

To outline specific qualifications required for eligibility and selection of residents/fellows (residents/fellows) entering a TIGMER Graduate Medical Education training program.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

Program Responsibilities
Monitoring and compliance of the eligibility requirements is expected at the Program Level.

FAQ

DEFINITIONS

RELATED INFORMATION

- National Residency Matching Program (NRMP): https://www.nrmp.org/
- ACGME Common Program Requirements: https://www.acgme.org/what-we-do/accreditation/common-program-requirements/
- Texas Medical Board – Physician in Training Permit: https://www.tmb.state.tx.us/page/pit-overview
- UIW Non-Discrimination Policy: https://my.uiw.edu/hr/non-discrimination.html

Licensing Examinations (IR IV.B; CPR III.A)

Effective Date: July 20, 2022
Origination Date: May 2019

POLICY STATEMENT

The program, in collaboration with the Clinical Competency Committee (CCC) must verify that a resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice upon completion of the program.

A key component of autonomous practice is evidenced by the successful completion of medical licensing examinations, including the United States Medical Licensing Examination (USMLE) Step 3 examination or the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 3 examination.

All residents should successfully complete and pass the USMLE Step 3 examination or the COMLEX Level 3 examination, prior to the mid-point of the second post-graduate year (PGY-2). Failure to demonstrate passage within the stated timeline may result in a disciplinary action or non-renewal or termination from the training program at the end of the academic year. Programs may develop their own program-specific policies to accommodate the specialty's needs.

REASON FOR POLICY

Texas statute requires passage of a licensure examination within three attempts to ensure that residents enrolled in graduate medical education training programs meet eligibility requirements to obtain a Full Texas Medical License, beyond the level of the Physician In Training License.

PROCEDURES

Programs must monitor completion and passage of the USMLE Step 3 or COMLEX Level 3 examinations.

The CCC must determine if a corrective action is warranted. In the event of a corrective action, the DIO must review the documentation prior to the program director/resident meeting.

In the event of a dismissal/termination, the Texas Medical Board must be notified.

- Board rule §171.5 states in part that each PIT holder shall report in writing to the Executive Director of the Board, the following events within 30 days of their occurrence:(1) the opening of an investigation or disciplinary action taken against the PIT holder by any licensing entity other than the TMB§171.6. Duties of Program Directors to Report: The director of each approved postgraduate training program shall

report in writing to the executive director of the board the following circumstances within 30 days of the director's knowledge for all participants completing postgraduate training:

(7) if the program has requested termination or terminated the physician from the program, requested or accepted withdrawal of the physician from the program, or requested or accepted resignation of the physician from the program and the action is final.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

The USMLE Step 3 examination assesses whether you can apply medical knowledge and understanding of biomedical and clinical science essential for the unsupervised practice of medicine, with emphasis on patient management in ambulatory settings. It is the final examination in the USMLE sequence leading to a license to practice medicine without supervision. Step 3 provides a final assessment of physicians assuming independent responsibility for delivering general medical care.

The COMLEX-USA is a three-level, national standardized licensure examination designed for licensure for the practice of osteopathic medicine. The COMLEX-USA Examination Series is designed to assess osteopathic medical knowledge, knowledge fluency, clinical skills, and other competencies essential for practice as an osteopathic generalist physician. It is also a requirement for promotion within graduate medical education training programs.

RELATED INFORMATION

https://www.tmb.state.tx.us/page/physicians-are-you-eligible
https://www.usmle.org/step-exams/step-3
https://www.nbome.org/assessments/comlex-usa/comlex-usa-level-3/

Resident/Fellow Agreement (Contract) (IR IV.C, IV.D, IV.M)

Effective Date: September 21, 2022
Origination Date: February 2016

POLICY STATEMENT

The Resident Agreement is a required, binding contract between the resident/fellow and TIGMER. The effective date of the initial agreement is the first mandatory date the resident/fellow is required to report to their GME training program.

Issuance of Agreement

The program will prepare a written Resident Agreement, outlining the terms and conditions of the resident's appointment to a program The Resident Agreement will directly contain or provide a reference to the following items:

- resident responsibilities;
- duration of appointment;
- financial support for residents;
- conditions for reappointment and promotion to a subsequent PGY level;
- grievance and due process;
- professional liability insurance, including a summary of pertinent information regarding coverage;
- health insurance benefits for residents and their eligible dependents;
- disability insurance for residents;
- vacation, sick, and leaves of absence for residents, including medical, parental, and caregiver leaves of absence, and compliant with applicable laws;
- timely notice of the effect of leave(s) on the ability of residents to satisfy requirements for program completion;
- information related to eligibility for specialty board examinations; and,
- institutional policies and procedures regarding resident clinical and educational work hours and moonlighting.

Execution of Agreement

The GME Office will issue all Resident Agreements and monitor the implementation of terms and conditions of appointment.

The Resident Agreement is executed once all the following signatures are obtained:

- The Resident or Resident Candidate
- The Program Director
- TIGMER Designated Institutional Official
- Dean, University of the Incarnate Word School of Osteopathic Medicine
- CFO / VP for Administrative Services

Matriculation

Each resident will be considered as enrolled based on the starting date of the fully executed Resident Agreement. If a resident is unable to begin training on the date indicated in the Resident Agreement due to a failure to meet all the preconditions of employment, a Match waiver may be requested. A new Agreement will be issued when the resident has provided documentation that all the preconditions have been met.

Withdrawal of Resident Agreement Offer

Resident Candidates: The Program Director will request a Match waiver and withdraw an offer at any time prior to the commencement date of that Agreement if the Program Director finds that the resident has misrepresented themself in any way during the application/interview process (including without limit, providing false or misleading information or failing to provide relevant information). If the Program Director withdraws an offer before the Agreement has been signed by all parties as described above, the resident shall have no rights to appeal that decision.

Current Residents: The Program Director may withdraw an offer based on a resident's performance (failure to meet the program standards or requirements) at any time prior to the new agreement date. If the Program Director withdraws an offer before the Agreement has been signed by all parties as described above, the resident shall be entitled to due process as set forth in the Grievances and Appeals Policy.

Advancement/Promotion

The program director, along with the Clinical Competency Committee, must determine the criteria for promotion and/or renewal of a resident’s appointment. The program director must provide documentation to the GME Office that a resident on probation has fulfilled the requirements specified in the corrective action plan before the resident will be extended a resident agreement for advancement to the next level of training.

Due Process

The program must notify the GME Office and provide a resident with a written notice of intent when that resident’s agreement will not be renewed, when that resident will not be promoted to the next level of training, or when that resident will be dismissed. The resident shall have the right to appeal the non-renewal, non-promotion, or dismissal in the manner set forth in the Grievances and Appeals Policy, regardless of when the action is taken during the appointment period.

Resident Resignation

Any resident wishing to resign must submit a written request for release from the remaining term of their agreement to their Program Director. The Program Director has the right to delay or specify the actual termination date to ensure coverage of services. The resident training will terminate on the date agreed to by the Program Director. In such instance, no further pay or benefit will be owed to the resident. The paycheck will be issued at the next regular pay period, provided the resident has completed the human resources clearance process.

Declining to Sign the Resident Agreement

A resident may choose to decline to renew an offered Agreement for the following year by not signing and returning the Agreement. The resident will remain in good standing during the remainder of the current agreement without prejudice and will perform the usual resident functions until the end of the term of the agreement.

Non-competition

Neither TIGMER nor any of its Accreditation Council for Graduate Medical Education (ACGME) accredited programs will require a resident to sign a non-competition guarantee or restrictive covenant.

REASON FOR POLICY

The ACGME requires that the Sponsoring Institution ensure that residents/fellows are provided with a written agreement of appointment/contract outlining the terms and conditions of their appointment to a program.

PROCEDURES

The agreement template is reviewed annually by GME Administration in collaboration with the Office of the General Counsel. GME Administration presents recommended revisions to the Graduate Medical Education Committee (GMEC) for their review, discussion, and approval.

GME Administration ensures that each Resident Agreement is fully executed (all parties have signed and dated it) prior to the effective date.

Presuming the original agreement with all required signatures and dates is scanned and saved in New Innovations, the paper copy may be destroyed. The scanned copy becomes the official agreement.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Resident/Fellow Promotion, Appointment Renewal, and Dismissal and Due Process (IR IV.D.)

Effective Date: September 21, 2022
Origination Date: February 2016

POLICY STATEMENT

Misconduct, failure to comply with the policies and procedures governing the program, or unsatisfactory performance based on one or more evaluations may adversely affect the residents/fellows standing in the program.

After satisfactory completion of each year of GME experience, as attested to by the program director, a resident/fellow in good standing may be promoted to the next level of training subject to the terms, limitations, and conditions described in this document and the Resident Agreement.

The program director, along with the Clinical Competency Committee (CCC), must determine the criteria for promotion and/or renewal of a resident's/fellow's appointment. These criteria may include but are not limited to:

1. satisfactory completion of all training requirements
2. satisfactory trainee performance
3. documented competence and Milestone achievement commensurate with level of training
4. successful completion and passing of the USMLE Step 3, COMLEX-USA Level 3 prior to entering the PGY-3 level
5. full compliance with all terms of the Resident Agreement

Due Process

The program must notify the GME Office and provide a resident with a written notice of intent when that resident's agreement will not be renewed, when that resident will not be promoted to the next level of training, or when that resident will be dismissed. The resident shall have the right to appeal the non-renewal, non-promotion, or dismissal in the manner set forth in the Grievances and Appeals Policy, regardless of when the action is taken during the appointment period.

REASON FOR POLICY

In accordance with ACGME Institutional Requirements, TIGMER must have a policy that requires each of its ACGME-accredited programs to determine the criteria for promotion, renewal of a resident's/fellow's appointment, and dismissal.

Each training program is structured to ensure that residents/fellows assume increasing levels of responsibility commensurate with individual progress in experience, skill, knowledge, and

judgment.

The term of the TIGMER Resident Agreement is one year. However, candidates accepting appointments have an expectation that they will be allowed to complete their training having shown satisfactory progress in meeting the training requirements of their program. This policy outlines the criteria to consider when promoting residents/fellows to the next level.

PROCEDURES

The GME Office will ensure that each of its programs provides a resident/fellow with a written notice of intent when that resident's/fellow's agreement will not be renewed, when that resident/fellow will not be promoted to the next level of training, or when that resident/fellow will be dismissed.

The program director must provide documentation to the GME Office that a resident/fellow on probation has fulfilled the requirements specified in the corrective action plan before they will be extended a resident agreement for advancement to the next level of training.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Disciplinary and Corrective Actions (IR IV.D.1.b))

Effective Date: September 21, 2022
Origination Date: September 2020

POLICY STATEMENT

The decision for probation, suspension, non-renewal, non-promotion, and dismissal of residents in TIGMER ACGME-accredited programs is the primary responsibility of the Program Director along with the Clinical Competency Committee (CCC) and shall follow the guidelines listed below. The administrative action imposed shall be based on individual circumstances and will not necessarily follow the sequential order in which they are presented and described below. A resident involved in any of the actions of probation, suspension, non-renewal, non-promotion, or dismissal has the right to appeal according to the TIGMER Grievance and Appeals Policy.

REASON FOR POLICY

In accordance with ACGME Institutional Requirements, sponsoring institutions are required to have policies addressing resident performance, promotion/advancement, and conditions of reappointment, including non-renewal and dismissal.

PROCEDURES

Each program must clearly define and establish the standards of academic performance, evaluation criteria, and criteria for advancement based on the principles of graduated responsibility and achievement of milestones. The CCC will evaluate each resident's progress in attaining the advancement criteria and achieving milestones as defined by the ACGME and the program. The CCC will also address performance and behavioral concerns that may arise in connection with the residency.

The following are levels of disciplinary and corrective actions, each of which shall be presented to the resident in writing, unless otherwise stated:

Disciplinary Actions

Resident Counseling (verbal or in writing): Resident is counseled by the Program Director in an effort to eliminate possible misunderstandings and to explain what constitutes proper conduct or acceptable work and/or academic performance.

Written Warning
If the resident's performance has not improved following a Resident Counseling or if the circumstances are such that a Written Warning is appropriate, a Written Warning shall be issued. With input from the Clinical Competency Committee, the Written Warning shall detail the

situation, the remedy required of the resident, and the consequences of not correcting the problem. A copy of the letter will be placed in the resident's file.

Corrective Actions

The program director must notify the Designated Institutional Official (DIO) in writing if they intend to issue a resident a corrective action.

A resident may be placed on probation, suspended, or dismissed by the Program Director and the program's CCC for reasons including, but not limited to, any of the following:

1. Failure to meet the academic performance standards of an individual rotation.
2. Failure to meet the academic performance standards of the program.
3. Failure to meet the metrics and/or outcome of the Performance Improvement Plan.
4. Failure to conform to the terms of the Resident Agreement and/or comply with the policies and procedures of the program, TIGMER, UIW, or one of the participating sites of the program.
5. Misconduct that infringes on the principles and guidelines set forth by the training program.
6. Documented and recurrent failure to complete medical records in a timely and appropriate manner.
7. When reasonably documented professional, illegal, or unethical misconduct concerns are made known to TIGMER, the Program Director, or the program's CCC which bear on the resident's fitness to participate in the training program.
8. Performance and behavior which compromise the welfare of patients, self, or others.
9. Inability of the resident to pass the requisite examinations as indicated in the Medical Licensing Policy.
10. Failure to comply with federal, state, and local laws whether or not related to the medical profession.
11. Failure to provide patient care of satisfactory quality expected for the resident's training level.
12. Fraud by commission or omission in application for the residency position, or in completing other official TIGMER documents.
13. Suspension, revocation, or any other inactivation, voluntary or not, of a resident's license by the Texas Medical Board (TMB) for any reason.
14. Continued or lengthy absence from work assignments without reasonable excuse.
15. Failure to perform the normal and customary services of a resident as defined by the accrediting body.
16. Sexual harassment or abuse.

When a resident is issued a corrective action, the program director shall notify the resident in writing. Except in the case of dismissal, the written notice will include a Performance Improvement Plan with:

1. Reason(s) for the action.
2. Date the corrective action becomes effective and the term of the corrective action.
    a. Length of time in which the resident must correct the deficiency or problem.
    b. Failure to correct the infraction(s) in the period specified may lead to further corrective action, including dismissal/termination.
3. Specific remedial metrics and/or outcomes which the resident will be required to meet.

4. Consequences of non-compliance with the terms of the corrective action.
5. Activities of the program in which the resident may and may not participate.
6. Whether or not the resident is required to spend additional time in training to compensate for the corrective action period and be eligible for certification for a full training year.

A final copy of the letter shall be forwarded to the DIO.

The corrective action will be removed when the initiating reason has been corrected to the satisfaction of the program director and DIO.

The resident shall have the right to appeal the following Corrective Actions in the manner set forth in the Grievances and Appeals Policy.

Probation

1. If the length of Probation is greater than one month, the Program Director and resident shall notify the TMB.
2. Following evaluation of the resident's compliance with the terms of the probation set out in the Performance Improvement Plan as determined by the CCC, a resident may be:
    a. Continued on Probation
    b. Removed from probation and restored to good standing
    c. Placed on suspension
    d. Non-renewal of resident's contract (see "Dismissal" section)
    e. Dismissed from the residency program

Suspension

1. During the suspension, the resident will be placed on "administrative leave", with or without pay as appropriate depending on the circumstances. The program director and resident must notify the TMB of this action within 30 days.
2. At any time during or after the Suspension, resident may be:
    a. Reinstated with no qualifications
    b. Reinstated on probation
    c. Continued on suspension
    d. Dismissed from the program

Dismissal

Dismissal is the removal of a resident from a training program even though the resident holds a current Resident Agreement.

1. Dismissal can occur at any time without notification in instances of gross misconduct or unsatisfactory performance, including, but not limited to, theft of money or property, physical violence directed at an employee, visitor, or patient; use of, or being under the influence of, alcohol or controlled substances while on duty; patient endangerment; illegal conduct.
2. When a resident is dismissed, the Program Director shall provide the resident with a written letter of dismissal stating the reason for the action and the date the dismissal becomes effective.

3. The PD and resident must notify the TMB of the final action.

Non-promotion and Non-renewal

In instances when a resident will not be promoted to the next level of training or where a resident's agreement will not be renewed, the program director must notify the DIO and provide the resident with written notice at the earliest reasonable date prior to the end of the current contract.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

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DEFINITIONS

Good Standing: A trainee whose performance conforms to established evaluation criteria in a consistent and satisfactory manner will be considered to be in "good standing" with the program and institution.

RELATED INFORMATION

Grievances and Appeals (IR IV.E)

Effective Date: October 19, 2022
Origination Date: February 2016

POLICY STATEMENT

The procedure to appeal probation, general suspension, non-promotion, non-renewal of resident agreement, and termination/dismissal shall be the only means available to all TIGMER residents, to challenge corrective actions levied during their graduate medical education training.

The Graduate Medical Education Committee (GMEC) serves as the appeals body for all residents in programs sponsored by TIGMER, independent of their funding source, for dismissal or nonrenewal, or other actions that could significantly threaten a resident's intended career development, including non-promotion to a subsequent PGY level.

Formal Grievance Procedure - If a resident is to be placed on probationary status, suspended, dismissed, their training agreement not renewed, or not promoted to a subsequent PGY level, the resident may initiate a formal grievance procedure. The resident shall present the grievance in writing to the DIO within 30 working days after the date of notification of proposed corrective action. The grievance shall state the facts upon which the grievance is based and requested remedy sought. The DIO or designee shall respond to the grievance with a written answer no later than 15 working days after they received it. If the resident is not satisfied with the response, they may then submit, within 15 working days of receipt of the DIO's response, a written request for a hearing.

Hearing - The hearing procedure will be coordinated by the DIO or designee, who will preside at the hearing, but will not be a voting participant. The hearing will be scheduled within 30 working days of the resident's request for a hearing. The hearing panel will consist of at least three members of the GMEC. The DIO will determine the time and site of the hearing in consultation with the resident and program leadership. The resident shall have a right to self-obtained legal counsel at the resident's own expense; however, retained counsel may not actively participate or speak before the hearing participants, nor perform cross-examination.

The format of the hearing will include a presentation by the program director or the Chair of the Clinical Competency Committee (CCC); an opportunity for a presentation of equal length by the resident; an opportunity for response by the program representative, followed by a response of equal length by the resident. This will be followed by a period of questioning by the hearing panel. The DIO in consultation with the program representative and the resident will determine the duration of the presentations and the potential attendees at the hearing.

The resident will have a right to request documents for presentation at the hearing and the participation of witnesses. The DIO at their discretion will invite the latter, following consultation with the hearing panel. A final decision will be made by a majority vote of the hearing panel and will be communicated to the resident within 10 working days after the hearing. This process will represent the final appeal within TIGMER and its affiliated hospitals.

REASON FOR POLICY

The Accreditation Council for Graduate Medical Education (ACGME) requires that sponsoring institutions provide fair and reasonable written institutional policies and procedures for grievance and due process, which may be utilized when academic or other disciplinary actions taken against residents could result in dismissal, non-renewal of a resident's agreement or other actions that could significantly threaten a resident's intended career development, including non-promotion to a subsequent PGY level.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Professional Liability Insurance (IR IV.F)

Effective Date: August 17, 2022
Origination Date: February 2016

POLICY STATEMENT

All residents are provided with professional liability (malpractice) insurance coverage for claims arising during their training. Moonlighting is not covered.

Evidence of coverage will be furnished upon written request. Each resident is covered on the effective date of appointment. Coverage expires at termination of appointment. Residents, upon becoming aware of an actual or alleged claim, must immediately advise their Program Director, DIO, and the hospital risk manager.

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

Moonlighting is defined as voluntary, compensated, medically related work performed beyond a resident's or fellow's clinical experience and education hours and additional to the work required for successful completion of the program.

External moonlighting is defined as voluntary, compensated, medically related work performed outside the site where the resident or fellow is in training and any of its related participating sites.

Internal moonlighting is defined as voluntary, compensated, medically related work performed within the site where the resident or fellow is in training or at any of its related participating sites

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RELATED INFORMATION

Resident Salary and Benefits (IR IV.G.1)

Effective Date: September 30, 2022
Origination Date: February 2016

POLICY STATEMENT

Benefits

Current information on salary, benefits, and educational stipend amounts will be posted on the website annually.

Current information on benefits is posted on the University of the Incarnate Word Human Resources website https://my.uiw.edu/hr/employee-handbook.html

Vacation and Sick Leave

Residents receive 15 paid vacation days and 10 paid sick leave days total per contract period. Vacation and Sick Leave are requests that require the Program Director's approval. Unused Vacation and Sick Leave do not accrue and expire at the end of each contract period.

Holiday Leave

Holiday scheduling for residents/fellows is rotation-specific by program. The educational requirements and the 24-hour operational needs of the hospital are taken into consideration when scheduling holiday time off.

Medical, Parental, and Caregiver Leave(s) of Absence

Residents/fellows will be provided with a minimum of six weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program, starting the day the resident/fellow is required to report.

- Residents/fellows will be provided with 100 percent of their salary for the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken.
    - Residents/fellows must first use any available sick and vacation time at the outset of leave under this Medical, Caretaker, and Parental Leave provision.
    - While such paid leave is limited to six weeks, residents/fellows may be eligible for additional, unpaid leave under FMLA or other unpaid leave policies. (See UIW Employee Handbook Section 4.7 – Medical Leave of Absence and Section 4.8 – Family and Medical Leave.)
- Residents/fellows will be provided with a minimum of one week of paid time off reserved for use outside of the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken during the contract period in which the leave is taken.
- Continuation of health and disability insurance benefits will be ensured for residents/fellows and their eligible dependents during any approved medical, parental, or caregiver leave(s) of absence.

Other Types of Leave

Bereavement Leave

- A resident/fellow shall be granted, upon request to the program director, up to 5 days off to attend the funeral of an immediate family member.

- See UIW Employee Handbook Section 4.3 – Bereavement Leave

Military Leave

- The resident/fellow must notify the program as soon as they are called to active military duty. It is incumbent upon the Program Director to notify both the individual Review Committee and the appropriate medical specialty Board of this change in status.

- See UIW Employee Handbook Section 4.12 – Military Leave

REASON FOR POLICY

The Accreditation Council for Graduate Medical Education (ACGME) requires that the Sponsoring Institution, in partnership with its ACGME-accredited programs and participating sites, provide all residents/fellows with financial support and benefits to ensure that they are able to fulfill the responsibilities of their ACGME-accredited programs.

PROCEDURES

The program is responsible for defining and communicating the following items, including but not limited to:

- The vacation and sick leave policy.
- The process for requesting time off.

Programs are responsible for tracking time off for all leaves to ensure that residents are provided with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's/fellow's eligibility to participate in examinations by the relevant certifying board(s).

Programs must work with their residents/fellows to report all leaves in the Residency Management Suite (RMS) according to instructions received by Human Resources. Programs must also forward documentation to HR for leaves that extend the trainee's time in the program.

Leaves of Absence

Resident/Fellow must check with their program to determine:

- the type of paperwork that needs to be completed;
- if you qualify for Family Medical Leave Act (FMLA) and how it will be managed;
- how your pay will be impacted;
- how your benefits need to be coordinated; and,

- if your leave will extend your time in the program

Please see your Program Manual for specific departmental policies and procedures.

FORMS/INSTRUCTIONS

https://my.uiw.edu/hr/employee-handbook.html

RESPONSIBILITIES

FAQ

DEFINITIONS

- “Vacation” is defined as time off for a vacation or personal time.
- “Sick Leave” is defined as time off for personal or family illness.
- “Immediate Family” is defined as husband, wife, father, father-in-law, mother, mother-in-law, son, daughter, brother, sister, grandfather, or grandmother.

RELATED INFORMATION

Resident Supervision (IR IV.J; CPR VI.A.2)

Effective Date: August 17, 2022
Origination Date: February 2016

POLICY STATEMENT

There must be sufficient institutional oversight to ensure that residents/fellows are supervised in a manner that provides graded authority and responsibility according to their level of education, proven ability, and experience. On call schedules for teaching faculty must be structured to ensure that supervision is readily available to residents/fellows on duty.

Resident Progressive Authority and Conditional Independence

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

The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.

Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.

Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

REASON FOR POLICY

This policy delineates the roles and responsibilities of the residents/fellows, program directors, faculty members, and Graduate Medical Education Committee (GMEC) to ensure that each resident/fellow participating in a TIGMER graduate medical education program is adequately supervised.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

PROGRAM RESPONSIBILITY

It is the responsibility of program directors to establish detailed written program-specific policies describing trainee supervision at each level. The policies must be maintained in the Program Manual.

The requirements for on-site supervision will be established by the program director for each residency/fellowship in accordance with ACGME requirements and should be monitored through periodic department reviews, with institutional oversight.

The program director must monitor resident supervision at all participating sites.

Programs should establish policies that support Effective Supervisor Behaviors, see related information.

Set clear expectations

- When to call
- Situations in which residents/fellows should always call
- How to call – provide accurate pager/phone numbers
- Residents/fellows' role in the care of the patient

Create a safe learning environment

- Reassure the trainee that it is always appropriate to call if uncertain
- Recognize and address uncertainty in the resident/fellow

Be readily available

- Answer pages and phone calls promptly
- Planned communication (schedule times for calls)

Balance supervision with resident/fellow autonomy.

- Provide input but don't take over the case
- Be respectful
- Be patient with the trainee regardless of time of day
- Don't yell at or belittle a resident/fellow

FAQ

DEFINITIONS

- Direct Supervision
    - the supervising physician is physically present with the resident/fellow during the key portions of the patient interaction
    - the supervising physician and/or patient is not physically present with the resident

and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology

- Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision
- Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after the care is delivered

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RELATED INFORMATION

Effective Resident/Fellow Behaviors

- Trainee may request the physical presence of an attending at any time and is never to be refused
- Know and follow your program's policies for when you must always contact supervisor
- If you are uncertain…call your supervisor
- If a patient has a change in status…call your supervisor
- Present data to supervisor accurately. If you omitted part of the exam let them know
- Provide feedback to supervisor regarding what was helpful

Clinical and Educational Work Hours (IR IV.K; CPR VI.F.)

Effective Date: August 17, 2022
Origination Date: February 2016

POLICY STATEMENT

All programs are required to adhere to and monitor compliance of their residents/fellows with the ACGME work hour standards as outlined in the revised ACGME Common Program Requirements. Programs must also follow the program-specific guidelines as outlined by their individual Review Committees. The sponsoring institution monitors program's adherence to the work hour requirements through regular review of work hour violations in RMS, the Special Review process as well as annual review of program manuals to ensure the proper policies are in place.

REASON FOR POLICY

To outline the revised ACGME work hour requirements and the responsibilities of the residents/fellows, the programs, and the sponsoring institution.

PROCEDURES

Duty Hours
Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care; time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

Maximum Hours of Clinical and Educational Work per Week

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

Mandatory Time Free of Clinical Work and Education

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

- Residents should 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 hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.

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

- Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Clinical Work and Education Period Length

- 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.

Clinical and Educational Work Hour Exceptions

- In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

    - to continue to provide care to a single severely ill or unstable patient;
    - humanistic attention to the needs of a patient or family; or,
    - to attend unique educational events.

- These additional hours of care or education will be counted toward the 80-hour weekly limit.

Moonlighting (see separate Moonlighting Policy)

- PGY-1 residents are not permitted to moonlight
- Moonlighting must not interfere with the ability of a trainees to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety.
- Time spent by trainees in internal and external moonlighting must be counted towards the 80-hour maximum weekly limit

In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.

Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night when averaged over a four-week period.

At-Home Call

- Time spent on patient care activities by residents on at-home call must count towards the 80-hour maximum week limit. The frequency of at-home call is not subject to the 'every third night' limitation, but must satisfy the requirement for one-in-seven free of clinical work and education when averaged over a four- week period.
    - At home call must not be so frequent or taxing to preclude rest or reasonable personal time for each resident
- 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 patient care must be included in the 80-hour maximum weekly limit.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

Oversight

Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident clinical and educational work hours, including moonlighting, and to that end, must:

1. distribute these policies and procedures to the residents and faculty.

2. monitor resident clinical and educational work hours with a frequency sufficient to ensure compliance with ACGME requirements;

3. adjust schedules as necessary to mitigate excessive service demands and/or fatigue;

4. if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue;

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

Recording and Reporting Work Hours
Residents must report their clinical and educational work hours, including clinical work done from home and all moonlighting, at least once per week in the residency management suite (New Innovations).

The Program Director will monitor the compliance summary reports and will take necessary corrective action when compliance issues are reported.

Reporting Duty Hour Violations
Residents/fellows concerned about continuous work hour violations by their program can contact the Designated Institutional Official.

FAQ

DEFINITIONS

Clinical and educational work hours: All clinical and academic activities related to the program: patient care (inpatient and outpatient); administrative duties relative to patient care; the provision for transfer of patient care; time spent on in-house call; time spent on clinical work done from home; and other scheduled activities, such as conferences. These hours do not include reading, studying, research done from home, and preparation for future cases

Moonlighting is defined as voluntary, compensated, medically related work performed beyond a resident's or fellow's clinical experience and education hours and additional to the work required for successful completion of the program.

External moonlighting is defined as voluntary, compensated, medically related work performed outside the site where the resident or fellow is in training and any of its related participating sites.

Internal moonlighting is defined as voluntary, compensated, medically related work performed within the site where the resident or fellow is in training or at any of its related participating sites

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RELATED INFORMATION

1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.
2. The learning objectives of the program must be accomplished without excessive reliance on residents to fulfill non-physician obligations.
3. Didactic and clinical education must have priority in the allotment of residents' time and energy.
4. Work hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

Moonlighting (IR IV.K.1; CPR VI.F.5)

Effective Date: August 17, 2022
Origination Date: June 2017

POLICY STATEMENT

Although residency education is considered a full-time endeavor, moonlighting by residents may be allowed under the following conditions:

- Resident must be in good standing with the program, without probation, suspension, or having outstanding medical records.
- Resident must have an In-training composite performance score at the 25th percentile or higher for their year level.
- Resident must have completed at least 12 months of post-graduate training with a TIGMER training program.
- Resident must have a current, full Texas medical license and DEA number.
- Resident must obtain written permission by the Program Director.
- Resident understands the TIGMER liability coverage will not be extended to cover moonlighting activities of the resident that fall outside the course and scope of the individual's residency appointment.

Moonlighting guidelines:

- Maximum of 24 hours per f4-week block for a "call" rotation
- Maximum of 48 hours per 4-week block for a "non call" rotation
- A 12-hour shift cannot be a night shift proceeding a regular workday or following a night on-call
- All moonlighting hours must be documented in New Innovations
- The total number of hours worked per week (including residency rotations and all moonlighting time) cannot exceed 80 hours, per ACGME rules.

In the event a resident is given permission to moonlight, the program director will monitor the resident's performance for the effect of these activities upon performance in the trainee's program. Should moonlighting interfere with the ability of the resident to achieve the goals and objectives of the residency program, the program director may withdraw permission allowing the resident to engage in professional activities outside the training program.

Violation of the above rules and guidelines may result in loss of moonlighting privileges and disciplinary action against the resident.

REASON FOR POLICY

In accordance with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements, the Sponsoring Institution must maintain a policy on moonlighting.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

Clinical and educational work hours: All clinical and academic activities related to the program: patient care (inpatient and outpatient); administrative duties relative to patient care; the provision for transfer of patient care; time spent on in-house call; time spent on clinical work done from home; and other scheduled activities, such as conferences. These hours do not include reading, studying, research done from home, and preparation for future cases

Moonlighting is defined as voluntary, compensated, medically related work performed beyond a resident's or fellow's clinical experience and education hours and additional to the work required for successful completion of the program.

External moonlighting is defined as voluntary, compensated, medically related work performed outside the site where the resident or fellow is in training and any of its related participating sites.

Internal moonlighting is defined as voluntary, compensated, medically related work performed within the site where the resident or fellow is in training or at any of its related participating sites

RELATED INFORMATION

See Professional Liability Insurance Policy

Physician Impairment (IR IV.I.2)

Effective Date: October 19, 2022
Origination Date: February 2016

POLICY STATEMENT

Impairment can be due to medical and/or mental illness, including substance use. It is the policy of TIGMER to provide a drug-free workplace by prohibiting the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance or alcohol.

A resident will be required to undergo a drug and alcohol test any time a supervisor has a suspicion (based on abnormal speech, appearance, odor, attendance, behavior, or conduct, etc.) that a resident's behavior is unusual/impaired as a result of the use of drugs and/or alcohol. Residents/Fellows who refuse to be tested for drugs and/or alcohol will be considered insubordinate and will be subject to disciplinary action up to and including termination.

When a resident has been identified, as having a substance use disorder or dependency problem, the resident will be referred to the Employee Assistance Program for counseling and assistance in the mandatory reporting to the Texas Physician Health Program (TXPHP). The resident will be removed from work pending evaluation and recommendations from the TXPHP. The TXPHP also evaluates professionals who may be experiencing mental disorders that interfere with patient care and professionalism.

If the TXPHP recommends a treatment plan, TXPHP will require the resident to sign a contract stipulating the conditions under which the resident can return to the training program and care for patients in the State of Texas. Prior to returning to work, the resident must provide a copy of the TXPHP treatment plan recommendation and signed contract to the Designated Institutional Official (DIO). If the TXPHP does not recommend monitoring of and/or a treatment plan for the resident, then the responsible program director and the DIO will discuss alternative monitoring and/or intervention for the resident. In addition, the resident may be required to sign an agreement supplemental to the Residency Agreement which outlines conditions under which the resident may continue in the training program and any other matters specific to the individual resident's circumstances.

The resident must agree to submit to periodic alcohol or drug screening testing, as appropriate to the impairment, anytime at the request of the DIO or the program director. Similarly, the resident must agree to undergo medical and/or psychiatric evaluation, as appropriate to the impairment, anytime at the request of the DIO or program director. Failure to comply with such requests will be subject to disciplinary action up to and including termination.

REASON FOR POLICY

TIGMER is committed to maintaining the physical and mental health of resident physicians, as well as to maintaining a drug-free clinical learning environment (CLE). Some health conditions,

including substance abuse, are incompatible with high quality patient care, optimal performance of healthcare teams, and personal and professional growth. Prevention of impairment is a primary goal.

The purpose of this policy is to ensure a fair, reasonable, and confidential assessment of a physician who is suspected of being impaired, to facilitate the impaired resident's recovery, and to assist the resident's program in developing a reasonable plan for the resident's professional progress after treatment/recovery.

This policy will focus primarily on resident impairment related to substance use and/or mental health disorders.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Texas Physician Health Program Website: https://www.txphp.state.tx.us/

Harassment (IR IV.I.3)

Effective Date: October 19, 2022
Origination Date: February 2016

POLICY STATEMENT

It is TIGMER's policy to maintain a work environment free of sexual and discriminatory harassment on the basis of race, color, religion, gender, national origin, sexual preference, height, weight, age or disability/handicap. All Residents/Fellows are expected to conduct themselves so as to maintain a work environment free of harassment. No retaliation or reprisals will be tolerated against any individual who complains of, reports, or participates in the investigation of any incident of alleged harassment.

All residents/fellows are required to comply with the University of Incarnate Word's Policy on Harassment-Free Work and Learning Environment (Chapter 9) as described in the UIW Employee Handbook.

Situations involving behavior described above should be reported immediately to the resident's program director or the Designated Institutional Official (DIO).

REASON FOR POLICY

The Sponsoring Institution must have a policy, not necessarily GME-specific, covering sexual and other forms of harassment, that allows residents/fellows access the processes to raise and resolve complaints in a safe and non-punitive environment and in a timely manner, consistent with applicable laws and regulations.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, and other verbal and/or physical conduct of a sexual nature when: (a) submission to such conduct or communication is made a term or condition, either explicitly or implicitly, to obtain or retain employment or enrollment in a GME program; (b) submission to, or rejection of, such conduct or communication by an individual as a factor in any work related (employment) decision affecting such individual; (c) such conduct or communication has the purpose or effect of unreasonably interfering with a person's work performance or creating an intimidating, hostile, or offensive work environment.

Discriminatory harassment is defined as verbal or physical conduct including written statements or displayed materials by agents, supervisory employees, co-workers or non-employees directed against any person on the basis of that person's race, color, religion, gender, national origin, sexual preference, height, weight, age or disability/handicap, or that person's relatives, friends or associates when such conduct has a purpose or effect of interfering with the person's work environment, or affecting an individual's work related (employment) opportunities or causing or aggravating tension or animosity between different racial, ethnic, gender or religious groups.

RELATED INFORMATION

https://my.uiw.edu/hr/employee-handbook.html

Accommodations for Disabilities (IR IV.I.4 and III.B.7.d).(6))

Effective Date: October 19, 2022
Origination Date: February 2016

POLICY STATEMENT

Refer to Chapter 15 of the UIW employee handbook at: https://my.uiw.edu/hr/employee-handbook.html

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REASON FOR POLICY

The Sponsoring Institution must have a policy, not necessarily GME-specific, regarding accommodations for disabilities consistent with all applicable laws and regulations

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PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Vendors (IR IV.L)

Effective Date: October 19, 2022
Origination Date: February 2016

POLICY STATEMENT

In accordance with guidelines set forth by the American Medical Association Statement on Gifts to Physicians, acceptance of gifts from industry vendors is discouraged. Any gifts accepted by residents/fellows should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate only if they serve a genuine educational purpose. Acceptance of gifts should not influence prescribing practices or decision to purchase a device. Any gifts from patients accepted by trainees should not be of substantial value.

REASON FOR POLICY

The Sponsoring Institution must maintain a policy that addresses interactions between vendor representatives/corporations and residents/fellows and each of its ACGME-accredited programs.

To clarify the considerations residents and fellows should consider when interacting with industry representatives. The term “industry” includes but is not limited to pharmaceutical, biomedical device, equipment, and other health-care related industries.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

Program Directors are responsible for educating their residents/fellows on the proper protocol for interacting with industry representatives. Program Manuals may have specific policies. Hospitals may also have specific policies.

FAQ

DEFINITIONS

Individual Conflicts
An individual conflict exists when a relationship between a covered individual's private business or financial interests, or those of the covered individual's family members, and the covered individual's expertise and responsibilities might cause an independent observer to reasonably question whether the individual's objectivity in the performance of TIGMER responsibilities could be compromised by considerations of personal gain.

Institutional Conflicts
An institutional conflict of interest exists when the research, teaching, outreach, or other activities of TIGMER may be compromised because of an external financial or business relationship held at the institutional level that may bring financial gain to TIGMER, any of its member institutions, or the individuals covered by this policy.

RELATED INFORMATION

https://my.uiw.edu/hr/employee-handbook.html (See Section 7.6 Gifts and Gratuities and Appendix 6)

Substantial Disruptions in Patient Care or Education (IR IV.N)

Effective Date: October 19, 2022
Origination Date: February 2016

POLICY STATEMENT

Following declaration of a disaster or other substantial disruption in patient care or education, the Designated Institutional Official (DIO), Graduate Medical Education Committee (GMEC) and other sponsoring institution leadership will strive to restructure or reconstitute the educational experience as quickly as possible following the disaster/disruption.

In the event of a disaster or interruption in patient care that would cause residents/fellows to be displaced from their scheduled training programs and/or training sites, to the best of the institution's/program's ability, temporary training sites will be arranged for the displaced residents/fellows.

Residents/fellows who transfer temporarily will be informed initially and continually by the program director about the estimated duration of the transfer.

If the disaster prevents the sponsoring institution from re-establishing an adequate educational experience within a reasonable amount of time following the disaster, then permanent transfers will be arranged.

The TIGMER DIO will be the primary institutional contact with the ACGME and the Institutional Review Committee Executive Director regarding disaster plan implementation and needs within the sponsoring institution.

REASON FOR POLICY

Substantial Disruptions in Patient Care or Education: The Sponsoring Institution must maintain a policy consistent with ACGME Policies and Procedures that addresses support for each of its ACGME-accredited programs and residents/fellows in the event of a disaster or other substantial disruption in patient care or education.

TIGMER is committed to protecting the well-being, safety, and educational experiences of the residents/fellows.

The policy provides guidelines for communication with residents/fellows and program leadership to assist in reconstituting or restructuring the trainee's educational experiences as quickly as possible after the disaster/disruption or determining need for transfer or closure in the event of being unable to reconstitute normal program activity.

PROCEDURES

1. **Upon the occurrence of the disaster/disruption and immediately following - up to 72 hours: Immediate email communication to all parties and detailing the future communication plan.**

   a. **DIO (GME Administration)**

      i. The DIO is the primary institutional contact with the ACGME and Institutional Review Committee Executive Director regarding disaster plan implementation and needs within the sponsoring institution. The DIO consults with leadership from the major participating sites as needed and may convene a planning meeting to work through important details in managing the situation.

      ii. Immediate email communication to all parties will go out through Graduate Medical Education Administration, hereby referred to as GME Administration.

      iii. If email communication is not possible, then GME Administration will contact the Program Directors by phone.

   b. **Program Director**

      First point of contact. They are responsible for getting communications out to their residents/fellows. Program Directors must update their email listservs and list of phone numbers on an annual basis. Programs must ensure that this data is kept in a separate geographic location.

   c. **Residents/Fellows**

      i. Initially, residents/fellows are expected to report to their originally assigned hospital/clinic. In the event the hospital/clinic or patient load is affected by the disaster and unable to operate in the usual fashion the residents/fellows may need to be reassigned by the DIO in collaboration with the Program Director and hospital/clinic leadership.

      ii. Placement of residents/fellows will be continuously monitored and the need for temporary or permanent adjustments will be determined by the DIO in collaboration with the GMEC and hospital/clinic leadership.

2. **Communications Going Forward**

   a. **DIO**

      i. The DIO will communicate (call or email) with ACGME regarding the impact of the disaster.
      ii. Within **ten days** after the declaration of a disaster by the ACGME, the DIO (or another institutionally designated person, if the institution determines that the DIO is unavailable), will contact the ACGME to discuss due dates that ACGME will establish for the programs:

(1) To submit program reconfigurations to ACGME and
(2) To inform each program's residents/fellows of transfer decisions.

iii. The due dates for submission shall be no later than **30 days** after the disaster unless other due dates are approved by ACGME.

iv. The DIO will monitor the progress of both healthcare delivery and functional status of GME training programs for their educational mission during and following a disaster. They (or their designees) will work with the ACGME to determine the appropriate timing and action of the options for disaster impacted institution and/or programs:

(1) Maintain functionality and integrity of program(s),
(2) Temporary resident transfers until program(s) reinstated, or
(3) Permanent resident transfer, as necessitated by program or institution closure.

v. Information and decision communications will be maintained with Program Directors and residents/fellows, as appropriate to circumstances of the individual disaster event.

b. **Program Director**

The Program Director(s) will communicate (call or email) with their appropriate Review Committee(s) regarding the impact of the disaster. The ACGME website provides instructions for changing resident email information in the ACGME Accreditation Data System.

c. Residents/Fellows

The residents/fellows should call or email the appropriate Review Committee Executive Director with information and/or requests for information. On its website, ACGME will provide instructions for changing resident email information on the ACGME Web Accreditation Data System.

d. **ACGME**

i. If within the **ten days** the ACGME has not received communication from the DIO or designee, the ACGME will attempt to establish contact with the DIO(s) to determine the severity of the disaster, its impact on training, and next steps.

ii. ACGME will establish a fast-track process for reviewing (and approving or not approving) submissions by programs relating to program changes to address disaster effects, including, without limitation, (a) the addition or deletion of a participating institution, (b) change in the format of the educational program, and (c) change in the approved resident complement.

iii. Once information concerning a disaster-affected program's condition is received, ACGME may determine that one or more site visits is required. Prior to the visits, the DIO will receive notification of the information that will be required. This information, as well as information received by the ACGME during these site visits, may be used

for accreditation purposes. Site visits that were scheduled prior to a disaster may be postponed.

iv. The new ACGME policy will supersede these current policies as they become enacted.

e. **Residents/Fellows Transfer**

Institutions offering to accept temporary or permanent transfers from programs affected by a disaster can identify their program's available positions through the ACGME ADS.

3. When the Disaster has Ended:

a. Plans will be made with the participating sites to which residents/fellows have been transferred for them to resume training at TIGMER participating sites.

b. Appropriate credit for training will be coordinated with the ACGME and the applicable Review Committees.

c. Decisions as to other matters related to the impact of the disaster on training will be made.

4. Finance

a. During and/or immediately following a disaster, TIGMER will make every effort to ensure that the residents/fellows continue to receive their salary and fringe benefits during any disaster event recovery period, and/or accumulate salary and benefits until such time as utility restoration allows for fund transfer.

b. Longer term funding will be determined based on the expected operations of the teaching sites, CMS and governmental regulations and the damage to the infrastructure of the finance and hospital operations.

5. Administrative Information and Redundancy and Recovery

a. Trainee's demographic documentation stored in New Innovations. Full backups are done weekly by the vendor.

b. Data and documents stored in New Innovations are stored on two IIS servers and two SQL servers at each data center in separate cities. Data from each server is copied to the other server every hour. The servers also have full backups run every night and the backups are located on a backup sub-system own and operated by another company.

c. Programs are responsible for establishing procedures to protect the academic and personnel files of all residents from loss or destruction by disaster. This should include at least a plan for storage of data in a separate geographic location away from the sponsoring institution or in a cloud-based filed which can be accessed off-site.

6. **Legal and Medical-Legal Aspects of Disaster Response Activity**

   Residents/fellows serving under the direction of their program in disaster response efforts will be covered by their employer's liability insurance company. Residents/fellows who act as emergency responders under an executive order issued by the governor of Texas are immune from damages for their good faith acts/omissions in rendering emergency care, advice, or assistance under emergency plans.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

A disaster is defined herein as an event or set of events causing significant alteration to the residents/fellows' experience of a TIGMER GME training program.

This policy and procedure document acknowledges that there are multiple types of disaster including but not limited to acute disaster with little or no warning (e.g. tornado, bombing), and the insidious disruption or disaster (e.g. pandemic event). This policy and procedure will address disaster and disruption in the broadest terms.

RELATED INFORMATION

ACGME Disaster Policy; AMA Guidelines; CMS Guidelines

CMS Funding: http://www.cms.hhs.gov/AcuteInpatientPPS/Downloads/Katrina_Fact_Sheet.pdf

Training Program Reduction/Closure OR Sponsoring Institution Closure Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

The TIGMER is committed to providing a high-quality educational experience for all residents/fellows (trainees) enrolled in ACGME accredited and non-ACGME accredited graduate medical education training programs.

In the event of program closure or to reduce the trainee complement, whether by ACGME, departmental, or institution necessity, the program director must notify the Designated Institutional Official (DIO) and the program's trainees immediately. See responsibilities outlined below.

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

Program Responsibilities

- Program closure or reduction due to ACGME adverse action
  - Program director must notify the DIO and trainees as soon as notification is received. Trainees must be made aware of how the reduction in complement will affect their training.
  - Program director will work closely with the office of the DIO to make every effort within budgetary constraints to allow existing trainees to complete their education or provide assistance in transferring the trainee to another program.
- Reduction in trainee complement
  - Program director should discuss the impact of the reduction with the current trainees.
  - Program director must submit a request through ACGME WebADS.
  - Request is reviewed and voted upon by the Graduate Medical Education Committee (GMEC).

Sponsoring Institution/DIO Responsibilities

- Program closure or reduction due to ACGME adverse action
  - DIO will present the request to the GMEC.
  - DIO will work collaboratively with the program director as outlined above.
- Reduction in trainee complement
  - DIO will bring request to the GMEC for review and action.
  - GME Administration will approve the change in WebADS.
- Major participating site closure or reduction
  - GME Administration will work with program and other major participating sites and participating institutions to redistribute the affected trainee population.
- Sponsoring Institution closure or reduction
  - The TIGMER Board of Directors must notify the DIO within 30 days of the decision to close or reduce programs.
  - DIO will notify programs and trainees as soon as possible.
  - The Sponsoring Institution will make every effort within budgetary constraints to allow existing trainees to complete their education or provide assistance in transferring the trainees to another program.

FAQ

DEFINITIONS

RELATED INFORMATION

Resident and Fellow Forum Policy

Effective Date:
Origination Date:

POLICY STATEMENT

All TIGMER residents and fellows are invited to participate in the resident and fellow forum established to provide an opportunity for communications and the exchange of information related to the working environment of residents and fellows at TIGMER clinical sites. The forum will occur monthly.

Through this forum residents and fellows are able to raise issues in a confidential manner without fear of intimidation or retaliation. Residents and fellows have the option, at in least in part, to conduct their forum without the DIO, faculty members, or other administrators present.

The forum provides an open, group discussion that allows residents and fellows to discuss their educational and work environments, their programs and other relevant issues they may face during training, along with promoting the well-being of the residents and fellows.

One individual resident or fellow from each program will be elected by his or her peers to serve as a representative to the forum. These individuals will bring relevant issues to the GMEC with the assurance of confidentiality.

REASON FOR POLICY

In accordance with ACGME Institutional Requirements, residents/fellows must have the opportunity to communicate and exchange information with each other relevant to their ACGME-accredited programs.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Quality Improvement/Patient Safety Policy

Effective Date:
Origination Date: July 2017

POLICY STATEMENT

Each residency and fellowship program must ensure that each resident/fellow participates in real and or simulated interprofessional clinical patient safety /quality improvement activities. In accordance with ACGME Common Program Requirements “Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients.”

TIGMER’s Graduate Medical Education Committee (GMEC) requires each ACGME accredited residency and fellowship program to develop policies to ensure all residents are involved in Quality Improvement/Patient Safety activities.

Quality Improvement/Patient Safety activities include but are not limited to the following:

Quality Improvement/Patient Safety Conferences (e.g., Morbidity and Mortality)
Participation in institutional Quality Management Committees
Grand Rounds
Patient Satisfaction Surveys Core Measures
Utilization Management
Elective Quality Improvement rotations
Scholarly activity resulting in implementation of initiatives to improve patient quality and safety of care.

Every training program must incorporate Quality Improvement/Patient Safety resources that focus on root causes, risk reduction and other didactic modules that can be accessed by both faculty and residents. At a minimum, every training program must incorporate Quality Improvement/Patient Safety Conferences (e.g., Morbidity and Mortality) into its curriculum.

In conjunction with the Annual Program Evaluation, The DIO for TIGMER will provide the GMEC with a report of Quality Improvement/Patient Safety activities as they pertain to the residents and the teaching programs.

The DIO will address insufficient Quality Improvement/Patient Safety involvement.

REASON FOR POLICY

TIGMER Graduate Medical Education Committee (GMEC) requires each ACGME accredited residency and fellowship program to develop policies to ensure all residents are involved in Quality Improvement Patient Safety activities.

PROCEDURES

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DEFINITIONS

RELATED INFORMATION

GMEC Conflict of Interest Policy

Effective Date: December 2016
Origination Date: April 2016

1. TIGMER members must disclose the existence of any actual or possible conflict of interest and be given the opportunity to disclose all material facts to the disinterested members of TIGMER.

2. A disinterested member of TIGMER may bring to the attention of the consortium a possible conflict of interest situation involving another member of TIGMER.

3. A TIGMER member unilaterally may determine that he or she has an actual or possible conflict of interest and voluntarily recuse him or herself from the evaluation, deliberation or action of TIGMER in question at any time. In the event that a TIGMER member recuses him or herself, TIGMER need not make a formal determination with regard to the existence of a possible or actual conflict of interest.

4. If, after disclosure of facts or circumstances that suggest an actual or possible conflict of interest, the TIGMER member does not recuse him or herself, and after any discussion with the interested party, he or she shall leave the TIGMER meeting while the determination of an actual or possible conflict of interest is discussed and voted upon by the disinterested TIGMER members.

5. In the event a TIGMER member recuses him or herself or he or she is deemed to have an actual or possible conflict of interest by a vote of the disinterested members of TIGMER, he or she shall leave the meeting during the discussion of, and the vote on, the matter involving the actual or possible conflict of interest.

6. If TIGMER has reasonable cause to believe a Board of Trustees member has failed to disclose an actual or possible conflict of interest and he or she has failed to recuse him or herself, it shall inform the individual of the basis for such belief and afford the person an opportunity to explain the alleged failure to disclose.

7. Each member of TIGMER annually shall sign a statement that affirms the following: (1) The individual has received a copy of the Conflict-of-Interest Policy; (2) The individual has read and understands the policy; and (3) The individual has agreed to comply with the spirit and intent of the policy.

REASON FOR POLICY

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RELATED INFORMATION

Conflict of Interest Signature Form

By affixing my signature below, I hereby acknowledge and affirm:

I have received a copy of the Texas Institute of graduate Medical Education and Research (TIGMER) Conflict of Interest Policy.

I have read and understand the Conflict-of-Interest Policy.

I agree to comply with the spirit and intent of the Conflict-of-Interest Policy.

Signature _____

Name _____

Date _____

Medical Board Mandatory Reporting Policy

Effective Date: June 2017
Origination Date: June 2017

POLICY STATEMENT

The Texas Medical Board requires that the **director** of each postgraduate training program report in writing to the Executive Director of the Board the following events within 30 days of the director's knowledge:

1. if a physician did not begin the training program due to failure to graduate from medical school as scheduled or for any other reason(s);

2. if a physician has been or will be absent from the program for more than 21 consecutive days (excluding vacation, military, or family leave not related to the participant's medical condition) and the reason(s) why;

3. if a physician has been arrested after the permit holder begins training in the program;
4. if a physician poses a continuing threat to the public welfare as defined under Tex. Occ. Code §151.002(a)(2), as amended;

5. if the program has taken final action that adversely affects the physician's status or privileges in a program for a period longer than 30 days;

6. if the program has suspended the physician from the program;

7. if the program has requested termination or terminated the physician from the program, requested or accepted withdrawal of the physician from the program, or requested or accepted resignation of the physician from the program and the action is final.

*The Texas Medical Board requires that any **resident** who holds a Physician in Training License report in writing to the Executive Director of the Board the following events within 30 days of their occurrence:*

(a) Failure of any PIT holder to comply with the provisions of this chapter or the Medical Practice Act §160.002 and §160.003 may be grounds for disciplinary action as an administrative violation against the PIT holder.

(b) The PIT holder shall report in writing to the executive director of the board the following circumstances within thirty days of their occurrence:

(1) the opening of an investigation or disciplinary action taken against the PIT holder by any licensing entity other than the TMB;
(2) an arrest, fine (over $250*), charge or conviction of a crime, indictment, imprisonment, placement on probation, or receipt of deferred adjudication; and

(3) diagnosis or treatment of a physical, mental or emotional condition, which has impaired or could impair the PIT holder's ability to practice medicine.

REASON FOR POLICY

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Footwear	Closed-toed shoes that completely cover and protect the tops and sides of feet should be worn.
Lab Coat/ Scrub Suits	Lab coats and scrub suits should be worn as directed by the applicable program and should be clean and without signs of wear or stains.
ID Badge	The trainee’s identification badges are to be worn at all times at the trainee hospital. ID Badges need to be visible and worn above the waist.

Grooming Guidelines

Cologne/Perfume	Fragrance is strongly discouraged due to patient sensitivities and allergies.

Facial Hair	Mustaches and beards should be clean, neatly groomed, and moderate.
Fingernails	Fingernails are to be kept clean and neatly trimmed and of an appropriate length to perform job duties. Artificial nails are prohibited from being worn by any direct patient care staff.
Hair	Hair shall be neat, clean, of a natural occurring or naturally occurring dyed color. Extreme haircuts are inappropriate.
Jewelry	Jewelry or body piercing should not interfere with direct patient care or other on duty responsibilities.

RESPONSIBILITIES

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Dress Code Policy

Effective Date: March 2018
Origination Date:

POLICY STATEMENT

Every resident is a representative of TIGMER and of the hospital/ clinic at which they are completing their GME training. Residents are expected to dress according to generally accepted professional standards appropriate for their training program. Dress, personal hygiene and grooming standards contribute positively to the professional image the resident physician presents to patients and their families. Clothing should be appropriate for all patient care, with patient respect in mind. Each individual's training program may set more specific guidelines for dress code. Each individual's training program may evaluate and make determinations regarding dress code policy compliance.

REASON FOR POLICY

To establish guidelines to ensure that the resident/fellows portray a professional image to the patients, visitors, and fellow employees that allows for the safe performance of job duties when working at a trainee hospital location.

PROCEDURES

FORMS/INSTRUCTIONS

General Dress Guidelines
The resident/fellow's personal appearance while on duty, or in areas where contact with patients or their families is possible, shall be neat, clean, professional.

Professional Dress

Professional Dress	Blouses, sweaters, suit or sport jackets, professional shirts, dress shirts, sweaters, polo-type shirts, turtlenecks, dress pants, slacks, trousers, khaki type slacks, skirts, dresses, skirted suits, professional dresses, and skirts with or without slits should be knee length or longer.

	Tight fitting or revealing garments, blue jeans, or items of clothing imprinted with advertising or objectionable language are prohibited.

GME Forms

Effective Date: March 2018
Origination Date:

List of Forms

1. Conflict of Interest Form
2. Clinical Competency Committee Protocol and Requirements
3. Program Evaluation Committee Protocol and Requirements

Conflict of Interest Signature Form

By affixing my signature below, I hereby acknowledge and affirm:

1. I have received a copy of the Texas Institute of graduate Medical Education and Research (TIGMER) Conflict of Interest Policy.
2. I have read and understand the Conflict of Interest Policy.
3. I agree to comply with the spirit and intent of the Conflict of Interest Policy.

Signature _____

Name _____

Date _____

Clinical Competency Committee Protocol and Requirements

The Clinical Competency Committees (see below) will review and use assessment data, including faculty member assessments of residents on rotations, self-evaluations, peer evaluations, and evaluations by nurses and other staff members. Each program may continue to use its current resident assessment tools, and phase in tools developed specifically for the milestones when these become available.

The Program Director is responsible for appointing faculty to the CCC.

At a minimum the CCC must be comprised of three key members of the program faculty. Others eligible for appointment to the committee can include faculty from other programs and non-physician members of the health care team.

The Clinical Competency Committee will:

1. Review all resident evaluations semi-annually;
2. Prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME, and;
3. Advise the program director regarding resident progress, including promotion, remediation, and dismissal.

The Clinical Competency Committee will annually review their program-specific requirements to ensure compliance with all aspects of CCC duties, responsibilities and reporting to the ACGME.

Program Evaluation Committee Protocol and Requirements

The Program Evaluation Committee (defined below) must document formal, systematic evaluation of the curriculum and program administration at least annually and is responsible for rendering a written and Annual Program Evaluation (formally referred to as the Annual Program Review (APR).

The Program Director is responsible for appointing faculty to the Program Evaluation Committee (PEC). The Program Evaluation Committee:

1. Must be comprised of at least two program faculty members and should include at least one resident;
2. Must have a written description of its responsibilities; and,
3. Should participate actively in:
    a. Planning, developing, implementing, and evaluating educational activities of the program;
    b. reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
    c. addressing areas of non-compliance with ACGME standards; and,
    d. reviewing the program annually using evaluations of faculty, residents, and others, as specified below.

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

The program, through the PEC, must monitor and track each of the following areas: resident performance

1. faculty development
2. graduate performance
3. program quality as:
    a. Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
    b. The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program.
4. progress on the previous year's action plan(s).

The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above, as well as delineate how they will be measured and monitored. The written action plan can also include areas of innovation as it relates to program improvement.

The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.