Texas Institute for Graduate Medical Education and Research

Policy and Procedure Manual

07-20-2022

Table of Contents

Contents

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.

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

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 of 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.

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

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

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

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.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

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

PROCEDURES

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.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

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.).

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

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/

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

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

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 _____

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

Disaster Planning Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

This policy applies to all GME training programs sponsored by TIGMER.

Following declaration of a disaster, 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.

In order to maximize the likelihood that trainees will be able to complete program requirements within the standard time required for certification in that specialty, steps will be taken to transfer the affected trainees to other local sites. If leadership determines that the sponsoring institution can no longer provide adequate educational experience for its trainees, the sponsoring institution will, to the best of their ability, arrange for temporary transfer of trainees to programs at other sponsoring institutions until such time as the sponsoring institution is able to resume providing the educational experience.

The Program Director will then give the trainees, who temporarily transfer to other programs as a result of a disaster, an estimated time that relocation to another program will be necessary. Should that initial time need to be extended, the trainees will be notified by their Program Director using written or electronic means identifying the estimated time of the extension.

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

This Disaster Planning Policy and Procedures is intended to augment existing plans that are applicable to the institutions affected.

It is intended to protect the well-being, safety and educational experiences of the residents/fellows, hereby referred to as trainees, enrolled in TIGMER GME training programs. It provides guidelines for communication with trainees and program leadership to assist in reconstituting or restructuring the trainee's educational experiences as quickly as possible after the disaster or determining need for transfer or closure in the event of being unable to reconstitute normal program activity.

It provides general information and procedures to support TIGMER GME training programs and trainees in the event of a disaster or interruption in their educational experience.

PROCEDURES

1. Upon the occurrence of the disaster and immediately following- up to 72 hours: Immediate email communication is to all parties and details the future communication plan.

Associate Dean/DIO (GME Administration)
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 hospital leadership as needed and may decide to convene a planning meeting to work through important details in managing the situation.

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

If email communication is not possible, then GME Administration will contact the core residency Program Directors by phone or pager. Fellowship Directors should contact the Program Directors of their core residency program with fellowships to determine next steps.

Program Director
First point of contact. They are responsible for getting communications out to their trainees and if necessary to their fellowship directors. Program Directors must update their email list- serves and list of phone and pager numbers on an annual basis. Programs and/or departments must insure that this data is kept in a separate geographic location.

Residents/Fellows (Trainees)
Initially they are expected to report to their originally assigned hospital/clinic location. In the event the hospital/clinic is affected by the disaster and unable to operate in the usual fashion or if the patient load is skewed by the disaster, some or all of the trainees may need to be reassigned by the DIO after discussion with the Program Director and approval of the DIO with the hospital officials.

2. Institutional Assessment and Decision-making on Program and Institution Status and Resident Transfer - 3-30 days following disaster

Communications going forward

Associate Dean/DIO (GME Administration)
The DIO will communicate (call or email) with ACGME regarding the impact of the disaster.

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:
  - To submit program reconfigurations to ACGME and
  - To inform each program's trainees of transfer decisions.

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

The DIO will monitor 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.

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

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

Residents/Fellows (Trainees)
The trainees 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.

ACGME
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.

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.

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.

New ACGME policy will supersede these current policies as they become enacted.

Residents/Fellows (Trainees) Transfer
Institutions offering to accept temporary or permanent transfers from programs affected by a disaster must complete a form found on the ACGME website. Upon request, ACGME will give

information from the form to affected programs and trainees, and post the information on its website, upon authorization.
At the outset of a temporary transfer, a program must inform each transferred trainee of the minimum duration and the estimated actual duration of his/her temporary transfer, and continue to keep each trainee informed of such durations. If and when a program decides that a temporary transfer will continue to and/or through the end of a residency year, it will so inform each transferred resident.

3. When the Disaster has Ended:
   - Plans will be made with the participating institutions to which trainees have been transferred for them to resume training at TIGMER institutions.
   - Appropriate credit for training will be coordinated with the ACGME and the applicable Residency Review Committees and
   - Decisions as to other matters related to the impact of the disaster on training will be made.

Finance
During and/or immediately following a disaster, TIGMER will make every effort to insure that the trainees 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.

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

Administrative Information and Redundancy and Recovery
Trainee's demographic documentation stored in TIGMER on-line GME management system (New Innovations). Full backups are done weekly by the vendor.

Data and documents stored in the Residency Management Suite (RMS) by 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.

The TIGMER servers also have a detailed back-up and recovery system in place.
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.

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 trainees' 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

ACGME policies and procedures:

Supervision Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

There must be sufficient institutional oversight to assure that trainees are appropriately supervised. Appropriate supervision means that a trainee is supervised by the teaching faculty in such a way that the trainees assume progressively increasing 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 trainees on duty. The level of responsibility accorded to each trainee must be determined by the program director and the teaching faculty.

REASON FOR POLICY

To ensure that the TIGMER GME programs provide appropriate supervision for all trainees that is consistent with proper patient care, the educational needs of trainees, and the applicable ACGME Review Committee (RC) and Common Program Requirements.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

PROGRAM RESPONSIBILITY

It is the responsibility of individual program directors to establish detailed written policies describing trainee supervision at each level for their residency/fellowship programs. 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 guidelines and should be monitored through periodic department reviews, with institutional oversight through the GMEC internal review process.

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

Set clear expectations

- When to call
- Situations in which trainees should always call
- How to call – provide accurate pager/phone numbers
- Trainees role in the care of the patient

Create a safe learning environment

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

Be readily available

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

Balance supervision with trainee 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 trainee

FAQ

DEFINITIONS

- Direct – the supervising physician is physically present with the trainee and patient
- Indirect
  - With supervision immediately available the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision
  - With direct supervision available the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by phone and/or other electronic modalities and is available to provide direct supervision
- Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after the care is delivered

---

RELATED INFORMATION

EFFECTIVE SUPERVISEE (TRAINEE) BEHAVIORS

- Trainee may request the physical presence of an attending at any time and is never to be refused
- Know and follow your programs 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

Discipline, Dismissal, Non-Renewal Policy & Procedure

Effective Date: November 2020
Origination Date: February 2016

POLICY STATEMENT

The decision for probation, suspension, non-renewal, and dismissal of residents in TIGMER ACGME accredited training programs is the primary responsibility of the Program Director along with the Clinical Competency Committee. The specific actions of probation, suspension, non-renewal, and dismissal 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, 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 Clinical Competency Committee will evaluate each resident's progress in attaining the advancement criteria and achieving milestones as defined by the ACGME and the program. The Clinical Competency Committee will also address performance and behavioral concerns that may arise in connection with the residency.

The following are levels of disciplinary action, each of which shall be presented to the resident in writing, unless otherwise stated. The levels of disciplinary action may not follow the sequential order in which they are presented if the act leading to the discipline is of such a nature to warrant a non-sequential order.

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.

Warning (verbal or in writing): Following one or more unsuccessful attempts to correct performance through Resident Counseling, the resident shall be warned that further discipline, including a Written Warning may follow if the resident continues to not meet performance expectations, or does not otherwise correct the work and/or academic performance deficiency(ies).

Written Warning
If the resident's performance has not improved following a Resident Counseling or a Warning or if the circumstances are such that a Written Warning is appropriate, a Written Warning or Performance Improvement Plan shall be issued. The Written Warning shall inform the resident of the misconduct or the work and/or academic performance deficiency(ies), and expectations.

Performance Improvement Plan
Depending on the circumstances, a Performance Improvement Plan with input from the program's Clinical Competency Committee (CCC), which will include metrics and/or outcomes which the resident will be required to meet.

Probation

1. A resident may be placed on probation by the Program Director and the program's Clinical Competency Committee (CCC) for reasons including, but not limited to, any of the following:
    a. Failure to meet the academic performance standards of an individual rotation.
    b. Failure to meet the academic performance standards of the program.
    c. Failure to comply with the policies and procedures of the GMEC, TIGMER or the participating sites of the program.
    d. Misconduct that infringes on the principles and guidelines set forth by the training program.
    e. Documented and recurrent failure to complete medical records in a timely and appropriate manner.
    f. When professional misconduct or ethical charges are brought against a resident which bear on his/her fitness to participate in the training program.
    g. When professional conduct or ethical standard concerns are made known to TIGMER, the Program Director or the program's Clinical Competency Committee which bear on the resident's fitness to participate in the training program.

2. When a resident is placed on Probation, the Program Director shall notify the resident in writing. The notice of Probation will include a Performance Improvement Plan with the specific remedial metrics and/or outcomes which the resident will be required to meet, the length of time in which the resident must correct the deficiency or problem, and the consequences of non-compliance with the remedial measures.

3. If the length of Probation is greater than one month, the Program Director and resident shall notify the Texas Medical Board (TMB).

4. 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. A resident may be suspended from a residency program for reasons including, but not limited, to any of the following:

a. Failure to meet the requirements of probation.
b. Failure to meet the performance standards of the program.
c. Failure to comply with the policies and procedures of the GMEC, UIW, or the participating institutions or the program.
d. Misconduct that infringes on the principles and guidelines set forth by the training program.
e. When reasonably documented professional misconduct or ethical charges are brought against a resident or otherwise made known to TIGMER, the Program Director or the program's Clinical Competency Committee which bear on the resident's fitness to participate in the training program.
f. When reasonably documented legal charges have been brought against a resident which bear on his/her fitness to participate in the training program.
g. If a resident is deemed an immediate danger to patients, himself or herself or to others.

2. When a resident is suspended, the Program Director shall notify the resident of the Suspension and provide a Performance Improvement Plan to include:
    a. Reasons for the action.
    b. Appropriate measures to assure satisfactory resolution of the problem(s).
    c. Activities of the program in which the resident may and may not participate.
    d. The date the suspension becomes effective and the term of the suspension.
    e. Consequences of non-compliance with the terms of the suspension.
    f. Whether or not the resident is required to spend additional time in training to compensate for the period of suspension and be eligible for certification for a full training year.
3. A copy of the Suspension and Performance Improvement Plan shall be forwarded to the Assistant Dean for GME and the DIO.
4. During the suspension, the resident will be placed on "administrative leave", with or without pay as appropriate depending on the circumstances. The PD and resident must notify the TMB of this action within 30 days.
5. 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

1. Dismissal from a residency program may occur for reasons including, but not limited to, any of the following:
    a. Failure to meet the performance standards of the program.
    b. Failure to comply with the policies and procedures of the GMEC, UIW, or the participating institutions or the program.
    c. Illegal conduct.
    d. Unethical conduct.
    e. Performance and behavior which compromise the welfare of patients, self, or others.
    f. Inability of the resident to pass the requisite examinations for licensure to practice medicine in the United States, if required by the individual residency program.

    g. Misrepresentation of information in the residency appointment application per NRMP policies and procedures.
2. 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.
3. The Program Director, with the guidance of the CCC, shall contact the Assistant Dean for GME and the DIO and provide written documentation which led to the proposed dismissal action.
4. When performance or conduct is considered sufficiently unsatisfactory that dismissal is being considered, the Program Director shall notify the resident with a written statement to include:
    a. Reasons for the proposed action
    b. The appropriate measures and timeframe for satisfactory resolution of the problem(s).
5. If the situation has not improved within the timeframe, the resident will be dismissed. 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. A copy of this letter shall be forwarded to the Assistant Dean for GME and DIO. The PD and resident must notify the TMB of the final action.
6. In instances where a resident agreement is not going to be renewed, TIGMER ensures that its ACGME accredited programs provide the resident with a written notice of intent not to renew a resident's current agreement no later than four months prior to the end of the resident's current agreement. However, if the primary reason(s) for the non-renewal occurs within the four months prior to the end of the agreement, TIGMER ensures that its ACGME accredited programs provide the resident with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement.

Resignation
If a resident resigns prior to the end of the term of the current resident agreement, and such resignation is accepted by the Residency Program Director, then the current agreement will end on the effective date of resignation. In such instance, no further pay or benefit will be owed to the resident and no renewal or further resident agreement will be offered or effective.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Grievance and Appeals Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

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.

Dismissal or non-renewal or non-promotion to a subsequent PGY level could occur because of failure to comply with the resident's responsibilities, failure to demonstrate appropriate medical knowledge or
skill as determined by the program's supervising faculty, or failure to abide by the terms of the resident's contract of employment. This appeals mechanism is open to a resident who has suffered an adverse action including dismissal during an academic year or non-renewal of contract for the following academic year in a categorical program in which there has been no explicit information provided to the resident that advancement was based on a pyramidal system, as well as nonpromotion to a subsequent PGY level.

Academic failure – Residents are learners within our programs. When a resident fails to progress academically, it is the responsibility of the program director to document a warning period prior to instituting probationary status, dismissal, failure to reappoint, or failure to promote to the subsequent PGY level; to demonstrate efforts for the provision of opportunities for remediation; and to notify the DIO of the proposed action(s). It should be very unusual to dismiss a resident for academic failure without a probationary period. Opportunities should be provided (and documented) for the resident to discuss with the program leadership the basis for probation, the expectations of the probationary period and the evaluation of the resident's performance during the probation.

Misconduct – In addition to their academic responsibilities, residents have clinical responsibilities within our programs. Dismissal without warning may be justified in response to specific examples of misconduct. Examples include (but are not limited to) the following: lying; falsification of a medical record; violation of medical record privacy; being under the influence of intoxicants or drugs; disorderly conduct, harassment of other employees (including sexual harassment), or the use of abusive
language on the premises; fighting, encouraging a fight, or threatening, attempting, or causing injury to another person on the premises.

Informal procedure – Residents who are concerned about actions within their programs that could significantly threaten their intended career development are encouraged to contact the DIO regarding their concerns. The DIO will work with the resident and the program as the particular situation requires.

Formal grievance procedure - In the event that a resident is to be placed on probationary status, dismissed, his/her training agreement not renewed, or not promoted to a subsequent PGY level, he/she may initiate a formal grievance procedure. The resident shall present the grievance in writing to the DIO within thirty (30) working days after the date of notification of proposed adverse status. The grievance shall state the facts upon which the grievance is based and requested remedy sought. The DIO or designate shall respond to the grievance with written answer no later than fifteen (15) working days after he/she received it. If the resident is not satisfied with the response, he/she may then submit, within fifteen (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 designate, who will preside at the hearing, but will not be a voting participant. The hearing will be scheduled within thirty (30) working days of the resident's request for a hearing. The hearing panel will consist of at least three (3) 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 his/her 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 a departmental representative; an opportunity for a presentation of equal length by the house officer; an opportunity for response by the representative, followed by a response of equal length by the house officer. This will be followed by a period of questioning by the hearing panel. The ADGME in consultation with the departmental representatives 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 his/her 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 ten (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

Duty Hours Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

All programs are required to adhere to and monitor compliance of their trainees with the ACGME duty 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 (RCs). The sponsoring institution monitors program's adherence to the duty hour requirements through regular review of duty hour violations in RMS, the Internal 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 duty hour requirements and the responsibilities of the trainees, the programs and the sponsoring institution.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

Program Responsibilities:

Supervision

Programs must ensure that appropriate levels of supervision are provided to each trainee based on their level of training. Programs must enhance their current supervision policies to include the new ACGME requirements.

Transition of Care

- Must design clinical assignments to minimize the number of transitions in patient care
- Programs must ensure that trainees are competent in communication with team members in handover process
- Attendings and trainees must inform patients and family members of their roles in their care
- Alertness Management

- Must educate faculty and trainees to recognize the signs of fatigue and sleep deprivation
- Must educate faculty and trainees in fatigue mitigation process
- Develop fatigue mitigation processes to manage potential issues with patient care and learning (i.e. strategic napping, back-up call schedules). Programs must have a process in place to ensure that there is backup in case a trainee is unable to perform his/her patient care duties

Sponsoring Institution Responsibilities:

Supervision
Sponsoring Institution is responsible for ensuring that programs have the appropriate supervisory lines in place for each PGY Level.

Transition of Care
- Along with the program the Institution must ensure and monitor effective, structured handover process to facilitate both continuity of care and patient safety
- Must assure the availability of schedules that inform patients and all members of the healthcare team of faculty and trainees currently responsible for patient care.
- Alertness Management
- Must provide adequate sleep facilities and/or safe transportation options who may be too fatigued to safely drive home

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.

Max Hours per Week
- Duty hours must not exceed 80 hours per week averaged over a four-week period inclusive of call and moonlighting activities
- Trainees in their final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods within the context of the 80-hour max.

Continuous Duty Hours
- PGY-1 trainees must not exceed 24 hours. Trainees may spend an additional 4 hours to complete transitions in care.
- PGY-2 trainees and above: must not exceed 24 hours. Trainees may spend an additional 4 hours to complete transitions in care. Residents may not attend continuity clinics after 24 hours of continuous in- house duty. Trainees must have at least 14 hours free after 24 hours of in-house duty

Duty Hour Exceptions
Duty hour exceptions of 80 hours per week averaged over a four-week period for select programs with sound educational rationale are permissible. Program must obtain permission

from the Designated Institutional Official and Graduate Medical Education Committee prior to submission to their Review Committee.

Mandatory Time Free of Duty

- Trainees must have a minimum of one day free of duty every week (when averaged over four weeks). At home call cannot be assigned during this time.
- PGY-1 residents should have 10 hours and must have eight hours free between duty periods.
- Intermediate-level residents should have 10 hours and must have eight hours free between duty periods. There must be at least 14 hours free of duty after 24 hours of in-house duty.

Call

- **In-House Call**
  - Trainees: every third night when averaged over a four- week period.

- **At-Home Call**
  - Time spent in the hospital must count towards the 80- hour week limit. At home call is not subject to the 'every third night' limitation however trainees must receive one-in-seven free of duty when averaged over a four- week period.
  - At home call should not be so frequent or taxing to preclude rest or reasonable personal time for each resident
  - Trainees are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80- hour weekly maximum will not initiate a new off-duty period

Night Float

Trainees must not be scheduled for more than six consecutive nights of night float. Check with your individual RCs for maximum number of months of night float per year that may be allowed.

Moonlighting

- 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.
- Time spent by trainees in Internal and External moonlighting must be counted towards the 80-hour maximum weekly duty hour limit

Recording and Reporting Duty Hours

In accordance with the Residency Management Suite (RMS) updating and approving assignments and hours in the duty hours' policy, trainees are required to accurately record their duty hours in New Innovations.

Reporting Duty Hour Violations

Trainees concerned about continuous duty hour violations by their program can contact the Designated Institutional Official.

Harassment Policy

Effective Date: February 2016
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.

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.

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

Situations involving behavior described above should be reported immediately to your Program Director or the DIO.

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Resident/Fellow Agreement Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

The residency/fellowship (trainee) agreement is a required, binding contract between the trainee and the institution. The effective date of the initial agreement is the first mandatory date the trainee is required to report to their GME training program.

Programs accredited by the American Osteopathic Association (AOA) must have the agreement signed and dated by all parties within 10 days of the AOA Match.

REASON FOR POLICY

PROCEDURES

The agreement template is reviewed no less than 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 trainee's 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, the paper copy may be destroyed. The scanned copy becomes the official agreement.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Resident/Fellow Renewal and Promotion Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

Resident/Fellow 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. 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 trainees standing in the program.

Promotion

After satisfactory completion of each year of GME experience, as attested to by the program director and department chair, 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/Fellow Agreement.

Promotion to the next level of training is determined by the program and the Sponsoring Institution. The decision to promote is dependent on several factors, which include, but are not limited to:

1. satisfactory completion of all training requirements
2. satisfactory trainee performance
3. documented competence commensurate with level of training
4. successful completion and passing of the USMLE Step 3, COMLEX, etc. prior to entering the PGY-3 level
5. full compliance with all terms of the Resident/Fellow Agreement
6. continuation of the Sponsoring Institution and program ACGME accreditation

A trainee who is on probation may be promoted at the discretion of the program director and department chair. If the decision to promote is made, the probationary status remains in effect until the terms of the remediation agreement are met.

REASON FOR POLICY

Each training program is structured to assure that trainees assume increasing levels of responsibility commensurate with individual progress in experience, skill, knowledge, and judgment.

The term of the TIGMER Resident/Fellow 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 considerations to take into account when promoting trainees to the next level.

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Resident/Fellow Qualification Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

Eligibility

Residents:
Prior to their program start date residency 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 (AOA), OR
3. Graduation from a medical school outside the United States, Canada or Puerto Rico with one of the following:
    a. A current valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), OR
    b. An unrestricted license or residency permit to practice medicine in Texas, OR
    c. Successful completion of a Fifth Pathway Program in an LCME accredited medical school in the United States; and
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 trainees entering a program after a Transitional or Preliminary PGY-1 year, a written or electronic verification of previous educational experiences and a summative evaluation of the resident performance addressing the six ACGME competencies.

Fellows:
In addition to the previous 5 requirements, fellowship program applicants must also provide their program with documentation of the following qualifications to be eligible for appointment:

1. Graduation from an appropriate ACGME 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 previous educational experiences and a summative competency- based performance evaluation of the trainee.

Selection

1. Programs select from among eligible applicants based on their educational preparedness, ability, aptitude, academic credentials, communication skills and personal qualities such as motivation and integrity.
2. The Medical School 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. The Medical School 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.

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 of the transferring resident.
2. Proof that they have passed the USMLE Step 3 or COMLEX **for PG3 residents or higher.**

A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

REASON FOR POLICY

To outline specific qualifications required for eligibility and selection of residents/fellows (trainees) 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 Department/ Program Level.

FAQ

DEFINITIONS

RELATED INFORMATION

National Residency Matching Program ACGME Common Program Requirements
Texas Medical Board License Eligibility Requirements

Resident/Fellow Recruitment and Selection Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

Programs must have a policy in place and ensure the following requirements of the Sponsoring Institution and the Accreditation Council for Graduate Medical Education (ACGME) for all candidates (applicants) selected for an interview are met:

1. Candidates for programs must be informed, in writing or by electronic means, of the terms, conditions, and benefits of their appointment.

2. Programs should select from among eligible applicants on the basis of criteria such as educational preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Programs must not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status.

3. The program director, in conjunction with the program's Education Committee, if applicable, and/or teaching faculty reviews all applications, and personal interviews are granted to those applicants thought to possess the most appropriate qualifications, as determined by guidelines established by the program.

4. The Medical School participates in the Electronic Residency Application Service (ERAS), and 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.

5. An offer for residency training is extended directly to the applicant by the program director or his/her designee, through a letter of offer following the completion of the National Match.

6. 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 Department of all candidates accepted and providing a copy of the following:

    a. Copy of medical school diploma
    b. Documentation of any previous residency training
    c. Copy of Texas medical license (when available)
    d. Copy of ECFMG certificate (if applicable)

REASON FOR POLICY

To outline specific qualifications required for selection of residents/fellows (trainees) 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 Department/Program Level.

FAQ

DEFINITIONS

RELATED INFORMATION

National Residency Matching Program ACGME Common Program Requirements
Texas Medical Board License Eligibility Requirements

Restrictive Covenant Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

Trainees in TIGMER residency and fellowship programs will not be required to sign non-compete agreements or any other form of restrictive covenant.

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Transitions of Care/Handoffs Policy

Effective Date: February 2016
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 the quality and safety of patient care when transfer of responsibility occurs during duty hour shift changes and other scheduled or unexpected circumstances.

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, 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

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 duty 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 should 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 trainees 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
6. 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:
    a. There is a standardized process in place that is routinely followed
    b. There consistent opportunity for questions
    c. The necessary materials are available to support the handoff (including, for instance, written sign-out materials, access to electronic clinical information)
    d. A setting free of interruptions is consistently available, for handoff processes that include face-to-face communication
    e. Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines

---

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

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

Vendor/Conflict of Interest Policy

Effective Date: February 2016
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 (trainees) 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

To clarify the considerations residents and fellows should take into account 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 RESPONSIBILITIES

Program Directors are responsible for educating their trainees 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

Compensation and Benefits Policy

Effective Date: June 2018
Origination Date: February 2016

POLICY STATEMENT

Benefits

Current information on benefits are posted on the UIWHR website
https://my.uiw.edu/hr/employee-handbook.html

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

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Learner Disability Assessment and PsychoEd Evaluation Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

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

The costs associated with learner disability assessments and psycho-educational evaluations are the responsibility of the trainee. 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 trainee and the program to do so.
- If the assessment or evaluation is a condition of the trainee's appointment, then the cost of the assessment or evaluation is the responsibility of the program.

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Physician Impairment and Substance Abuse Policy

Effective Date: February 2016
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 to be insubordinate and will be subject to disciplinary action up to and including termination.

When a Resident has been identified, as having a substance abuse 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 (TPHP). The Resident will be removed from work pending evaluation and recommendations from the TPHP. The TPHP also evaluates professionals who may be experiencing mental disorders that interfere with patient care and professionalism.

If the TPHP recommends a treatment plan, TPHP 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 TPHP treatment plan recommendation and signed contract to the DIO. If the TPHP does not recommend its 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 he/she 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

The Sponsoring Institution 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 assure 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

Disability Accommodations Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

Please refer to the UIW employee handbook at: https://my.uiw.edu/hr/employee-handbook.html

Chapter 15

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Professional Liability Insurance Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

All interns and residents (house staff) in training are provided with professional liability (malpractice) insurance coverage for claims arising in the course of their training. "Moonlighting" is not covered.

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

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Counseling and Support Services Policy

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

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

Call 1-800-319-7819 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 housestaff 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 by calling 512-305-7462 or by visiting their web site at www.txphp.state.tx.us/index.html.The TXPHP can confidentially direct the resident or fellow to resources to assist with issues of impairment due to substance abuse or psychological illness.

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

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Holiday Leave Policy and Procedure

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

Holiday scheduling for trainees 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.

REASON FOR POLICY

To define who determines the holiday time off policy for residents/fellows (trainees) enrolled in TIGMER Graduate Medical Education training programs.

PROCEDURES

Program Responsibility

Programs are responsible for tracking time off for all leaves to insure that specialty board requirements are met prior to graduation from the program.

Programs must work with their trainees to report all leaves in the Residency Management Suite (RMS) according to instructions received by their program coordinator.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Bereavement Leave Policy and Procedure

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

A resident/fellow (trainee) shall be granted, upon request to the program director, up to 3 days off to attend the funeral of an immediate family member.

Please see UIW Employee Handbook Section 4.3 – Bereavement Leave
https://my.uiw.edu/hr/employee-handbook.html

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Medical Leave Policy and Procedure

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

The resident/fellow (trainee) please see UIW Employee Handbook Section 4.7 – Medical Leave of Absence
https://my.uiw.edu/hr/employee-handbook.html

REASON FOR POLICY

PROCEDURES

Trainee Next Steps

**** Check with your department/program to determine****:

- what type of paperwork 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.

Program Responsibility

Programs are responsible for tracking time off for all leaves to insure that specialty board requirements are met prior to graduation from the program.

Programs must work with their trainees 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.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Family Medical Leave Act Policy

Effective Date: February 2016
Origination Date:

POLICY STATEMENT

Residents and fellows (trainees) please see UIW Employee Handbook Section 4.8 – Family and Medical Leave

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

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Military Leave Policy and Procedure

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

The resident/fellow (trainee) 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 RRC and the Board of this change in status.

Please see UIW Employee Handbook Section 4.12 – Military Leave
https://my.uiw.edu/hr/employee-handbook.html

REASON FOR POLICY

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Vacation and Sick Leave Policy and Procedure

Effective Date: February 2016
Origination Date: February 2016

POLICY STATEMENT

RESIDENTS receive 15 paid vacation days and 10 paid sick leave days total per contract period. “Vacation” is defined as time off for a vacation or personal time, and “Sick” leave is defined as time off for personal or family illness. Vacation and Sick Leave are requests which require the Program Director’s approval. Unused Vacation and Sick Leave do not accrue and expire at the end of the contract.

REASON FOR POLICY

PROCEDURES

Program Responsibility

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

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

Programs are responsible for tracking time off for all leaves to insure that specialty board requirements are met prior to graduation from the program.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Moonlighting Policy

Effective Date: June 2017
Origination Date: June 2017

POLICY STATEMENT

The nature of the postgraduate training requires that residents understand their extensive clinical activity and availability to patients at times other than the regular working day and that the program has a continuing academic component that requires continual personal effort. 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 four (4) week block for a "call" rotation
- Maximum of 48 hours per four (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 duty 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

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

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

PROCEDURES

FORMS/INSTRUCTIONS

RESPONSIBILITIES

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

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

Professionalism – Code of Conduct

Effective Date:
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

PROCEDURES

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 trainees.
- 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.

FORMS/INSTRUCTIONS

RESPONSIBILITIES

FAQ

DEFINITIONS

RELATED INFORMATION

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.

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

FAQ

DEFINITIONS

RELATED INFORMATION

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.