GRADUATE MEDICAL EDUCATION

Non-ACGME Accredited GME Programs and Additional Training (700)

Clinical departments may offer training in a specialty area that is outside of the oversight of the Accreditation Council for Graduate Medical Education (ACGME). Non-ACGME accredited training programs fall into two types:

- Programs that are accredited or overseen by an American Board of Medical Specialties board or other accrediting agency that provides standards for the curriculum and training experiences.
- Programs for which there is no accreditation process or standard of oversight provided by an American Board of Medical Specialties board or other accrediting agency.

College of Medicine requirements for both situations are outlined below.

Accredited GME Programs Not Overseen by the ACGME

The College of Medicine will sponsor GME programs that are accredited or overseen by a recognized specialty board or other accrediting agency that provides standards for a structured curriculum and set of training experiences. Development of all such programs must be approved by the Graduate Medical Education Committee (GMEC). Each program is expected to follow all GME policies and procedures of the College of Medicine including but not limited to College of Medicine GME Eligibility Requirements, policy on clinical and educational work hours, and moonlighting.

Trainees will be considered employees of the College of Medicine and will sign a Resident Agreement similar to other College of Medicine residents and fellows. They will be afforded the same rights and privileges and held to the same standards of conduct as all other residents as outlined in the *Resident Handbook*.

Each program must maintain the following:

1. An appropriately credentialed program director with protected time sufficient to fulfill administrative and teaching responsibilities;
2. Program accreditation as defined by the recognized specialty board or other accrediting agency;
3. Stable funding;
4. An explicit and well-defined curriculum;
5. Fully developed supervisory and administrative policies consistent with all other College of Medicine GME programs;
6. Standards for evaluation and promotion of residents consistent with all other College of Medicine GME programs;
7. Signed formal Resident Agreements that outline the responsibilities of both the resident and the College which all participants are required to sign.

Oversight of program standards will be documented through the Annual Program Evaluation and Annual Program Review process as defined in GME policy 730.

Note: To maintain sponsorship by the College of Medicine, these programs must remain in good standing, comply with College of Medicine Policies and Procedures and complete the following each academic year.

1. Provide an up-to-date letter from the recognized specialty board or accrediting agency that shows the program is compliant with the requirements of accreditation or oversight. This letter must be provided to the Designated Institutional Official (DIO) as soon as it becomes available and must clearly indicate the standing of the program and the period of accreditation that has been granted by the oversight body.
2. The program must participate in the GMEC Annual Program Review Process (Policy 730). Based on the review findings, the GMEC may:
   a. Grant continued sponsorship
   b. Schedule a special review to:
      i. determine the status of the program and define the terms for continued sponsorship of the program, or
      ii. consider withdrawal of sponsorship and set an appropriate time frame for closure of the program.

Non-Accredited Graduate Medical Education Training

In order to obtain College of Medicine sponsorship of a graduate medical education program for which there is no formal oversight body, a clinical department has two choices.

1. The department may elect to formally request that a non-accredited program be approved by the Graduate Medical Education Committee (GMEC) of the College of Medicine and function as an approved but non-accredited training program under the College of Medicine. If the focus of the non-accredited program is contained within the scope of education of an accredited residency or fellowship program at OUCOM-Oklahoma City, then the non-accredited residency program must be directed or co-directed by a full-time member of the faculty from the accredited residency or fellowship program, who possesses ABMS certification in that specialty.
   a. A sponsored non-accredited residency program is considered a formal training program under the Graduate Medical Education (GME) Office and the GMEC.
   b. It is expected to meet all standards of accredited GME programs including
      i. An appropriately credentialed program director with protected time sufficient to fulfill administrative and teaching responsibilities;
      ii. Stable funding;
      iii. An explicit and well-defined curriculum;
      iv. Fully developed supervisory and administrative policies consistent with all other College of Medicine GME programs;
      v. Standards for evaluation and promotion of residents consistent with all other College of Medicine GME programs.
      vi. Signed formal Resident Agreements that outline the responsibilities of both the resident and the College which all participants are required to sign.
   c. To maintain sponsorship, the responsible department must be in good standing with any associated professional societies. If the responsible department has other fully accredited programs, these must also be in good standing with those accrediting bodies.
   d. The program must participate in the GMEC Annual Program Review Process (Policy 730). Based on the review findings, the GMEC may:

i. Grant continued sponsorship
ii. Schedule a special review to:
1. determine the status of the program and define the terms for continued sponsorship of the program, or
2. consider withdrawal of sponsorship and set an appropriate time frame for closure of the program.

e. Trainees will be considered employees of the College of Medicine and will sign a Resident Agreement similar to other College of Medicine residents and fellows. They will be afforded the same rights and privileges and held to the same standards of conduct as all other residents as outlined in the Resident Handbook.
f. Formal GMEC approval of a non-accredited residency and fellowship program is required, and the development of such a program must follow procedures outlined in GME Policy 709, Changes in Residency Program Structure, Size and Development of New Program.
g. These programs may be designated as either residency or fellowship programs.

2. The department may elect to offer a course of additional training without developing a formal program.
a. An additional training program within a department may be developed as long as there are no accreditation or recognition organizations providing standards for a structured curriculum and set of training experiences.
b. The department holds the full responsibility for oversight of the program and must meet the following requirements:
i. Additional training may only be offered to qualified professionals in a particular specialty who are qualified to become faculty.
1. Trainees shall be appointed as clinical instructors through the sponsoring department.
2. Contractual arrangements are made through the department.
3. Trainees must be credentialed by all appropriate credentialing bodies where their work and training will occur.
ii. Additional training programs must be for a specified period of time.
iii. Additional training programs cannot be offered if a formally accredited residency or fellowship program is already in place for this particular specialty.
c. The sponsoring department must send a letter to the GME Office providing the name(s) of individual(s) receiving additional training prior to first day of training.
d. At the completion of training, the individual is eligible for a College of Medicine Certificate of Additional Training for the period of time completed.
i. The sponsoring department must send a letter to the GME Office reflecting the information that should appear on the certificate.
ii. The certificate(s) will indicate verification of "additional training", but will not use the term “residency” or "fellowship."
iii. The GME Office will maintain a copy of this certificate.
e. All departments providing additional training opportunities must assure that the number of learners and the work done by them does not dilute the required experience of learners in the accredited and non-accredited residency and fellowship programs sponsored by the department and the College of Medicine.
f. These programs may be designated as additional training programs and may not be designated as residency or fellowship programs.

- **Policy Date: 05/13/2004**
- **Approved By: Graduate Medical Education Committee**
- **Date Revised: 10/14/21**
- **Date Reviewed: 10/14/21**

Guidelines for Mental Health Services for Residents or Fellows (701)

Mental health services are available for residents and fellows at all times. The College of Medicine provides access to these mental health services through several mechanisms. Mental health services are confidential and are includes as in the employee benefits programs. Services include assessment, counseling, and treatment. Non-urgent care may be provided through the Clinical Practice Group, the Employee Assistance Program, and university health insurance plans during usual business hours. Urgent care may be provided through the Employee Assistance Program, Student Counseling, and through the Emergency Department which is available 24 hours a day 7 days a week.

Periodically, program directors find it necessary to arrange for a resident to be seen by a mental health professional and to have reports from the mental health professional sent to the program director.

The content and frequency of reports from the mental health professional will be specified in writing in a letter from the program director to the resident when the treatment is initiated. An appropriate signed HIPAA Authorization form will be obtained from the resident permitting the mental health professional to share certain information with the program director.

Additional resources are available by contacting the GME Office.

- **Policy Date: 05/06/1997**
- **Approved By: Graduate Medical Education Committee**
- **Date Revised: 10/14/21**
- **Date Reviewed: 10/14/21**

Appointment of Advanced Residents to Faculty Positions (702)

Residents and fellows actively enrolled in the College of Medicine's graduate medical education programs are generally **not** eligible for faculty appointments.

However, there are limited instances in which residents or fellows who are taking training beyond that required by the ACGME or certifying board, and who provide specific teaching and other services, may qualify for a modified faculty appointment subject to the following:

- Residents and fellows may be appointed only as volunteer faculty with the title of Clinical Instructor.
- Additional funds for teaching or other services paid to the resident/fellow above the standard GME stipend are processed as special pay requests or added to the annual salary using a departmental or clinical funding source.
- Due to the temporary designation of instructor appointments for residents or fellows, the trainee is not eligible for University-funded participation in the Oklahoma Teachers Retirement System or other

retirement plans. Residents and fellows with temporary appointments as clinical instructors may be eligible to participate in retirement plans administered by the University and/or by OU Health.
- Any exceptions to this policy must be approved in writing by the Dean or DIO.

- **Policy Date: 05/06/1997**
- **Approved By: Graduate Medical Education Committee**
- **Date Revised: 10/14/21**
- **Date Reviewed: 10/14/21**

DEA Registration Regarding Interns and Residents (703)

Scope

This policy applies to interns and residents who do not have a full Oklahoma Medical License and therefore are unable to obtain a DEA registration. All residents and fellows who hold a full and unrestricted Oklahoma Medical License should obtain an individual DEA registration which, for program assigned activities, is Fee Exempt.

According to Federal Drug Enforcement Administration (DEA) policy:

Practitioners (e.g., intern, resident, staff physician, mid-level practitioner) who are agents or employees of a hospital or other institution, may, when acting in the usual course of business or employment, administer, dispense, or prescribe controlled substances under the registration of the hospital or other institution in which he or she is employed, in lieu of individual registration provided that:

- The dispensing, administering or prescribing is in the usual course of professional practice;
- The practitioner is authorized to do so by the state in which they practice;
- The hospital or institution has verified that the practitioner is permitted to administer, dispense, or prescribe controlled substances within the state;
- The practitioner acts only within the scope of employment in the hospital or institution;
- The hospital or institution authorizes the practitioner to administer, dispense, or prescribe under its registration and assigns a specific internal code number for each practitioner.

An example of a specific internal code number is as follows:

Hospital DEA Registration Number *AB1234567 – 012 Physician's Hospital Code R or I

1. The identifying suffix assigned to residents and interns will include an alpha designator along with the three-digit suffix. They will assign either "R" or "I" as part of the number indicating either resident or intern.
2. Residents should expect to have their prescriptions filled as written; interns must have their prescriptions countersigned by a DEA-licensed physician.
3. Residents who already have an assigned suffix and do not have an alpha character should include the words "resident physician" with their signature. Interns should sign "intern" and their prescriptions will be countersigned.

A current list of internal codes and the corresponding individual practitioners is to be maintained by the hospital or other institution. This list is to be available at all times to other registrants and law enforcement agencies upon request for the purpose of verifying the authority of the prescribing individual practitioner. Pharmacists should contact the hospital or other institution for verification if they have any doubts in filling such prescription.

Please Note: The use of the "institutional number" applies only within the scope of employment in the hospital, i.e., in residency program assigned activities. To use the registration for practice outside this scope, e.g. "moonlighting," a Fee Paid DEA Registration must be obtained.

- **Policy Date: 06/30/1996**
- **Approved By: Graduate Medical Education Committee**
- **Date Revised: 10/14/21**
- **Date Reviewed: 10/14/21**

Release of Resident Information (704)

Release of Directory Information

In compliance with the Family Educational Rights and Privacy Act ("FERPA"), the College of Medicine is periodically required to provide "directory information" concerning residents to Medicare, Office of the Inspector General, and other designated authorities for the purpose of auditing costs of graduate medical education. Directory information may also be requested by any other 3rd party.

"Directory Information", as stipulated in the FERPA includes name, address, telephone listing, date and place of birth, major field of study, dates of attendance, degrees and awards received, and the most previous educational agency or institution attended.

Note: For purposes of this policy, FERPA only applies to residents who are medical school graduates from the University of Oklahoma College of Medicine.

Resident photos are not considered "directory information" and require a separate approval for release.

Release of Information Regarding Resident Academic/ Professional/Legal Issues to Affiliated Institutions

There are circumstances in which the OU College of Medicine and/ or a residency or fellowship program becomes aware of information pertaining to alleged or actual resident misconduct that an affiliated facility needs to know in order to ensure a safe work and/or care environment for staff and patients. This may include (but is not limited to):

1. Arrest (other than for routine traffic violations);
2. Evidence of substance and/or alcohol abuse;
3. Evidence of abnormal behavior affecting the physician's ability to provide clinical care services;
4. Evidence of unprofessional behavior affecting the physician's ability to provide clinical care services;
5. Corrective action or changes in academic standing involving a need for increased supervision or limited role in or withdrawal from patient care.

In the event of such circumstances, the training program and GME office will work in conjunction with University of Oklahoma Legal Counsel to

determine the specific information that should be shared with affiliated institutions.

- **Policy Date: 05/01/1995**
- **Approved By: Graduate Medical Education Committee**
- **Date Revised: 10/14/21**
- **Date Reviewed: 10/14/21**

Resident/Fellow Appointment Stipend Levels (705)

Individuals appointed to residency or fellowship positions are to be paid at the functional level to which they are appointed, not at a higher level related to some prior training. The functional level is defined as the actual training level, in accordance with ACGME and Board Requirements, for the program in which the trainee is currently engaged, without regard for other training or research years.[1]

Some examples follow:

1. Individuals graduating from medical school and entering the first year of residency training are paid at the P1 level.
2. Individuals who complete partial training in one discipline, then change to another discipline where they begin as a first-year resident are paid at the P1 level. For example, an individual spends one year in internal medicine training (P1), then transfers to a surgical training program where they start as a surgery "intern" is paid at the P1 level again, rather than at a P2 level.
3. Individuals who complete partial training in a given discipline elsewhere, then transfer here to complete training are paid at the usual level. For example, an individual completes two years (P1 and P2) of internal medicine training elsewhere, then transfers to OUHSC to continue training in internal medicine would be paid at the P3 level.
4. Individuals who complete partial clinical training in a discipline, enter a specialized area for a year or two, then re-enter clinical training are paid at the functional level to which they return. For example, an individual completes two years of internal medicine training (P1 and P2), then enters a specialized program, not in clinical training for two years, then returns to finish core internal medicine training. Upon re-entering the core program, the individual will be paid at the P3 level, not at the P5 level.
5. Individuals who completed residency training in a discipline, entered practice for several years, then obtain an appointment for residency training in a new discipline are to be paid at the entry level. For example, an individual completed three years of family practice training (P1-P3) in 2000, then obtains a residency in general surgery beginning in 2015 will be paid at the beginning P1 level; they will not start pay at the P4 level.

[1] Starting training levels may vary for programs with alternative training pathways such as Pain Medicine, Sleep Medicine, Child & Adolescent Psychiatry, and Radiology fellowships.

- **Policy Date: 02/17/1995**
- **Approved By: Graduate Medical Education Committee**
- **Date Revised: 10/14/21**
- **Date Reviewed: 10/14/21**

Resident Records and Retention of Records (706)

The following documents shall be maintained in resident files during the period of residency training:

- Copies of a formal summative evaluation from any prior GME training (if applicable) assuring that the resident meets requirements for training at a particular PGY level and verifying the resident's level of competency in the field
- Copies of signed contracts and letters of appointment
- ERAS application or specialty application for non-ERAS programs
- ECFMG documentation
- Medical school diploma and/or medical school transcript with graduation date
- Copies of letters or memos to resident
- Evaluation forms from multiple evaluators, including self-evaluations, as specified in ACGME requirements
- Record of evaluation discussions with resident to include semiannual and final summative evaluations
- Record of rotations schedule for resident which, when required, are adequate to document completion of requirements for specialty boards
- Special achievements
- Scores of any required examinations that influence evaluation of resident
- Records of required additional training such as ACLS, PALS, etc.
- Records of scholarly activity and quality improvement projects, including records of presentations, abstracts, and publications
- Record of procedural log as required by ACGME, specialty board, or program
- Record of any administrative academic actions as outlined in the *Resident Handbook*
- Record of any disciplinary actions
- Moonlighting written approval by the program director
- HIPAA Forms/Encryption Forms (HR and GME)

The following individuals have access to resident files:

- The individual resident
- Program director and/or department chair
- Program director's administrative assistant handling resident matters
- Any committee of the faculty designated by the program director to participate in resident evaluation and determination of promotion
- The DIO for Graduate Medical Education as required to handle administrative academic actions or disciplinary issues
- Any person within the institution with a *legitimate* need for access

The following documents shall be maintained in a resident's permanent file following a resident's successful completion of a training program:

- Copies of signed contracts or other documents indicating *actual dates of service* as a resident
- ERAS application or specialty application for non-ERAS programs
- ECFMG documentation
- Medical school diploma and/or medical school transcript with graduation date

- Record of rotations schedule for resident which, when required, are adequate to document completion of requirements for specialty boards
- Final summative evaluation of all training completed and preparedness for independent, unsupervised practice
- Letters and summative evaluation provided to a training program regarding a transfer resident
- Record of procedural log as required by ACGME, specialty board, or program
- Record of any attestation by program director to a specialty certification board of declaration of eligibility to sit for the certifying examination
- Record of any formal administrative academic action as outlined in the *Resident Handbook* (if any exist, then the individual evaluations of the resident that are germane to the action should be retained)
- Record of any disciplinary action (if any exist, then the individual evaluations of the resident and other documents that are germane to the action should be retained)
- Moonlighting written approval by the program director
- HIPAA Forms/Encryption Forms (HR and GME)

The following documents shall be maintained in a resident's permanent file should a resident not successfully complete a training program:

- Copies of signed contracts or other documents indicating *actual dates* of service as a resident
- ERAS application or specialty application for non-ERAS programs
- ECFMG documentation
- Medical school diploma and/or medical school transcript with graduation date
- Evaluation forms from multiple evaluators, including self-evaluations, as specified in ACGME requirements
- Record of evaluation discussions with resident to include semiannual and final summative evaluations
- Record of rotations schedule for resident including rotations successfully completed
- Record of training experiences including training experiences successfully completed
- Documents explaining the reason the resident did not complete the program (resignation vs. termination)
- Letters and summative evaluation provided to a training program regarding a transfer resident
- Record of procedural log as required by ACGME, specialty board, or program.
- Copies of any letters to or from resident indicating non-renewal of appointment, termination of training and reasons, program resignation, and anything else that may assist you later in explaining reasons for resident not completing program
- Record of any administrative academic action as outlined in the *Resident Handbook*
- Record of any disciplinary action
- Moonlighting written approval by the program director
- HIPAA Forms/Encryption Forms (HR and GME)

The length of time these documents shall be maintained and the format in which they shall be maintained is as follows:

- The permanent file, in its final form, should be maintained indefinitely.
- The program may maintain files in hard paper form or by an appropriate image retrieval system.

Document	During Training	Successful Completion	Unsuccessful Completion
Final summative evaluation from all prior GME training verifying resident level of competency	X	X	X
Signed contracts and letters of appointment	X	X	X
ERAS or specialty application	X	X	X
ECFMG documentation	X	X	X
Medical school diploma and/or transcript with graduation date	X	X	X
Letters or memos to resident	X		X
Evaluations from multiple evaluators, including self-evaluations	X		X
Semiannual evaluations and discussions with resident	X		X
Final summative evaluation		X	X
Letters and summative evaluation provided to a training program regarding a transfer resident		X	X
Rotations schedule	X	X	X (note successfully completed)
Training experiences			X (note successfully completed)
Special achievements	X		
Required examinations	X		
Required additional training	X		

Scholarly activity and quality improvement projects, presentations, abstracts, and publications	X		
Procedural log	X	X	X
Attestation to specialty certification board of eligibility for the certifying exam		X	
All administrative academic actions	X		X
Non-remediated administrative academic actions		X	
Disciplinary actions	X	X	X
Explanation of reasons for non-completion			X
Letters to or from resident indicating non-renewal, termination, resignation, or other related correspondence			X
Moonlighting written approval	X	X	X
HIPAA Forms/ Encryption Forms	X	X	X

- **Policy Date: 11/04/1999**
- **Approved By: Graduate Medical Education Committee**
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- **Date Reviewed: 10/14/21**

Institutional Policy on Clinical and Educational Work Hours (707)

1. Clinical and educational work hours must be consistent with the current respective Review Committee (RC) Program Requirements and the ACGME Institutional Requirements that apply to all programs. Each program must document compliance with the clinical and educational work hours requirements of its specific RC. The current clinical and educational work hours requirements are available on the ACGME website at: www.acgme.org (http://www.acgme.org).
2. Each program will be responsible for promoting patient safety and resident and faculty well-being and assuring a supportive educational environment.
3. The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations.
4. Each program must ensure that residents are provided appropriate backup support when patient care responsibilities are especially difficult or prolonged or in the event that a resident is unable to perform their patient care responsibilities.
5. Each training program will establish formal policies governing resident clinical and educational work hours that foster education, provide reasonable opportunities for rest and personal well-being, and facilitate the care of patients.
6. Clinical and educational work hours must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Nonetheless, resident clinical and educational work hours and on-call time periods must not be excessive. In addition, all clinical and educational work hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.
7. Each training program will assure accurate and timely reporting of clinical and educational work hours via the MedHub Residency Management System and formally monitor resident clinical and educational work hours for compliance. Programs will provide prompt and accurate responses to concerns raised by the GMEC as part of its institutional monitoring program.
8. Moonlighting, whether paid or unpaid, must be included in clinical and educational work hours reported via the MedHub system, and count toward ACGME designated maximum allowable hours.
9. Clinical and educational work performed from home must be included in clinical and educational work hours reported via the MedHub system, and count toward ACGME designated maximum allowable hours.
10. Should an area of non-compliance be identified, the program will immediately notify the GMEC of the method of resolution instituted by the program or formally request GMEC assistance in resolving the non-compliance if necessary.
11. The program will assure that didactic and clinical education has priority in the allotment of residents' time and energy.
12. The program will assure that faculty and residents are appropriately educated to recognize the signs of fatigue and sleep deprivation and will adopt policies to prevent and counteract its potential negative effects on patient care and learning.

- **Policy Date: 08/2000**
- **Approved By: Graduate Medical Education Committee**
- **Date Revised: 10/14/21**
- **Date Reviewed:10/14/21**

Program Closure and Reduction (708)

Although the University expects to receive the full funds necessary to support the current fiscal year budget, it reserves the right to institute budget reduction actions in accordance with State law, including changes in resident salary and/or benefits or program closure. In the event of a reduction or closure of a program, the University will make every effort to allow residents in the program to complete their education. If any residents are displaced, the University will make every effort to assist

the residents in identifying programs in which they can continue their education.

- GMEC will oversee all processes related to reductions in size and closures of individual programs, major participating sites, and the Sponsoring Institution.
- When the University intends to reduce the size of or close any program or the Sponsoring Institution, the University will inform the GMEC, DIO, and affected residents/fellows as soon as possible.
- The University will allow residents in an affected program to complete their education at the Sponsoring Institution or assist them in enrolling in another ACGME accredited program in which they can continue their education.

- **Policy Date: 08/2000**
- **Approved By: Graduate Medical Education Committee**
- **Date Revised: 10/14/21**
- **Date Reviewed: 10/14/21**

Changes in Program Structure, Size and Development of New Programs (709)

All proposed changes to residency training programs including ACGME or ABMS accredited and non-accredited programs are handled through the Graduate Medical Education Committee (GMEC) of the College of Medicine. The Academic Affiliation Council will also review those proposals requiring additional funding. Additionally, the Veterans Affairs Medical Center (VAMC) may be required to review these proposals.

For ACGME accredited programs, the ACGME requires the GMEC to review and approve all proposals prior to submission to the ACGME. In addition, all correspondence and applications to the ACGME must be co-signed by the Designated Institutional Official (DIO). For the College, the DIO is the Associate Dean for Graduate Medical Education (refer to policy 715). This policy also applies to non-accredited programs (refer to policy 700).

Reasons for Program Changes

There are five major reasons that programs and departments may find it necessary or desirable to change. These include:

- The need to increase or decrease the number of residents in a training program.
- Changes in the number of required years of training within a discipline.
- The decision to organize and apply for the development and accreditation of a new program.
- The decision to voluntarily request withdrawal of an accredited training program.
- The decision to move any major site of training for a program.

Such changes frequently impact other training programs, patient care, and resources of the associated institution. Because of this, all potential changes must be considered in the light of how those changes can or will affect the institutions and departments involved. Coordination of resources and workforce is of the utmost importance and must be considered within the context of the ability of all involved institutions to meet their goals and responsibilities.

Procedure

Creation of a Proposal for Program Changes

A proposal must be sent to the Office of GME for review by the GMEC. Proposals should include the information noted below and be made available for review no later than three weeks prior to the meeting of the GMEC which is held generally monthly. A schedule of meeting times is available through the Office of GME. In addition, program directors and/or department chairs should appear before the GMEC to briefly discuss the proposal. The presentation of the proposal should last no more than ten minutes. The program's ACGME Review Committee meeting calendar should be reviewed with regard to deadlines.

Information to be included in a proposal:

- The explicit reason for the proposed change.
- How the proposed change could affect the educational mission of the program and department. For new programs and major changes, how the proposal addresses the strategic goals of the College. How changes will affect the growth and development of the affiliated institutions.
- How accreditation requirements affect proposed changes. How the requirements will be assured. Proposals for new programs must indicate how critical accreditation requirements will be met.
- How changes will be handled so as not to adversely affect clinical care or other training programs. Letters of support from chairmen, clinic managers, and/or program directors are an important part of the proposal.
- The financial implications for the proposed changes. Indicate how the program intends to finance the new positions or programs.

Review of the Proposal

Proposals referred by the GMEC are subsequently reviewed by the Office of GME in collaboration with the leadership of the College and the affiliated institutions to assess how they meet the strategic goals. The review has the following actions or options available:

- Proposals will be approved and forwarded to the appropriate funding entities for determination of funding or reallocation of resources. The GME budget will be amended to reflect agreed upon changes. A formal notification will be provided to the GMEC if action is required.
- Proposals will be tabled for further information.
- Proposals will be rejected if felt not to be in the best interest of the College and its affiliated institutions.

Review by the GMEC

Once the proposal has been presented to GMEC, the GMEC may question the presenter on the content noted above. The role of the GMEC is to assure that the proposal is educationally sound, meets the requirements of accrediting bodies, and meets the strategic goals of the College. The GMEC has the following options or actions available:

- Approve the proposal if the GMEC determines that the proposal is sound and is in the best interest of the institution.
- Table the proposal and ask for additional information.
- Reject the proposal if it is not educationally sound or is not in the best interests of or has the likelihood of adversely impacting the College and its affiliated institutions.

Review by the Academic Affiliation Council and/or Associate Chief of Staff for Education at the VAMC

Some proposals may be required to be reviewed and acted upon by the Academic Health Systems Council or the VAMC. The GMEC and the

Office of GME will be informed of actions approved by these entities, and appropriate changes to the budget and/or allocations will be made. Any correspondence with sponsoring institution and/or accrediting bodies that is necessary for approval must be coordinated through the Office of GME.

- **Policy Date: 5/22/2001**
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- **Date Revised: 10/14/21**
- **Date Reviewed: 10/14/21**

Visiting Residents (710)

Educational programs and learners may benefit when the opportunity for a learning experience is afforded to residents from another institution. Therefore, residents from programs that are accredited by The Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or that are formally sponsored by an affiliated institution may participate in visiting Graduate Medical Education experiences at The University of Oklahoma College of Medicine (OU COM) in accordance with the procedure outlined below.

Applications

Applications to participate in a Graduate Medical Education (GME) experiences must be made in writing from the Program Director of the requesting program to the Program Director of the appropriate OU COM department and follow the process noted below:

1. A Visiting Resident Application Form and the following documentation must be received and reviewed by the Program Director before approval may be considered or granted:
   a. A letter from the program director attesting to the resident's good standing in that program and endorsing the request to participate in the OU COM learning experience.
   b. Proof of appropriate Oklahoma medical licensure (defined as a valid special medical license, full medical, or DO license as required by OU COM policy for the appropriate level of training)
   c. Proof of Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) and Drug Enforcement Administration (DEA) registration if applicable for the experience, as well as current certification in Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), or Advanced Trauma Life Support (ATLS) as required by the Program or Affiliated Institution.
   d. Proof of adequate professional liability insurance coverage, meeting the minimum limits required by institutions where experiences will occur, and for the dates of the experience. Preferred proof is certification by the insurance carrier. Minimum information required in a certification includes the name and address of the carrier, the dates of coverage, policy type and policy limits.
   e. Proof of appropriate health screenings required by OU Physicians Employee Health and the affiliated training sites where the learner will be participating in the care of patients (see checklist attached to the Visiting Resident Application).
   f. Proof of HIPAA training: Completion of OU on-line HIPAA training or current proof of completion from home institution and completion of the Incoming Trainee Confidentiality Agreement.
   g. Any applicable/required GME Letters of Agreement as requested by the OU COM and/or teaching hospital(s) through which the resident may rotate.
2. After receipt, review, and verification of all material, the OU COM Residency Program Director will be responsible for approving all visiting resident rotations and render a decision to approve or reject the proposed visiting resident and/or rotation. Considerations include availability of faculty supervision, adequacy of case volumes, scheduling and educational constraints, and administrative resources available to manage visit residents. Program Director approvals/rejections will be forwarded to the Office of GME for review and approval.
3. Upon approval from the Office of GME, the Program Director will respond with the decision, in writing, to the Program Director of the requesting GME program. Only applicants with an approved application will be allowed to participate in an OU COM GME experience.

Evaluations

Upon completion of the learning experience, a written evaluation will be prepared by the appropriate OU COM department and forwarded to the resident's program director. A copy will be maintained by the program for documentation and verification purposes.

Please Note: no evaluation will be provided to the resident's program director until the OU COM training program has confirmed that all medical records have been completed by the visiting resident.

Adherence to Institutional Policy

During the time spent at OU COM, the visiting resident must abide by institutional policies and procedures as outlined in the Resident Handbook, and as required by training sites.

Copies of all correspondence and documentation will be forwarded to the Office of GME.

The visiting resident policy may be modified at any time to ensure compliance with institutional and clinical site requirements.

- **Policy Date: 11/08/2001**
- **Approved By: Graduate Medical Education Committee**
- **Date Revised: 10/14/21**
- **Date Reviewed: 10/14/21**

Resident Eligibility, Selection, and Required Documentation (711)

Eligibility Criteria for Appointment to PGY1 Positions

Education and Certification Requirements

Applicants for graduate medical education programs sponsored by the University of Oklahoma College of Medicine and its clinical departments are eligible for appointment if they meet *one* of the following qualifications:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education who have passed Step 1 and Step 2 CK of the United States Medical Licensing Examination (USMLE). (No more than three attempts per USMLE step allowed by state licensing board.)
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association who have passed Level 1 and Level 2 CE of the COMLEX USA. (No more than three attempts per COMLEX Level allowed.)

3. Graduates of medical schools outside the United States and Canada who meet *both* of the qualifications noted below. To assure that eligibility standards are met, prior to ranking or offering a position to an IMG, programs must complete the Resident Eligibility Checklist and submit the completed form to the GME Office. The checklist can be found under GME Documents in MedHub. Failure of the applicant to obtain all required qualifying elements will result in either withdrawal of the residency offer or immediate termination of the residency appointment if an agreement has been signed. These actions will be taken even if the applicant was matched through a program such as the National Resident Matching Program (NRMP).
    a. Hold a valid Standard Certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) the requirements for which include passing both Step 1 and Step 2 CK of the USMLE. Eligibility requirements can be found at www.ECFMG.org (http://www.ECFMG.org). It is the responsibility of the applicant to complete all ECFMG requirements, visa requirements, and licensure requirements before beginning residency training. Failure to do so may result in withdrawal of the residency offer or immediate termination of the residency appointment.
    b. Are citizens of the United States or hold either a J-1 visa or a permanent immigrant visa ("green card"). An H-1B visa or Employment Authorization Document (EAD) in appropriate categories will be considered on a case by case basis and must be approved prior to ranking by the DIO.

Note: Non-U.S. Citizens who are graduates of medical schools in the United States and Canada are not considered international medical graduates and do not require ECFMG sponsorship, however, they must meet visa requirements as noted above.

Licensure and Federal Eligibility Requirements

Additionally, all applicants to residency programs will be considered only if, at the time of application, they are eligible for all of the following items:

1. Appropriate licensure in the State of Oklahoma. For allopathic physicians and international medical graduates, refer to Oklahoma Administrative Code Sections 435:10-4-4 through 435:10-4-6 available at the Oklahoma State Board of Medical Licensure website (www.okmedicalboard.org (http://www.okmedicalboard.org)) under Rules, Laws and Policies. For osteopathic physicians, refer to the Oklahoma Board of Osteopathic Examiners website at www.osboe.ok.gov (http://www.osboe.ok.gov).

   As applicants who are currently U.S. senior allopathic or osteopathic medical students will not yet qualify for medical licensure at the time of completing their residency application, verification of their anticipated graduation date via their Dean's letter will be sufficient to include the applicant on the National Resident Matching Program Rank Order List.
2. Participation in Federally qualified health programs such as Medicare and Medicaid. A list of individuals with sanctions that disqualify their participation can be found on the Health and Human Services Office of Inspector General Website at www.oig.hhs.gov (http://www.oig.hhs.gov).

Issues that may preclude eligibility for the above items include, but are not limited to, prior felony convictions, substance abuse, malpractice judgments or settlements, or disciplinary actions by a state medical board.

Eligibility Criteria for Appointment to PGY2 and Above Positions

In addition to the qualifications noted in the sections above regarding PGY1 positions, initial appointments and all re-appointments of residents currently in GME programs to levels of training beyond the PGY1 level must also meet the following requirements:

1. US Graduates: Allopathic (MD) and Osteopathic (DO) applicants or re-appointments at the PGY2 and above must have passed Steps 1-3 of their respective licensure examinations (USMLE for allopathic and COMLEX for osteopathic) and possess an unrestricted license in the State of Oklahoma. Renewal of the Resident Agreement for the PGY2 year is contingent upon passing the respective Step 3 examination. Failure of a current resident to pass Steps 1-3 and obtain an unrestricted license by the expected time of promotion to the PGY2 level will result in termination as determined by the Associate Dean for GME.
2. International Medical Graduates: Applicants or re-appointments at the PGY2 and above levels must have passed Steps 1-3 of the USMLE. Renewal of the resident agreement for the PGY2 year is contingent upon passing the Step 3 examination. International Medical Graduates must complete 2 years of ACGME accredited training to be issued an unrestricted Oklahoma license.

Renewal of the resident agreement for the PGY3 year is contingent upon receiving an unrestricted medical license. Failure of an International Graduate to pass Steps 1-3 of the USMLE prior to the beginning of the PGY2 year and obtain an unrestricted licensure by the expected time of promotion to the PGY3 level or above will result in termination as determined by the Associate Dean for GME.

Selection Process

Residents must meet ACGME eligibility requirements in effect at the time of appointment. Residents are selected from among eligible, qualified applicants on the basis of their academic credentials, abilities, aptitude, preparedness, communication skills, and personal qualities including motivation and integrity. The University of Oklahoma, in compliance with all applicable federal and state laws and regulations does not discriminate on the basis of race, color, national origin, sex, sexual orientation, genetic information, gender identity, gender expression, age, religion, disability, political beliefs, or status as a veteran in any of its policies, practices, or procedures. This includes, but is not limited to: admissions, employment, financial aid, and educational services.

For an allopathic applicant to be eligible for ranking within the NRMP the applicant must have taken and submitted documentation to the program of a passing score for Step 1 and Step 2 CK.

For an osteopathic applicant to be eligible for ranking within the NRMP the applicant must have taken and submitted documentation to the program of a passing score for COMLEX Level 1 and Level 2 CE.

1. First Postgraduate Year
   First-year residency positions will be offered to U.S. graduating seniors selected through the National Resident Matching Program (NRMP). Most residency programs require applicants to apply through the Electronic Residency application Service (ERAS). First-year residency positions offered to candidates other than U.S. graduating seniors will also be selected through an organized matching program, except in special circumstances allowed by national matching program policies. Programs and applicants for

these positions should consult the publications of the NRMP for specific requirements and deadlines.

2. Second Postgraduate Year and Above
   Appointments for second year and above levels are made in accordance with policies established by each specialty program in compliance with the standards of the NRMP, Accreditation Council for Graduate Medical Education (ACGME), its Residency Review Committees, and the requirements of the respective American specialty certification boards. Selections for advanced level positions are generally made through an organized matching program when a matching program exists for the specialty or subspecialty. Programs and applicants for these positions should consult the publications of the NRMP for specific requirements and deadlines. The PGY level of the initial appointment is determined by the amount of previously completed graduate medical education that is acceptable for credit by the specialty board of the training program to which the resident is appointed and the functional level at which training will be pursued.

   All previous GME training must be assessed and verified by the program director prior to appointment and assigning level of training. Whenever there is uncertainty in this regard, the applicant shall obtain from the specialty board a written appraisal of previous training and a statement of additional training requirements that must be met to qualify the resident for certification by that board.

Providing false or misleading statements, or failure to provide complete and accurate information on an application for acceptance to an OU residency program will result in the inability of the resident to meet the OU College of Medicine Eligibility and Selection Policy.

Residents selected for appointment as a resident will not be required by the University of Oklahoma College of Medicine nor any of its training programs to sign a non-competition guarantee or restrictive covenant.

Documentation of Previous Training and Resident Transfers

When residency training has been done in another OU residency program or at an outside institution, the OU College of Medicine program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the resident prior to extending an offer to enter training. Refer to the ACGME specialty-specific program requirements for additional information.

Examples of verification of previous educational experiences could include a list of rotations completed, evaluations of various educational experiences, and procedural/operative experience, or a certificate of successful completion of residency training.

Meeting the requirement for verification before accepting a resident is complicated in the case of a resident who has been simultaneously accepted into the preliminary PGY1 program and the PGY2 program as part of the match. In this case, the “sending” program should provide the “receiving” program a statement regarding the resident’s current standing as of one to two months prior to anticipated transfer along with a statement indicating when the summative competency-based performance evaluation will be sent to the “receiving” program.

Any previous training that a transferring resident has completed and been given any credit for by a certifying specialty Board must be discussed with the DIO. The transferring resident will not be given partial credit to promote to the next PGY level early but will be assessed at the end of training and may be allowed to graduate early as long as they meet competency.

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- **Date Reviewed: 10/14/21; 10/10/2023**

Resident Moonlighting (712)

Moonlighting is defined as any professional medical activity outside the usual training experience and includes both compensated and uncompensated (e.g., voluntary) activities. The University of Oklahoma College of Medicine and its program directors must closely monitor all moonlighting activities to insure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program, the resident’s fitness for work or patient safety. Therefore, residents must obtain prior written approval from their program director to moonlight and must submit all moonlighting hours into MedHub, the clinical and educational work hours tracking system.

All moonlighting activities must be approved by the DIO prior to participation by a resident in any moonlighting activity.

Moonlighting requests must be submitted through MedHub and approvals by the program director and DIO will be communicated to the resident by automated emails through MedHub.

Unsupervised moonlighting (a.k.a. "external moonlighting") refers to professional medical activity engaged in by the resident outside the context of the residency program and where the resident acts as an independent contractor. Some residents may choose such work in their free time to supplement their incomes or to incorporate experiences not otherwise found in their formal training programs. This practice can be beneficial to the individual if prudently employed. If abused, however, patient care may suffer, the training of the individual may be impaired, and the burdens imposed upon peers may become excessive. Some residency programs do not allow or strongly discourage moonlighting activities, while other programs accept such activities as long as they do not compromise the resident's ability to meet his/her obligations to assigned patient care and to satisfy program performance requirements. A resident may not, however, under any circumstances open or work in a self-owned private practice office while in training. Professional liability insurance coverage for unsupervised moonlighting is not provided under standard coverage provided for residency education and is fully the responsibility of the resident. External moonlighting at sites affiliated with the institution may only be performed in an outpatient setting or in the emergency department.

Supervised Moonlighting (a.k.a. “internal moonlighting”) is fully supervised patient care that is over and above the usual program training experiences and is for the express purpose of additional elective supervised training. The Program Director must assure that all such activities are fully supervised and evaluated in accordance with all applicable College and affiliated institutional policies on resident supervision including clear documentation in the medical record of the supervision provided. Though there may be extra compensation for this activity, the activity is considered supplementary to the resident's formal training and is not a substitute for the formal core curriculum.

Professional liability coverage for supervised moonlighting is covered under the resident's policy for residency training. Moonlighting which is not a part of the resident’s training program (i.e., external moonlighting)

is not covered by the resident's OU professional liability coverage. Any resident approved for external moonlighting must obtain separate coverage for that activity.

Moonlighting is an optional activity that is generally discouraged because the time burden competes with the opportunity to study and reduces opportunities to rest and have a more balanced lifestyle. No resident of the University of Oklahoma College of Medicine may be required to engage in moonlighting activities, either unsupervised or supervised, that may be needed to cover services within the affiliated institutions. Supervised moonlighting within the context of the residency program, as well as unsupervised moonlighting that occurs within the sponsoring institution and its affiliated clinical training sites, must be counted toward the clinical and learning work hour limitations established by the Accreditation Council for Graduate Medical Education.

As stipulated in the residency contract, residents agree not to engage in any moonlighting activity without the explicit knowledge and prior written approval of the residency's Program Director and the DIO. This written approval, generated through MedHub, must become a part of the resident's file. Based on these limitations, the discretion of the program director, and/or resident's performance in the program, the Program Director will inform the resident in writing of any limitations on his or her moonlighting activities.

Any type of moonlighting without the knowledge and prior written approval of the Program Director and DIO is considered grounds for immediate dismissal from the training program. Residents must also be monitored by the Program Director for the effect of moonlighting on their performance. Evidence of adverse effects will be considered grounds for withdrawal of permission to moonlight.

The independent practice of medicine without licensure and appropriate credentialing is illegal. In Oklahoma, residents must satisfactorily complete at least one full year of approved postgraduate training before unrestricted licensure is granted. Unsupervised moonlighting by residents holding a restricted (special) license is illegal and against University policy. In addition, residents holding J-1 and H1-B visas are restricted from moonlighting. Violators of this policy are subject to immediate dismissal and possible prosecution by appropriate law enforcement agencies.

It is also the responsibility of the entity or institution hiring a resident to moonlight to determine whether unrestricted licensure is in place, whether adequate liability insurance is in place, appropriate OBNDD and DEA certification has been obtained, and whether the resident has the appropriate training and skills to carry out assigned duties. All applications for moonlighting must be accompanied by evidence of any required licensure, liability insurance, and **fee paid** OBNDD and DEA certification.

In promulgating this moonlighting policy, the University of Oklahoma College of Medicine is not encouraging nor does it require its residents to engage in moonlighting or professional employment. The University accepts no responsibility for the financial consequences to residents who engage in moonlighting if permission for that employment is withdrawn as a consequence of poor performance in the training program or for other causes such as work hour restrictions. Each residency program may prohibit moonlighting by residents.

All moonlighting activity must be counted toward the same ACGME clinical and learning work hour limitations (e.g. 80hr, 10hr, 30hr, 1 day off in 7 etc.) pertaining to all clinical and academic activities related to the program.

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Resident Supervision in Graduate Medical Education (713)

Supervision is oversight provided by a supervising practitioner to a resident. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the resident while monitoring the quality and safety of professional services delivered. Supervision is exercised through observation, consultation, directing the learning of the resident, and role modeling. Documentation of supervision is the written or computer-generated medical record evidence of a patient encounter that reflects the level of supervision provided by a supervising practitioner.

In a health care system where patient care and the training of health care professionals occur simultaneously, there must be clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether they are trainees or full-time staff. Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. As resident trainees acquire the knowledge, judgment, skills, and attitudes required to enter unsupervised practice that accrue with experience, they are allowed the privilege of increased authority for patient care. The following major principles will be adhered to:

1. The University of Oklahoma College of Medicine (OU COM) programs follow the institutional and common requirements of the Accreditation Council for Graduate Medical Education (ACGME). To promote and ensure appropriate oversight of resident supervision while providing for graded authority and responsibility, programs must use the following classification of supervision:
   - Direct Supervision
     The supervising physician is physically present with the resident and patient during the key portions of the patient interaction, or as specified by the respective Review Committee.
     - PGY-1 residents must initially be supervised directly but may be progressed to indirect supervision if specified by the individual Review Committees

       Or, the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
   - Indirect Supervision
     The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.
   - Oversight
     The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

2. Each patient must have an identifiable appropriately qualified attending physician who is responsible and accountable for the patient's care. This information must be available to all members of the healthcare team and to the patient. All members of the health care team are expected to inform each patient of their respective role in the provision of direct patient care.
3. Each program will maintain a supervision policy consistent with the ACGME institutional policy and the respective ACGME Common and specialty specific Program Requirements as well as the OU College of Medicine institutional supervision policy. This policy must include information defining when the physical presence of a supervising physician is required, limits of resident authority, the circumstances under which the resident is permitted to act with conditional independence and levels of supervision as they related to the residents competency and the clinical situation.
4. Each program must inform residents/fellows of the mechanisms by which they can report inadequate supervision and accountability in a protected manner that is free from reprisal.
5. OU COM affiliated facilities will follow ACGME institutional requirements and maintain accreditation by The Joint Commission (TJC) and/or other health care accreditation bodies as is appropriate. Principles of good training and educational supervision are not likely to change radically with time. Rules governing billing and documentation, however, will inevitably evolve.
6. Each affiliated training facility must also adhere to Oklahoma law for all matters pertaining to the resident training program, including the level of supervision provided.
7. The requirements of the various certifying bodies must be incorporated into the OU COM training programs and fulfilled through local facility policy to ensure that each successful program graduate will be eligible to sit for a certifying examination.
8. In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged supervising practitioner is available for supervision during clinic hours. Patients followed in more than one clinic must have an identifiable supervising practitioner for each clinic. Supervising practitioners are responsible for ensuring that appropriate care is provided to patients in that clinical setting.
9. Affiliated training facilities must ensure that medical staff overseeing resident training provide appropriate supervision for all residents, as well as a clinical and educational work hour schedule and a work environment that are consistent with proper patient care, the educational needs of residents, and all applicable program requirements.
10. A fully credentialed and board certified faculty member must be designated as the responsible party for oversight of any resident training that occurs at sites primarily staffed by non-faculty providers or educators.
11. Supervising physicians will be immediately available to the resident in person or by telephone 24 hours a day during clinical duty. Residency program directors will assure that residents know which supervising physician is responsible and how to reach this individual.
12. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
13. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria and the ACGME Milestones.
14. Faculty members functioning as supervising physicians are expected to delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
15. Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
16. Supervising physicians will have the authority to accordingly adjust the responsibilities of those residents assigned to the care of their patients.
17. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.
18. Supervising physicians will also be responsible for determining when a resident is unable to function at the level required to provide safe, high quality care to assigned patients and will have the authority to adjust clinical and educational work hours as indicated to assure that patients are not placed at risk by physicians that are overly fatigued.

Levels of Supervision and Responsibility

Each training program is constructed to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment. The determination and documentation of graduated levels of responsibility are outlined below.

1. Supervising Practitioners
   Supervising practitioners are responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings where applicable, such as long-term care and community settings. Faculty members should inform patients of their respective roles in each patient's care. When a resident is involved in the care of the patient, the responsible supervising practitioner must continue to maintain reasonable personal involvement in the care of the patient. A supervising practitioner must provide a reasonably appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the resident and of the complexity of patient care needs.

   The supervising practitioner oversees the care of the patient and provides the appropriate type of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. All services must be rendered under the reasonable oversight of the responsible practitioner or be personally furnished by the supervising practitioner.

   Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.
2. Chief Residents
   a. Chief Residents-In Training:
      Chief residents in training, while quite senior, are considered residents and must be reasonably supervised by a supervising practitioner. Graduated levels of responsibility, however, may allow a wide range of practice.

b. Chief Residents-Post Training:
Chief residents post training may function either as a resident or as a supervising practitioner, depending on the type of personnel appointment, salary level and source, and privileges assigned.

Chief residents post training may be paid as trainees at a trainee salary scale and have resident appointments. To act as a supervising practitioner however, they must go through an appropriate credentialing process and possess a full medical practice license. These chief residents are bound by Resident Handbook and resident supervision standards. Chief residents post training, when appropriately appointed as adjunct faculty and credentialed, may countersign other resident and student notes, supervise other trainees, and function as independent practitioners within the specialty for which they have independent privileges.

c. Residents
Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. They must not attempt to provide clinical services or perform procedures for which they are not trained.
    - In particular, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available and may not take at-home call.

Residents must know the graduated level of responsibility described for their level of training and not practice outside that scope of service. Clinical responsibilities of each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. Residents should inform patients of their respective roles in each patient's care.

Each resident is also responsible for communicating significant patient care issues to the supervising practitioner. Such communication must be documented in the record. Failure to function within graduated levels of responsibility, communicate significant patient care issues to the responsible supervising practitioner, or appropriately document the level of attending physician oversight may result in the removal of the resident from patient care activities.

In some cases, residents including chief residents have completed one residency program and are board eligible or board certified while enrolled in an additional residency training program. These individuals may at times be credentialed and privileged for independent practice, but only in the discipline of their board eligibility or certification.

Graduated Levels of Responsibility

As part of their training program, residents should be given progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervising practitioner present, or to act in a teaching capacity is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. When available, this evaluation should be guided by specific national standards-based criteria.

The Residency Program Director defines general levels of responsibilities for each year of training by preparing a set of curriculum, goals and objectives for each educational experience. Graduated levels of responsibility defined in these goals and objectives will be in accordance with ACGME and TJC guidelines. The type of reasonable supervision required by residents at various levels of training must be consistent with the requirement for progressively increasing resident responsibility during a residency program, the application of program requirements of the individual department, and common standards of patient care. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

The supervising practitioner is responsible for determining which activities or procedures may be performed by a resident without direct supervision on any given educational experience. The overriding consideration must be the safe and effective care of the patient. In the event that any hospital staff member needs to know whether a particular resident can perform a specific procedure without direct supervision, the supervising practitioner should be contacted. The supervising practitioner will take into account the resident's level of training, clinical experience, judgment, knowledge, and technical skill, and determine whether it is appropriate for the resident to perform the procedure without direct supervision or if other arrangements are required.

Documentation of Supervision of Residents

Supervising Practitioner Involvement

The medical record must clearly demonstrate the involvement of the supervising practitioner in each type of resident-patient encounter described below. Documentation of supervision must be entered into the medical record by the supervising practitioner or reflected within the resident progress note or other appropriate entries in the medical record (e.g., procedure reports, pathology reports, imaging reports, consultations, or discharge summaries.) Types of documentation are the following:

1. Progress note or other entry into the medical record by the supervising practitioner.
2. Addendum to the resident progress note by the supervising practitioner.
3. Countersignature of the progress note or other medical record entry by the supervising practitioner. The supervising practitioner's countersignature signifies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Reports related to reviews of patient material (pathology, radiology, etc.) must be verified and countersigned by the supervising practitioner. Countersignature alone however may not be adequate documentation for billing purposes.
4. Resident progress note or other medical record entry documenting the name of the supervising practitioner with whom the case was discussed, a summary of the discussion, and a statement of the supervising practitioner's oversight responsibility with respect to the assessment or diagnosis and/or the plan for evaluation and/or treatment. Statements such as the following are acceptable to demonstrate the supervising practitioner's oversight responsibility: I have seen and discussed the patient with my supervising practitioner, Dr. "X," and Dr. "X" agrees with my assessment and plan. I have discussed the patient with my supervising practitioner, Dr. "X," and Dr. "X" agrees with my assessment and plan. The supervising practitioner of record for this patient care encounter is Dr. "X."

The type of documentation will vary according to the clinical setting and kind of patient encounter. In all cases, the responsible supervising practitioner must be clearly identifiable in the documentation of the patient encounter or report of reviews of patient material (e.g., pathology or imaging reports).

5. Each clinical department, working with the organized medical staff and leadership of the affiliated institution, will be responsible for defining a standard of documentation for supervising physician oversight. These should be reviewed on a periodic basis by that institution's medical staff and leadership.

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GMEC Composition and Responsibilities (715)

The Graduate Medical Education Committee (GMEC) is responsible for the institutional oversight of residency training programs under requirements established by the Accreditation Council for Graduate Medical Education (ACGME). Major areas of GMEC responsibility include program oversight, review and approval of administrative actions and correspondence, and institutional review and improvement. The GMEC works with the College of Medicine administration, program directors, and a wide variety of institutional liaisons to carry out its responsibilities.

GMEC Composition

For the College, the Designated Institutional Official (DIO) is the Associate Dean for Graduate Medical Education and serves as chair of the GMEC. Voting members of the GMEC include the DIO; program directors from our core residency programs (Anesthesiology, Family Medicine, General Surgery, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry, and Radiology), Chief Medical Officers who, by the nature of their positions, also serve as GMEC representatives for patient safety and quality improvement of both Adult and Pediatric Services at OU Medical Center, the Chief Educational Officer of the VA Medical Center, an institutional patient safety and quality improvement representative, peer selected residents to include the Chair and Co-Chairs of the Resident Council and two additional at-large members who serve as alternates in the absence of Resident Council leaders, three (3) other program directors appointed by the GMEC, additional program directors who request GMEC membership, and four (4) program coordinator representatives of the Coordinators Group. The program coordinators serve a two year term with two new representatives rotating in annually. All GMEC meetings may be attended by any program director, program coordinator, or resident.

GMEC and Subcommittee Meetings

The GMEC will meet at least quarterly and will maintain written minutes documenting execution of all required GMEC functions and responsibilities and attendance at each meeting. At least one peer selected resident must attend each GMEC meeting. Fifty percent + one of voting members present must concur with any motion in order to constitute a quorum for a proposal under consideration. There are no standing Subcommittees of GMEC but such committees may be may be formed as standing subcommittees or on an ad-hoc basis to carry out portions of the GMEC's responsibilities. Members will be appointed by the DIO and must include a peer-selected resident/fellow. Subcommittee timelines will be established upon formation of the Subcommittee and Subcommittee actions that address required GMEC responsibilities must be reviewed and approved by the GMEC.

GMEC Responsibilities

The GMEC will review and approve institutional GME policies and procedures that ensure accreditation standards are met, enhance the quality of the educational experiences, and assure a high-quality learning and working environment for the residents in all programs. It will assure, at a minimum, that the following responsibilities are met and that the institution is effective in supporting and promoting its sponsored residency training programs.

1. Oversight of:
   a. The ACGME accreditation and recognition status of the Sponsoring Institution and each ACGME-accredited program to assure that accreditation concerns are identified and resolved and that its ACGME-accredited programs are effectively addressing their identified concerns in order to maintain accreditation.
   b. The quality of the GME learning and working environment within the Sponsoring Institution, its ACGME-accredited programs, and its participating sites by attending to the criteria set forth in the Clinical Learning Environment Review (CLER) process.
   c. The quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME common and specialty/subspecialty-specific Program Requirements.
   d. The ACGME-accredited programs' Annual Program Evaluation (APE) and improvement activities, and the programs' self-study. Oversight will be provided via an Annual Program Review (APR) process conducted by the Office of GME that assesses the quality and accuracy of the individual APE activities and reports the findings to departmental leadership, the DIO, and the GMEC, and the Executive Dean of the College, and provides feedback to the Program Director for each program. Information submitted by the program as its APE will be summarized and presented to the GMEC for review and when indicated, approval.
   e. Underperforming programs will be reviewed through a Special Review process as outlined in GME policy 733, which includes a protocol that:
      i. establishes criteria for identifying underperformance that includes, at a minimum, program accreditation statuses of Initial Accreditation with Warning, Continued Accreditation with Warning, and adverse accreditation statuses,
      ii. results in a timely report that describes the quality improvement goals of the program, the corrective actions, and the process for GMEC monitoring of outcomes including timelines.
   f. All processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution.
   g. The provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members and, at a minimum, verification that such summary information is being provided.
2. Review and approval of:
   a. Institutional GME policies and procedures;
   b. GMEC subcommittee actions that address required GMEC responsibilities;
   c. Annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits;
   d. Applications for ACGME accreditation of new programs;

e. Requests for permanent changes in resident/fellow complement;
f. Major changes in ACGME-accredited programs' structure or duration of education including change in a program's primary clinical site;
g. Additions and deletions of ACGME-accredited programs' participating sites;
h. Appointment of new program directors;
i. Progress reports requested by a Review Committee;
j. Responses to (CLER) reports;
k. Requests for exceptions to duty hour requirements;
l. Voluntary withdrawal of ACGME program accreditation;
m. Requests for appeal of an adverse action by a Review Committee;
n. Appeal presentations to an ACGME Appeals Panel; and
o. Exceptionally qualified candidates for resident/fellow appointments who do not satisfy the College of Medicine resident/fellow eligibility policy and/or resident/fellow eligibility requirements in the Common Program Requirements.

3. Institutional review and improvement:
The GMEC will provide effective oversight of the Sponsoring Institution's responsibilities that affect its accreditation status through an Annual Institutional Review (AIR) process. In this process GMEC will identify and monitor institutional performance indicators to include:
a. results of the most recent institutional letter of notification,
b. results of ACGME surveys of residents/fellows and core faculty,
c. each ACGME-accredited program's accreditation information, including accreditation and recognition statuses and citations and self-study visits.
d. an executive summary of the AIR will include a summary of institutional performance on indicators, action plans identified from the AIR, and monitoring procedures resulting from the AIR which will be submitted annually to the Governing Body.

- **Policy Date: 04/14/2005**
- **Approved By: Graduate Medical Education Committee**
- **Date Revised: 10/14/21**
- **Date Reviewed:10/14/21**

Resident Evaluation and Promotion (716)

Appointments to a Graduate Medical Education (GME) programs sponsored by the University of Oklahoma College of Medicine are for one (1) year unless terminated earlier. Appointments to any given level of training are based on a resident meeting eligibility standards and demonstrating appropriate performance, professionalism, level of competency, and readiness for required levels of responsibility. While it is anticipated that the majority of residents will be offered reappointment and promotion through all required levels of training, initial appointment or subsequent reappointment to a residency does not, in and of itself, guarantee promotion and/or continued employment.

Evaluation and Academic Determinations

Faculty and program directors use a variety of methods and tools to regularly evaluate residents regarding their attainment of required competencies. Programs may incorporate evaluation methods that include peers, nursing staff, and patients in the process. Other recognized methods of evaluation that provide assessment of core competencies outlined by the Accreditation Council for Graduate Medical Education (ACGME) may be added by programs on an ongoing basis.

Evaluation of resident performance and competency occurs in many different environments, including but not limited to the following: inpatient unit activities, outpatient clinics, conferences, seminars, and journal clubs. Accreditation standards require that each program's Clinical Competency Committee has a comprehensive discussion with respect to every resident's performance over time. This comprehensive group review brings together multiple evaluative perspectives that can reveal patterns of performance often missed by individual evaluator assessments completed at any single point of time.

Evaluation of resident performance must comply with accreditation standards, including completion of evaluations and accessibility for review by residents in a timely manner following completion of each assignment.

All residency programs must define the performance criteria and expected levels of competency for learners at each level of training including criteria for promotion and/or renewal of a resident's appointment in the training program. These criteria and expectations, as well as assessment of the resident's readiness for promotion, are based upon the objective that residency training is a progressive development of knowledge, professionalism, and clinical competency that supports the learner assuming increasing levels of responsibility for patient care under the supervision of the faculty. The University, through its faculty, clinical competency committees and residency program directors, uses appropriate evaluative processes to make academic determinations regarding performance and level of competency, professional conduct, suitability for continued training, readiness for higher levels of responsibility, and eligibility for specialty certification of its **resident physicians**. The final determination of the adequacy of a resident's performance, his or her degree of competency, and progression toward independent practice rests with the program's Program Director under advisement from the Clinical Competency Committee.

Each program will maintain appropriate documentation of its evaluations and competency assessments. Also, as required by accrediting bodies, each program will provide appropriate feedback to residents, report competency based milestone assessments to the accrediting body, and complete summary assessments that become part of the resident's permanent academic record.

Each program must provide a resident with a written notice of intent when that resident's agreement will not be renewed, when that resident will not be promoted to the next level of training, or when that resident will be dismissed.

Reappointment and Promotion

Reappointment with promotion to a higher level of postgraduate training is based upon the program's academic determination that the resident has:

1. Satisfactorily completed all required curricular and program requirements for the current level of training;
2. Met the performance standards of the program;
3. Demonstrated consistent and sustained ability to perform at the expected levels of competency for his or her level of training;
4. Obtained the required type of licensure for the next level of training; and
5. Met all requirements for promotion as relates to a specific Administrative Academic Action (if applicable) and is not on a Corrective Action Plan.

6. Programs must provide residents not meeting requirements for reappointment or promotion with written notice of non-renewal, non-promotion, or dismissal.

Note:

1. Candidates for reappointment and promotion must fully understand the impact that Administrative Academic Actions can have, including but not limited to Suspension, Non-promotion, Non-renewal of Resident Agreement, and or Termination (see GME policy 731). Any resident on a Corrective Action Plan (CAP) will not be promoted to the next level of training until all requirements of the CAP have been successfully completed to the program's satisfaction. CAP's are a common reason that promotions are delayed.
2. Candidates for any reappointment must also meet all eligibility requirements as outlined in the OU College of Medicine GME Policy 711 Resident Eligibility and Selection. Copies of all applicable policies are available on the GME Website.

- **Policy Date: 10/13/2005**
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- **Date Revised: 10/14/21**
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GME Faculty Commitment to the Teacher Learner Relationship (717)

College of Medicine Graduate Medical Education programs uphold the highest standards of commitment to the Teacher Learner relationship. As such, the College endorses the Association of American Medical College's document entitled: *Compact Between Resident Learner and Their Teachers*.

In addition, the College holds a **no tolerance** policy regarding any faculty using a position of authority to compromise resident well-being or coerce residents toward unprofessional conduct. The official College of Medicine faculty statement of commitment modified from the AAMC document is as follows:

Faculty Statement of Commitment

1. As role models for our residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.
2. We commit to the highest standards of professionalism in our relationships with our residents. Our position of authority will not be used to compromise resident well-being or coerce residents into unprofessional conduct.
3. We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation; and we will cultivate a culture of tolerance among the entire staff.
4. We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers.
5. In fulfilling our responsibility to nurture both the intellectual and the personal development of residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.
6. We will do our utmost to ensure that resident physicians have opportunities to participate in and with sufficient frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.
7. We will provide resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare residents to function effectively as members of healthcare teams.
8. In fulfilling the essential responsibility we have to our patients, we will ensure that residents receive appropriate supervision for all of the care they provide during their training.
9. We will evaluate each resident's performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.
10. We will ensure that resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.
11. We will nurture and support residents in their role as teachers of other residents and of medical students.

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GME Resident Commitment to the Teacher Learner Relationship (718)

The College of Medicine also expects its learners to adhere to the highest standards of professionalism in their relationships with their patients, faculty, colleagues, and the staff of programs and institutions associated with their training. The official College of Medicine resident statement of commitment is as follows:

Resident Statement of Commitment

1. We acknowledge our fundamental obligation as physicians—to place our patients 'welfare uppermost; quality health care and patient safety will always be our prime objectives.
2. We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors required to fulfill all objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.
3. We embrace the professional values of honesty, compassion, integrity, and dependability.
4. We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability or sexual orientation.
5. As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.
6. We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted

with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.

7. We recognize the need to be open and truthful with our patients, faculty, and colleagues about matters related to patient care including medical errors that may affect the safety and well-being of patients, the care team, or associated institutions.
8. We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.
9. We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.
10. We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.
11. In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

- **Policy Date: 03/08/2007**
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- **Date Reviewed: 10/14/21**

Relationship with Vendors (719)

Statement of Purpose

The purpose of this policy is to ensure that College of Medicine Residency Programs maintain ethical working relationships with vendors in accordance with state ethics laws, federal regulations, guidelines of professional and industry organizations, and the ethical standards of medical professionals.

Public perceptions of bias in medical decision-making introduced by interactions of medical personnel with vendors led the Accreditation Council for Graduate Medical Education (ACGME) in early 2009 to charge all residency training programs in the United States with developing policies to guide interactions of faculty physicians and residents with medical vendors. The Association of American Medical Colleges (AAMC) published guidelines on "Industry Funding of Medical Education" which became effective in July of 2009. The Pharmaceutical Research and Manufacturers of America (PhRMA) promulgated a new Code on Interactions with Health Professionals which placed new restrictions on such activities effective as of January of 2009. Lastly, in 2011 the Accreditation Council for Continuing Medical Education (ACCME) and the AMA Council on Ethical & Judicial Affairs both published stricter guidelines on industry support of CME and other educational activities.

Statement of Objective

Our primary objective is that residency programs teach and role model care and professional standards that help them maintain the highest quality of care for all patients. The goal of this policy is to ensure that interactions with vendors are focused on informing faculty and residents about available products and services, providing scientific and educational information, and supporting medical research and education, while minimizing sources of bias and eliminating inappropriate influences in medical decision-making that can result from our interactions with them.

Scope

This policy applies to all residency programs, its faculty and their staff, and to residents in training.

Definitions

Clinics: Any location or area that is instrumental to the clinical practice of medicine by faculty and resident physicians, ancillary providers, and clinical staff.

Vendor: Any corporation or entity external to the University of Oklahoma and the OU College of Medicine that provides or may provide goods or services for administrative or clinical operations. This includes (but is not limited to): pharmaceutical organizations, home health care agencies, hospice organizations, durable medical equipment providers, laboratories, office supply (copiers, office equipment, etc.) organizations, consultants, etc.

Operating Protocol

1. As state employees, residency faculty, residents, and staff will comply with the Oklahoma State Ethics Rules, which shall supersede this policy if there is a conflict. The State Ethics Commission requires that "a state officer or employee shall not use his or her State office
   a. for his or her own private gain,
   b. for the endorsement of any product, service or enterprise,
   c. for the private gain of a family member or persons with whom the state officer or employee is affiliated in a nongovernmental capacity, including nonprofit organizations of which the state officer or employee is an officer or member, or
   d. for the private gain of persons with whom the state officer or employee seeks employment or business relations."

   For questions about the State Ethics Rules, please contact the Office of Legal Counsel at (405) 271-2033.
2. Access - To protect patients, patient care areas, and work schedules, access by pharmaceutical and vendor representatives to individual physicians should be restricted to non-patient care areas and nonpublic areas and should take place only by appointment or invitation of the residency program and or clinical practice administration.
3. Educational & Training Programs - Educational programs and training by vendor representatives can provide useful scientific information and training to faculty, residents, and staff. These programs and training sessions are acceptable when felt by the residency program to meet their educational needs and can be arranged through the residency program director. These may not include presentations that are mainly intended to market the vendor's drugs, materials, or services. Gifts and meals may not be provided in conjunction with any such programs or training by vendor representatives.
4. Continuing/Graduate Medical Education - Industry support can facilitate sponsorship by OU College of Medicine clinical departments of continuing medical education meetings and other scientific, educational, and professional meetings. The information presented should be objective and balanced. Any financial support provided by a vendor should be given to the conference's sponsor to reduce the overall conference registration fee for all attendees. It must be unrestricted and should be acknowledged by the CME sponsors. Industry support for these activities may be accepted in the form of unrestricted grants. The provision of modest meals or snacks by the CME sponsor within these activities is allowed: meals or snacks may not be provided directly by vendor representatives. Marketing

presentations during the time allotted for the educational activity are not allowed. Corporate interests should have no control over the speaker(s) or content. Speakers shall provide full disclosure of all commercial relationships prior to the presentation. Speakers' materials generally should not be supplied by vendor, but if the speaker deems the materials to be of high quality and important to the presentation, they may be allowed as long as they are clearly labeled as provided by the vendor, and the speaker discloses that fact. There should be no use of trade names in such materials. Any marketing activities, materials or exhibits must be geographically and temporally separate from the educational activity.

Other continuing medical education and/or graduate medical education activities, such as grand rounds and journal clubs, provided by OU Faculty members, should also provide balanced, objective information. All educational activities should adhere to the above standards. If complying with all the requirements for Category I CME credit is not feasible, the activities should at least meet the basic guidelines outlined above, and comply with University policy on educational/professional speakers (Attachment 1- Memo from the Provost dated October 2, 2012).

Physicians, trainees, and staff shall not allow their professional presentations of any kind, oral or written, to be ghostwritten by any party, industry or otherwise.

Vendor support for educational programs (such as trainee retreats or orientations) is allowed, as long as the support is unrestricted, is received as an ORA-approved contract to the responsible academic section or department, and is acknowledged. Vendor support for recreational or entertainment activities as part of such programs is prohibited. Marketing activities as part of such activities are prohibited.

Underwriting of travel expenses to attend meetings or training seminars may be accepted by residency programs when a product/device company requires specific training before a product or device can be used. No payments should be made directly to attendees and no payments may be made in excess of the basic expenses of travel, room and board.

Financial assistance for students, trainees, and other health care professionals to support attendance at appropriate educational conferences or national meetings is permitted provided that the selection of the meeting and of the attendees is made by the appropriate academic unit supervisor. Such funds must be provided as an unrestricted grant, through an ORA-approved contract, to the academic supervising unit and not directly to the attendee.

5. Gifts - No gifts shall be accepted from vendors. This includes books, reference manuals, training materials, or promotional objects (such as pens, mugs, or notepads). Cash or cash equivalents, such as gift certificates, stocks, bonds, or frequent-flyer miles of any amount may not be accepted.
6. Fees for Consultation Services - Consultancy agreements may be contracted by the OU College of Medicine for the provision of scientific, professional or educational expertise rendered to industry. A contract for any advisory or consulting relationship between a vendor interest and a faculty or staff member should be approved by ORA prior to its initiation. All compensation under such a contract must be commensurate with the level of service provided and specified. These fees should not be accepted in exchange for merely attending a meeting or event, or having some loosely defined association with a company.
7. Promotional Speakers- As outlined in the OUHSC Provost's letter dated October 2, 2012, residency faculty shall not serve as promotional speakers for a company's particular products or services. Residency faculty may serve as educational speakers and discuss products or services generally. University policy requires that contracts for employees to serve as educational speakers for private industry are routed through ORA for negotiation and authorized signature.
8. Samples and Other Clinical Items - Drug samples, patient education devices, products for direct patient care, and educational materials may be accepted for patient use. Drug samples and other patient care products are not to be taken for personal use by faculty, residents or staff. Additional information may be found in OU Physicians CP17 entitled Sample Drugs in Clinical Areas Not Maintained in the Central Pharmacy.
9. Recreational Activities - Attendance at vendor-provided recreational or entertainment activities is prohibited, whether associated with approved educational activities or as separate activities. Industry support of attendance at approved educational activities by nonprofessional spouses or other guests is prohibited.
10. Off-Campus Educational Activities Sponsored by Vendors- Meals will not be accepted by OU residents or fellows except in conjunction with educational activities as outlined in item D, or when provided in conjunction with an event of substantive primary educational value. On occasion, vendor-sponsored off-campus meetings may offer unique educational opportunities for OU Faculty physicians or staff. When attending such functions, attendees must be sensitive to the increased potential for commercial bias in such presentations and must be careful to avoid any appearance that attendance implies an endorsement of any commercial product by the College of Medicine.
11. Formulary and Clinical Practice Committee Members – OU health care professionals who serve on any committees dealing with pharmacy, formulary, equipment or device selection, or clinical practice guidelines shall disclose to the respective committee membership any consulting or sponsoring relationships they have with any commercial entity during the time of their committee service and for two years after termination of the relationship. Such professionals should recuse themselves from any committee decisions which may suggest conflict from their commercial relationship(s).
12. Research - Vendor support for research activities and other potential sources of conflict-of-interest are governed by existing policies of the University of Oklahoma, and are outside the purview of this policy.
13. Payments from Vendors - No faculty, resident, or staff member may directly receive any compensation or any other "thing of value" from any vendor for any scientific, clinical, professional, or educational services. Any services for which payment or other compensation is earned must be via a grant or a contract routed through and approved by the Office of Research Administration. Vendor payments made directly to an individual physician or staff member may be subject to the State Ethics rules; payments made under an ORA-approved grant or contract are payments to the University of Oklahoma, its officers, or regents and therefore are not subject to the State Ethics Rules. Additional information may be obtained from the OUHSC ORA or the Office of Legal Counsel for guidance.

14. Improper Inducements - No vendor support of any type should be accepted in exchange for prescribing products, purchasing services, or providing referrals to a vendor.
15. Education about Policy - It shall be the responsibility of each academic department to provide every faculty and resident physician with a copy of this policy and the appended State Ethics Rules. This information should be included in resident physician orientation activities.
16. Compliance - Monitoring and enforcement of compliance with this policy is the communal responsibility of all College of Medicine faculty, residents, other providers, and staff. The College of Medicine encourages all employees to be aware of these policies in all dealings with vendors and identify and report any deviations from these policies to appropriate managers and supervisors. Anyone who realizes that they have inadvertently violated these policies out of lack of knowledge or through oversight are encouraged to self-report such violation; this admission of responsibility will be taken into account in reviewing the violation and in determining any corrective action.

Any corrective action or disciplinary consequences for residents violating this policy will follow GME policy as noted in the Resident Handbook. Any violations by faculty physicians (except those specified in the following paragraph) will follow the guidelines in the COM Faculty Handbook and be at the discretion of the departmental chair.

Please refer to the OU Physician for additional references regarding Relationships with Vendors.

- **Policy Date: 04/12/2007**
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Administrative Support for Residents in the Event of Disaster or Substantial Disruption of Patient Care or Education (720)

The University of Oklahoma College of Medicine is committed to assisting in reconstituting and restructuring residents' educational experiences as quickly as possible after a disaster or substantial disruption in patient care or education in one or more residency programs.

Definition of Disaster

For the purposes of this policy, a disaster is an event or set of events that causes substantial disruption or alteration to the patient care or educational training experiences in one or more residency programs.

Declaration of a Disaster

When warranted, the President of the University, the Executive Dean of the College of Medicine or his designee will make a formal declaration of disaster. A notice of declaration will be made known as soon as possible and, depending on the size and extent of the disaster, will be published on the College of Medicine website, the University of Oklahoma website, and other appropriate and available media sources. Along with information relating to the disaster, there will be instructions regarding actions to be taken by individuals affected by the disaster, including information on how residents, faculty, staff, and program directors are to contact College administration for further instruction.

Reporting of Disaster to the Accreditation Council for Graduate Medical Education

Within ten days after the declaration of a disaster, or sooner if possible, the Associate Dean for Graduate Medical Education (or another institutionally designated person if the institution determines that the Associate Dean is unavailable) will contact the ACGME to formally notify them of the disaster declaration and discuss the projected impact on resident education and preliminary response plans. The ACGME will work with the institution to establish reasonable due dates for the affected programs to (a) submit program reconfigurations to ACGME if necessary and (b) inform each program's residents of reconfigurations and resident transfer decisions that may be required to provide continuation of training. The due dates for submission shall be no later than 30 days after the disaster declaration unless other due dates are approved by ACGME.

Resident Support, Transfers and Program Reconfiguration

The College of Medicine will provide administrative and other support appropriate to the situation for each ACGME-accredited program and its residents/fellows in the event of a disaster or interruption in patient care. Due to the significant variability in disasters or interruptions in patient care, determination regarding short and long term continuation of salary, benefits, professional liability coverage, and resident/fellow assignments will be made by the College of Medicine in collaboration with each program based on consideration of the projected impact on the educational program and its trainees. In the event of temporary relocation, salary and benefits will generally continue, however, professional liability coverage and assignments will be addressed in collaboration with the temporary training site to ensure appropriate coverage and educational continuity. In the event of permanent relocations, benefits, professional liability coverage, and assignments will be assumed by the new training site. Salary continuity will be considered on an individual basis in collaboration with the new training site.

Insofar as the College of Medicine and its major affiliated institutions cannot provide at least an adequate educational experience for each of its residents/fellows because of a disaster, the College will work with program directors to (a) arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows, or (b) assist the residents in permanent transfers to other programs/institutions; i.e., enrolling in other ACGME-accredited programs in which they can continue their education.

If more than one program/institution is available for temporary or permanent transfer of a particular resident, the preferences of each transferring resident will be considered by the program and the College of Medicine. Decisions for temporary or permanent transfers and reconstitution of the institutions program(s) will be made expeditiously to maximize the likelihood that each resident will complete the resident year with minimal disruption and in a timely fashion.

At the outset of a temporary resident transfer, the residency program must inform each transferred resident of the minimum duration and the estimated actual duration of his/her temporary transfer and continue to keep each resident 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 must so inform each such transferred resident.

ACGME Responsibilities in the Event of a Disaster

1. On its website, ACGME will provide, and periodically update, information relating to the disaster.
2. On its website, ACGME will provide phone numbers and email addresses for emergency and other communication with ACGME from disaster affected institution and programs. In general,
   a. DIO can call or email the Institutional Review Committee Executive Director with information and/or requests for information.
   b. Program Directors can call or email the appropriate Review Committee Executive Director with information and/or requests for information.
   c. Residents can call or email the appropriate Review Committee Executive Director with information and/or requests for information.
3. On its website, ACGME will provide instructions for changing resident email information on the ACGME Web Accreditation Data System.
4. ACGME will establish a fast track process for reviewing and approving or not approving submissions from 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.

Responsibilities of the ACGME and Institutions Offering to Accept Transferring Residents

Institutions offering to accept temporary or permanent transfers from programs affected by a disaster are required by the ACGME to complete the appropriate ACGME form (found on the ACGME website). Upon request, the ACGME will provide necessary information to affected programs and residents. Subject to authorization by an offering institution, ACGME will post information from the form on its website. ACGME will also expedite the processing of requests for increases in resident complement from non-disaster affected programs to accommodate resident transfers (move next line up) from disaster affected programs. The Review Committees will expeditiously review applications, make decisions, and communicate decisions to institutions offering to accept transferring residents.

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Certificate of Training (721)

Certificates of Training for Residency or Fellowship Programs Accredited by the ACGME or Other Accrediting Agencies

Certificates of Training are issued officially by the University at designated times through the Office of Graduate Medical Education. Certificates will be provided only for those residents who have fulfilled all requirements established by their training programs, including fulfillment of time requirements. Attestation by the Program Director of resident fulfillment of all requirements is required. Certificates of Training will not be issued for incomplete or partial training.

Time away from the training program, regardless of circumstances, must be made up to the satisfaction of the Program Director before a resident will be considered to have completed the training program.

Certificates of training issued by the University are not equivalent to certification or attestation by the Program Director of eligibility to take the certifying examinations of the various specialty boards. Certification or attestation of eligibility to take the certifying examinations of the specialty boards is done at the individual residency program level by the Program Director and denotes that exacting standards of excellence have been met.

Each specialty board defines these standards. Residents should consult with their Program Directors regarding specific board certification issues.

Certificates of Training for Non-Accredited Programs Designated as “Additional Training”

The sponsoring department must send a letter to the GME Office providing the name(s) of individual(s) receiving additional training. At the end of the period of training, the individual is eligible for a College of Medicine Certificate of Additional Training for the period of time completed. Once the sponsoring department has sent a letter reflecting the information that should appear on the certificate, the GME Office will provide the certificate(s). The certificate will state that it verifies "additional training" but will not use the term "fellowship." The GME Office will maintain a copy of this certificate.

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Program Director Qualifications and Responsibilities (722)

In accordance with the Common Program Requirements of the Accreditation Council for Graduate Medical Education (ACGME) the College of Medicine endorses the following requirements regarding its residency program directors:

1. There must be a single program director with authority and accountability for the operation of the program. The Graduate Medical Education Committee (GMEC) is responsible for initial approval of a program director and any subsequent changes. Upon GMEC approval, the Designated Institutional Official (DIO) will submit the program director’s recommendation to the ACGME via the Accreditation Data System (ADS).
2. Each ACGME Review Committee may further specify the qualifications and responsibilities of the program director within the specialty-specific requirements. These qualifications and responsibilities must be met in order to be considered qualified by the GMEC.
3. The program director is expected to continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.
4. At a minimum, the following program director qualifications apply:
   a. support to meet the requirements as specified by the ACGME Review Committee;
   b. requisite specialty expertise and at least three years of documented educational and administrative experience or qualifications acceptable to the Review Committee;

c. current certification in the specialty by the specialty's governing Board, or specialty qualifications that have been deemed acceptable by the ACGME Review Committee; and,
d. current medical licensure and appropriate medical staff appointment
e. ongoing clinical activity.

5. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas and must be provided with non-clinical administrative time acceptable to the specialty Review Committee. To accomplish this, the program director must:
   a. have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care;
   b. be a role model of professionalism;

Administration and Operations

1. design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program;
2. develop and oversee a process to evaluate candidates prior to approval as program faculty members of participation in the residency program education and at least annually thereafter;
3. have the authority to approve or to remove program faculty members for participation in the residency program education at all sites;
4. have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program;
5. ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination;
6. be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
7. prepare and submit accurate and complete information required and requested by the DIO, GMEC and ACGME, including but not limited to the program application forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;
8. obtain review and approval of the sponsoring institution's DIO/GMEC before submitting to the ACMGE information or requests for the following:
   a. all applications for ACGME accreditation of new programs;
   b. changes in resident complement;
   c. major changes in program structure or length of training including additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month or more;
   d. progress reports requested by the Review Committee;
   e. responses to all proposed adverse actions;
   f. requests for increases or any change to resident duty hours;
   g. voluntary withdrawals of ACGME-accredited programs;
   h. requests for appeal of an adverse action;
   i. appeal of presentations to a Board of Appeal or the ACGME; and,
   j. proposals to ACGME for approval of innovative educational approaches.
9. obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
   a. program citations, and/or
   b. request for changes in the program that would have significant impact, including financial, on the program or institution.
10. appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process;
    a. assure that a complete Annual Program Evaluation is completed by the Program Evaluation Committee and submitted to the GMEC for review.
    b. assure that the Annual Program Evaluation process is used to affect an appropriate programmatic improvement process with the goal of achieving high quality educational outcomes as defined by the ACGME and its associated CLER process.

Teaching and Scholarly Activity

1. oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

Resident Recruitment and Selection

1. provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s);
2. comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;

Evaluation

1. evaluate each resident's abilities based on specific criteria, guided by the Milestones;
2. assure each resident is provided with documented semiannual evaluation of performance with feedback;
3. ensure that all residents completing training (either in full or partial) have an appropriate summative evaluation on file that meets ACGME requirements;
4. develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter;
5. evaluate program faculty and approve the continued participation of program faculty based on evaluation;

Promotion of Residents

1. document and provide, within 30 days, (as indicated) verification of residency education for all residents, upon completion of the educational period including those who leave the program prior to completion;

Disciplinary Action

1. ensure compliance with grievance and due process procedures as set forth in the Common Program and Institutional Requirements and implemented by the Sponsoring Institution;

Supervision of Residents

1. approve a local director at each participating site who is accountable for resident education;
2. monitor resident supervision at all participating sites;

Resident Education in the Context of Patient Care

1. administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains;
2. provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation;
3. implement policies and procedures consistent with the institutional and program requirements for resident clinical and educational work hours and the working environment, including moonlighting, and, distribute these policies and procedures to the residents and faculty;
    a. monitor resident clinical and educational work hours, according to Sponsoring Institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
    b. adjust schedules as necessary to mitigate excessive service demands and/or fatigue;
    c. monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue
    d. monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

Program Director Extended Leave

There are times such as vacation, medical leave, or military leave when a program director may be unable to directly administer the residency program. Individual review committees may have requirements related to notification or coverage in the absence of the program director. In addition, the Office of GME requires notification for all program director absences in excess of two weeks and for any shorter absences if there is an ACGME requirement.

Therefore, for anticipated absences, the program director must take the following steps to ensure continuous leadership of the program:

1. Review the ACGME program requirements to determine if the review committee has a reporting requirement and comply with those requirements;
2. Contact the Office of GME with:
    a. The anticipated dates of absence;
    b. The name, contact information, and qualifications of the person who will be responsible during the program director's absence;
    c. The anticipated date of return;
3. Notify the residents and faculty of the anticipated absence and the contact information for the person who will cover during the program director's absence.
4. Notify the Office of GME upon the return of the program director.

- **Policy Date: 12/10/2009**
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Faculty Qualifications and Responsibilities (723)

In accordance with the Common Program Requirements of the Accreditation Council for Graduate Medical Education (ACGME) the College of Medicine endorses the following requirements regarding its residency program faculty:

1. Programs must assure that at each participating site, there will be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.
2. A faculty member must be designated as the responsible party for oversight of any resident training that occurs at sites primarily staffed by non-faculty providers or educators.
3. Each ACGME Review Committee may further specify the qualifications and responsibilities of the faculty within the specialty-specific requirements.
4. At a minimum the faculty must:
    a. devote sufficient time to the educational program to fulfill their supervisory, teaching, and evaluative responsibilities,
    b. demonstrate a strong interest in the education and evaluation of residents,
    c. administer and maintain an educational environment conducive to educating and evaluating residents in each of the ACGME competency areas,
    d. be role models of professionalism,
    e. demonstrate commitment to the delivery of safe, quality, cost effective, patient-centered care,
    f. regularly participate in organized clinical discussions, rounds, journal clubs, and conferences, and
    g. pursue faculty development designed to enhance their skills at least annually
        - as educators,
        - in quality improvement and patient safety,
        - in fostering their own and their residents' well-being,
        - in patient care based on their practice-based learning and improvement efforts.
5. The physician faculty must have current certification by the program's specialty board or possess qualifications that have been deemed acceptable to the ACGME Review Committee.
6. The physician faculty must possess current medical licensure and appropriate medical staff appointment.
7. The non-physician faculty must have appropriate qualifications in their field, hold appropriate institutional appointments, and be approved by the program director.
8. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component and should encourage and support residents in scholarly activities.
    a. The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.
    b. Some members of the faculty should also demonstrate scholarship by one or more of the following:
        i. Peer-reviewed funding;
        ii. Publication of original research or review articles in basic science, education, translational science, patient care, or population health in peer-reviewed journals or chapters in textbooks;
        iii. Publication or presentation of case reports, clinical series, posters, abstracts, systematic reviews or other work at local, regional, or national professional and scientific society meetings; or,
        iv. Contribution to professional committees, educational organizations, or editorial boards
        v. Quality improvement and/or patient safety initiatives

vi. Innovations in education such as creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials

9. Core faculty members as designated by the program director must:
   a. have a significant role in the education and supervision of residents including teaching, evaluation, and provision of formative feedback to residents,
   b. devote a significant portion of their entire effort to resident education and/or administration
   c. complete the annual ACGME Faculty Survey.

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Resident Off-Campus Experience (724)

Purpose: To define criteria for approval of resident off-campus experiences that both, enrich the educational experience of residents and limit liability and the impact of reimbursement to the University.

Definition of an Off-Campus Experience

An educational experience that, due to the intended purpose, cannot be obtained at one of College of Medicine's major affiliated institutions and that is not part of the individual residency core curriculum. Generally, Off-Campus Experiences should be conducted in an ACGME-accredited program, count toward residency requirements, and, if applicable, meet specialty board requirements. Off-Campus clinical experiences should be at least two weeks in length and no more than one month in length. Programs must comply with ACGME requirements related to off-campus electives and participating sites.

Criteria for Approval of Off-Campus Experience

The program director is required to:

1. Demonstrate that the proposed experience will provide a professional experience that is important for the resident's education and enhances the individual resident's ability to meet specific career needs. Examples include exposure in an institution where the resident is seeking a subspecialty fellowship, or an experience needed as preparation for a specific aspect of their planned career,
2. Demonstrate that the experience cannot be obtained at the OU College of Medicine or one of its major affiliates,
3. Demonstrate that the experience will be appropriately supervised and evaluated by responsible faculty at the site,
4. Demonstrate that this experience meets requirements and standards of the residency program and the Review Committee (RC), for any course that counts toward residency requirements.

Requirements

1. The resident seeking approval for an experience must be in good standing in the program (i.e. cannot be under academic remediation or on a corrective action plan).
2. The program director must submit the Proposal and Funding Request for GME Off-Campus Experiences, along with any relevant supporting documents to the GME Office.
3. Resident or fellow visa holders who are seeking off-campus or international educational experiences must provide documentation to the GME Office assuring that they will be in compliance with any visa restrictions, as well as with University of Oklahoma and Federal policy.
4. Resident experiences outside the United States present concerns related to educational quality, clinical supervision, medical liability, and workplace and personal safety. In general, off-campus experiences outside the United States will not be allowed. For some international sites, OU has mitigated these concerns through formal inspections and affiliation agreements. In special circumstances where these concerns are adequately addressed, foreign experiences may be allowed, but must meet all requirements for Off-Campus Experiences as well as have prior written approval from the Office of Enterprise Risk Management, and the Office of International Faculty & Staff Services. In addition, the resident must show proof of appropriate health and travel/evacuation insurance coverage prior to approval and will be required to sign a waiver of liability. If required, residents must show proof of appropriate medical licensure to practice medicine out of the United States.
5. The application must identify a verified source for funding the resident's employment expenses, including salary, benefits, and health and professional liability insurance, that is consistent with College and University policies. If the off-campus experience is extended to residents in subsequent academic years, verification of funding must be confirmed annually.
6. All clinical experience and educational work hours must be accurately recorded in MedHub.
7. PGY-1 residents are not eligible for off-campus experiences.
8. Requests for the Off-Campus Experience should be submitted to the program director for approval at least 120 days prior to the requested date. No requests will be approved within 90 days of the requested date.
9. If approved by the program director, the request must be forwarded to the DIO at least 90 days prior to the requested date. No request will be approved within 90 days of the requested date.
10. When applicable, a Program Letter of Agreement may be required.
11. Submission of a request for an off-campus experience does not guarantee its approval by either the University or the Off-Campus Experience facility. Residents are cautioned to not make travel, lodging, or other arrangements until they have been notified that the off-campus experience has been approved by all parties.
12. Program must submit to the GME Office a signed Resident Off-Campus Experience Checklist and all required documentation.

Securing Professional Liability Insurance for Approved Out-of-State Experiences (if Applicable)

1. Residents approved to take an out-of-state experience must receive verification of professional liability insurance that is underwritten for that specific experience location and effective dates.
   a. A notification form for resident's professional liability insurance for out-of-state experiences must be sent to the OU-OUMI Risk Management Office via email after having been, completed by the residency program coordinator.
2. A separate notification must be given to OU-OUMI Risk Management for each experience location.
3. OU-OUMI Risk Management will provide the program with a certificate specific to the experience location. The residency program coordinator will provide the certificate to the experience location.
4. The amount of coverage will be the amount Oklahoma law limits resident liability ($100,000 per claim). If the site requests additional

coverage, the program director must be notified immediately and a discussion held with OU-OUMI Risk Management.

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Standards for Conducting Meetings and Conferences as Peer Review (725)

The purpose of this policy is to provide mechanisms to:

1. conduct meetings and conferences that meet the definition of peer review as a confidential peer review process of the clinical practice of medicine and,
2. maintain the legal protections that underlie them.

In Graduate Medical Education, the clinical practice of medicine and education are inexorably linked. Therefore, Peer Assessment and Peer Review are integral to providing both high quality clinical and educational outcomes. Performance Improvement and Quality Improvement cannot be done without them. Without an environment of confidentiality, critical concerns may not be raised or brought forward in ways that help both individuals and educational programs learn from their outcomes.

Additionally, accurate assessment can only occur when parties understand that actions are being treated confidentially and in a protected manner. This ability to carefully review and discuss peer and learner performance and the associated clinical patient care outcomes (both in the hospital and ambulatory care settings) is therefore vital to the education of well-trained physicians. These specifically include the competencies of critical assessment, evaluation, and process improvement that are part of Practice Based Improvement and Systems Based Practice. Similarly, the ability to critically evaluate the educational programs that are integrally linked with our systems of care is critical to performance improvement in the health care setting.

The most common educational settings for this type of review and discussion include

1. Morbidity and Mortality Conferences,
2. Clinical Competency Committee meetings and
3. Program Evaluation and Review activities related to competence, professional conduct, and faculty credentials.

In addition to their educational value, these conferences and meetings are also an integral part of the clinical practices at the University of Oklahoma College of Medicine (College). Among other things, they are a means to assess, review, study and evaluate the health care services provided by health care professionals employed by the College. As such, they are considered an integral part of the College peer review process and are therefore private, confidential and privileged. Where appropriate, the College may provide information, interviews, reports, statements, memoranda or other data relating to the condition and treatments of patients to an in-hospital staff committee.

Process for Maintaining Peer review Protection

In order to maintain the legal protections of the peer review process, College of Medicine programs must maintain the confidentiality of all information presented to and/or discussed in these meetings and conferences to the extent required by law as follows:

1. Conference and meeting files, documents and patient information, if any, are to be appropriately secured to maintain their confidential nature. Only authorized persons who must have access to this confidential information in order to perform their job functions relating to this policy shall have access to such information.
2. If any documents are distributed and reviewed during a meeting or conference, the documents should be placed into a single numbered packet and marked as “Privileged and Confidential - Peer Review and Quality Management”. Copies of all information packets provided at the conference are to be collected from all participants at the end of the meeting or conference and accounted for.

All documents and files (which include any minutes of the actions discussed) that are retained must be returned to and maintained in a secured location.

1. All non-retained documents must be appropriately shredded or securely disposed of.
2. All persons permitted to attend these meetings and conferences will be required to sign a confidentiality statement, a copy of which is attached.

Failure to follow any or all of the above noted safeguards will jeopardize the legal protections afforded under the confidential peer review process that is granted to OU College of Medicine physicians and the affiliated institutions in which our faculty and residents practice medicine.

Policies and procedures related to these peer review functions shall also carry the following information:

Policy Subhead: Peer Review

This process is intended to facilitate robust and open dialogue about patient care and peer review issues without the disincentive of its use in claims or litigation. This policy describes a legally protected process in accordance with state and federal laws related to peer review and morbidity and mortality review. The work of the committee or subcommittees, the members and ad hoc members, and administrative staff in facilitating the process is considered confidential and privileged work product not discoverable in litigation or otherwise.

Footer:

This communication and material is protected by state and federal statute related to peer review and morbidity and mortality review. It is legally privileged and intended to remain confidential work product.

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Transitions of Care/Hand-overs (726)

Purpose

To establish protocol and standards within the University of Oklahoma College of Medicine’s Graduate Medical Education programs to ensure the quality and safety of patient care when transfer of patient care responsibility occurs during duty hour shift changes, location or service transfers, or other scheduled or unexpected circumstances.

Definition

A hand-over is defined as the communication of information to support the transfer of care and responsibility for a patient or group of patients

from one provider to another. Transitions of care are necessary in the clinical settings for various reasons. The hand-over 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
2. Admission from Emergency Department, outpatient clinic, or outpatient procedure area
3. Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas
4. Discharge to home or another facility
5. Change in provider shift or rotation change

Policy

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.

Procedure

The hand-over process must involve provider to provider interaction including both verbal and written/computerized communication, with opportunity for the receiver of the information to ask questions or get clarification about specific issues. The transition process should include, at a minimum, the following information in a standardized format across all services:

1. Identification of patient, including several patient identifiers
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, tests, or studies – what needs to be completed during the shift
6. Contingency plans for anticipated or potential changes in patient condition

Hand-overs may be conducted in person or over the phone as long as both parties have access to an electronic or written version of the sign-out sheet and patient confidentiality is ensured.

Each program must develop specialty specific procedures to comply with the institutional transition of care policy. Programs are required to develop scheduling and hand#over procedures to ensure that:

1. Residents comply with specialty specific/institutional work hour requirements
2. Faculty are scheduled and available to provide the appropriate level of supervision 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.
4. All resident/fellow and faculty call schedules are available on department#specific password protected websites and through the hospital operators.
5. Patients are not endangered in any way due to the frequency of transitions in their care.
6. All parties involved in the patient's care before, during, and after the transition have the opportunity for communication, consultation, and clarification of information.
7. Safeguards exist for coverage when unexpected changes in patient care occur due to circumstances such as resident illness, fatigue, or emergency.
8. Programs provide an opportunity for residents to give and receive feedback from each other or faculty physicians about their hand-over skills.

Each program must:

1. Include the transition of care process in its curriculum.
2. Facilitate professional development for core faculty members regarding effective transitions of care.
3. Ensure and monitor effective, structured hand-over processes that facilitate continuity of care and patient safety at participating sites
4. Ensure that residents are competent in communicating with team members in the hand-over process and provide resident evaluation and feedback in transitions of care.

Programs must develop and utilize a method of monitoring the transition of care process to ensure:

1. There is a standardized process in place that is routinely followed
2. There is consistent opportunity for questions
3. The necessary materials are available to support the hand-over (i.e. written sign out materials, access to electronic clinical information)
4. A quiet setting free of interruptions is consistently available, for hand-over processes that include face to face communication
5. Patient confidentiality and privacy are ensured in accordance with HIPAA

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Grievances (727)

This policy outlines the procedures for resident grievances.

Definition of a Grievance

1. An allegation of wrongful academic or disciplinary action (e.g., failure of the Program Director to follow established policy or procedures) that has resulted in or could result in dismissal, non-renewal of a residency agreement, non-promotion to the next level of training, or other actions that could significantly threaten a resident's intended career development and result in restriction of residency activity, failure to promote, suspension, or termination of residency training.
2. A formal request for adjudication of an unresolved complaint concerning work environment or issue related to the residency program and/or faculty, but specifically excluding complaints of discrimination; harassment of a sexual, racial, or other nature; or appropriate accommodation for disability that is investigated and addressed through University Equal Employment Opportunity policy and procedure.
3. Actions, including termination of residency training, resulting from a resident's failure to comply with the requirements of the medical licensure laws of the State of Oklahoma or the University's Compliance Program are not subject to these grievance procedure(s).

4. Actions resulting from a resident's repeated failure to pass or failure to be eligible to take all of the requisite examinations for licensure to practice medicine in the United States, including termination of residency training on this basis, are not subject to the grievance procedure(s).
5. Actions resulting from a resident's inability to maintain required professional liability insurance, including termination of residency training on this basis, are not subject to the grievance procedure.

Grievance Procedure

1. Residents who exercise their right to use this procedure agree to accept its conditions as outlined. While timelines are addressed in this policy, the chair of the grievance committee reserves the right of establishing all timelines for a grievance hearing.
2. A resident may have a grievance only on the matters stated in items 1 or 2 under the Definition of a Grievance section above.
3. The resident shall first discuss his/her grievance with the Residency Program Director and attempt to resolve the issue within the program. In order to pursue the right to file a grievance, this discussion must occur within seven (7) University business days of the date on which the resident was notified by the Program Director of the action in question.
4. If the resident is unable to resolve the matter at the level of the Program Director and intends a formal grievance hearing, he/she must request a meeting with the Designated Institutional Official (DIO) for the purpose of discussing his/her grievance. In order to pursue the right to file a grievance, this request must be in writing and must contain the specific grounds for filing the grievance. The request must be submitted within seven (7) University business days of the failed attempt to resolve the issue with the Program Director.
5. The DIO or designee shall meet with the resident to discuss his/her grievance in a timely manner.
6. The DIO shall attempt to resolve the grievance between the parties involved. Both parties will be notified in writing by the DIO of the resolution or if the DIO determines that the matter cannot be resolved.
7. Within seven (7) University business days of notification of the resident by the DIO that the matter cannot be resolved, the resident may request a grievance hearing by a Resident Appeals Committee. The request for a hearing shall be in writing and submitted to the Executive Dean of the College of Medicine. If no request is filed within the seven (7) University business day period, the matter is considered closed.
8. Upon receipt of a properly submitted request for a hearing, the Executive Dean of the College of Medicine shall appoint an ad hoc Resident Appeals Committee for the purpose of considering the specific grievance(s) made by the resident physician.
9. The Resident Appeals Committee shall be composed of six (6) members: three (3) selected from the non-academic administrative faculty of the College of Medicine clinical departments and three (3) selected from residents within programs in the College of Medicine. Committee members cannot be from same department as the resident. The Chair of the Resident Appeals Committee shall be selected by the Executive Dean of the College of Medicine from the faculty members appointed and is a voting member. The parties shall be notified of the membership of the Committee and given the opportunity to object due to bias. Committee members with a conflict of interest will be replaced.
10. The Chair of the Resident Appeals Committee shall notify the parties of the date, time, and location of the hearing. Parties are responsible for (a) giving such notice to any witnesses whom they wish to call for testimony relevant to the matters in the grievance, and (b) arranging for participation of witnesses in the hearing. The hearing shall be scheduled to ensure reasonably that the complainant, respondent, and essential witnesses are able to participate. Administrative support will be provided by the GME Office to the Chair of the Appeals Committee to maintain the agenda, make copies of documents, manage the witness list, arrange for audio recording, reserve adequate meeting space, and provide other support services at the request of the Chair of the Resident Appeals Committee.
11. The resident may be advised by an attorney at his/her own expense. If the resident intends to have an attorney present at the hearing, the resident must notify the Chair of Appeals Committee in writing at least fifteen (15) University business days prior to the Appeals Committee hearing. The respondent may have an attorney present at the hearing only if the resident has an attorney at the hearing. Attorneys for the complainant and the respondent may advise their clients at the hearing but may not directly address the Appeals Committee or witnesses. Legal Counsel for the University may advise the Chair and Appeals Committee at the request of the Chair.
12. If the resident is accompanied by an attorney at the hearing or, if permitted by the Chair of Appeals Committee at any prior steps where the resident and University official(s) meet, University legal counsel representing the faculty member or the Program Director shall also be present.
13. The parties shall each submit a list of the witnesses to be called, including a brief description of the expected testimony, and the actual exhibits to be presented at the hearing to the Chair of Appeals Committee at least seven (7) University business days in advance of the hearing. The parties are responsible for acquiring evidence and requesting witnesses' attendance. The list of witnesses and copies of exhibits from each party will be provided to the Appeals Committee Chair, who shall make them available to the other party. In the event either party objects to the listed witnesses or exhibits, the party shall make such objection to the Appeals Committee Chair in writing at least three (3) University business days prior to the hearing. The Chair shall make a determination regarding any objections and shall notify the parties in writing prior to the hearing. The deadlines are subject to revision by the Appeals Committee Chair.
14. In the event the grievance is resolved to the satisfaction of all parties prior to the hearing, a written statement prepared by the Chair shall indicate the agreement that has been reached by the parties and shall be signed and dated by each party and by the Chair of the Appeals Committee. This agreement shall be filed with the Executive Dean of the College of Medicine. A copy of the final decision shall also be included in the resident's file and forwarded to the DIO for the administrative file maintained in the Graduate Medical Education Office.
15. If no resolution is agreed upon, the Resident Appeals Committee shall hear the grievance. The hearing shall be closed. The hearing shall be recorded, and copies of the recording will be provided to the parties upon request.
    a. Witnesses will be asked to affirm that their testimony will be truthful.
    b. Witnesses other than the complainant and the respondent shall be excluded from the hearing during the testimony of other witnesses. All parties and witnesses shall be excluded during the deliberations of the Appeals Committee.

c. Burden of proof is upon the complainant to convince a majority of the Appeals Committee that his/her allegation is true by a preponderance of the evidence.
d. Formal rules of evidence shall not apply.
e. The parties will have reasonable opportunity to question witnesses and present information and argument deemed relevant by the Appeals Committee Chair.
f. Committee members may also question parties and witnesses.
g. Final decisions by the Appeals Committee shall be by majority vote of the members present and voting.

16. The Committee Chair shall determine additional procedures and conduct of the hearing.
17. The Appeals Committee shall render a signed, written report of its findings and recommendations to the Executive Dean of the College of Medicine. The Committee's report shall be prepared by the Chair and transmitted within seven (7) University business days after conclusion of its deliberations.
18. The Executive Dean of the College of Medicine shall review the findings and recommendations of the Appeals Committee and render a final decision regarding the grievance and appropriate action. Within fifteen (15) University business days of receipt of the Appeals Committee's findings and recommendations, the Executive Dean shall inform the resident and the Program Director of the findings of the Appeals Committee and of the Dean's decision. A copy of the Dean's decision shall be transmitted to the Chair of the Appeals Committee and to the DIO to be placed in the resident's administrative file maintained in the Graduate Medical Education Office.

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Learning and Work Environment (728)

The ACGME sets accreditation standards for GME programs and emphasizes that GME should occur in a learning and working environment that:

1. assures the highest quality of patient care in its affiliated institutions,
2. attends to the core standards for accreditation and associated educational outcomes, and
3. is engaged in regular self-assessment and improvement.

In accordance with the ACGME Institutional Requirements, the Sponsoring Institution and its programs, in collaboration with its participating sites, must provide support services and develop health care delivery systems to minimize residents' work that is extraneous to their ACGME-accredited programs' educational goals and objectives and to ensure that residents' educational experience is not compromised by excessive reliance on residents to fulfill non-physician service obligations.

The Sponsoring Institution must also provide access to medical literature so faculty members and residents have ready access to specialty/subspecialty-specific electronic medical literature databases and other current reference material in print or electronic format.

At the program level, each program must design mechanisms to engage its faculty and learners in providing safe and effective care and continually improving that care. In addition, they must assure that processes to provide oversight of each content area are included as a part of the residency program's monitoring, evaluation, and improvement efforts.

At the institutional level, affiliated institutions must assure that appropriate systems and opportunities are in place for learner engagement. Through the Annual Program Evaluation (APE) and Annual Program Review (APR) process, the Graduate Medical Education Committee (GMEC) will provide institutional level oversight and documentation of resident engagement in the seven content areas. The GMEC will work closely with each participating institution to assure that the necessary systems and processes are in place to assure a high-quality educational environment and allow each program to provide appropriate resident engagement.

Major content areas used by the ACGME to describe high quality learning and working environments as well as institutional policies and processes to ensure provision of a high-quality learning and working environment include:

1. Patient Safety:
   a. Access to systems for reporting errors, adverse events, unsafe conditions, and near misses in a protected manner that is free from reprisal;
   b. Opportunities to contribute to root cause analysis or other similar risk-reduction processes.
2. Quality improvement:
   a. Access to data to improve systems of care, reduce health care disparities, and improve patient outcomes;
   b. Opportunities to participate in quality improvement initiatives.
3. Transitions of Care:
   a. Professional development opportunities for faculty members and residents regarding effective transitions of care;
   b. Monitoring activities to ensure effective, structured patient hand-over processes to facilitate continuity of care and patient safety and participating sites.
4. Supervision and Accountability:
   a. Supervision of residents consistent with institutional and program-specific policies;
   b. Mechanisms by which residents can report inadequate supervision and accountability in a protected manner that is free from reprisal.
5. Clinical Experience and Education:
   a. Accurate and timely reporting of resident and fellow clinical and work hours are consistent with the Common and Specialty/Subspecialty-specific Program Requirements across all programs to include addressing areas of non-compliance in a timely manner;
   b. Systems of care and learning and working environments that facilitate fatigue mitigation particularly as it relates to patient care and learning such as naps and back-up call schedules;
   c. Educational programs for residents and faculty members in sleep deprivation, alertness management, and fatigue mitigation;
   d. Processes to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties;
   e. Adequate safe, quiet, private, available and accessible sleep facilities to support education and safe patient care and safe transportation options for residents who may be too fatigued to return safely home.
6. Professionalism:

a. Provision of a culture of professionalism that supports patient safety and personal responsibility including a professional, respectful and civil environment that is free from unprofessional behavior, including mistreatment, abuse and/or coercion of residents/fellows, other learners, faculty members, and staff members;
b. Education of residents and faculty members regarding unprofessional behavior including a confidential process for reporting, investigating, monitoring, and addressing such concerns;
c. Education of residents/fellows and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients;
d. Systems for education in and monitoring of:
    - Resident, fellow, and faculty members' fulfillment of educational and professional responsibilities, including scholarly pursuits;
    - Accurate and timely completion of required documentation by residents/fellows.

7. Well-Being:
    a. Provision of systems at institutional and program levels to address the well-being of residents/fellows and faculty members, consistent with the Common and Specialty-/Subspecialty-specific Program Requirements;
    b. Education of faculty members and residents/fellows in identification of the symptoms of burnout, depression, and substance use disorder, including means to assist those who experience these conditions;
    c. Education of residents/fellows and faculty members in how to recognize those symptoms in themselves, and how to seek appropriate care;
    d. Systems to encourage residents and faculty members to alert their program director, DIO, or other designated personnel or programs when they are concerned that another resident or faculty member may be displaying signs of burnout, depression, substance use disorder, suicidal ideation, or potential for violence;
    e. Access to appropriate tools for self-screening;
    f. Access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week;
    g. Access to food while on duty; safe, quiet, clean;
    h. Safety and security measures for residents/fellows appropriate to the participating site.

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Resident Council (729)

Resident physicians play a central role in both educational and clinical activities within the College of Medicine (College) and its affiliated institutions. A mechanism whereby residents can have a participatory voice in governance, management, and policy setting is crucial to providing high quality educational experiences, good patient care, an emphasis on patient safety and quality improvement, and successful working relationships among the College, its affiliated institutions, and its residents.

To accomplish these goals, and to provide a forum in which all residents/fellows from within and across the Sponsoring Institution's ACGME-accredited programs may communicate and exchange information with other residents/fellows relevant to their ACGME-accredited programs and their learning and working environment, the College's GME Office, in conjunction with OU Health, supports a Resident Council (Council) that focuses on the following areas: Education, Patient Care, Communication, and Well-being but may include additional focus areas as determined by the Resident Council.

The Council has formal meetings held 10 months each year. Voting members are peer-selected each year from each residency program. The Council selects a Chair and a Co-Chair to lead Council activities from its members. The Council may choose to select an additional Co-Chair, and a Secretary or Recorder, as needed. Members of the Council have the opportunity to become voting members on major hospital working committees.

The peer selected Chair and one or both Co-chairs will serve as voting members of GMEC. Two at-large peer selected Council members will serve as alternate members in the event a voting member is unable to attend a GMEC meeting. Other interested residents may attend as nonvoting members of the GMEC.

The Council may conduct its business in the presence of all members and non-members or in an executive session where the DIO, faculty members, and administrators are not present so that matters of a sensitive nature may be discussed solely by resident members. Any resident from the College's programs can attend the monthly meetings to provide information or raise a concern to the Council. Any resident may present concerns that arise from discussions at the Council directly to the DIO and/or the GMEC.

The Council also consists of a PGY 1 working group that meets to address concerns specifically affecting first year residents. This group also selects a Chair and a Co-Chair to lead the group's activities and may select a Secretary or Recorder as needed. The Chair of the PGY 1 working group reports directly to Resident Council. Activities of this group are determined by its members but include development of orientation and training materials for new residents and hosting of social activities specifically for PGY 1 residents.

The Council also provides all residents with an independently operated Resident/Fellow Ombudsman Program that provides an avenue for residents to confidentially raise concerns related to their education or work environment without fear of intimidation or retaliation. Faculty who act as an ombudsman are selected by the Resident Council and must have the skills and experience needed to serve as mentors to the residents in this process. Lastly, in conjunction with the College and affiliated institutions, the Council will be involved in planning orientation activities for new residents.

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Program Evaluation Committee and Annual Program Evaluation (730)

Graduate Medical Education (GME) takes place within an educational setting that provides a formal curriculum, educational resources, and a learning environment that supports the development of requisite knowledge, skills, and appropriate attitudes in its learners. The educational objective of GME is that upon completion, the learner will be fully competent to practice in their specialty independently and without supervision. The Accreditation Council for Graduate Medical Education (ACGME) sets accreditation standards for GME programs and emphasizes that high quality GME can occur only in an environment that assures the highest quality of patient care in its affiliated institutions, is attentive to the core standards for accreditation and its educational outcomes, and is committed to regular self-assessment and improvement.

Program Evaluation Committee

In order to assure that each program meets ACGME standards and carries out meaningful self-assessment and improvement, the program director must appoint a Program Evaluation Committee (PEC) that is responsible for oversight, evaluation, and planning within the program and is responsible for conducting and documenting the Annual Program Evaluation as part of the program's continuous improvement process.

The PEC must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident.

The program should maintain a written description of the responsibilities of the PEC which must include:

1. Acting as an advisor to the program director, through program oversight which includes:
   a. Planning, developing, implementing, and evaluating educational activities of the program,
   b. Reviewing and making recommendations for revision of the curriculum and competency-based goals and objectives,
   c. Addressing areas of non-compliance with ACGME standards, (i.e., citations) and
   d. Reviewing the program annually using evaluations of faculty, residents, and other data as noted below.
2. Reviewing the program's self-determined goals and progress toward meeting them
3. Guiding ongoing program improvement, including development of new goals, based upon outcomes
4. Reviewing the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.
5. Evaluating the program's mission and aims, strengths, areas for improvement, and threats.
6. Participate in and complete a Self-Study prior to the programs' 10-Year Accreditation Site Visit a summary of which must be submitted to the DIO.

Program Oversight

In order to provide effective oversight, evaluation, and improvement of the program, the PEC should, at least annually, monitor and track each of the following areas:

- Program curriculum
- Aggregate resident performance, including in-training examinations (where applicable) and achievement of the Milestones,
- Aggregate faculty evaluation and professional development,
- Aggregate resident and faculty well-being, recruitment and retention, engagement in quality improvement and patient safety, and scholarly activity,
- Graduate performance, including performance of program graduates on the certification examination,
- Program quality as reflected in:
  - Outcomes from prior Annual Program Evaluation(s),
  - ACGME letters of notification, including citations, Areas for Improvement, and comments
  - Quality and safety of patient care
  - Resident surveys and evaluations of the program
  - Faculty surveys and evaluations of the program
  - Record of resident and faculty scholarly activity
  - Adequacy of program resources
- Quality of the clinical learning environment as reflected by the Clinical Learning Environment Review (CLER) Pathways to Excellence.

Program Assessment and Evaluation

The PEC must:

1. Document the findings of its formal, systematic evaluation of the program and its curriculum at least annually via the Annual Program Evaluation,
2. Assure that residents and faculty evaluate the program confidentially and in writing at least annually.

Program Planning and Quality Improvement

The PEC must use the results of residents' and faculty members' evaluations of the program and data obtained through program oversight to assure that effective planning and improvement occurs in the program.

1. The PEC must prepare a written Annual Program Evaluation and a plan of action to document initiatives to improve performance in one or more areas of oversight as well as delineate how progress toward improvement will be measured and monitored.
2. The Annual Program Evaluation Summary with improvement goal(s) and action plan(s) must be distributed to and discussed with the members of the teaching faculty and the residents and documented in meeting minutes.
3. This summary must also be submitted to the DIO as part of the Annual Program Review.
4. The action plan(s) should be periodically reviewed to assess progress. Progress shall be documented in the PEC meeting minutes.

Annual Program Evaluation (APE)

The PEC will render a written APE Summary to the program faculty and residents, the chairman of the sponsoring academic department, the DIO and the Graduate Medical Education Committee (GMEC). This report will be in a standardized format determined by the GMEC. This report will be assessed by the GMEC for the quality of its preparation, recommendations, plan of action and indication for institutional resource allocation. The APE will form the basis of the GMEC's Annual Program Review and will be a critical element in determining whether a more intensive Special Review of the program will be required. Data

obtained from the Annual Evaluation will also be used in GMEC's Annual Institutional Review process.

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Administrative Academic Action (731)

The University, through its faculty and residency program directors, makes determinations regarding the academic qualifications, performance and level of competency, professional conduct, suitability for continued training, readiness for higher levels of responsibility, and eligibility for specialty certification of its resident physicians. Administrative Academic Actions are those actions a residency program takes based on these determinations. The type of Action is dependent upon the unique circumstances surrounding each resident's overall performance, including but not limited to prior notifications of performance deficiency or the degree of resident success in a Corrective Action Plan.

Administrative Academic Actions include but are not limited to Oral Reminders, Coaching and Development Plans, Written Notifications and Corrective Action Plans, Suspensions, Non-Promotions, Non-Renewals of Residency Agreement, and Terminations from the residency programs. The particular action taken may not necessarily follow the sequential order in which they are described below. In the event a resident is subject to any Administrative Academic Action beyond an Oral Reminder, the Program Director shall provide the resident written notification of the action, with a copy to the resident's file and the Designated Institutional Official (DIO). In addition, residents may choose to meet with their program's Clinical Competency Committee (CCC) to further discuss the action.

For purposes of this policy, the term "disclosure" refers to the disclosure of Administrative Academic Actions taken to affiliated institutions, medical licensing agencies, and credentialing bodies when requested by those agencies for legitimate business purposes. The term "reporting" refers to the reporting of Administration Academic Actions to the Oklahoma Board of Medical Licensure and Supervision (Board of Licensure) when required by Oklahoma law.

Oral Reminder

An Oral Reminder is a discussion between the Program Director and a resident concerning a minor or isolated performance deficiency. The objective is to correct the deficiency through a constructive discussion concerning how the resident's performance falls short of program expectations and to provide an explanation of what must be done to correct the deficiency.

Note: Oral reminders are not subject to disclosure or reporting unless they become a part of the documentation relating to a subsequent Administrative Academic Action that does require disclosure or reporting.

Coaching and Development Plan (CDP)

A Coaching and Development Plan is a plan of remediation designed to provide written notification of a resident's lack of proficiency in one or more ACGME Competencies and/or lack of progress in achieving one or more ACGME Milestone levels. A CDP is an educational tool to provide the resident with guidance regarding how to correct areas of unsatisfactory academic performance. Issuance of a CDP does not trigger a report to any outside agencies as its purpose is solely for academic improvement. Failure to remediate unsatisfactory performance will result in additional academic actions.

1. A CDP must be in the form of a memo from the Program Director to the resident and provides formal notice of the specific unsatisfactory academic performance. The CDP outlines the expected performance and/or remedial actions and improvement required to reach satisfactory performance.
2. At the end of the CDP period, the Program Director must provide the resident with written notice as to whether or not the CDP has been satisfactorily remediated. If the resident has failed to satisfactorily address the unsatisfactory academic performance by the end of the CDP period, a renewal of the CDP or other academic action will be issued. A copy of this letter must be maintained in the resident's training file and provided to the GME Office.

Written Notification and Corrective Action Plan (CAP)

If the use of an Oral Reminder or CDP did not correct the performance deficiency, is impractical or inappropriate for the level of attention required or the deficiency is not an isolated matter, a Written Notification and CAP is warranted. The Written Notification portion formalizes the discussion between the Program Director and the resident concerning the performance deficiency. The CAP outlines a plan of corrective action, describes further monitoring and evaluation, specifies any required practice restrictions, and describes the time frame and deadlines related to the action. The CAP's terms may or may not require extension of training beyond the usual program requirements, but they will likely subject the resident to performance monitoring that is distinct from the level of monitoring experienced by other residents at the same post graduate year of training but who are not on a CAP.

1. Significant deficiencies that warrant Written Notification and Corrective Action Plan may include but are not limited to any of the following:
   a. failure to meet performance standards set by the residency program,
   b. misconduct that infringes on the principles and guidelines set forth by the residency program,
   c. documented and recurrent failure to complete medical records in a timely and appropriate manner,
   d. failure to meet the requirement to inform the Program Director of any professional employment outside the residency program or to comply with limitations established,
   e. reasonably documented professional misconduct or ethical charges brought against a resident that bear on his/her fitness to participate in the residency program or patient care,
   f. failure to comply with University's Compliance Program or University policy or to provide safe and effective patient care, or
   g. failure to participate in required University training, including but not limited to risk management training, health screening, and OSHA training.
2. The Written Notification and CAP shall be provided to the resident in a timely manner, usually within one week of the deficiency being investigated and confirmed. The Written Notification portion must clearly describe both the performance deficiency and the standards used to define the deficiency, and the CAP portion must then set forth a clear set of expectations for future performance.
3. The Written Notification and CAP will also establish a reasonable length of time in which the resident must correct the deficiency and clearly identify any practice restrictions required during that period. If the CAP extends the expected length of residency training

or affects the resident's eligibility for taking certification examinations or making application for additional training, those consequences should also be specifically stated.

4. A copy of the Written Notification and CAP will be placed in the resident's file and provided to the DIO.
5. Depending on compliance with the CAP and the duration of the CAP, the resident may, at the end of the established time period, be:
   a. reinstated to the program without further corrective action,
   b. continued on a plan of corrective action with or without restrictions,
   c. ineligible for promotion with the possibility that duration of training will require extension,
   d. placed on Suspension,
   e. notified of Non-Renewal of Residency Agreement, or
   f. terminated from the residency program.

Note:

1. **A Written Notification and CAP is intended to remediate an identified deficiency and prevent the need for other administrative or disciplinary actions. Therefore, a successfully completed CAP would not, in most circumstances, require disclosure or reporting. Examples of when reporting or disclosure may be required include but are not limited to the action being associated with a reportable event as defined by Oklahoma law or extension of training beyond the usual duration.**
2. **Resignation or Non-Renewal of Residency Agreement without successful completion of a CAP is considered incomplete remediation of a performance deficiency. That deficiency may require disclosure as a part of the program's Summative Evaluation of the level of competency achieved.**
3. **Termination while on a CAP requires both disclosure and reporting.**

Suspension

Suspension is the documented removal of a resident from clinical and/or educational responsibilities for a limited period of time. It is intended for events or circumstances that rise to a serious level of concern and require investigation and/or short-term immediate action. Suspension may or may not be part of a formal disciplinary action.

1. A resident may be suspended from a residency program for reasons including but not limited to any of the following:
   a. any of the reasons listed in section B.1.a-g,
   b. failure to meet the requirements of a Written Notification and CAP, pending determination of further action,
   c. the resident is deemed an immediate danger to patients, himself or herself, or to others-pending further investigation/determination,
   d. failure to comply with the medical licensure laws of the State of Oklahoma - pending further investigation or appeal,
   e. failure to maintain required professional liability coverage as stipulated in the eligibility requirements of the College - pending further investigation or appeal,
   f. failure to obtain required licensure- pending licensure board action, or
   g. the resident is being investigated for suspected disruptive behavior, alcohol, or substance abuse – pending determination.
2. The Program Director shall provide the resident a written notice of Suspension, the reasons for the action, and the period of Suspension, and shall place a copy of the notice in the resident's file and forward one to the DIO. If the Suspension extends the length of residency training or affects eligibility for taking specialty certification examinations or making application for additional training, those consequences should be specifically stated.
3. Suspension may be with or without pay, depending upon the circumstances.
4. Suspension must be followed by appropriate measures determined by the Program Director to assure satisfactory resolution of the issue(s). During Suspension, the resident may be removed from clinical activities, other regular duties, and/or educational conferences, as the Program Director deems appropriate.
5. Subsequent to a period of Suspension, a resident may be:
   a. reinstated without further corrective action,
   b. reinstated on a CAP with or without restrictions,
   c. reinstated with delay of promotion,
   d. continued for an additional period on suspension,
   e. notified of Non-Renewal of Residency Agreement, or
   f. terminated from the residency program.
6. Periods of Suspension must be appropriately and reasonably limited in duration, depending upon the reason(s) for the Suspension.

Note: Suspension without disciplinary action does not require reporting or disclosure, unless associated with a reportable event as defined by Oklahoma law. Suspension with disciplinary action does require disclosure and, possibly reporting.

Non-Promotion With/Without Extension of Training

1. A resident may be denied promotion to the next level of training and/or have his or her training extended for reasons including but not limited to any of the following:
   a. failure to meet the requirements of a Written Notification and CAP,
   b. being on a CAP at the usual time of promotion,
   c. Program Director determination that the resident's performance and level of acquired competency does not meet the standard necessary to assume the next level of progressive responsibility required within the residency program, or
   d. failure to obtain required type of licensure for level of training.
2. The Program Director shall provide the resident a written notice of Non-Promotion with or without extension of training, the reasons for the action and the period of the action, and shall place a copy in the resident's file and forward one to the DIO. Non-promotion always requires a Written Notification and CAP that describes the program's expectations for the period of the action. Additionally, the CAP must explain how this action is expected to impact the resident's remaining training components and how long, if at all, it will extend the overall length of training. If the Non-Promotion is expected to affect a resident's eligibility to participate in additional training experiences or take specialty certification examinations, those consequences should be described in the notice.
3. Subsequent to a period of Non-Promotion, a resident may be subject to actions including but not limited to:
   a. successful completion of the CAP with promotion to the next level of training
   b. an additional period of training at the current level on a continued or new CAP
   c. Non-Renewal of Residency Agreement, or
   d. Termination from the residency program.

4. A resident on a CAP may not be promoted to the next level of training while on the plan.

Note: Non-Promotion does not require disclosure or reporting unless it is associated with a disciplinary action or a reportable event as defined by Oklahoma law or it extends training beyond the expected length of the residency program.

Non-Renewal of Residency Agreement

1. Non-Renewal of a Residency Agreement from a residency program may occur for reasons including but not limited to any of the following:
   a. any of the reasons listed in section D.1.a-d,
   b. failure to meet the requirements of a Written Notification and CAP,
   c. Program Director determination that the resident's performance and level of acquired competency does not meet the standard necessary to assume the next level of progressive responsibility required within the residency program,
   d. failure to obtain required type of licensure for level of training,
   e. failure to fully comply with the terms and conditions of Suspension, or
   f. failure to show appropriate progress toward the level of performance and/or competency necessary for promotion after a Corrective Action Plan has been implemented.
2. The Program Director shall provide the resident a written letter stating the reasons for Non-Renewal and shall place a copy in the resident's file and forward one to the DIO.

Note: Non-Renewal of Residency Agreement may require disclosure if the resident failed to successfully complete a CAP at the time of Non-Renewal, as this is considered incomplete remediation. It may also require reporting if the action is associated with a reportable event as defined by Oklahoma law.

Termination

1. Termination from a residency program may occur for reasons including but not limited to any of the following:
   a. Any of the reasons listed in section E.1.a-f,
   b. failure to meet the requirements of a Written Notification and CAP,
   c. failure to fully comply with the terms and conditions of suspension,
   d. illegal conduct,
   e. failure to comply with the medical licensure laws of the State of Oklahoma,
   f. failure to maintain required professional liability coverage as stipulated in the eligibility requirements of the College of Medicine,
   g. failure to pass required medical licensing exams and/or obtain required licensure,
   h. participating in any type of moonlighting activities without the knowledge and prior written approval of the Program Director, or
   i. failure to continue in a Physician Recovery Program as a part of an ongoing treatment plan.
   j. Making false or misleading statements, or failing to provide complete and accurate information on application for acceptance to a Program.
2. At the time of notification of Termination to the resident, the Program Director shall provide the resident a written letter of Termination stating the reasons for such action and the date it becomes effective and shall place a copy of this notice in the resident's file and forward one to the DIO.

Note: Termination will require disclosure and, by Oklahoma law, must be reported to the Board of Licensure.

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Compensation and Benefits (732)

This policy is current as of the date it was written. Information about University benefits and leave may be obtained from the University's HR office.

Salary (Stipend)

The GMEC will review annually and provide recommendations to the Sponsoring Institution regarding resident salary (stipends), benefits, and funding for resident positions.

A salary will be paid to each resident on a biweekly basis. Salary levels are based upon the resident's *functional level of postgraduate training* in the specific program in which he or she is currently training. PGY levels attained in previous training programs (if applicable) are not relevant to determining current salary level. Salaries are adjusted periodically upon review and recommendation of the GMEC and upon approval by the major affiliated institutions approved by the ACGME for residency training that provide funding for resident salaries. Salaries are distributed by the central payroll office of the University of Oklahoma Health Sciences Center (OUHSC) and are distributed via electronic direct deposit. Additional information about salary distribution will be provided to the resident by the Residency Program.

Benefits

In addition to the biweekly salary, the University provides employee benefits including medical, basic dental, vision, life insurance, and long-term disability. Full details on employee benefits can be found at http://www.hr.ou.edu/. Health insurance for residents/fellows and their eligible dependents (if any), and disability insurance for residents/fellows are provided on the first day of employment.

Medical coverage is available in a variety of options. The specific tier, and the medical coverage option selected by the resident will determine the additional cost (if any) which must be paid by the resident. Other resident-paid options include an increase over the basic dental, vision and life insurance coverage, and dependent health benefits coverage. Residents are also eligible to participate in the University's voluntary retirement plan at their own expense.

An OUHSC benefits coordinator may be reached by phone at (405) 271-2180 or in person at the Employee Service Center, 865 Research Park, Suite 270.

Professional Liability Insurance

The University provides professional liability insurance for residents and fellows through Academic Physicians Insurance Company, a captive insurance company covering University and OU Health faculty physicians, residents, and students for professional liability. Residents' coverage is limited to assigned educational experiences related to providing medical

care through a residency or fellowship program. It does **not** cover any other work outside of that assigned by the University.

The following guidelines pertain to residents in regard to their professional liability insurance coverage:

1. Timely completion of the University's mandatory annual risk management training is required by the College of Medicine for all physicians, APPs, and residents.
2. All residents are automatically enrolled in professional liability coverage through APIC, which provides an occurrence policy for supervised medical practice within the scope of the training program and covers claims arising from incidents occurring during training regardless of when the claim is filed.
3. Residents who are involved in an adverse outcome or any situation where a claim by a patient can be anticipated against any medical provider, receive communication from an investigator or outside legal counsel, or who have been notified of legal action, must immediately notify OU Health Clinical Risk Services at 271-1800.
4. Professional activities that occur outside the scope of the residency training program, including most external moonlighting activities, are not covered by the residency program policy. Residents engaging in any such professional activities must seek written approval from their Program Director and must apply for and purchase, at their own expense, additional professional liability insurance covering these activities. This coverage cannot be supplied by APIC. The policy on resident moonlighting is listed on the GME Website at: https://www.oumedicine.com/college-of-medicine/information-for/residency-programs-(gme) (https://www.oumedicine.com/college-of-medicine/information-for/residency-programs-(gme/).

Questions regarding coverage, and reports of adverse events, can be addressed by OU Health Clinical Risk Services at 271-1800. A Risk Manager is available 24/7 and calls after hours are transferred to the on-call risk manager.

Time Away from Training

Time away from training, consistent with ACGME Institutional Requirements, includes annual leave (vacation), medical (sick), parental, and caregiver leave, and other leaves of absence for any reason, including but not limited to educational leave, jury duty, bereavement, personal legal matters, parent/teacher conferences, or other absences from training granted in accordance with federal and state laws and institutional program policies. Each program may supplement this policy with written procedures regarding application for and use of leave. The Graduate Medical Education Committee will, at least annually, oversee program implementation of policies for vacation and leaves of absence including medical (sick), parental, and caregiver leaves of absence and, in collaboration with programs, will ensure the availability of resources to support resident well-being and education by minimizing impact to clinical assignments resulting from leaves of absence. Programs will ensure that all applicants and residents are informed of program and institutional vacation and leave of absence policies as well as the impact of vacation, leave of absence, and extended leave of absence on their ability to satisfy requirements for program completion and their eligibility to participate in examinations by the relevant certifying board.

Annual Leave (Vacation)

Each resident earns a maximum of 15 days (M-F)/120 hours of paid annual leave per year which may be used for vacation, employment interviews, bereavement, or other activities as determined by the resident or not specifically covered by other leave benefits. Training regulations imposed by the national certifying boards in some specialties may limit the amount of leave which may be taken by a resident to a lesser amount. Earned but unused annual leave may not be carried over from one academic year to another and may not be used to shorten the length of training. No additional payment will be made for unused annual leave upon completion of residency training or at any other time. The annual leave request should be submitted to the Program Director at least 120 days prior to the requested date. Programs may deny requests submitted within 90 days of the requested date.

There is a legitimate need for Program Directors to limit the number of residents who are absent at any one time and to otherwise assure continuity of quality health care for the patients on their service. Annual leave requests shall be honored according to the policy established by each residency program.

Time off for the purpose of employment interviews must be accounted for as annual leave, up to the amount of benefit time earned.

Time off for interviews for fellowships or other additional training must be accounted for as annual leave or educational leave, at the discretion of the Program Director, up to the amount of benefit time earned. **Annual leave must be used if a fellowship interview occurs during a VA rotation.**

In addition to annual leave (vacation), residents may request approval from the Program Director for time away from the program for individual circumstances. In all circumstances, time away from the program may require an extension of training. Circumstances may include:

1. Jury Duty - Residents summoned for jury duty must provide the program with a copy of the summons and at the completion of jury duty, a statement from the Court Clerk for each day they are required to be present. Residents will be excused from clinical duties. Approved days will be counted as time away from the program, however, they will not be counted against annual leave or medical (sick), parental, and caregiver leave.
2. Bereavement - Residents who wish to take time away for bereavement may use annual leave or leave without pay after annual leave is exhausted.
3. Residents taking time away for personal legal matters, parent/teacher conferences, or other absences may use annual leave or leave without pay after annual leave is exhausted.

Note: Resident annual leave does not accrue or roll over from one academic year to the next. For residents who have followed the above policy regarding the timely submission of annual leave requests, the program will make every effort to see that each resident receives their annual leave benefit for the current academic year.

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

Each resident earns a maximum of 15 days (M-F)/120 hours of paid medical (sick), parental, and caregiver leave of absence per year, which may be used as described below. A physician's statement regarding illness or injury and "fitness for duty" may be required for absences for medical (sick), parental, and care giver leave of absence. Unused medical (sick), parental, and caregiver leave of absence will not be carried forward to the next academic year. No additional payment will be made for unused medical (sick), parental, and caregiver leave of absence upon completion of residency training or at any other time.

1. Medical (Sick) Leave of Absence is leave taken by the resident related to their own illness, injury, treatment, or prevention. The

annual allotment of medical (sick) leave of absence may be taken intermittently.

2. Parental Leave of Absence is leave taken by the resident related to maternity, paternity, adoption, and foster care. Parental Leave of Absence may not be taken intermittently.
3. Caregiver Leave of Absence is leave taken by the resident to care for their spouse, partner, child or parent. Caregiver Leave of Absence may be taken intermittently.

Beyond the 15 days of paid medical (sick), parental, and caregiver leave of absence, additional options may be available including:

1. Leave of absence without pay
   a. Residents may be approved for leave of absence without pay contingent upon recommendation by the Program Director and approval by the GME Office. The University complies with the Family Medical Leave Act. Requests for extended leave of absence for FMLA qualifying reasons may require documentation from a healthcare provider and should be submitted through the Leave Administrator.
2. Leave of absence with pay for medical (sick), parental, and caregiver leave of absence for qualifying reasons
   a. Consistent with ACGME Institutional Requirements, residents who anticipate or experience a situation requiring medical (sick), parental, and caregiver leave for qualifying reasons may request leave as follows:
      i. Once during training in the program, residents will be provided with six weeks of medical (sick), parental, and caregiver leave of absence for qualifying reasons consistent with applicable laws.
         - Medical (sick), parental, and caregiver leave is available starting the first day the resident is required to report.
         - During the first six weeks of the first approved medical (sick), parental, and caregiver leave of absence residents will be provided with the equivalent of 100 percent of their salary.
         - Health and disability insurance availability continues for residents and their eligible dependents during any approved medical (sick), parental, and caregiver leave of absence.
      ii. Residents requesting medical (sick), parental, and caregiver paid leave of absence for qualifying reasons must submit a request form including projected beginning and end dates for the leave and the qualifying reason. The request must be submitted to the Program Director. The resident must notify the program of changes to the request should they arise.
         - Qualifying reasons for medical (sick), parental, and caregiver leave include:
            - Medical: A serious health condition that makes the resident unable to perform the functions of their job.
            - Parental: The birth of a child or placement with the resident of a child for adoption or foster care and to bond with the child. Caregiver: To care for a spouse, child, stepchild, or parent with a serious health condition. Other remote family members, including in-laws are not included.
      iii. During the year in which a resident requests medical (sick), parental, and caregiver leave, all available annual medical (sick), parental, and caregiver leave (up to 3 weeks) and a maximum of 2 weeks of available annual (vacation) leave will be applied to account for the requested paid time off. One week of annual (vacation) leave will be reserved for use by the resident for vacation or other activities at their discretion and may be used before or after the leave of absence.
         - Residents with a full leave balance will generally utilize leave as follows:
            a. 2 weeks annual (vacation) leave
            b. 3 weeks medical (sick), parental, and caregiver leave
            c. 1 additional week paid medical (sick), parental, and caregiver leave
            d. 1 week of reserved annual (vacation) leave.
         - Residents with a partial leave balance will generally utilize leave as follows:
            a. Up to 2 weeks annual (vacation) leave
            b. Up to 3 weeks medical (sick), parental, and caregiver leave
            c. Up to 6 additional weeks paid medical (sick), parental, and caregiver leave
            d. 1 week of reserved annual (vacation) leave utilized.
         - Any paid time off reserved for use as annual (vacation) is to be available during the appointment year(s) in which the leave is taken and may not be carried over into subsequent years of the program.
         - The process for submitting and approving requests for additional medical (sick), parental, and caregiver leave includes:
            a. Complete the Medical (sick), Parental, and Caregiver leave of absence request form.
            b. Submit the request to the Program Director for review and approval.
            c. For instances of foreseeable leave of absence, residents must submit requests at least 30 days in advance of the beginning date.
            d. Meet with the program director to review
               i. Past, current and projected leave utilization including annual (vacation) leave, medical (sick), parental, and caregiver leave, conference leave, jury duty leaves, bereavement leave, and all other absences from the program.
               ii. Current board certification requirements regarding allowable time away from training including impact of leave on eligibility for specialty and subspecialty certification.
               iii. Requirements for satisfactory completion of the program including competency expectations including fulfillment of board specialty and subspecialty requirements, ACMGE requirements, and institutional and program requirements.
               iv. Projected extensions of training that may occur as a result of time away from the program.
            e. Residents must meet all specialty board, program and competency requirements but may, solely at their own discretion, elect to use less than the allowable medical (sick), parental, and caregiver leave in lieu of extending training.
      iv. Requests for additional leave beyond the first six weeks or for subsequent occurrences of medical (sick), parental, and caregiver leave must be submitted to the Program Director. Residents must use annual leave allotments, FMLA

(if eligible), and unpaid leave according to program and university policies.

Note: A request for medical (sick), parental, and caregiver leave of absence may be denied if it is determined that it was not submitted in good faith.

Off-Cycle Residents

Residents starting off-cycle will receive a pro-rated amount of paid annual and medical (sick), parental, and caregiver leave during their first and last year of training. For year one of training an accrual rate of 10 hours per month for annual leave and 10 hours per month for medical (sick), parental, and caregiver leave of absence will be applied based upon the 1st day of the month that the resident begins training through the remainder of the academic year which ends on June 30th. For the last year of training an accrual rate of 10 hours per month for annual leave and 10 hours per month for medical (sick), parental, and caregiver leave of absence will be applied beginning on July 1st and will continue accruing through the last day of the month that training is completed. Maximum allowed annual leave and medical (sick), parental, and caregiver leave of absence is 15 days/120 hours for each per 12-month period. Programs will submit the Leave Adjustment Form with the pro-rated hours to Payroll Services for the first and last year of training.

Extended Leaves of Absence

Leaves of absence generally and broadly refer to resident requests to take leave from work to manage personal and family needs, personal or family illness, pregnancy, military service, etc. Residents **must** follow the procedure/guidelines of their training program in requesting and scheduling leaves of absence. Failure to follow program policies may result in the request being denied. Each resident must submit a leave request in writing to their Program Director and to the Leave Administrator for FMLA leave requests. Program Directors, or their designees, have the final authority to approve leave of absence requests. The total time allowed away from a GME program in any given year or for the duration of the GME program will be determined by the requirements of the applicable specialty board and will be tracked by each program. In general, extended leaves of absence of 6 months or more in an academic year will result in termination of residency or, in certain situations, repeat of prior completed training. Extension of training is at the discretion of the Program Director and subject to availability of funding and space in the program. Residents are encouraged to refer to the specialty board for specific details regarding extended leaves of absence.

If the leave of absence is for **personal reasons**, as determined by prior approval of the GME Office, and not for medical reasons and the resident has accrued annual leave, the leave of absence will be paid to the extent of the accrued annual leave. *Once the annual leave is exhausted, the remainder of the leave of absence will be unpaid.* Any leave of absence without pay must be approved by the Program Director and the DIO. During leave without pay, some benefits, such as health insurance, may not be paid by the University.

Administrative Leave

Administrative leave may be awarded for an emergency as defined by the GME Office, and may be with or without pay, depending upon the circumstances, as determined by the GME Office. In the event of inclement weather, residents are expected to present to work to provide direct patient care in hospitals and clinics that remain open. Should a clinic or service close due to the weather, the Program Director may elect to allow the resident to remain at home or may reassign the resident to another location.

Holiday Leave

Residents do not receive credit or additional pay for holiday time during clinical rotations. Since hospitals and some clinics do not observe a holiday schedule for patient care, residents are expected to follow their assigned schedule. If annual leave time is scheduled during a holiday period, then the holiday must be scheduled as annual leave. If the resident is assigned to a clinic that observes a holiday schedule, then the resident need not count that time toward his/her annual leave time. Residents should check with their Program Director's office for further clarification of holiday leave time.

Educational Leave

Educational leave is limited to the time of participation in a professional meeting related to the resident's area of specialty or may be used for the time required to interview for fellowships or other additional training. Residents should be aware that some specialty boards count educational leave as time away from training and may require an extension of their training dates.

Interviews for fellowships or other additional training must be accounted for as annual leave or educational leave, at the discretion of the program director, up to the amount of benefit time earned. Residents may request up to five days of educational leave each year. Unused educational leave may not be carried over to subsequent years of training. The request should be submitted to the program director at least 120 days prior to the requested leave date. No requests will be approved within 90 days of the requested date. The meeting can be no more than one week in duration and must be within the USA. Approval is granted solely at the discretion of the Program Director, who also determines the travel reimbursement policy for the individual residency program.

International travel for educational leave is subject to the requirements in GME policy 724 regarding resident off-campus experiences. Of special note in GME policy 724 are instructions for visa holders seeking off-campus or international educational experiences, instructions for all residents regarding University approval of sites for educational experiences outside the United States, and rules for booking travel and applying for travel reimbursement.

Because of the tax implications of direct reimbursement to residents from outside entities being viewed by the IRS as earned income, travel reimbursement must be processed by following current OU travel procedures and carried out by their department. Reimbursement will be based only on those items supported by actual receipts and in accordance with current departmental and University travel policy. **Residents must consult their Program Director's office well in advance of attending any such event in order to obtain guidance on these matters.**

Family Leave (FMLA)

Federal law mandates that, **after one year of University employment**, qualified employees may take up to 12 weeks of leave (available paid leave and then unpaid leave) during any 12-month period for

1. the birth and care of a newborn child;
2. the placement of a child for adoption or foster care and to care for the newly placed child;
3. the care of a spouse, parent, or child or stepchild with a serious health condition; and
4. a serious health condition; and

5. certain qualifying exigencies arising out of a covered military member's active duty status, or notification of an impending call or order to active duty status, in support of a contingency operation.

The most up to date information can be found on the Human Resources webpage at https://hr.ou.edu/Employees/Holidays-Time-Off-Leave/Family-Medical-Leave-FMLA (https://hr.ou.edu/Employees/Holidays-Time-Off-Leave/Family-Medical-Leave-FMLA/).

Residents are required to use all available annual paid medical (sick), parental, and caregiver leave as well as all available annual (vacation) leave. Subsequent time off, outside of the time granted once during residency for medical (sick), parental, and caregiver leave consistent with ACGME Institutional Requirements, will be unpaid. The University will continue to pay the cost of the University-provided insurance coverage for residents for the 12 weeks of FMLA protected leave. The residents will continue to be responsible for payment of premiums for any elective coverage. It is the resident's responsibility to contact Human Resources to determine premium payment requirements.

The following guidelines pertain to resident requests for FMLA:

1. **Maternity/Paternity Leave**
   Available sick leave, annual leave time, or leave without pay may be used in accordance with the Family Leave Act guidelines as described above. Specific questions should be addressed to the Program Director.
2. **Requests for Family Leave**
   Residency program schedule changes require considerable planning to assure that patient care and residency colleagues' education are not impacted negatively. Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. Therefore, requests for family leave should be made in writing to the Program Director as soon as the need is known. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with normal call-in and other time and attendance procedures. The University also requires both periodic reports of the employee's status during the course of the leave and his or her projected date of return to work.

Effect of FMLA or Extended Leave of Absence on Specialty Board Requirements

Depending on specialty board requirements, periods of leave may extend the length of the residency training needed to meet the specialty board requirements. Information regarding eligibility for specialty board examinations and requirements is available through your program director and each individual specialty board. This information should be carefully reviewed and discussed with your program director prior to requesting leave.

Resources for Counseling and Psychological Support Services

Counseling and support services are available for a variety of resident issues including, but not limited to, the following: study and test-taking skills, reducing test/evaluation anxiety, depression, stress management, difficulty sleeping, and other counseling and psychological issues.

The Employee Assistance Program provides assistance for employees in dealing with personal problems including alcohol and drug abuse or dependency, mental or emotional disturbance, or other conditions that may adversely affect their job performance. The Employee Assistance Program can be contacted at 1-800-327-5043. Residents may also use Student Counseling Services located in the David L. Boren Student Union on the 3rd floor, Room 300, telephone 271-7336. Services are available 8:00 a.m. to 5:00 p.m. Monday-Friday. The Physician Wellness Program through the Oklahoma County Medical Society provides confidential counseling sessions with a community psychologist. Appointments can be made by calling 405-340-4321.

Guidelines for impaired physicians are covered in the *Resident Handbook* section on the Physician Recovery Program in place through the Oklahoma State Medical Association Oklahoma Health Professionals Program, Inc. In addition, the University of Oklahoma Staff Handbook includes a policy on Prevention of Alcohol Abuse and Drug Use on Campus and in the Workplace. The complete policy is also available upon request from the Human Resources Office. The HR office can be reached by phone at (405) 271-2180. The OU Staff Handbook policy can be accessed online at: https://apps.hr.ou.edu/staffhandbook (https://apps.hr.ou.edu/staffhandbook/).

- **Policy Date: 05/08/2014**
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- **Date Reviewed:10/14/21, 8/11/22, 9/8/22**

Special Review (733)

The Accreditation Council for Graduate Medical Education (ACGME) requires the Graduate Medical Education Committee (GMEC) to demonstrate effective oversight of underperforming programs through a Special Review process. This policy establishes the criteria for identifying underperformance, the composition of the Special Review Committee, the protocol of evaluation performed by the Special Review, and the components of the Special Review Report which will describe the quality improvement goals, corrective actions, and the process for GMEC monitoring of outcomes.

Criteria for identifying program underperformance

Evidence of underperformance or noncompliance with ACGME standards that is considered by GMEC to risk a program's accreditation may prompt a Special Review. This includes, but is not limited to any of the following:

1. ACGME program accreditation status of
   a. Initial Accreditation with Warning,
   b. Continued Accreditation with Warning, or
   c. Adverse accreditation statuses
2. Evidence of noncompliance based upon review of:
   a. ACGME Resident Survey results compared to national norms,
   b. ACGME Faculty Survey results compared to national norms,
   c. Annual Program Review indicating areas for concern
3. Review Committee notification to the program of citations or warnings considered by GMEC to risk accreditation status
4. Major change in the program or department which may affect accreditation status
5. Request by a program director for review of their own program

Special Review Committee: The Special Review Committee will be comprised of members outside of the reviewed program and will include at least: 1 program director (may be an associate program director), one residency program coordinator, 1 resident, the DIO and the GME Director or designee. The GMEC may appoint additional members as deemed appropriate for the review. In certain circumstances, a Special Review may be conducted that involves confidential information regarding

individual faculty or residents. In these situations, the membership of the Special Review Committee will be defined separately by the DIO to ensure protection of individuals involved in the reporting of concerns.

Special Review Protocol: When any of the criteria for Special Review are met, the GMEC will determine the appropriateness for the Special Review, the timeframe for submitting its report to GMEC, and whether this is a Limited or Comprehensive review of the program. Members of the Special Review Committee will be appointed by the DIO. The DIO and GME Director will provide administrative support for the Special Review Committee.

The Special Review Committee will meet, in separate sessions, with the program's residents representing each of the post graduate training years, a representative group of program's core, and the program director and residency coordinator. The Special Review Committee may request additional meetings.

The program undergoing Comprehensive Special Review will provide to the Special Review Committee all of the materials, updated within the most recent 6 months, comprising the Annual Program Evaluation. These updated materials must be available to the Special Review Committee no less than 10 business days prior to the Special Review meetings. In addition, the GMEC, Special Review Committee, or DIO may request additional data or reports considered relevant to the review.

If the GMEC determines that only a Limited Special Review is appropriate, the GMEC will define the data required for the review.

The Special Review report will be evaluated by GMEC, and will describe the findings, improvement goals, corrective actions, methods for monitoring improvement, and the timeline for evaluating and reporting progress to GMEC.

Report: The report of the Special Review Committee will include the following:

1. Date of the Special Review report
2. Identification of the program undergoing Special Review, the program director, associate program director(s) and residency coordinator
3. Indication for the Special Review
4. A summary of the data and materials regarding program performance evaluated by the Special Review Committee
5. The names and positions of members of the Special Review Committee
6. The names and positions of participants in each of the meetings along
7. Date(s) of the meetings held with each participant group
8. Findings of the Special Review Committee. Wherever possible, the findings should be identified by its corresponding ACGME program or institutional requirement.
9. Recommendations for improvement goals and corrective actions, with establishment of measurable outcomes wherever possible, along with timelines and responsibilities for completion of corrective actions.
10. Prior to review of the report by GMEC, the program director will have no more than 30 days to provide the Special Review Committee with input about methods for achieving improvement goals and corrective actions, as well as participate in establishing timelines and responsibilities.

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Information Technology Policies, Standards, and Guidelines (734)

The University of Oklahoma Health Sciences Center campus wide information technology policies address in a consistent manner all areas related to computer security within the College of Medicine, to include all faculty, staff, and trainees. If you have questions and concerns related to computer security please review the areas identified in the attached link.

http://it.ouhsc.edu/policies/

If you are still unable to identify an answer to your question please consult with your supervisor, your applicable Associate Dean, Course Director, or your section IT representative.

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- **Date Reviewed: 10/14/21**

Well-Being in Graduate Medical Education (735)

Residency education must occur in the context of a learning and working environment that emphasizes a commitment to the well-being of students, residents, faculty members, and all members of the health care team. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism and is a skill that must be learned and nurtured in the context of other aspects of residency training.

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients.

The following major principles will be adhered to:

1. The University of Oklahoma College of Medicine (OU COM) programs follow the Accreditation Council for Graduate Medical Education (ACGME) Institutional and Common Program Requirements. As such, OU COM is committed to providing a safe environment and to protecting the health and welfare of patients, students, residents, faculty, visitors, and employees.
2. In order to ensure patient safety and quality patient care in an environment of concern, respect, and cooperation with faculty, staff, patients, and visitors, and to provide the opportunity to maximize the educational experience of the resident, all residents and faculty are expected to report for each shift fit for duty.
3. The OU COM encourages residents and faculty to be proactive in their self-care and seek assistance voluntarily before clinical, educational, or professional performance is affected.
4. Supervising physicians are responsible for determining when a resident is unable to function at the level required to provide safe, high quality, care to assigned patients and have the authority to

adjust resident workload to assure that patients are not placed at risk.

Resident and Faculty Responsibility

1. Residents and faculty have a professional responsibility to report to the working and learning environment fit for duty and able to perform their clinical duties in a safe, appropriate, and effective manner free from the adverse effects of physical, mental, emotional, and personal problems including impairment due to fatigue. They must be appropriately rested and must manage their time before, during, and after clinical assignments to prevent excessive fatigue.
2. Residents and faculty are responsible for assessing and recognizing impairment, including illness and fatigue, in themselves and in other healthcare providers.
3. All residents and faculty should be aware of the behavior and conduct of other residents and faculty. If a resident or faculty observes physical, mental, or emotional problems affecting the performance of a resident or faculty member, including impairment due to excessive fatigue, the resident or faculty should immediately notify the program director, their supervising faculty, or the department chairperson.
4. Residents and faculty experiencing problems are encouraged to voluntarily seek assistance before clinical, educational and professional performance and interpersonal relationships or behavior are adversely affected. Those who voluntarily seek assistance for physical, mental, emotional and/or personal problems, including drug and alcohol dependency, before their performance is adversely affected, will not jeopardize their status by seeking assistance.
5. Residents and faculty must maintain their health through both acute and routine medical and dental care and if needed mental healthcare.
   - All residents should seek acute care for illnesses (physical or mental) or dental emergencies during work hours and at no time will residents be denied emergency care visits.
   - Non-urgent appointments should be scheduled in advance with approval of the residency program.
   - Allocated sick leave time will be used for medical and dental care appointments.
   - Faculty should follow the appropriate protocol established by their departments and the University of Oklahoma College of Medicine.

Residency Program Responsibility

1. Each training program must be constructed to encourage a commitment to the psychological, emotional, and physical well-being of students, residents, faculty members, and all members of the health care team.
2. Programs must promote practices that enhance the meaning that residents and faculty find in the experience of being a physician. For residents, this should include protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, enhancing professional relationships.
3. Programs must ensure that resident assignment schedules, work intensity, and work compression do not negatively impact resident well-being.
4. It is the responsibility of the Program to provide opportunities for excessively fatigued residents to take therapeutic naps and to provide facilities for residents to sleep if too tired to return to their homes following clinical duties.
5. Programs must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities due to fatigue, illness, and family or other emergencies. These policies must be implemented without fear of negative consequences.
6. It is the responsibility of each program, residents, and faculty members to be aware of resident and faculty behavior and conduct.
7. If a program, resident, or faculty member observes physical, mental, or emotional problems affecting the performance of a resident, including impairment due to excessive fatigue, the program must take steps to verify the impairment and take appropriate actions.
8. Programs are encouraged to screen for burnout and/or depression at regular intervals and as part of all semiannual assessments.
9. Programs must ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.
10. It is the responsibility of the program to provide reasonable accommodations to enable the resident to participate in mandated counseling.
11. The program along with the Sponsoring Institution must
    a. Educate faculty members and residents, through training sessions, online modules, seminars, notices or other educational formats in identification of the symptoms of burnout, depression, and substance use disorder, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care.
    b. Ensure that residents and faculty members are aware of their role in and systems for alerting the program director, department chairperson, Ombudsman, Behavioral Intervention Team, Employee Assistance Program, Office of Graduate Medical Education or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.
    c. Provide access to tools for self-screening and access to confidential, affordable mental health assessment, counseling and treatment, including access to urgent and emergent care 24 hours a day, seven days a week;
    d. Evaluate workplace safety data and address the safety of residents and faculty members to provide security and safety measures appropriate to the site. This may include gathering information and utilizing systems that monitor and enhance resident and faculty member safety, including physical safety including monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.
    e. Ensure mechanisms are in place for access to food during clinical and educational assignments which, depending on the work site, may include access to refrigeration to store food, vending machines, and/or cafeterias.
    f. Provide residents with information regarding available safe transportation options for those too fatigued to safely return home on their own
    g. Provide residents with access to safe, quiet, clean and private sleep/rest facilities available and accessible with proximity appropriate for safe patient care even when overnight call is not required.

h. Provide clean and private lactation facilities with proximity appropriate for safe patient care and access to clean and safe refrigeration for the storage of human milk.
i. Provide reasonable accommodations for those with disabilities consistent with institutional policies.

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Institutional Support for Pain Medicine Program (750)

Background

The University of Oklahoma College of Medicine provides support to one Pain Medicine training program. Because pain medicine is a multidisciplinary approach to a common problem, the ACGME requires that there be an institutional policy governing the educational resources committed to pain medicine. This policy ensures cooperation of all involved disciplines.

There must be a multidisciplinary fellowship committee to regularly review the program's resources and its attainment of stated goals and objectives.

Purpose

The purpose of this policy is to ensure that the educational training experience for the sponsored pain medicine program complies with the institutional and program-specific RRC requirements, and that the allocation of clinical and other resources is monitored.

Monitoring and Compliance

The residency program will perform an annual program evaluation as outlined in Policy 730 Program Evaluation Committee and Annual Program Evaluation. The Designated Institutional Official (DIO) and the GME Committee (GMEC) will monitor educational resources committed to the pain medicine training program through the Annual Program Review process and the appropriate resident and faculty surveys.

If difficulties in the distribution of resources committed to pain medicine training are identified, the DIO will meet with members of the program involved to assess the issues and to recommend corrective action. The DIO will report these findings to the GMEC, which may meet with the pain medicine program director and/or other hospital/institutional officials.

Any request for program changes in pain medicine would be reviewed through customary GMEC processes.

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