Policy/Procedure Title: RESIDENT ESSENTIAL JOB FUNCTIONS  
ACGME Policy: IRD Section II.D.4.a  
Effective Date: 7/1/2012  
Reviewed: 11/30/15

PURPOSE: This policy identified tasks that are representative of those required of residents at The Institute for Family Health. The list is not meant to be all-inclusive, nor does it constitute all academic performance measures or graduation standards. It does not preclude the residency from temporarily restructuring resident duties as it deems appropriate for residents with acute illness, injury, or other circumstances of a temporary nature. The residents are expected to perform these tasks in support of the Institute’s mission of focusing its efforts on underserved and vulnerable communities.

PATIENT CARE: Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health by a family physician. Residents are expected to:

- gather essential and accurate information about their patients;
- perform an appropriate physical exam based on the chief complaint and history of present illness;
- present well organized case presentations to other physicians or supervisors;
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment;
- develop and carry out patient management plans in a timely fashion in emergency, ambulatory and hospital settings;
- counsel and educate patients and their families;
- use information technology to support patient care decisions and patient education, including reading charts and monitors;
- demonstrate timely, consistent and reliable follow-up on patient care issues such as laboratory results, patient phone calls, or other requests;
- perform competently all medical and invasive procedures considered essential for the area of practice, including but not limited to:
  - Administer injections and obtain blood samples
  - Use sterile technique and universal precautions
  - Perform cardiopulmonary resuscitation
  - Deliver a baby and learn to repair an episiotomy
  - Assist at operations
- provide health care services aimed at preventing health problems or maintaining health;
- move throughout the clinical sites and hospitals to address routine and emergent patient care needs; and
- work with health care professionals, including those from other disciplines, to provide patient-focused care.
MEDICAL KNOWLEDGE
Residents must demonstrate knowledge about established and evolving biomedical, clinical, and
cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to
patient care. Residents are expected to:
 demonstrate an investigatory and analytic thinking approach to clinical situations; and
 know and apply the basic and clinically supportive sciences which are appropriate to their
discipline.

PRACTICE-BASED LEARNING AND IMPROVEMENT
Residents must be able to investigate and evaluate their patient care practices, appraise and
assimilate scientific evidence, and improve their patient care practices. Residents are expected to:
 analyze practice experience and perform practice-based improvement activities using a
  systematic methodology;
 locate, appraise, and assimilate evidence from scientific studies related to their patients’ health
  problems;
 obtain and use information about their own population of patients and the larger population from
  which their patients are drawn;
 apply knowledge of study designs and statistical methods to the appraisal of clinical studies and
  other information on diagnostic and therapeutic effectiveness;
 use information technology to manage information, access on-line medical information and
  support their own education; and
 facilitate the learning of students and other health care professionals.

INTERPERSONAL AND COMMUNICATION SKILLS
Residents must be able to demonstrate interpersonal and communication skills that result in effective
information exchange and teaming with patients, their patients families, and professional associates.
Residents are expected to:
 create and sustain a therapeutic and ethically sound relationship with patients and their families;
 communicate effectively and demonstrate caring and respectful behaviors when interacting with
  patients and their families;
 use effective listening skills and elicit and provide information using effective nonverbal,
  explanatory, questioning, and writing skills;
 work effectively with others as a member or leader of a health care team or other professional
  group;
 Input and retrieve computer data through a keyboard and read a computer screen; and
 Perform documentation procedures such as chart dictation and other paperwork in a timely
  fashion.

PROFESSIONALISM
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to
ethical principles, and sensitivity to a diverse patient population. Residents are expected to:
 Fulfill all duties that are assigned by residency leadership, including overnight call as assigned,
  manage multiple patient care duties simultaneously and satisfactorily complete all required
  rotations in the curriculum;
 demonstrate organizational skills required to eventually care for 10 or more outpatient cases
  per half day;
 demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and
  society that supersedes self-interest; accountability to patients, society, and the profession; and
  a commitment to excellence and on-going professional development;
 demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical
  care, confidentiality of patient information, informed consent, and business practices; and
 demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities.
SYSTEMS-BASED PRACTICE
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice;
- know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources;
- practice cost-effective health care and resource allocation that does not compromise quality of care;
- advocate for quality patient care and assist patients in dealing with system complexities; and
- know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

Approved By: ____________________________
Date: 11/30/2015
Designated Institutional Official
Policy/Procedure Title: LEAVE OR OTHER ABSENCE FROM RESIDENCY
ACGME Institutional Requirement: IV.G
GMEC Review Date: 7/5/16
Policy Effective Date: 7/5/16

SCOPE: This policy applies to all ACGME-accredited residency programs at the Institute for Family Health. This policy is superseded by relevant provisions of collective bargaining agreements (See CIR contract).

PURPOSE: This policy establishes the guidelines that govern resident vacations and other leaves of absence, as required by the Accreditation Council for Graduate Medical Education (ACGME).

POLICY:

ABFM Provisions
The Institute adheres to the policies of the American Board of Family Medicine (ABFM) regarding Absence from the Residency (https://www.theabfm.org/cert/absence.aspx). Consistent with these policies, the Institute allows residents a maximum of 30 days leave per residency year without requiring an extension of training prior to advancement. Residents should refer to these policies to determine the impact of any proposed leave of absence on residency training requirements and advancement.

Vacation, Illness, and other Short-term Absences
Absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one (1) month per academic year. Please see the ABFM policy for additional restrictions on short-term leaves. Each Institute residency program may set its own leave policies as long as they are consistent with ABFM guidelines.

Personal Leave
Personal leave for documented, legitimate reasons and for a specified duration may be granted at the discretion of the Program Director. Approval is not guaranteed and may be withdrawn at any time, contingent upon circumstances.

Personal leave will be uncompensated and any continuation of insurance benefits during that period will have to be borne by the resident. Requests for personal leave must be submitted to the Program Administrator and Program Director in writing at least one month in advance. Leaves of absence in excess of three months are considered a violation of the ABFM continuity of care requirement and require approval from the ABFM. Should a leave exceed that time limit, the resident may not return to the program at a level beyond that which was attained at the time of departure and may require the resident to complete additional continuity of care time requirements beyond what is normally required to be eligible for certification, subject to approval from the ABFM. Any absence from the residency taken beyond the 30 days allowed by the ABFM must be made up before advancement to the next training level and/or may result in extension of the residency program.
FMLA
Pursuant to the Family and Medical Leave Act (FMLA), residents who have been employed with the Institute for at least one year and worked at least 1,250 hours are entitled to a total of 12 work weeks of unpaid leave during any 12-month period for one or more of the following reasons:
   a. for the birth and care of newborn child of the employee;
   b. for placement with the employee of a son or daughter for adoption or foster care;
   c. to care for an immediate family member (spouse, child, parent, domestic partner) with a serious health condition; or
   d. to take medical leave when the employee is unable to work because of a serious health condition.

Please see the Institute’s FMLA policy for details and the ABFM policy on Long-Term Absence for training requirements and impact advancement and graduation. The Institute’s personnel policies are documented in the Employee Handbook (available at the following link: N:\Institute Policies\Corporate Administration\Human Resources\Employee Handbook_07-01-15.pdf). Residents should consult the Institute’s Human Resources Department for further requirements for taking leave under the FMLA, including application forms and documentation requirements. Any FMLA leave taken beyond the annual 30 days absence from the program allowed by the ABFM must be made up before advancement to the next training level and/or may result in extension of the residency program.

Conference Days
Time away from the residency for educational and scholarly purposes such as conferences and workshops are granted at the discretion of Program Director based upon objectives, department needs, and performance evaluation. Per ABFM policy, these absences should be limited to five days annually.

Holidays
Holidays are designated by Institute for Family Health policy and are subject to ABFM requirements. Resident physicians in their capacity of professional health providers may be required to work on holidays to cover essential services. The Chief Residents will work with the Program Coordinators to ensure that these responsibilities are covered in an equitable manner.

Parental Leave
Parental leave is defined as maternity leave, paternity leave, and adoption leave. Residents are eligible for parental leave as specified in the Institute’s Parental Leave policy. Please see the Institute’s Parental Leave policy for details. Any parental leave taken beyond the annual 30 day absence from the program allowed by the ABFM must be made up before advancement to the next training level and/or may result in extension of the residency program.

Condolence/Bereavement Leave
In the unfortunate event of the death of an immediate family member (spouse, parent, grandparent, guardian, child, sibling or corresponding in-law or step relationship), employees may take up to five (5) consecutive days off with pay within a reasonable date of the death for the purpose of attending the funeral or making arrangements. Please see the Institute’s Bereavement Leave policy for additional details. Any bereavement leave taken beyond the 30 days allowed by the ABFM must be made up before advancement to the next training level and/or may result in extension of the residency program.
**Jury Duty**

Jury Service is required of all US Citizens. Residents must consult with the Residency Administrator and Program Director immediately upon notification to report for jury duty. All attempts will be made to accommodate the specific dates listed on the jury summons. However, in some instances, requests for delay of jury duty may be required by Program needs. In such cases, Program Administration will assist residents in postponing their jury duty. Any jury duty leave taken beyond the 30 days allowed by the ABFM must be made up before advancement to the next training level and/or may result in extension of the residency program.

**Military Leave**

An employee who is a member of the United States Army, Navy, Air Force, Marines, Coast Guard, National Guard, Reserves or Public Health Service will be granted an unpaid leave of absence for military service, training or related obligations in accordance with applicable law. Please see the Institute’s Military Leave policy for additional details. Any military duty leave taken beyond the 30 days allowed by the ABFM must be made up before advancement to the next training level and/or may result in extension of the residency program.

Approved By: ___________________________ Date: 7/5/16

Designated Institutional Official
1. **Purpose:**
   To provide guiding principles and dress code standards that define acceptable dress and grooming guidelines consistent with a professional healthcare environment.

2. **Policy:**
   1.1 It is the policy of the Institute to consider the dress and appearance of all employees while they are on duty to be important in fostering a positive and professional work environment.

   1.2 In enforcing the antidiscrimination provisions of the Title VII of the Civil Rights Act of 1964 the Equal Employment Opportunity Commission takes the position, "An employer may require all workers to follow a uniform dress code even if the dress code conflicts with some workers' ethnic beliefs or practices. However, if the dress code conflicts with religious practices, the employer must modify the dress code unless doing so would result in undue hardship.

   1.3 The Institute dress code policy does not restrict employees’ clothing or appearance on the basis of gender. Transgender and gender non-conforming employees must comply with company’s dress code policy in a manner consistent with their gender identity or gender expression.

   1.4 Accommodation of religious beliefs in terms of attire may be difficult in light of safety issues for staff members. Those requesting a workplace attire accommodation based on religious beliefs should be referred to the human resource (HR) department. Examples of religious dress and grooming practices include: wearing religious clothing or articles: observing a religious prohibition against wearing certain garments, or adhering to shaving or hair length observances. (EEOC, Sept 2015)

3. **Procedure**
<table>
<thead>
<tr>
<th>Dress Code Elements</th>
<th>Expectations</th>
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| **ID Badges**       | • Must be worn above the waist while at work  
|                     | • Employee name, title and photo must be visible at all times.  
|                     | • Only Institute issues stickers or pins or stickers may be attached |
| **Hair**            | • Well-groomed, clean, dry  
|                     | • Mustache, sideburns and beard neatly trimmed  
|                     | • Hair must not obstruct vision, and in clinical environments, must be pulled back if greater than shoulder length to prevent contact with patient, equipment and supplies.  
|                     | • Hair accessories should not interfere with job performance or cause a distraction and should be consistent with a professional appearance |
| **Jewelry**         | • Moderate amounts of jewelry allowed, however jewelry is discouraged in clinical setting.  
|                     | • Jewelry that poses a health and/or safety risk or distraction (dangling chains/earrings, etc.) are prohibited  
|                     | • Jewelry must be reasonable in shape and size, appropriate to the work setting and may not interfere with patient care, job performance, or safety.  
|                     | • Rings must be small enough to allow for the use of gloves, with no risk of tearing the glove. Visible piercings are limited to ears, nose, and eyebrow.  
|                     | • Nose piercings must be limited to one small stud no greater than 11/8 inch. Employees with a nose piercing must have a back-to-back nose stud in place.  
|                     | • Tongue piercings, etc., must be removed while at work |
| **Fingernails**     | • In all settings: Nail polish must be un-chipped and freshly applied, chipped polish holds germs  
|                     | • Clean, trimmed to a length that will not interfere with employees work.  
|                     | • In Clinical Settings:  
|                     |   o Clean, trimmed to a length that will not interfere with employees work not to exceed 1/4" in length  
|                     |   o Artificial nails or extenders are prohibited. This also includes any nail product that requires "curing" under an ultraviolet light.  
|                     |   o Nail Charms and 3D nail art are not allowed, (risk scratching patients, ripping gloves and holds germs)  
|                     | • Nail polish un-chipped and freshly applied, chipped polish holds germs |
| **Fragrance**       | • Fragrance should be minimal and used with discretion. |
| **Tattoos**         | • Tattoos that could be construed as offensive must not be visible.  
|                     | • Tattoos should be covered when possible |
| **Body odor**       | • Must Practice personal hygiene and be free of offensive odor |
| **Make-up**         | • Excessive makeup is not permitted  
|                     | • Make-up must be appropriate for work. Shades that are complimentary to natural coloring should be used. Extreme make-up styles are not acceptable. |
| **Adornments:**     | • Hard chain apparel including but not limited to, metal chain belts and clothing ornaments are not permitted. |
| **Footwear**        | • Footwear must be appropriate for work performance. Shoes should
2.1 The Institute must maintain an atmosphere of cleanliness, orderliness and neatness. An employee’s appearance should reflect this image and his/her attire should be appropriate to the tasks they are performing. Employees must be clean and neat at all times and clothing well fitted.

2.2 The following standards of dress will apply to the employee groups listed below:

<table>
<thead>
<tr>
<th>Patient Services Representatives</th>
<th>Are required to wear business casual while at work.</th>
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<tbody>
<tr>
<td></td>
<td>White shirt and black or navy pants/skirt preferred. Institute sweaters are to be worn when temperature allows. White shirt and dark bottoms will be required after January 1st 2017 following disbursement of uniform allowance.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Registered Nurses, Licensed Practical Nurses, Medical Assistants, Medical Office Assistants, Dental Assistants and Dental Office Assistant</th>
<th>Are required to wear an appropriate nursing uniform. Solid color scrubs/nursing uniforms preferred. Each site may vote for color preferred. Uniformity of color will be required after January 1st, 2017 following disbursement of uniform allowance.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>White sneakers are permitted for nursing staff providing patient care. (Please consult with your nurse manager if unsure of appropriateness).</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Nurse Managers/Charge Nurses</th>
<th>Must wear professional attire business casual with a short lab coat, professional attire or nursing uniform.</th>
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</thead>
</table>

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<tr>
<th>Technical employees such as HIT / IT</th>
<th>Are not required to wear uniforms but should wear clothing appropriate to their job functions within the limitations established in this policy.</th>
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<tr>
<th>Maintenance employees</th>
<th>Are required to wear uniforms as designated that maintain safety within their job functions</th>
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</table>

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<tr>
<th>Providers (Physicians, Psychiatrists, Nurse Practitioners, Dentists, Physician Assistants and Direct Care providers)</th>
<th>Must be professional in appearance at all times.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White coats are an option for Primary Care Providers, which are available upon request from the Purchasing Department.</td>
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<tr>
<td></td>
<td>Scrub suits may not be worn within our ambulatory care setting.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Managers, and professional non-managerial employees</th>
<th>Must be professional in appearance at all times.</th>
</tr>
</thead>
</table>

- Promote a professional appearance and be clean and in good repair.
  - In clinical settings:
    - Closed toe shoes must be worn at all times
# CLOTHING GUIDELINES

## Uniforms

Employees with uniforms are required to have those neat and clean at all times.

Uniforms must be of appropriate lengths for task performed.

Crocs with holes are not permitted.

Closed-toe shoes must be worn in clinical areas.

## Acceptable

- Skirt and dress length should be no more than two inches above the knee.
- Professional dress slacks, corduroys, khakis calf-length dress Capri are acceptable.
- Professional dresses, sleeveless dresses and sleeveless tops that cover shoulders are permitted.
- Collared shirts, mock turtle necks, sweaters and Polo shirts are acceptable.
- Open-toe and sling back shoes are acceptable in non-clinical setting and but not permitted in the Community Programs, even when out in the field.
- Maximum height of heels should not exceed three inches. Shoes must be clean, safe and professional.
- Hosiery is not required.
- Ties are optional. If wearing a tie while interacting with patients, ties must be clipped to the shirt.

## Unacceptable

- Skin-tight or see-through clothing including but not limited to mesh tops are not permitted.
- Low cut dresses and tops, which expose the abdominal or chest area are not permitted.
- Tank tops, spaghetti straps, halter-tops and t-shirts are not permitted.
- Beachwear, crop tops, clothing showing midriffs are not permitted.
- Leggings, exercise wear, Shirts with writing (other than company logo) are not permitted.
- Shorts, miniskirts, sweat tops and bottoms are not permitted.
- Denim jeans pants, skirts and dresses. (Denim jeans includes black jeans) are not permitted.
- Cargo pants of any color are not permitted.
- Thongs, flip flops and croc-like sandals are not permitted.
- Jelly shoes, foam shoes and plastic shoes are not permitted.
- Baseball caps, hats, head dress of non-religious nature are not permitted.
An employee not appropriately dressed for duty will be issued with a verbal warning. Such an employee may be sent off duty as unprepared without pay. If feasible, the employee may be allowed to return to work the same day if properly attired. If an employee arrives for work inappropriately dressed repeatedly, the employee may face further disciplinary action up to and including termination.

References


Policy/Procedure Title: CRITERIA FOR ADVANCEMENT/PROMOTION OF RESIDENTS

ACGME Policy: IRQ Part 3 IV.C.1

Effective Date: 7/1/12    Rev: 2/12/15

Scope: This policy applies to all ACGME-accredited residency programs sponsored by The Institute for Family Health. This policy is superseded by any relevant collective bargaining agreements.

Purpose: To establish criteria for the advancement and promotion of residents in graduate medical education programs sponsored by the Institute for Family Health.

Policy: The decision to promote a resident from PGY-1 to PGY-2, PGY-2 to PGY-3 and from PGY-3 to graduation will be determined by the Program Director in conjunction with the Clinical Competency Committee.

Criteria for Promotion: The criteria for promotion/advancement consist of, but are not limited to, the following:

<table>
<thead>
<tr>
<th>PGY-1→PGY-2</th>
<th>PGY-2→PGY-3</th>
<th>GRADUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>FPC Patient numbers (150)</td>
<td>FPC Patient numbers (500)</td>
<td>FPC Patient numbers (1000)</td>
</tr>
<tr>
<td>Attending/Advisor Evaluations</td>
<td>Attending /Specialist Evaluations</td>
<td>Attending /Specialist Evaluations</td>
</tr>
<tr>
<td>Procedures</td>
<td>Procedures</td>
<td>Procedures (Required)</td>
</tr>
<tr>
<td>OB Deliveries</td>
<td>OB Deliveries</td>
<td>OB Deliveries (Incl continuity)</td>
</tr>
<tr>
<td>Research Proposal</td>
<td>Research Continuation</td>
<td>Research Presentation</td>
</tr>
<tr>
<td>BLS/ACLS/NRP Courses</td>
<td>Home Visits</td>
<td>Home Visits</td>
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<tr>
<td>Nursing Home Visits</td>
<td>Nursing Home Visits</td>
<td></td>
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<tr>
<td>ALSO Course</td>
<td></td>
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<tr>
<td>Passing score for USMLE Step-3/COMLEX*</td>
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* Residents are strongly encouraged to take USMLE/COMLEX Step 3 by the end of the third month of their PGY-2 year; a onetime reimbursement of the Step 3 fee will be paid upon notification of passing by the end of the fifth month of the PGY-2 year and will not be reimbursed thereafter. Failure to pass Step 3 by the fifth month of the PGY-2 year (usually November 30) may result in the resident being placed on mandated academic remediation. Non-participation or lack of success in the required remediation process may result in further actions (including probation/leave or non-renewal of contract for the PGY-3 year).

The above criteria shall be based upon the following parameters, all of which will judged as appropriate for each level of advancement:

2. **Medical knowledge** - Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to demonstrate an investigatory and analytic thinking approach to clinical situations, and to know and apply the basic and clinically supportive sciences which are appropriate to their discipline.

3. **Professional Behavior** – areas include maintenance of satisfactory working relationship with others, acceptance of responsibility, punctuality, reliability, thoroughness, and completeness and timeliness of medical record.

4. **Communication and interpersonal relationships** - 360 evaluations are included in summative assessments.

5. **Practice Based Learning** - Ability to improve one’s practice through quality improvement projects and incorporating evidence based medicine.

6. **System Based Learning** - Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:
   - understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice;
   - know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources;
   - practice cost-effective health care and resource allocation that does not compromise quality of care;
   - advocate for quality patient care and assist patients in dealing with system complexities; and
   - know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

It is further expected that all residents satisfactorily attend to their administrative responsibilities including timely completion of all documentation requirements, such as medical records, time sheets, credentialing information, and evaluation forms.

Review of residents regarding promotion will take place during the third quarter of the academic year during semi-annual review. In order to advance to PGY-2 or PGY-3, the resident must be judged competent to supervise others and to act with limited independence. In order to graduate, the resident must be deemed competent to practice medicine independently.

**Adverse Action for Poor Resident Performance**: Any resident who has received multiple deficient evaluations in any of the six competences may be subject to adverse actions detailed below, as recommended by the Program Director after consultation with the involved faculty and/or Chief Resident(s). These disciplinary actions may only be authorized by the Program Director subject to final review by the DIO.

Adverse actions will be based on documented, recurrent deficiencies or on a single serious deficiency involving an adverse effect on patient care or serious harm to the program, individual staff, faculty members, or fellow residents. Except in the latter case, the resident will have at least one verbal or written warning indication if the deficiencies cited are repeated and adverse action could result. The adverse action will depend upon the nature and degree of the deficiency and could include, but not be limited to, any of the following:

1. Written reprimand in the resident's personnel file.
2. A period of probation which may include extra/remedial assignments that must be completed satisfactorily in order to remain/progress in the program. Assignments may consist of additional call, repeating rotations, extra educational activities, or others as deemed appropriate by the Program Director. The duration of assignments and probation is at the discretion of the Program
Director. Determination of satisfactory completion of assignments/return to good standing will be made by the Program Director in consultation with designated faculty.

3. Suspension from duties: Time lost due to suspension must be made up prior to advancement to the next training level and/or graduation, per ACGME requirements. Vacation and/or conference time may be used, if available.

4. Non-renewal of contract: When it is anticipated that the contract will not be renewed, or when a resident will not be promoted to the next level of training, the program will provide the resident with a written notice of intent no later than four (4) months prior the end other this contract. If the primary reason(s) for the non-renewal or non-promotion occurs within the four (4) months prior to the expiration of the contract, the program will provide as much written notice of the intention as circumstances will reasonably allow and the resident may have to extend his or her training.

5. Dismissal from Program: The resident may be dismissed from the program after repeated attempts to correct deficiencies have failed. The Program Director can recommend dismissal from the residency after consultation with the faculty and review by the DIO, who has final authority or that decision.

Residents subject to delayed promotion or dismissal, or who wish to contest any terms of their promotion, can grieve these decisions as set forth in the Institute’s GME Grievance Policy.

Approved By: ____________________________ Date: 02/12/2015
Designated Institutional Official
Title: EVALUATION OF RESIDENT PERFORMANCE

Original Effective Date: 03/85
Revised Date: 4/17

Evaluation of resident performance follows the guidelines of the General Requirements of the Accreditation Council for Graduate Medical Education and the Special Requirements of the American Board of Family Medicine. Resident evaluation occurs periodically throughout the duration of their training. It is the responsibility of every resident and attending to be familiar with the evaluation format.

Components of evaluation are:

A. Rotational Evaluations

1. At the conclusion of every rotation each supervisory faculty member/attending physician/resident is expected to complete an evaluation form for each resident supervised. These evaluations are to be reviewed with the resident and submitted to the Program Director within 25 business days of the end of the rotation.

2. In the event of unsatisfactory performance, it is expected that the resident is made aware of deficiencies during the rotation; notification of failure must be made to the resident and the Program Director within one week of the completion of the rotation.

B. Precepting Evaluations

Clinic faculty will submit a quarterly precepting evaluation form with specific comments regarding knowledge, attitude, skills, strengths and weaknesses, of each resident with whom they have had significant contact. These evaluations are compiled and reviewed quarterly by the resident and their advisor. Twice a year, the precepting evaluations are reviewed by all faculty as part of the semi-annual summative assessment. This composite is then reviewed with the resident and placed in the resident's file.

There will be a place on the evaluation form for the HSO's signature or acknowledgement – this will only signify that the resident has seen the evaluation, not that they agree with it. A HSO has the right to attach written commentary to the evaluation that is placed in his/her file.

Residents will be evaluated at least semi-annually using the Family Medicine Milestones. This will be done by the Curriculum Competency Committee (CCC) and available to the residents for review.

C. Clinical Volume

Clinical Volume must meet ACGME/ACOFP Guidelines.
D. Inpatient/Outpatient Chart Reviews

Inpatient/Outpatient Chart Reviews are filed in the resident’s file after review by the resident as per CQI guidelines.

E. Attendance at Lectures/Educational Sessions

Attendance at lectures/educational sessions as outlined in Policy #R0009.

F. In-Training Assessment Examination (ITAE)

The annual ITAE is mandatory for all residents in each year of their training. Performance on this examination is utilized to assess the resident’s overall cognitive level and to identify areas requiring individual attention and/or remediation.

G. Advisor Reports

Documentation of periodic resident meetings with their advisor is maintained in the resident’s evaluation binder. As outlined in the Advisor Checklist, this provides information regarding clinical performance, skills, documentation and lecture attendance as well as individual issues pertinent to the resident’s performance.

H. Continuing Quality Improvement

Quality issues/incident reports may be maintained in the resident’s permanent record at the discretion of the Program Director.

I. Feedback

Feedback may be transmitted to a resident via private, verbal communication not requiring written documentation. Performance or behavioral issues of significant nature require written documentation to the Program Director and the involved resident. These communications will be maintained in the resident’s permanent record at the discretion of the Program Director.

J. Annual Mid-Year/Year-End Evaluations

Each resident will meet with the Program Director or designee every six months to review their progress. A written summation of this meeting is given to the resident’s for his/her own records and a copy is filed in the resident’s evaluation binder.

K. Resident Review of Evaluation Information

Residents are expected to review their evaluation binder periodically (at least quarterly) and initial all forms on file.

Approved by: ______________________________     Date: _________________

Andrea Maritato, MD
Program Director
PURPOSE: The Accreditation Council of Graduate Medical Education (ACGME) Institutional Requirement VI.D states: “The Sponsoring Institution must have a policy that outlines the procedures for submitting and processing resident/fellow grievances at the program and institutional level and that minimizes conflicts of interest.” The purpose of this policy is to provide residents and fellows participating in post-graduate training programs a process for grieving matters other than those listed in General Grievances below, as well as due process to follow while appealing the imposition of Corrective Actions.

SCOPE: This policy applies to all Graduate Medical Education (GME) training programs at the Institute for Family Health. For the purpose of this policy, ACGME Common Program Requirements will apply to residents receiving training in Institute programs. This policy is superseded by relevant provisions of collective bargaining agreements (see CIR contract).

GENERAL GRIEVANCES: If a resident has a complaint or grievance related to matters other than job performance, corrective action plans, discrimination or sexual harassment, the resident should first attempt to resolve it by consulting with the chief resident or the Program Director. If the resident is unable to resolve it at that level, the resident should present the complaint or grievance to the Designated Institutional Official (DIO). If the resident is unsatisfied with the DIO’s decision, recommendation or other handling of the complaint or grievance, the resident may present the complaint or grievance in written form to the Graduate Medical Education Committee (GMEC), which shall provide a written response to the resident within ten (10) business days of receipt of the written complaint. The decision of the GMEC shall be final and binding.

SEXUAL HARASSMENT AND DISCRIMINATION: If a resident has a complaint or grievance related to discrimination or sexual discrimination, the resident shall have the right to address said complaint in accordance with the policies and procedures set forth in the Sexual Harassment and Protected Class Policy.

DUE PROCESS PROCEDURE: A resident may seek relief from a corrective action plan by using the following process:
Initial Request by a Resident to Review a Corrective Action Plan: The resident may request to have any corrective action reviewed. A request for review should be submitted to the Graduate Medical Education office within five (5) business days of the resident learning of the corrective action. Upon receipt of a request for review, GME administration will appoint an attending faculty physician who is not a member of the faculty of the resident’s program to review the complaint and determine whether the matter is reviewable under this policy. The physician reviewer will:

- Review the complaint
- Meet with the resident
- Review the resident’s or fellow’s file
- Meet with the program director
- Consider any extenuating circumstances
- Consult with others, as appropriate, to assist in the decision making process; and
- Determine whether this policy was followed, i.e. the resident received notice of deficiency and an opportunity to cure, and the decision to take the corrective action was reasonably made.

GME Administration will:

- Appoint the physician reviewer
- Assist the physician reviewer in identifying other potential participants, if warranted
- Provide procedural guidance to the physician reviewer, if warranted
- Coordinate communications between the physician reviewer and the resident
- Monitor timely completion of the review process
- Assist the physician reviewer with the written report to the resident and Program Director (should be provided within 30 business days of the resident’s or fellow’s request for review).

2. Second Request by a Resident to Reconsider Initial Review or Hearing: The resident shall present the grievance in writing to the GME Administration within five (5) business days after receiving the written report of the physician review. The grievance shall state the facts upon which this additional grievance is based and state clearly why an additional review or hearing is warranted.

Grievance Hearing Committee Review: GME Administration shall organize a hearing of a Grievance Hearing Committee within ten (10) business days of receiving the resident’s request for a hearing. No member of the Hearing Committee should have any direct involvement with the circumstances in question. The Hearing Committee shall consist of the following three individuals, none of whom may be from the program of the resident in question:

1. One program director or attending faculty of equivalent experience and standing at the Institute who shall act as chairperson of the ad hoc review panel;
2. Two additional faculty members; and
3. One GME administrator (non-voting member of the panel)

The Hearing Committee will set a date for the hearing within thirty (30) days from the receipt of the grievance and allow at least 10 days advance notice to the resident. The Chair of the Hearing Committee may choose to discuss the complaint with the resident and the Program Director independently. The resident shall have the following rights during this review:

1. The right to know the reason for the action resulting in the corrective action plan.
2. The right to know the time and place of the Hearing as well as the names of the Hearing Committee members in writing at least 10 business days in advance.
3. The right to provide a written rebuttal of the accusations and be heard in person.
4. The right to be accompanied by an advisor. The advisor can be an attorney or staff from the CIR union. While the advisor may consult with and advise the resident during the review, the advisor shall not in any way participate in the proceedings. The Institute shall have the right to have a legal representative in attendance.
5. The right to a written statement prepared by the hearing body setting forth its recommendations and/or conclusions, its reasons for reaching such recommendations or conclusions, and the facts relied upon in reaching such recommendations or conclusions.

**Hearing Committee Procedure:** The format of the hearing will include a presentation by the program director (max 20 minutes); an opportunity for a presentation of equal length by the resident; an opportunity for response by the program director (max 10 minutes), followed by a response of equal length by the resident. This will be followed by a period of questioning by the hearing panel.

Documents to be considered by the review panel must be completed and distributed to the other party and the ad hoc review panel not less than five (5) business days before the review. Such submission shall include pertinent subject matter (in writing) from relevant participants (other faculty, residents, or staff) and the relevance of that participants’ evidence to the matter being heard.

The Hearing Committee at its sole discretion may decide to expand participants at the hearing to include the individuals who provided witness statements for the Program Director or the resident, and choose to interrogate them at their own discretion.

The Hearing Committee may choose to schedule additional sessions if additional time is needed to interview principle participants or if additional participants need to be interviewed.

The Hearing Committee shall deliberate privately.

A final decision will be made by a majority vote of the Hearing Committee and the Committee’s finding and recommendation will be communicated in writing within ten (10) business days following completion of the Hearing.

**Appeal to the DIO:** If the resident does not agree with the recommendations and/or findings of the Hearing Committee, the resident may appeal in writing within ten (10) business days of receipt of the Hearing Committee decision to the DIO. The DIO shall consider the matter and within ten (10) days will provide a written determination to the resident or fellow. The determination of the DIO shall be final and binding and no further review or appeal process will be available.

**Related Matters**

1. The burden of persuasion is upon the resident to demonstrate by clear and convincing evidence that the action taken was arbitrary and capricious, i.e., not based on legitimate academic or professional reasons.
2. The Hearing Committee record is confidential and shall not be open to the public, except (a) to the extent both parties agree in writing or (b) as may otherwise be appropriate in response to a governmental or legal process.
3. Failure of the resident to meet the time limits for formal grievance shall constitute a withdrawal of the appeal.

Approved By: _______________________________ Date: __2/18/15_____

Designated Institutional Official
Policy/Procedure Title: RESIDENT WORK HOURS

Revision Date: 4/12/19

Purpose: To ensure that the working hours and working conditions of residents hired by the Institute for Family Health promote the provision of high quality medical care, the well-being of residents, an optimal training experience, and compliance with the New York State Department of Health Regulation 405 and the ACGME work hours requirements, the Institute for Family Health maintains the following guidelines for scheduling and supervising the working hours of its residents.

Policy:

Maximum Work Hours:
1. Residents’ clinical and educational work hours shall not exceed eighty (80) hours per week averaged over a four-week period. This limit is inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Clinical Work and Education
2. Residents shall have eight hours off between scheduled clinical work and education periods.
3. In circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education, this must occur within the context of the 80-hour and the one-day-off-in-seven requirements.
4. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
5. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Clinical Work and Education Period Length
6. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. Up to three hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.
Clinical and Educational Work Hour Exceptions
7. In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
   1) to continue to provide care to a single severely ill or unstable patient;
   2) humanistic attention to the needs of a patient or family; or,
   3) to attend unique educational events.
   These additional hours of care or education will be counted toward the 80-hour weekly limit.

8. The GMEC and DIO will not consider requests for exceptions to the 80-hour limit to the residents' work week, per the Family Medicine Review Committee policy.

Moonlighting
9. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident’s fitness for work nor compromise patient safety.

10. Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.

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

In-House Night Float
12. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. Night float experiences must not exceed 50 percent of a resident’s inpatient experiences.

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

At-Home Call
14. Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.

15. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

16. Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

Maximum High Intensity Shift
17. While on duty in the emergency department, residents may not work longer than 12 consecutive hours. There must be at least an equal period of continuous time off between scheduled work periods. A resident must not work more than 60 schedule hours per week seeing patients in the emergency department, and no more than 72 total hours per week.
Supervision of Work Hours

18. Residents must appropriately complete duty hour logs for each block rotation and are expected to report work hours violations. The Residency Administrative Office will monitor work hours compliance on or before the Friday following the conclusion of the block and contact residents who are not in compliance.

19. The supervising attending in either the hospital or ambulatory setting is responsible for ensuring that the residents follow these prescribed limitations of work hours on their schedule.

20. Program Directors are responsible for reviewing all work hour violations reported each month. The Program Director will “sign off” on all violations where this option is available.

- “Sign off” indicates that the Program Director has reviewed the violation. It does not indicate that the Program Director “approves” the violation, nor that it is “acceptable”.
- The Program Director should review all violations, and make adjustments to program schedules or processes when recurrent violations are noted.

21. Residency Administration will submit quarterly reports to the GME Committee for review. A standard threshold for administrative action in response to reporting noncompliance is as follows:

- Two months of non-compliance in any given academic year will generate a Letter of Concern from the Program Director or Chair of GME to be placed in the resident’s file citing a pattern of reporting non-compliance that reflects negatively on the resident’s professionalism.
- Continued reporting non-compliance following receipt of a Letter of Concern will trigger a review by the GME Committee and may result in disciplinary action up to and including dismissal.

22. A confidential, anonymous Hotline is available for employees who wish to register a complaint under this policy anonymously. Use of this Hotline should be restricted to those employees who wish to remain anonymous. The Hotline telephone numbers are:

Policy/Procedure Title: MOONLIGHTING (Dual Employment)
ACGME Policy: IRQ Part 3 IV.J.1
Effective Date: February 12, 2015

POLICY
Any resident who is working an average of 80 hours per week over a four week period within a resident training program is prohibited by the New York State Health Code, Part 405.4 from working at any other job as a physician providing patient care services (moonlighting).

For the purpose of this policy, “moonlighting” includes any non-residency work or academic activities, including non-medical work or enrollment in an outside educational program, whether a degree is granted or not.

Moonlighting does not replace any part of the clinical experience that is required of residency training and may not interfere with training. Residents are not required to engage in moonlighting as part of their educational experience or terms of contract.

PROCEDURE
1. Resident physicians may not moonlight without the prior written approval of the Program Director.

2. A resident physician who wishes to “moonlight” outside the scope of his or her residency program must submit a written request to the Program Director describing:
   - Location of the planned moonlighting site
   - Scope of the moonlighting practice
   - Expected work or academic hours
   - Expected responsibilities
   - Type of supervision
   - Verification of malpractice coverage (Institute malpractice coverage does not cover moonlighting)

3. Approval will be contingent upon academic good standing and fulfilling the following requirements:
   - Good attendance at conferences (>80% of possible attendance, i.e. not including vacation, away electives or post-call)
   - Good performance on the In-training Examination: (>50% of national average for respective PG year)
   - 10 continuity deliveries and 30 rotation deliveries
   - All Home Visits completed
Nursing Home Visits current  
Up-to-date on NRP, ALSO, ACLS, BLS  
Meets training level competency expectations  
NY State License  
Residents with J1 Visa and most H1-B visas cannot moonlight due to employer and position specific restrictions.

4. Any resident physician who is found to be moonlighting without having notified and gained the Program Director's prior written approval will be subject to disciplinary action.

5. For the duration of moonlighting, the resident must provide a planned work schedule for all moonlighting activities, taking into account rotation requirements and assuring compliance with the 405.4 regulations.

6. Scheduling requests have to be signed off by the Chief Resident(s) and the Residency Administrator.

7. If a resident is needed for program coverage (e.g. for back up, sick-call, other emergencies) during a moonlighting shift, the resident will be required to cover the staffing needs of the program over moonlighting activities.

8. Resident must remain in good standing with the program at all times while moonlighting as certified by the resident's advisor, residency administrator, and program director.

9. The resident's performance will be monitored to assess the effect of the moonlighting activities on performance. Adverse effects will lead to withdrawal of permission to moonlight.

10. Duties and procedures performed during moonlighting cannot be utilized to fulfill procedural and/or patient care requirements of the residency training program.

Approved By: ___________________________ Date: 2/12/15
Designated Institutional Official
Policy/Procedure Title: IMPAIRED RESIDENTS AND FACULTY (Including Mental Impairment, Physical Disability and Substance Abuse)

ACGME Policy: IRQ Part 3 IV.H.2

Effective Date: 7/1/12 Revised Date: 2/17/15

PURPOSE: The Institute for Family Health is committed to providing the highest quality health care in the safest and most effective settings, while optimizing the quality of its residency training programs.

POLICY: The Institute promotes a healthy work and training environment for its residents as documented in its GME Policy on Fatigue Management, and recognizes that on occasion faculty and residents may be unable perform their jobs properly. This policy establishes a process for identifying and managing residents and faculty whose performance is impaired and requires a plan for corrective action to protect patients, staff, and the physicians at risk. This policy applies to all residents and clinical faculty of the Institute’s residency training program. The policy defines impairment as the inability to perform the responsibilities and tasks of a resident or an attending faculty member due to a mental illness, physical limitation, substance abuse, or significant behavioral problem that places patients or trainees at risk.

PROCEDURE:

Identifying Physicians at risk: The Institute recognizes the importance of identifying physicians at risk of impairment as soon as possible and will make every effort to support a work and training environment to encourage self-disclosure of possible impairment by residents and faculty. Residents or faculty members who believe they are unable to perform job duties due to an impairment as defined above are encouraged to inform the program director or the program administrator as soon as possible. Residents and faculty members who observe behavior of another resident or faculty member that suggests impairment are required to bring this observation to the program director or program administrator as soon as possible. The identity of the individual making this observation will be kept confidential.

Investigation: In the event that a possibly impaired physician is identified, the program director, in consultation with the Designated Institutional Official (DIO), will develop a plan to investigate, assess, and manage the resident or faculty member who is alleged to be impaired. This investigation will be conducted with the Institute’s Human Resources (HR) Department and in consultation with experts in assessing impairments in the workplace. If the physician is a resident whose employment is covered by a collective bargaining agreement, then the relevant parties (CIR) will be informed and included in this process as set forth in this agreement.

The identified physician will be interviewed by the program director, the DIO, and the HR consultant, with CIR representation as required. This investigation may include other members of the residency program or Institute staff as determined by the investigation team.

Corrective Action: If this team determines that the identified physician is at impaired, they will propose a corrective action plan in consultation with the HR Director and CIR as appropriate. The final decision on
this plan rests with the DIO. The plan will have specific measurable milestones with deadlines for subsequent assessments and return to work.

The plan may include, but is not limited to, the following:

- Required written evaluation by a psychiatrist and/or psychologist, an independent medical examination, and referral to specific programs for substance abuse, anger management.
- Required enrollment in the New York State Committee of Physicians Health Program (CPH), which provides a supportive non-adversarial assessment and treatment program for impaired physicians.
- Consultations may be provided by the identified physician, their primary care provider, or CIR.

The reimbursement for the costs for this evaluation will be from the benefits program of the physician, if applicable, or negotiated with the physician. Every effort will be made to ensure that cost is not an obstacle to a thorough, prompt, and accurate assessment and management plan.

**Monitoring the Recovery:** At designated intervals the impaired physician will meet with the program director and/or the DIO to monitor the progress of recovery, and determine a date for return to work. The CPH provides very specific details regarding fitness to work, which will be considered by the DIO.

Every effort will made to support a timely and full recovery of an impaired resident or faculty member. In addition all information related to the investigation, action plan, and monitoring of an impairment will be kept confidential unless disclosure is required by federal, state, or regulatory agencies.

**Grievance or challenges to the assessment or plans for an impaired physician:** Should a physician identified as impaired disagree with this assessment and/or decline to participate in a corrective action plan, the physician can grieve this decision. At this point the process will follow the procedures set forth in Grievance policy.

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Approved By: ________________________________ Date: 2/18/15

Designated Institutional Official
Policy/Procedure Title: SEXUAL HARRASSMENT AND PROTECTED CLASS POLICY

ACGME Policy: IRD IV.H.3: Sexual and Other Forms of Harassment

Effective Date: 2/24/15

POLICY:
The Institute for Family Health is committed to providing the highest quality health care in the safest and most effective settings, while optimizing the quality of its residency training programs. The Institute promotes a healthy work and training environment for its entire staff including the residents which includes a work setting that is free from any harassment, sexual or otherwise, and free of an offensive work environment.

This policy establishes a process for identifying and managing incidents that involve any offensive behavior or interactions that residents may experience at an Institute site or program.

The Graduate Medical Education Office also will identify and manage any incidents of sexual harassment or offensive behaviors that residents may experience at other affiliated (non-Institute operated) program or sites to ensure that these sites are free of any harassment.

This policy may be amended or superseded by a collective bargaining agreement for any residents who are party to such an agreement.

Definition:
Protected class harassment is behavior based upon a person’s or persons’ protected class that affects tangible job benefits, interferes with an individual's work performance, or creates an intimidating, hostile or otherwise offensive work environment. Unwelcome sexual advances (either verbal or physical), requests for sexual favors, racially based insults, denial of employment advancement opportunities because of age, and other actions, comments or conduct based on protected class constitute harassment when they are:

• Unwelcome,
• Reasonably judged to be severe and offensive,
• Pervasive, repeated or significant in scope, and
• Determined by their impact, not their intent.

The Federally recognized protected classes are:
• Age over 40
• Gender
• Pregnancy
• Ethnic, national and racial groups (including skin color and citizenship)
• Religious affiliations and creeds
• Physical disability or condition (as defined by applicable law)
• Military status

In addition to the federally recognized protected classes, the City and State of New York also recognize:
• Gender identity or gender expression
• Age over 18
• Prior record of arrest or conviction
• Marital status
• Genetic predisposition or carrier status
• Sexual orientation
• Citizenship status
• Affectional preference
• Status as a victim of domestic violence, sexual offense or stalking.

Harassing behavior can involve men and men, women and women, men toward women, and women toward men. It can include any combination of work relationships: managers and staff, staff and other staff, managers and other managers, one on one, group on group, group on one. A harasser can be a co-worker, a client, a contractor or a visitor. This policy covers harassment that occurs in the workplace, off-premises, at an Institute sponsored event, or in a casual setting (co-workers getting together after work, for example).

Protected Class Harassment Procedures:
The Institute prohibits protected class harassment in the workplace. The Institute will respond to complaints of protected class harassment promptly by conducting an investigation. If it is determined that conduct in violation of this policy has occurred, the Institute will act to eliminate the conduct and promptly impose such necessary corrective action. This policy does not limit the Institute’s authority to discipline or take remedial action for conduct deemed inappropriate and unacceptable in the workplace, regardless of whether that conduct satisfies the definition of protected class harassment. Residents are treated as all Institute employees and subject to all the provisions of this policy as described.

An employee who believes he or she has been subjected to or witnessed protected class harassment must report this to any supervisory employee or the Human Resources Department immediately. Staff from the Human Resources Department is also available to provide information to employees about the Institute’s policy on protected class harassment and the complaint process. Residents have the option of contacting

A confidential, anonymous Hotline is available for employees who wish to register a complaint under this policy anonymously. Use of this Hotline should be restricted to those employees who wish to remain anonymous. The Hotline telephone numbers are: ENGLISH: 1- 800- 398-1496 SPANISH: 1- 800-216-1288.

No person should feel or believe that he or she cannot register a complaint about protected class harassment, even if that person chooses to remain anonymous. Employees must be aware that gossip, hearsay, rumors and similar sources are difficult, if not impossible to investigate. The more specific and detailed a complaint is, the better able the Institute is to investigate it and resolve any problems.
Managers/Supervisors Responsibilities
If a manager or supervisor receives information about conduct that might violate this policy, he or she must contact Human Resources immediately. Residents may also contact the Designated Institutional Official (DIO), Program Director, Program Administrator, or any staff from the office of Graduate Medical Education who will contact the Human Resources department for an investigation and review.

Non-Retaliation
Retaliation against an individual who has complained about protected class harassment, and retaliation against individuals for cooperating with an investigation of a protected class harassment complaint are unlawful and will not be tolerated by this organization. Any substantiated instances of retaliation will be disciplined appropriately. This will apply to all residents.

Protected Class Harassment Investigation
A prompt investigation will be conducted when Human Resources receives a complaint or becomes aware of a potential instance of protected class harassment. The investigation will be conducted to maintain confidentiality to the extent that is practical under the circumstances. The investigation will include interviews with the person(s) filing the complaint and other witnesses, where appropriate. The person(s) alleged to have committed protected class harassment will be interviewed. All employees of the Institute are required to cooperate in any investigation conducted by the Institute concerning complaints or allegations related to this policy. Refusal to cooperate or to provide a written statement will result in appropriate disciplinary action, up to and including termination. When the Institute has completed its investigation, to the extent appropriate, it will inform the person(s) filing the complaint and the person(s) alleged to have committed the conduct of the results of the investigation. Investigations involving residents will require participation from the DIO, relevant Program Director and Program Administrator, and any key residency faculty or staff. Investigations of incidents involving residents who are covered by a collective bargaining agreement would be subject to the procedures describes in this agreement as well.

Disciplinary Action
If it is determined that an employee or resident has engaged in conduct prohibited by this policy, The Institute will take appropriate action that may include disciplinary action, up to and including termination. Any disciplinary action will be in accord with a collective bargaining agreement.

Approved By: ____________________________ Date: 2/24/15
Designated Institutional Official
Scope: This policy applies to all applicants, residents, and residents seeking promotional opportunities. This policy is superseded by relevant collective bargaining agreements.

Purpose: The Institute for Family Health is committed to the fair and equal employment of people with disabilities. Reasonable accommodation is the key to this non-discrimination policy. While many individuals with disabilities can work without accommodation, other qualified applicants and residents face barriers to employment without the accommodation process. It is the policy of the Institute to reasonably accommodate qualified individuals with disabilities unless the accommodation would impose an undue hardship. In accordance with the Americans with Disabilities Act, accommodations will be provided to qualified individuals with disabilities when such accommodations are directly related to performing the essential functions of a job, competing for a job, or to enjoy equal benefits and privileges of employment.

Definitions

Disability: For purposes of determining eligibility for a reasonable accommodation, a person with a disability is one who has a physical or mental impairment that materially or substantially limits one or more major life activities.

Reasonable accommodation: A reasonable accommodation is a modification or adjustment to a job, an employment practice, or the work environment that makes it possible for a qualified individual with a disability to enjoy an equal employment opportunity. Examples of accommodations may include acquiring or modifying equipment or devices; modifying training materials; making facilities readily accessible; modifying work schedules; and reassignment to a vacant position.

Reasonable accommodation applies to three aspects of employment:

- To assure equal opportunity in the employment process;
- To enable a qualified individual with a disability to perform the essential functions of a job; and
- To enable a resident with a disability to enjoy equal benefits and privileges of employment.
Procedures

The resident should notify the Program Director, the Residency administrator or Human Resources Department directly of a need for an accommodation.

1. Both the resident and their physician will need to complete the ADA application and return it to the Human Resources Department.

2. When a qualified individual with a disability has requested an accommodation, the Institute shall, in consultation with the individual and the residency program:
   - Discuss the purpose and the essential functions of the particular job involved. Completion of a step-by-step analysis may be necessary.
   - Determine the precise job-related limitation.
   - Identify the potential accommodations and assess the effectiveness each would have in allowing the individual to perform the essential functions of the job.
   - Select and implement the accommodation that is the most appropriate for both the individual and the Institute. While an individual's preference will be given consideration, the Institute is free to choose among equally effective accommodations and may choose the one that is less expensive or easier to provide.
   - The Institute will work with the resident to obtain technical assistance, as needed.
   - The Institute will provide a decision to the resident within a reasonable amount of time.

Approved By: _______________________________  Date: ___10/18/11______

Designated Institutional Official
INSTITUTE FOR FAMILY HEALTH
POLICY AND/OR PROCEDURE STATEMENT
FOR GRADUATE MEDICAL EDUCATION

Policy/Procedure Title: CLOSURE/REDUCTION OF RESIDENCY PROGRAM

ACGME Policy: IRQ IV.N

Effective Date: 7/1/2012
Reviewed: 11/30/15

POLICY:
It is the expectation of the Institute for Family Health that all residency training programs will be continued with its current complement of residents and faculty in its current facilities. Any decision to significantly reduce the size of or close these programs will be made by the Board of Directors of the Institute for Family Health from a recommendation by the Graduate Medical Education Committee.

PROCEDURE:
1. The decision to reduce the size of a residency program or to close a program may be initiated either by the Board of Directors or the Graduate Medical Education Committee (GMEC). In either case, the GMEC will review the basis of this decision exploring all options, and make its recommendation in a timely fashion to the Board. The Institute’s Board of Directors will make the final decision regarding reduction or closure of a program also in a timely fashion. The Institute’s CEO will inform the DIO, GMEC, the Program Director, and the Residents of the Board’s decision as soon as possible.

2. All residents who are currently enrolled in the program will be permitted to complete the current academic year.

3. The Institute for Family Health will assist PGY-2 and PGY-1 residents in enrolling in another ACGME accredited program as much as possible.

4. The Program Director(s) will inform the appropriate accreditation organizations of the intention to reduce or close the affected program as soon as possible.

5. Records regarding residents may be sent for permanent storage to the Federation of State Medical Boards (FSMB) to ensure retention of records and continuing availability to hospitals and other credentials verifying organizations.

Approved By: ______________________________ Date: 11/30/15

Designated Institutional Official