NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Graduate Medical Education Institutional Policy Manual

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-001
Subject: Accreditation Oversight of ACGME Programs	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 3

PURPOSE

This policy outlines how the Noorda-COM, the sponsoring institution, has the ultimate authority and oversight of its ACGME-accredited programs and the actions it will employ to ensure it maintains its accreditation,

POLICY

A. The sponsoring institution will:
    1. Maintain its ACGME institutional accreditation and be in substantial compliance with the ACGME Institutional Requirements.
    2. Ensure each of its ACGME-accredited programs is in substantial compliance with ACGME's Institutional, Common, and specialty-specific Program Requirements and the ACGME Policies and Procedures.
    3. Identify a designated institutional official (DIO) who will:
        a. Approve program letters of agreement
        b. Oversee Annual Update submissions for each program and the Sponsoring Institution
        c. Oversee the submission of applications for ACGME accreditation and recognition, voluntary withdrawal requests, and program complement requests.
    4. Assemble and maintain a GMEC with voting rights that meets ACGME's GMEC roster/composition requirements and meets a minimum of once every quarter during the academic year with at least one peer-selected resident/fellow.
    5. Ensure its residents/fellows are only assigned to learning and working environments that facilitate patient safety and health care quality
    6. Confirm that hospital participating sites are accredited by a deeming authority, for participation in Medicare, to provide patient care.
    7. Sign and date a written Statement of Commitment to GME at least once every five years by the DIO, a representative of the sponsoring institution's senior administration, and a representative of the governing body.
    8. Complete a Self-Study prior to its 10-Year Accreditation Site Visit.

B. As accreditation oversight is the primary role for the Sponsoring Institution, DIO and/or a designee will conduct annual onsite visit(s) to each program to ensure compliance with common program, specialty-specific program requirements and ACGME's Policies and Procedures.
    1. The Noorda-COM staff and Program Director will collaborate to develop the itinerary and determine which faculty, trainees, and administration must be in attendance.
    2. If the visit is a standard Noorda-COM site visit focused on accreditation compliance,

the Noorda-COM Site Visit Checklist with corresponding explanations will be sent to the program director at least one month prior to the site visit. Certain documents demonstrating compliance with requirements may be requested in advance for off-site review.

3. Those conducting the Noorda-COM site visit will record findings during the visit and note follow-up items for both the institution and Noorda-COM.
4. A letter recapping the Noorda-COM site visit's findings and recommendations will be sent to the Program Director and other appropriate parties within the program.
5. The Noorda-COM recap letter will be shared at the next scheduled GMEC meeting. Critical feedback from the GMEC meeting will be shared with the Program Director if he or she is not in attendance during the Noorda-COM GMEC meeting.
6. A copy of the Noorda-COM recap letter will be maintained in the member file at Noorda-COM' Office of GME.

C. The Noorda-COM DIO and/or a designee will participate in person during CLER visits and in person or by telephone/video conference in program inspections based on CLER field representatives' instructions. Impressions from this activity will be shared at the next scheduled GMEC meeting for oversight purposes.
    1. The Noorda-COM DIO and/or a designee and the program director will collaborate with a designated CLER Director to orient GME program members and hospital/clinic administrators about CLER's purpose, upcoming CLER site visits, and to ensure program readiness prior to the event.
    2. CLER reports will be shared with and reviewed by the CLER Director, Program Director, and Noorda-COM's GMEC.
    3. If required, corrective action plans will be completed by the DIO in collaboration with the CLER Director and Program Director. Noorda-COM's GMEC will review and approve all corrective action plans prior tosubmission.
    4. The Noorda-COM DIO and/or a designee will work with the CLER Director and Program Director to ensure changes required in the corrective action plan have been fully implemented.

D. The Noorda-COM DIO, in collaboration with the GMEC and its subcommittees, have the authority and responsibility for administration and oversight of Noorda-COM's ACGME accredited programs as well as ensuring compliance with all institutional, common program, and specialty-specific program requirements.

RESPONSIBILITY

A. The CLER Director at the participating site and the Program Director(s) are responsible for:
    1. Adherence to and communication of ACGME standards pertaining to accreditation oversight of the sponsoring institution, program inspections, and CLER site visits;
    2. The CLER Director and appropriate Program Director(s) shall be present during any inspection or CLER site visit from the ACGME and the Noorda-COM annual site visit;
    3. The CLER Director and appropriate Program Director(s) shall submit all and any materials requested by the DIO in a timely manner.

B. The sponsoring institution will disseminate information related to this policy and ACGME's common program and specialty-specific program requirement updates, policies, and other relevant sponsored program information via written communication and/or face-to-face

meetings.

C. Noorda-COM's DIO and/or a designee will conduct periodic Noorda-COM site visits and all duties associated with this activity.

D. Noorda-COM's DIO and/or a designee will participate in program inspections, CLER site visits, and other activity conducted by the ACGME.

E. The GMEC shall receive and review documents related to all Noorda-COM site visits and all member inspections, providing feedback whenappropriate.

F. The Noorda-COM DIO and GMEC shall provide counsel and offer additional resources to programs that they deem to be substantially non-compliant with published requirements, as appropriate.

G. The GMEC will provide effective oversight, review and approve required action items as listed in the Institutional Requirements, review and approve the Annual Institutional Review, and conduct Special Reviews as needed.

H. The DIO must annually prepare the Annual Institutional Review (AIR) and present it to the GMEC each March and submit a written executive summary of the AIR to Noorda-COM's Governing Body each April. The written executive summary must include:
   1. A summary of institutional performance on indicators for the AIR.
   2. Action plans and performance monitoring procedures resulting from the AIR.

Sample Checklists

DOCUMENT CHECKLIST FOR ANNUAL SITE VISIT

Section 1

Please provide the Review Panel Members the following documents by Date:

1. The specialty-specific application questions
2. A list of faculty and resident scholarship updated over the past six months
3. Sample documents demonstrating resident involvement in patient safety and QI
4. Current block diagram
5. Program manual with all program specific policies, such as Supervision, Clinical and Educational Work Hours, Resident and Faculty Wellbeing, etc.) which includes competency-based, educational level-specific goals and objectives for all rotation/assignments
6. Conference schedule reflecting required didactics for the past and current academic year
7. Program Evaluation Committee (PEC) meeting minutes over the past year, a written description of the PEC, and a list of its members
8. Written description of Clinical Competency Committee (CCC) and membership
9. Sample of clinical and educational work hour compliance data demonstrating your monitoring system
10. Most recent APE inclusive of action plans resulting from the APE
11. 3 collective strengths and 3 areas for improvement submitted collectively by the residents directly to the DIO only.

Section 2

Please provide the following documents to Review Panel Members by 8:00 am on Date of Site Visit:

1. Sample of completed annual confidential evaluation of faculty by residents

2. Signed PLAs
3. A sample of a signed resident contract
4. Files of any trainees who have transferred in or transferred out of the program (documentation of prior training), or have resigned or been dismissed in past three years
5. Completed evaluations of residents for rotations
6. Completed multi-source evaluations (360 degree) and/or any other specialty assessments (eg. simulation, journal club, transitions of care, others) for 1-2 current trainees from each of the past three years)
7. Completed milestone reviews, semi-annual evaluation form, and summative evaluation form
8. Completed final evaluation forms form program graduates in the last three years (of 1-2 trainees from each of the past three years)
9. Program evaluations completed by faculty and by residents

Sample Schedule for Day of Special Review:

Program Director and Coordinator	90-100 Minutes
Residents	60 Minutes
Faculty	60 Minutes
Document review and analysis	90 Minutes
Closing meeting with Program Director and Coordinator	60 Minutes

Follow up regarding findings and recommendations with program director and coordinator within 7-10 business days. A report will be created as defined by the Special Review procedure and will be reported to the GMEC for review and approval and will define monitoring recommendations.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-002
Subject: Promotion, Appointment Renewal, and Dismissal	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 2

PURPOSE

The purpose of this policy is to clearly define and provide supporting guidelines for NOORDA-COM's ACGME-accredited programs to determine the criteria for promotion, appointment renewals, and dismissal of residents/fellows. (See Misconduct Matters, Academic Improvement, Grievances and Due Process Policies)

POLICY

Promotion:

1. Throughout the course of the training program, residents/fellows are expected to acquire progressively increasing competence. Promotion to the next level of training, or graduation as it is applicable, is dependent upon the achievement of program-specific Milestones and ACGME Competencies of professionalism; patient care and procedural skills; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; and systems-based practice.

2. The Clinical Competency Committee (CCC) is responsible for determining each trainee's achievement of specialty-specific Milestones, advising the Program Director about resident performance and progress, and making recommendations to the Program Director regarding trainees' promotion, remediation, and dismissal decisions.

3. Promotion to the next training level is also dependent upon:
    a. Satisfactory attendance at required didactic sessions and specialty conferences;
    b. Satisfactory completion of all required clinical rotations;
    c. Completion of all clinical logs and clinical and educational work hours; and
    d. Compliance with professionalism, Institutional and Program-specific policies and procedures, and all applicable state and federal laws.

Non-Renewal/Dismissal:

1. Programs will provide a written notice of intent to residents/fellows when their agreement will not be renewed, when that trainee will not be promoted to the next level of training, or when that resident/fellow will be dismissed.

2. Programs will provide residents/fellows written notice of intent no later than 4 months prior to the end of the resident's/fellow's current agreement or when the primary reason(s) for non-renewal occurs within those four months, programs will provide as much notice as is feasible.

PROGRAM RESPONSIBILITIES

1. Program Directors will have executed a remediation/performance improvement plan that was not successfully completed by the resident/fellow prior to not renewing an appointment or dismissing the resident/fellow.

    a. The remediation plan will be created to improve performance.

b. The plan must demonstrate the program director monitored progress weekly and wrote factual, fair, objective, complete, and consistent documentation about the resident's/fellow's progress with meeting learning goals.

2. Programs will provide residents/fellows due process relating to the following actions regardless of when the action is taken during the appointment period: suspension, non-renewal, non-promotion, or dismissal.

3. Program Directors will consult with the DIO prior to releasing any written notice of intent.

4. The Program Director will collaborate with the DIO and other appropriate departments (Human Resources and Legal Counsel at Noorda-COM or Affiliated Hospital) when preparing any written notice of intent concerning a resident.

RESIDENT RESPONSIBILITIES

1. Residents who receive a written notice of intent stating that one of the following actions is being taken: suspension, non-renewal, non-promotion, or dismissal, are entitled to a written explanation regarding the action taken. Decisions about promotion or reappointment of the resident will be communicated by the Program Director to the resident as soon as reasonably practicable under the circumstances and should occur at least four months prior to the end of the academic year.

2. If a Resident/Fellow believes they have been wrongfully suspended from the program, dismissed, not renewed or renewed without promotion, they may follow steps outlined in the Grievance Procedure. The grievance process is intended to protect the rights of the Resident/Fellow and the training program and to ensure fair treatment for both parties. Grievances are limited to allegations of wrongful dismissal, wrongful suspension, wrongful nonrenewal or wrongful renewal without promotion of the annual Resident/Fellow training agreement.

SPONSORING INSTITUTION RESPONSIBILITIES

1. The Sponsoring Institution will collaborate with program directors and others, as appropriate, to ensure all actions leading to suspension, non-renewal, non-promotion, or dismissal of a trainee is appropriate.

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Noorda-COM

POLICY		Policy No: IS-003
Subject: Agreement of Appointment Contract	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 2

PURPOSE

The purpose of this policy is to ensure residents/fellows are provided a written agreement of appointment/contract that outlines the terms and conditions for appointment to the program.

POLICY

Noorda-COM, the Sponsoring Institution, will monitor its programs to ensure they are implementing the terms and conditions of resident/fellow appointment to their program in writing. The Graduate Medical Education Committee will review and approve each program's contract as part of its oversight. The SI will monitor that each program implements the terms and conditions of the appointment.

Applicants must provide proof of the following status as graduate (or pending graduate) of:

1. United States and Canadian medical schools accredited by the Liaison Committee on Medical Education (LCME).
2. United States colleges of osteopathic medicine accredited by the American Osteopathic Association.
3. Medical schools outside of the United States and Canada who have a valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) and a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.

PROGRAM RESPONSIBILITIES

1. An applicant invited to interview for a GME position must be informed, in writing or by electronic means, of the contract terms, conditions and benefits of appointment to the ACGME-accredited program in effect at the time of the interview of that will be in effect at the time of the applicant's eventual appointment.
2. The program must provide the applicant information about stipends, benefits, vacation, leaves of absence, professional liability coverage, and health insurance accessible to residents/fellows and their dependents.
3. The program will notify residents when their contract is available for signature. NOTE: If a resident is off cycle, they will have 15-days from the date of notification to sign their contract.
4. Required elements of the agreement/contract: The program will execute a contract or agreement that directly contains or references the following items as outlined in the ACGME requirements:
   A. Resident responsibilities
   B. Duration of appointment
   C. Financial support for residents
   D. Conditions for reappointment and promotion to subsequent PGY level
   E. Grievance and due process, if not reappointed or promoted
   F. Professional liability insurance, including a summary of pertinent information regarding coverage. Liability coverage must include legal defense and protection against awards for claims reported or filed after the completion of the programs if the alleged acts or omissions are within the scope of the resident's duties in the program.

G. Health insurance benefits for resident and their eligible dependents with coverage starting on the first recognized day of their program
H. Disability insurance for residents with coverage starting on the first day of disability insurance eligibility
I. The program must also provide access to workers' compensation insurance to all residents for disabilities resulting from activities that are part of the educational program.
J. Vacation, parental, sick, caregiver, and other leaves for residents, compliant with applicable laws
K. Timely notice of the effect of leave(s) on the ability of resident to satisfy requirements for program completion
L. Information related to eligibility for specialty board examinations
M. Institutional policies and procedures regarding resident clinical and educational work hours and moonlighting

RESIDENT/FELLOWS RESPONSIBILITIES

1. Residents/Fellows will be expected to sign their contracts within a 15-day period (physically or electronically). After the 15-day period, the position offered will be considered unfilled and may be offered to another individual.
2. NOTE: Exceptions for exceeding the 15-day signing period will be made for those residents who are on an out-rotation.

NOORDA-COM and GMEC RESPONSIBILITIES

1. Noorda-COM will provide each program with a sample contract that meets ACGME requirements.
2. The GMEC will review program contracts for approval to ensure the documents contain specific reference to ACGME requirements.
3. The DIO will ask each program, at the start of the academic year, a to furnish an executed agreement of appointment contract, based on the DIO's random selection of the trainee(s), to verify the program is following the policy and share results with the GMEC for oversight.
4. During site visits, the Review Panel will ask for a copy of an executed agreement as well.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-004
Subject: Disaster or Interruption of Patient Care	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 3

PURPOSE

This policy defines the process and procedures for Noorda-COM and its ACGME-accredited programs to support its GME programs in the event of disruption by emergencies, catastrophic events, or natural disasters or program closure/reduction in patient care of education.

BACKGROUND AND RATIONALE

Severe weather, earthquakes, pandemic disease, and disasters have the capacity to profoundly disrupt the healthcare services and facilities where Graduate Medical Education programs are based. The ACGME has identified the need for planning for catastrophic losses of facilities and services that are outside the control of residency/fellowship programs and their sponsoring institutions.

DEFINITIONS

A **disaster** is defined herein as an event or set of events causing significant alteration to the residency or fellowship experience at one or more programs. This policy and procedure document acknowledges that there are multiple types of disaster: acute disaster with little or no warning (e.g. tornado, earthquake, utility outages, or bombing), intermediate with some lead-time and warning (e.g. inclement weather with severe snow storm, or flooding), and the insidious disruption or disaster (e.g. pandemics). This document will address disaster in the broadest terms.

A **substantial disruption** is defined as an event or set of events causing significant alteration to the trainee experience in one or more Noorda-COM GME programs. A substantial disruption may or may not result in disruption of the provision of patient care within a residency or fellowship program or throughout multiple programs and hospital departments. This may involve an internal event that involves an incident within a facility that disrupts normal operations (e.g. utility failure, threats to persons or buildings, armed intruder or hostage situations, and infant/pediatric abductions). A patient surge event may also disrupt normal operations with a large influx of victims from an internal or external event requiring treatment (e.g. victims of a disaster as noted above, fire, explosion, car/train wreck, mass-shooting or mass-casualty event).

PROCEDURE

1. In the event of a circumstance that temporarily impacts the ability of the institution to continue adequate residency or fellow education, the DIO in collaboration with the affected program director(s), department chair(s), and administration will determine if a disaster or substantial disruption has occurred.

2. An incident command center will be established (in person or virtually via phone, internet, or other means) to implement this policy and develop specific plans for any given situation and involve other representatives from the respective institutions as necessary.

3. The DIO will be the primary institutional contact with the ACGME and the Institutional Review Committee's Executive Director during disaster plan implementation.

4. Each Noorda-COM program will develop and implement both a disaster policy and plan that covers residents in all facilities where they provide care in case of disaster. Disaster planning

guidelines for residency training programs will be in accordance with the most current Institutional and Common Program Requirements established by the ACGME.

5. In the aftermath of a disaster and once all patients and personnel are safe, the following are priorities of Noorda-COM and the GME programs:
    a. Residents/fellows in ACGME accredited programs will have their salary, benefits and professional liability coverage continued by the Noorda-COM.
    b. Within 10-days of the declaration of a disaster, the DIO will contact the ACGME to discuss due dates that the ACGME will establish for the program(s) to submit program reconfigurations if needed to the ACGME and to inform each program's trainees of potential transfer decisions.
    c. The receiving institution must have the opportunity to review the credentials of the residents proposed for relocation to their institution; and based on such review can decline to accept individual residents. Institutions receiving residents under this disaster or substantial disruption policy will be able to claim the training time on their CMS cost reports. The sponsoring institution will adjust its CMS cost report accordingly.
    d. Once the sponsoring institution can resume its training activities, the residents/fellows will immediately resume training at their sponsoring institution.

6. If the disaster prevents residency training and fellowship programs from re-establishing an adequate academic experience within a reasonable time periods, permanent transfers will be pursued. The DIO in collaboration with the affected program director(s), department chair(s), and administration will coordinate all arrangements to expeditiously assist each resident in transitioning.

GENERAL PRINCIPLES FOR TRANSITIONING TRAINING TO ANOTHER INSTITUTION:

1. Residents/fellows in ACGME accredited programs will have their salary, benefits and professional liability coverage continued by the Noorda-COM while permanent training opportunities are located.

2. Training programs on probationary status shall not be eligible to accept resident/fellow transfers.

3. Training programs will be required to protect all academic and personnel files of residents/fellows from loss or destruction by a disaster. This shall include, if necessary, moving files to off-site facilities and using electronic media.

4. Residents/fellows will be orphaned by their sponsoring institution to the receiving institution under the following process:
    a. Residents/fellows are eligible to be orphaned due to closing of a program or hospital.
    b. The Program Director and/or DIO of the receiving institution will contact the ACGME to request an increase in resident complement during the disaster period.
    c. The receiving institution agrees to take resident(s).
    d. The sponsoring institution sends a letter to the receiving institution indicating orphan status.
    e. The receiving institution signs the letter and returns it to sponsoring institution.
    f. A copy of the signed letter given to the DIO of sponsoring institution.
    g. The sponsoring institution's DIO and CFO send a copy of the letter to CMS noting orphan status of involved residents and a statement that the sponsor will not be claiming reimbursement for remainder of resident's training.
    h. The sponsoring and receiving institution adjust their respective resident FTE counts for the purpose of CMS cost reporting.

5. In the event of a disaster or substantial disruption affecting other sponsoring institutions of graduate medical education programs, the DIO and the program leadership at Noorda College of Osteopathic Medicine will work collaboratively with its major clinical partners to coordinate the impact of a decision to accept transfer residents from other institutions. This will include the process to request complement increases with the ACGME that may be required to accept additional residents for training.
    a. Programs currently under a proposed or actual adverse accreditation decision by the ACGME will not be eligible to participate in accepting transfer residents.
    b. Decisions regarding changing the number of trainees in ACGME accredited programs will be reviewed by and approved by the GMEC.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-005
Subject: Clinical and Educational Work Hours	Approval: 07/12/2023 Last revision approved:	Page 1 of 2

PURPOSE

The purpose of this policy is to ensure each Noorda-COM program is committed to the provision of a high-quality medical education training environment, balancing time for educational experiences with patient care responsibilities.

DEFINITION

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

POLICY

1. Each residency program must design an effective structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. Each program should have written policies and procedures, beyond this policy, consistent with the Institutional and Program Requirements for clinical and educational work hours.
2. Any areas of non-compliance with clinical and educational work hours requirements must be reported promptly to the Assistant Dean for Graduate Medical Education/DIO at Noorda-COM. Exceeding the 80-hour maximum weekly limit must be reported by the DIO and Program Director at the GMEC meeting for oversight and will trigger a special review.
3. Clinical and educational work hours must be limited to 80-hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, andmoonlighting.
4. At home, the time residents devote to patient care activities, such as completing electronic health records and taking calls related to their patients, counts towards their 80-hours per week and time spent on self-directed study, such as reading, is excluded from the work-hour limit.
5. In-house call must not be more frequent than every third night.
6. 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.
7. Clinical and educational work periods for residents must not exceed 24-hours of continuous scheduled clinical assignments. Residents must have eight hours off between scheduled clinical work and education periods.
8. In unusual circumstances, after handing off all patients to the team responsible for their continuing care, residents, on their own initiative, may remain beyond the 24-hours up to a four-hour period of responsibilities to provide care to a single patient. Justifications for such extensions are limited to reasons of continuity for a severely ill or unstable patient, academic

importance of the events transpiring, or humanistic attention to the needs of a patient or family. Another justification is to attend educational events on the resident's/fellow's own initiative. These additional hours of care or education must be counted toward the 80-hour weekly limit.

9. Residents must have at least 14-hours free of clinical work and education after 24 hours of in-house call.
10. Residents must have one 24-hour period off each week when averaged over a 4-week period and shall have no call responsibility during that time.
11. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.
12. Each program must have a process for tracking clinical and educational work hours and reporting them through the Graduate Medical Education Committee for compliance with this policy.
13. Residents may report duty hour violations through the "Confidential Reporting" link on Noorda-COM's GME webpage.

PROGRAM RESPONSIBILITIES

1. Programs are expected to adhere to the 80-hour maximum weekly limit and to utilize flexibility in manner that optimizes patient safety, resident education, and resident wellbeing.
2. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is too fatigued to provide safe, high-quality care and for programs to ensure that residents remain within the 80-hour maximum weekly limit.
3. Flexibility should be used in an appropriate manner is a shared responsibility of the program and residents.
4. Any program that exceeds the 80-hour requirement will trigger a special review, which involves an investigation from the DIO to identify underlying issues contributing to the violations.
5. The program director, with the DIO, will report the GMEC violations and actions taken to prevent exceeding the 80-hour requirement.

RESIDENT RESPONSIBILITIES

1. Residents are expected to adhere to the 80-hour maximum weekly limit unless a rotation-specific exception is granted by a review committee and to utilize flexibility in a manner that optimizes, patient safety.
2. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is too fatigued to provide safe, high-quality care and for programs.
3. Residents are required to log their work hours every week. Flexibility should be used in an appropriate manner is a shared responsibility of the program and residents.

NOORDA-COM AND GMEC RESPONSIBILITIES

1. Oversee the quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites.
2. Any program that exceeds the 80-hour requirement will trigger a special review, which involves an investigation from the DIO to identify underlying issues contributing to the violations.
3. The program director, with the DIO, will report to the GMEC clinical and work hour violations, results of the special review and proposed next steps to prevent exceeding the 80-hour maximum will be shared with the GMEC for oversight purposes.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-006
Subject: Prohibition of Discrimination, Harassment, and Retaliation	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 3

PURPOSE

The purpose of this policy is to protect the rights of residents/fellows and provide a learning and workplace environment that is psychologically safe and that is free from all forms of discrimination and harassment on the basis of race, color, religion, gender, sex (including pregnancy), gender, sexual orientation, gender identity, national origin, age, marital status, veteran status, genetic information, disability, or any other protected status under all applicable laws and regulations. This policy ensures compliance with all applicable laws, emphasis on a fair and equitable learning and work environment, and a fair process for all concerned.

Noorda College of Osteopathic Medicine has in place a robust anti-harassment and Nondiscrimination Policy to which the Noorda-COM sponsoring institution adheres. For the complete and most up-to-date version of this policy, refer to the Noorda College of Osteopathic Medicines' *TITLE IX: Non-Discrimination and Anti-Harassment Policy* for reporting procedures, information about sexual and other forms of harassment, and definitions. This policy, and excerpts from it, appears within many Noorda-COM publications, both online and in print. Link to the policy https://www.noordacom.org/wp-content/uploads/2023/04/Non-Discrimination-and-Anti-Harassment-Policy-April-2023.pdf

DEFINTION

Psychological safety: An environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly

POLICY

The Noorda College of Osteopathic Medicine prohibits discrimination based on race, color, religion, ethnicity, national origin, sex (including pregnancy), gender, sexual orientation, gender identity, age, disability, veteran status, or any other status protected by applicable law. Dating violence, domestic violence, sexual assault, stalking, harassment, and retaliation are forms of discrimination prohibited by Noorda-COM under this policy.

1. Consistent with all applicable laws and regulations, the sponsoring institution prohibits discrimination in employment and in in the learning and working environment. Both the sponsoring institution and its ACGME-accredited program will provide a professional, equitable, respectful, and civil learning and working environment that is psychologically safe and free from unprofessional behavior, including discrimination, sexual discrimination and harassment, and other forms of harassment, mistreatment, abuse, and/or coercion of residents/fellows, other

learners, faculty members, and staff members. In this learning environment, residents must have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of retaliation or intimidation.

2. This policy applies to all residents/fellows, whether related to conduct engaged in by fellow employees or someone not directly connected to Noorda-COM (e.g., an outside vendor, consultant, or contractor). Conduct prohibited by this policy is unacceptable in the workplace and in any work-related setting outside the workplace, such as during business trips, business meetings, and business-related social events.

3. Residents/fellows are expected to attest to reading the sponsoring institution's Code of Professional Conduct, which educates trainees about professionalism expectations including the prohibition of harassment and discrimination.

4. Program leadership, upon learning about discrimination/harassment incidents, is responsible for monitoring and immediately reporting any perceived discrimination and/or harassment involving residents/fellows/employees to the Director of Human Resources and DIO, regardless if the resident/fellow/employee involved does not file a complaint.

5. Residents/fellows and GME program faculty who believe they have been the subject of or have witnessed discrimination and/or harassment must report it immediately to their program director, the Noorda-COM DIO, or Noorda-COM's Human Resources Director. Complaints can be made in a safe, confidential, and non-punitive environment. Confidential reports involving incidents or complaints will be investigated, monitored, and addressed in a timely manner. Below are the following methods anyone in GME can report discrimination and/or harassment incidents:

    a. Notify the Noorda-COM Director of Human Resources and/or Title IX Coordinator.
    b. Contact their program director who can assist the resident/fellow with reporting the incident to Human Resources. It is expected that Program Director immediately notify the DIO of such incidents.
    c. Contact the DIO directly by phone, in-person, or by email.
    d. Complete and submit a confidential incident form to the sponsoring institution on its GME website.

6. Any person who experiences, witnesses, or has knowledge of incidents of discrimination, harassment, retaliation, or any other situation prohibited by this policy, must report this information confidentially by contacting Noorda-COM's Director of Human Resources and/or Title IX Coordinator. Residents/fellows and GME faculty can also submit a confidential incident report through the sponsoring institution's online reporting.

Dave Sorenson
Director of Human Resources
198 East 1660 South
Provo, Utah 84606
dlsorenson@noordacom.org
1-385-375-8672

Dr. Tracy Hill
Title IX Coordinator
tahill@noordacom.org
1-385-375-8724

7. Upon notification of a situation involving harassment and/or discrimination, an investigation will be initiated to gather all facts about the complaint to monitor and to address/resolve the issue in a timely manner, consistent with applicable laws and regulations. This investigation will be conducted by the Director of Human Resources and Title IX Coordinator.

8. This policy prohibits retaliation against any individual who brings forth good faith harassment and/or discrimination complaints or cooperates/participates in a discrimination or harassment investigation, proceeding, or hearing. Deliberately false or malicious accusations of discrimination and harassment are just as serious an offense as discrimination or harassment and will be subject to appropriate disciplinary action.

9. Alleged acts of retaliation should be reported immediately to the Noorda-COM Director of Human Resources Department and they will be promptly investigated. Noorda-COM will take all appropriate and available steps to protect individuals who fear that they may be subjected to retaliation.

10. All residents/fellows and program faculty are required to cooperate with any investigation into a potential violation of this policy even if they are not named as responding parties.

11. Confidentiality will be maintained throughout the investigation process to the extent that all information is gathered to make an accurate judgment. During this process, Human Resources, supervisors, and administration will determine the final appropriate corrective action with or without outside consultants. Noorda-COM reserves the right to seek legal counsel, as needed, in the final resolution process of any report.

12. Upon completion of the investigation, a determination will be made in writing by appropriate management and the Director of Human Resources regarding resolution of the case. If warranted, corrective action will be taken, up to and including discharge from employment

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-007
Subject: Liability Insurance for Residents	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 1

PURPOSE

This is a Noorda-COM policy is designed to ensure consistent application of professional liability insurance coverage and provide trainees legal defense and protection against awards from claims.

POLICY

All programs must provide its trainees professional liability insurance as protection against potential legal action brought against them. Trainees will be provided coverage for liability arising out of acts or omissions while acting within the scope of their clinical duties and for professional services rendered in connection to approved rotational educational programs. The insurance coverage will provide trainees a legal defense and protection against awards from claims reported or filed after the completion of the GME program if the residents'/fellows' alleged acts or omissions occurred within the scope of the educational program.

The sponsoring institution and programs are not required to provide professional liability insurance or legal defense to cover any moonlighting activities or any activity where a trainee is not actively performing work for the sponsoring institution or that is not a documented requirement of their Graduate Medical Education program.

PROCEDURE FOR RESIDENTS

Residents/fellows must immediately notify their program director and follow program policy if they are served with legal documents, including summons and complaints (lawsuits) or personal subpoenas related to house staff activities and graduate medical education. Noorda-COM employees should immediately contact the Director of Noorda-COM Human Resources Education and their program director if residents/fellows:

1. are served with a summons and Complaint in a lawsuit involving medical negligence or receive a "Notice of Intent to Initiate Litigation"
2. are served with or otherwise receive any notice of a claim or potential claim
3. have received a subpoena to give testimony at a deposition, trial, or hearing
4. believe there could be a potential claim against them based on a bad outcome or other information, such as a patient telling the trainee they intend to pursue litigation against them
5. receive any notification regarding impending action or investigation by the Utah Board of Physician and Surgeon and Utah Division of Professional Licensing

PROGRAM RESPONSIBILITIES

Programs must provide official documentation of the detail of liability coverage upon request of the individual, sponsoring institution, and ACGME.

SPONSORING INSTITUTION RESPONSIBILITIES

Noorda-COM will ensure programs provide trainees professional liability insurance by requesting proof at the start of the academic year and during annual site visits. The DIO will report findings to the GMEC for its oversight.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-008
Subject: Non-Competition	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 1

PURPOSE

This policy is designed to create a fair working environment for trainees. The Accreditation Council for Graduate Medical Education (ACGME) specifically prohibits the use of restrictive covenants in trainee agreements.

POLICY

Noorda-COM specifically prohibits the creation and enforcement of any restrictive covenants or non-competition guarantees as a condition of participation in graduate medical education programs. No Noorda-COM-accredited programs will ask or require its residents to verbally agree to or sign a non-competition guarantee or restrictive covenant.

RESIDENT/FELLOW RESPONSIBILITY

1. Trainees must immediately notify the sponsoring institution's DIO if they are asked to sign a non-competition document or restrictive covenant.

NOORDA-RESPONSIBILITY

1. The DIO during annual site visits will conduct confidential meetings with trainees and ask them about this topic.
2. During annual site visits, the DIO will ask the Program Director and Coordinator about this topic and request to be furnished with a copy of an executed agreement of appointment contract to verify the program is following the policy.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-009
Subject: Trainee and Faculty Well-being	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 2

PURPOSE

The purpose of this policy is to address the increased risk of physician burnout and depression. 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; it is also a skill that must be learned and nurtured in the context of other aspects of residency training.

POLICY

Noorda-COM oversees its ACGME-accredited programs' fulfillment of responsibility to address the well-being of residents/fellows and faculty members, consistent with the common and specialty-specific program requirements, addressing areas of noncompliance in a timely manner.

1. Each Noorda-COM-accredited program in partnership with the sponsoring institution must:
    a. Strive to enhance the meaning that the resident/fellow finds in the experience of being a physician, including protecting time with patients, minimization of non-physician obligations, provision of administrative support, promotion of progressive autonomy and flexibility, and enhancement of professional relationships.
    b. Ensure a healthy and safe clinical and educational environment that provides for:
        - Access to food during clinical and educational assignments.
        - Sleep/rest facilities that are safe, quiet, clean, and private and that must be available and accessible for residents/fellows, with proximity appropriate for safe patient care.
        - Safe transportation options for residents/fellows who may be too fatigued to safely return home on their own.
        - Clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care, and clean and safe refrigeration resources for the storage of breast milk.
        - Safety and security measures appropriate to the clinical learning environment site.
        - Accommodations for residents/fellows with disabilities consistent with the Noorda-COM IS-022 Accommodation for Disabilities policy.
    c. Evaluate scheduling, work intensity, and work compression as it impacts resident/fellow well-being.
    d. Residents/fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours (at times that are appropriate to their individual circumstances).
    e. Programs are cogently encouraged to remind faculty and residents that access to mental health services are available to anyone affected by a safety event, such as Employee Assistance Program and counseling services.
    f. Educate faculty members and residents/fellows how to identify the symptoms of burnout, depression, and substance abuse including the means to assist those who experience these conditions. This responsibility includes educating residents/fellows and faculty members on how to recognize those symptoms in themselves and how to seek

appropriate care.

g. Encourage residents/fellows and faculty members to alert their program director, DIO, 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.
h. Provide trainees access to appropriate tools for self-screening.
i. Provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.
j. Develop and implement a policy and procedures that ensure patient care coverage if a trainee may be unable to perform their patient care responsibilities. There are circumstances where residents/fellows may be unable to attend work, including but not limited to fatigue, illness, and family emergencies.

NOORDA-COM RESPONSIBILITY

1. The sponsoring institution will ensure programs provide trainees a healthy and safe clinical and educational environments that promote resident/fellow well-being and provides for:
    a. Access to food during clinical and educational assignments; and,
    b. Safety and security measures for trainees appropriate to the participating site.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-010
Subject: Resident Eligibility and Selection	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 2

PURPOSE

The purpose of this policy is to outline the eligibility and selection criteria for Noorda-COM graduate medical education trainees.

POLICY

A. Programs must have written policies for eligibility, selection, evaluation, advancement, and termination that are specific to that program, incorporating the institutional policies.

B. Applicants must meet one of the following qualifications to be eligible for appointment to any Noorda-COM residency program:

   a. A graduate of a U.S. or Canadian medical school accredited by the Liaison Committee for Medical Education (LCME);
   b. A graduate from a college of osteopathic medicine in the U.S. accredited by the American Osteopathic Association Commission on Commission on Osteopathic College Accreditation (AOACOCA); or
   c. A graduate of a medical school outside the U.S. or Canada who holds a current valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) and a full, unrestricted license to practice medicine in the U.S. licensing jurisdiction where the program is located.

C. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)- accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.

   a. Programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS or ACGME-I Milestones evaluations from the prior training program upon matriculation. (The Review Committee may further specify prerequisite post graduate clinical education.)

D. Residency applicants must provide evidence of passing the following exams prior to the start of the contracted hire date:
   i. PGY 1: USMLE Steps I and II/ COMLEX Levels 1 and 2
   ii. PGY2 and above: USMLE Steps I, II, and 3/ COMLEX Levels 1, 2, and 3

E. Programs must inform applicants who are invited to interview in writing or by electronic means about the terms, conditions, and benefits of appointment to the program, including stipends, benefits, professional liability coverage, and disability insurance accessible to residents/fellows; institutional policy(ies) for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence; health insurance accessible to

residents/fellows and their eligible dependents; and information related to the applicant's eligibility for the relevant specialty board examination(s).

F. All applicants to Noorda-COM-affiliated graduate medical education programs must complete an application to the program they desire. Applicants to a PGY I or Transitional Year must apply through the Electronic Residency Application Service (ERAS). Applicants to a PGY 4 or higher postgraduate level of training must apply through the applicable Noorda-COM participating site's application process. Completed applications will be forwarded to the appropriate Program Director for their review.

G. Programs will select trainees from among eligible candidates on the basis of residency program-related criteria, such as their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities, such as motivation and integrity.
    i. Noorda-COM Graduate Medical Education programs do not discriminate about sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status.
    ii. Each Program Director may develop residency training program-specific policies that are consistent with the Noorda-COM Resident/Fellow Eligibility and Selection Policy approved by the GMEC.

H. To promote the highest ethical standards during the interview, ranking, and matching processes, program directors participating in a Match shall commit to the NRMP communication code of conduct http://www.nrmp.org/communication-code-of-conduct/ and follow the recommended steps in the interview:
    i. Set clear expectations for applicants on interview day about appropriate forms of post interview communications;
    ii. Limit post interview communications to objective information;
    iii. Provide a point person to handle all post interview communications;
    iv. Consider logging all post interview communications to safeguard ethical standards.

I. Before accepting a trainee who is transferring from another program, the Program Director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. The Program Director must confirm with the respective ABMS certifying board the amount of credit that can be applied from prior program to the current one.

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Noorda-COM

POLICY		Policy No: IS-011
Subject: Resident Fatigue Mitigation	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 2

PURPOSE

The purpose of this policy is to establish guidelines for mitigating fatigue in hospital, clinic, and non-patient care settings. (Refer to the Resident Impairment Policy and Resident Well-being Policy).

POLICY

1. Programs in collaboration with the Sponsoring Institution will educate all faculty and residents about recognizing the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation strategies.

1. Programs, in partnership with the Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options, even when overnight call is not required, for residents who may be too fatigued to safely return home.

2. The program director and faculty must address and protect the safety of patients at risk from sleep-deprived residents and faculty members, including transitioning patient care to a different practitioner.

3. Program must have policies and procedures in place to allow an appropriate length of absence for residents unable to perform their patient care responsibilities, to ensure coverage and continuity of patient care, and implement these policies without any negative consequences for the resident.

PROCEDURE

1. **Recognition of Excessive Fatigue**
    a. Signs and symptoms of resident fatigue and/or excessive stress may include but are not limited to the following:
        - Inattentiveness to details
        - Sleeping during conferences
        - Forgetfulness
        - Emotional liability
        - Mood swings
        - Increased conflicts with others
        - Lack of attention to proper attire or hygiene
        - Difficulty with novel tasks and multitasking
        - Awareness is impaired (fall back on rote memory)
2. **Response to Recognizing Fatigued Residents:**
    a. Upon recognizing a resident is demonstrating evidence of fatigue the attending physician will evaluate the resident and consider immediate release of the resident from any current patient care responsibilities.
    b. The attending physician should privately meet with the resident to identify the reason for excess fatigue (and/or stress) and estimate the amount of rest that may be required to alleviate the situation.

c. If excess fatigue is identified, the attending physician must advise the resident to rest for a period that is adequate to relieve the fatigue before operating a motorized vehicle.
d. The program will provide safe transportation for residents who may be too fatigued to safely drive home.
e. A resident who has been released from patient care cannot resume patient care duties without permission of the Program Director.
f. The attending physician must notify the Program Director about releasing the resident from patient care responsibilities.
g. The Program Director will confer with the Chief Resident on immediate adjustments in duty assignments to provide coverage.
h. The Program Director will retain documentation of the incident and actions taken and follow up with the resident upon return to work to ascertain how excess fatigue could be prevented in the future. Subsequently, the Program Director will review the resident's call schedules, work hours, extent of patient care responsibilities, any known personal problems, and stresses contributing to the resident status.

RESIDENT AND FACULTY RESPONSIBILITIES

1. Residents and faculty members have a professional responsibility to:
    a. Appear for work appropriately rested and fit to provide patient care, this includes managing their time before, during, and after clinical assignments to prevent excessive fatigue.
    b. Recognize the signs or symptoms of fatigue in themselves or others, and immediately notify the program director or other appropriate supervisor if they or a colleague are too fatigued to provide safe care.

PROGRAM RESPONSIBILITIES

1. Structure schedules that focus on the needs of the patients, continuity of care, and the educational needs of residents, while giving attention to work intensity and work compression that impacts resident well-being.

2. Educate all residents and faculty members about signs of fatigue, sleep deprivation, alertness management, and fatigue mitigation strategies.

3. Encourage residents and faculty members to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care, learning, and well-being.

SPONSORING INSTITUTION RESPONSIBILITIES

1. Ensure Adequate sleep facilities and safe transportation options are available for residents who may be too fatigued to return safely home.

2. Ensure work that is extraneous to residents' educational goals and objectives is minimized, and that their educational experience is not compromised by excessive reliance on trainees to fulfill non-physician service obligations.

3. The DIO or a designee will educate all residents and faculty members about signs of fatigue, sleep deprivation, alertness management, and fatigue mitigation strategies. The DIO will report to the GMEC when fatigue mitigation has been provided to programs for oversight.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-012
Subject: Vendor Interactions	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 2

PURPOSE

This is a Noorda-COM policy regarding vendor interactions between residents/fellows in affiliated programs. The policy is written in accordance with *ACGME Institutional Requirements.*

POLICY

Noorda-COM, as the Sponsoring Institution (SI), will ensure that each program oversees the activity between vendor representatives and residents in all approved programs.

PROGRAM RESPONSIBILITIES

1. Programs and participating sites are required to monitor the activity of representatives from vendor organizations, particularly when interacting with residents. At a minimum, it is expected the program and participating site(s) will include and enforce the following items in their local policies.
    a. Vendor Representatives shall provide the local GME Office with a copy of all printed materials they plan to distribute
    b. Vendor Representatives will always conduct themselves in a professional manner.
    c. Vendor Representatives shall not conduct business in unauthorized areas, particularly patient care areas.
    d. Vendor Representatives shall not visit house officer lounges, sleeping quarters, operating room lounges, or locker rooms
    e. Trainee acceptance of the following items from vendors must be approved by the Program Director:
        i. Pharmaceutical samples
        ii. Gifts
        iii. Food and beverages
        iv. Vendor-sponsored education
        v. Vendor training
        vi. Industry-sponsored programs
    f. The program will be responsible for addressing misconduct on the part of vendor representatives

2. Program directors must communicate this policy to their trainees as part of the program orientation, and reinforce it through inclusion in program handbooks and other information sites for resident reference.
    a. Programs should provide training to residents and fellows on vendor relations and conflicts of interest, including reference to this policy and other relevant institutional policies.
    b. Program directors are encouraged to include assessment of vendor interactions as part of the semi-annual review process, and require documentation of vendor interactions in resident/fellow portfolios.
    c. Programs should correct actions as needed to ensure that the policies described here are observed.

RESIDENT RESPONSIBILITIES

1. Trainees are responsible for learning and following the policies established by the program and participating sites.

2. Trainees will not accept items or gifts from vendors without obtaining Program Director approval (Refer to section 1.e of this policy).

NOORDA-COM RESPONSIBILITIES

1. Noorda-COM DIO will confirm its accredited programs have and follow appropriate GME policies and procedures either by requesting the program provide documentation and/or during the Annual Site Visit and share these findings with the GMEC for oversight purposes.

2. The Noorda-COM DIO and/or designees will bring concerns about program policies to the GMEC for review, action and follow-up, as appropriate.

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Noorda-COM

POLICY		Policy No: IS-013
Subject: Program Closure or Reduction in Size	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 1

PURPOSE

This policy delineates the sponsoring institution's responsibilities when the closure of the sponsoring institution or one of its training programs is necessary or if one of its programs is required to reduce its complement.

POLICY:

1. The senior leadership of the Sponsoring Institution, the Program Director, DIO, and GMEC will make appropriate efforts to avoid the closure of ACGME-accredited programs.
2. The Sponsoring Institution must inform the GMEC and the affected residents/fellows as soon as possible when it intends to reduce the size of or close one or more programs, or when the Sponsoring Institution itself intends to close.
3. In the event a decision is made that a training program must decrease its resident/fellow complement:
    a. The appropriate Department Chair and Program Director will inform the DIO, GMEC, and the residents as soon as possible following the decision.
    b. The DIO and GMEC will be responsible for monitoring the complement reduction process.
    c. Plans to reduce the complement of Residents in the program will be made, where reasonable, by first reducing the number of positions available to incoming Residents.
    d. If the reduction needs to include Residents currently in the training program, the Department Chair, Program Director, and DIO must assist affected Residents in enrolling in an ACGME-accredited program(s) in which training can continue.
4. In the event a decision is made that a training program must close:
    a. The appropriate Program Director will inform the DIO, GMEC, and the affected residents/fellows as soon as possible following the decision.
    b. The DIO and GMEC will be responsible for monitoring the closure process.
    c. The Sponsoring Institution will preferentially structure a closure when reasonable, that allows enrolled residents to complete the program as part of the "train out" process (provided they meet the policies for advancement and graduation).
5. If a program must be closed before one or more residents/fellows are able to complete their training, the Program Director and DIO will assist with facilitating placement of the accepted and enrolled program residents/fellows into other ACGME-accredited program(s).

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Noorda-COM

POLICY		Policy No: IS-014
Subject: Resident Impairment	Approval: 07/12/2023	Page 1 of 3

PURPOSE

We are committed to maintaining a safe and drug free clinical learning environment, supporting the physical and mental health of residents, minimizing the occurrence of impairment, protecting patients, and providing a mechanism for a fair, reasonable, and confidential assessment of a resident who is suspected of being impaired, including developing a plan to address the resident's professional progress.

The Sponsoring Institution follows the Noorda College of Osteopathic Medicine's (Noorda-COM) Drug Free Workplace Policy. The complete and up-to-date version of this policy can be found in *The Noorda-COM Employee Handbook, Section 8: Drug Free Workplace.*

DEFINITIONS

Impairment is defined as a physical or mental condition that causes a resident to be unable to practice medicine with care and safety commensurate with their level of training. Impairment of performance by resident physicians can put patients at risk.

POLICY

1. All residents and program faculty are prohibited from reporting to work or working while using alcohol and/or illegal or unauthorized substances, including while working from home (The Noorda-COM Employee Handbook, Section 8: Drug Free Workplace).
2. All faculty, resident, and staff have a duty to confidentially and immediately report concerns to an appropriate supervisor about possible impairment both in themselves and in others.
3. Residents and faculty members have a professional responsibility to appear for work appropriately rested. They must manage their time before, during, and after clinical assignments to prevent excessive fatigue.
4. The GME Office will support the responsible action of a resident seeking help for an alcohol, controlled substance, and psychological problems. Residents will not jeopardize their employment status by proactively seeking and obtaining treatment.
5. If a resident appears to be unfit for duty by virtue of behavior, deportment, or performance, the Program Director or appropriate supervising faculty member will immediately relieve the resident of assigned clinical responsibilities and notify the GME office. The resident, at the discretion of the program director or DIO, may be required to undergo an evaluation and/or drug screening. The resident shall be placed on paid administrative leave until a professional assessment is made.
6. The Noorda-COM and its GME program reserve the right to require a resident undergo drug screening if the behavior or performance suggests a resident is under the influence of illegal drugs or alcohol. Refusal to submit to a drug testing may result in disciplinary action, up to and including termination of employment.
7. If the drug screening results are positive or the psychiatric evaluation yields evidence of a

disorder, the resident will be required to undergo treatment in a program recommended by the state's professionals health program.

8. An impaired resident can be dismissed from the training program if they refuse to participate in the state's professional health program or discontinue treatment plan recommendations. If this occurs, the resident will be reported to the Utah Division of Occupational and Professional Licensure.
9. An impaired resident who obtains treatment will be reinstated after the DIO and program director have confirmed the trainee has a return-to-work recommendation, signifying compliance with all recommendations, from the state's professionals health program or recognized recovery/treatment entity. The program director will monitor the resident's performance with reports presented to the DIO.
10. Program directors and faculty shall communicate this policy to their residents and to enforce its provisions.

IDENTIFICATION OF IMPAIRMENT:

Listed below are some signs and symptoms of impairment. Isolated instances of any of these may not impair the ability to perform adequately, but if they are noted on a continued basis, or if multiple signs are observed, impairment may be present. The signs and symptoms may include:

1. Physical signs and symptoms such as fatigue, deterioration in personal hygiene and appearance, multiple physical complaints, accidents or eating disorders.
2. Disturbance in family stability or personal or professional relationship difficulties.
3. Social changes such as withdrawal from outside activities, isolation from peers, inappropriate behavior, undependability and unpredictability, aggressive behavior, or argumentative/belligerent behavior.
4. Professional behavior problems such as unexplained absences, tardiness, decreasing quality or interest in work, inappropriate orders, behavioral changes, altered interaction with other staff, or inadequate professional performance.
5. Behavioral signs such as mood changes, depression, slowness, lapses of attention, chronic exhaustion, risk taking behavior, excessive cheerfulness, or flat affect.
6. Self-prescribing controlled substances or asking peers to prescribe them controlled substances.
7. Substance use indicators such as excessive agitation or edginess, dilated or pinpoint pupils, self-medication with psychotropic drugs, stereotypical behavior, alcohol on breath at work, uncontrolled drinking at social events, blackouts, or binge drinking.

EDUCATION AND RESOURCES

Education about prevention and recognition of impairment, including from illness, fatigue, or substance abuse, for residents, faculty and program coordinators includes:

- Information in the Identification of Impairment Section
- Resources on the sponsoring institution's website
- Presentations about fatigue management, mitigation strategies, and alertness management
- Presentations about signs and symptoms of depression, substance abuse, and burnout
- Education reinforced by each training program according to its curriculum
- Specific educational offerings for programs or departments upon request

If a resident is experiencing problems, they are encouraged to voluntarily seek assistance before clinical, educational, and professional performance, interpersonal relationships or behavior are adversely affected. Residents who voluntarily seek assistance for physical, psychological, and or substance abuse problems, including drug or alcohol misuse, before their performance is adversely

affected, will not jeopardize their status as a resident by seeking assistance. Resources available to residents include, but are not limited to:

- Access to free, confidential counseling through Wasatch Behavioral Health
- Access to free, confidential counseling through Noorda-COM's Employee Assistance Program
- Support/mentorship via resident's training program
- Utah Professionals Health Program (UPHP)

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-015
Subject: Supervision	Approval: 07/12/2023	Page 1 of 3

PURPOSE:

The purpose of this policy is to define responsibility for supervision and accountability of residents/fellows in different clinical settings

DEFINITION:

Levels of Supervision

To ensure appropriate oversight of resident/fellow, each program must use the following classification of supervision:

1. **Direct Supervision**
    - The supervising physician is physically present with the resident/fellow and patient.
2. **Indirect Supervision**
    - **with direct supervision immediately available** – The supervising physician is physically within the confines of the site of patient care and is immediately available to provide Direct Supervision.
    - **with direct supervision available** – The supervising physician is not physically present within the confines of the site of patient care but is immediately available via phone and is available to provide Direct Supervision.
3. **Oversight**
    - The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Progressive Authority and Responsibility

The extent to which the privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care is delegated to each resident/fellow must be assigned by the program director and faculty members. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident/fellow and delegate to them the appropriate level of patient care authority and responsibility. In particular.

- The program director must evaluate each trainee's abilities based on specific criteria established by the faculty of the training program. These criteria should be guided by national standards-based criteria when such are available;
- Supervising faculty members will delegate patient care activities to resident/fellow based on the needs of the patient and the demonstrated abilities of the resident/fellow;
- Senior residents or should serve in a supervisory role of junior residents with appropriate patients, provided their demonstrated progress in the training program justifies this role;
- In each training program, there will be circumstances in which all residents/fellows, regardless of level of training and experience, must verbally communicate with appropriate supervising faculty. Programs must make provision for these circumstances, and at a minimum, these circumstances will include:
    - Emergency admission;
    - Consultation for urgent conditions;
    - Transfer of patient to a higher level of care;
    - Code Blue Team activation;

- Change in DNR status;
- Patient or family dissatisfaction with care;
- Patient requesting discharge AMA, or;
- Patient death.

POLICY

It is the expectation of the Noorda-COM GMEC that all residents/fellows involved in patient care are provided structured clinical supervision, which will include but not be limited to the following criteria:

1. Each Noorda-COM-affiliated program must demonstrate the appropriate level of supervision is in place for all residents based on each resident's level of training and ability, as well as patient complexity and acuity. The learning objectives of the program must generally ensure manageable patient care responsibilities.

2. Supervision may be exercised through a variety of methods, appropriate to the situation. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include a post-hoc review of resident-delivered care with feedback as to the appropriateness of thatcare.

3. Supervising physicians are to be actively involved in the care of patients. It is recognized that patient encounters occur on a 24-hour basis. It is permissible for some patient encounters (for example, admissions during the night or some emergency situations) to be reviewed with a supervising physician as oversight (as defined above). In these situations, notification of the attending physician will occur in a reasonable time frame. It is expected that a supervising physician be immediately available for consultation on a 24-hour basis

4. Each ACGME-accredited program must define when the physical presence of a supervising physician is required.
5. A Noorda-COM-affiliated program through its program director and faculty must assure that progressive authority and responsibility as defined above occurs.

6. Compliance with this policy will be demonstrated with the maintenance of appropriate documentation guidelines as required by the Centers for Medicare and Medicaid Services (CMS).

7. Residents and faculty must inform each patient of their respective roles in that patient's care when providing direct care and this information must be available to trainees, faculty members, the healthcare team, and patients.

GENERAL RESPONSIBILITIES

- Each patient has an appropriately credentialed and privileged attending physician who is ultimately responsible for that patient's care and is immediately available to theresident.
- PGY-1 level residents must be supervised either directly or indirectly, with direct supervision immediately available by an appropriately trained resident or attending physician.

PROGRAM FACULTY RESPONSIBILITIES

- Routinely review resident/fellow documentation in the medical record.
- Be attentive to compliance with institutional requirements such as problem lists, medication reconciliation, and additional field-defined document priorities.

- Provide resident/fellow with constructive feedback as appropriate.
- Serve as a role model to resident/fellow in the provision of patient care that demonstrates professionalism and exemplary communication skills.

RESIDENT/FELLOW RESPONSIBILITIES

- Each resident/fellow is responsible for knowing the limits of their scope of authority and the circumstances under which they are permitted to act with conditional independence.
- In recognition of their responsibility to the institution and commitment to adhere to the highest standards of patient care, the resident/fellow shall routinely notify the responsible attending physician based on the guidelines noted above, as well as any additional circumstances identified in their program-specific supervisory policy.
- A resident can report inadequate supervision and accountability in a protected manner that is free from reprisal by contacting the DIO.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-016
Subject: Leave of Absence and Resident Benefits	Approval: 07/12/2023	Page 1 of 2

PURPOSE

The purpose of this Noorda-COM policy is to define benefits provided to residents. The policy is written in accordance with *ACGME Institutional Requirements.*

POLICY

The Sponsoring Institution will ensure that each participating site provides fair and equitable benefits to residents in all approved programs.

PROGRAM RESPONSIBILITIES

Programs are required to provide health and disability insurance, vacation, and leaves of absence, including medical, parental and caregiver leaves of absence, at least annually.

1. Health insurance benefits must be provided for residents and their eligible dependents beginning on the first day of insurance eligibility. If the first day of health insurance eligibility is not the first day that residents are required to report to duty, then the residents must be given advanced access to information regarding interim coverage so they can purchase coverage if desired.

2. Disability insurance benefits for residents must be provided beginning the first-day disability insurance eligibility. If the first day of disability insurance eligibility is not the first day that Residents are required to report to duty, then the residents must be given advanced access to information regarding interim coverage so they can purchase coverage if desired. Residents with disabilities must be provided with accommodations consistent with applicable laws and regulations.

3. The program must have a policy for vacation and other leaves of absence, consistent with applicable laws. This policy must be clearly communicated to residents and always have the policy available for review by residents. This policy must:

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

    b. provide residents with at least the equivalent of 100% of their salary for the first six weeks of the first approved medical, parental, or caregiver leave of absence taken.

    c. provide residents with a minimum of one week of paid time off reserved for use outside of the first six weeks of the first approved, medical, parental, or caregiver leave(s) of absence taken.

    d. ensure the continuation of health and disability insurance benefits for residents and their eligible dependents during any approved medical, parental, or caregiver leave(s) of absence.

e. describe the process for submitting and approving a request for leaves of absence.

f. ensure that its ACGME-accredited program provides its residents with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's eligibility to participate in examinations by the relevant certifying board(s).

RESIDENT RESPONSIBILITIES:

1. Residents are responsible for learning and following the policies established by their program and participating sites.

NOORDA-COM RESPONSIBILITIES:

1. Noorda-COM will confirm that appropriate leave of absence, vacation, and resident benefits policies and procedures are in place reviewing said policies during the Annual Site Visit.

2. The Noorda-COM DIO and/or designees will bring any concerns regarding program and participating site policies to the GMEC for review, action, and follow-up, as appropriate.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-017
Subject: Special Review Policy and Protocol	Approval: **07/12/2023** Last Revision Approved:	Page 1 of 3

PURPOSE

To define underperforming ACGME-accredited residency and fellowship program criteria; define the special review process; and ensure effective oversight of underperforming GME programs by the sponsoring institution via the Designated Institutional Official and the Graduate Medical Education Committee.

POLICY

The GMEC has established criteria to identify program underperformance, develop protocols to use for special reviews and provide timely reports that describe the quality improvement goals and corrective actions the program will implement and the process that the GMEC will use to monitor outcomes.

Criteria for identifying Underperformance:
Underperformance by a program can be identified through a wide range of mechanisms. Deficiencies may include, but are not limited to:

Internal Criteria:

1. All programs moving from initial accreditation to continuing accreditation shall undergo a Special Review to comprehensively review and ensure compliance with ACGME requirements
2. At the request of the hospital, department, or program administration
3. Concerns identified by the GMEC on internal surveys or the APE
4. Concerns identified and communicated to the GME office or GMEC by residents or faculty in a particular program
5. Exceeding the 80-hour clinical and work hour maximum weekly, averaged over four weeks
6. Failure to submit GMEC required data on or before identified deadlines
7. Program-specific issues identified by the GMEC or its subcommittees
8. Failure to fill positions over three years

External Criteria:

1. Deviations from expected results in standard performance indicators:
    A. Accreditation statuses: The program receives continued accreditation with warning; initial accreditation with warning, probationary accreditation; administrative probationary accreditation; accreditation withheld; and other adverse accreditation statuses.
    B. Program Attrition:
        a. Change in program director more frequently than every 2-years.
        b. Resident attrition (withdrawal, transfer, or dismissal) greater than 1 resident/fellow per year over a 2-year period
    C. Major Organizational Changes of the Program

        a. Changes in major participating sites
        b. Consistent incomplete resident complement
        c. Major program structural change
        d. Loss of key faculty
    D. Scholarly Activity
    E. Board Pass Rate: Below the minimum required by the supervising RRC
    F. Clinical Experience, such as ACGME case log data from recent graduates indicating that minimum requirements are not being met
    G. Resident or Faculty Survey:
        a. Mean score less than three in two or more of the seven categories
        b. Two responses with less than 50% compliance and significantly below national norm in any of the categories
        c. A pattern of significant downward trends since the last survey
        d. Resident and faculty survey completion rates below the ACGME-required 100% for programs with fewer than four residents and faculty members or below 70% completion rate for programs with four or more residents and faculty members.
        e. ACGME request for progress report related to concerns identified on the Resident or Faculty Survey
    H. Non-compliance with responsibilities
        a. Failure to submit milestones data to the ACGME and GMEC on or before identified deadlines
        b. Failure to submit ACGME required data to ACGME and GMEC on or before identified deadlines
        c. Less than 80% of faculty evaluations completed within two-weeks of the rotation end-date

2. Communications about or complaints against a program indicating potential egregious or substantive noncompliance with the ACGME Common, specialty/subspecialty-specific Program, and/or Institutional Requirements; or noncompliance with institutional policy;

3. A program's inability to demonstrate progress in any of the following focus areas:
    A. Integration of residents into institution's Patient Safety Programs;
    B. Integration of residents into institution's Quality Improvement Programs and efforts to reduce Disparities in Health Care Delivery;
    C. Establishment and implementation of Supervision policies;
    D. Transitions in Care;
    E. Clinical and Work Hour policy and/or fatigue management and mitigation; and
    F. Professionalism

4. Self-report by Program Director, Associate Program Director, Core Faculty, or Department Chair

Initiating a Special Review:
Designation: Upon one or more deficiencies representing underperformance, depending on the severity, the DIO or the GMEC can call for a Special Review. Special Reviews shall occur within 60 days of a program's designation as "underperforming".

Special Review Panel: Each Special Review shall be conducted by a panel assigned by the DIO to complete this review. The panel will comprise the DIO, at least one additional member of the GMEC,

and one support staff person from the program. Additional reviewers may be included on the panel as determined by the DIO/GMEC.

Preparation for the Special Review:
The Chair of the Special Review panel, in consultation with the DIO/GMEC and/or other persons as appropriate, shall identify the specific concerns that are to be reviewed as part of the Special Review process. Concerns may range from those that broadly encompass the entire operation of the program to single, specific areas of interest. Based on identified concerns, the program being reviewed may be asked to submit documentation prior to the actual Special Review that will help the panel gain clarity in its understanding of the identified concerns.

The Special Review:
Materials and data to be used in the review process shall include:

A. the ACGME Common, specialty/subspecialty-specific Program, and Institutional Requirements in effect at the time of the review;
B. accreditation letters of notification from the most recent ACGME reviews and progress reports sent to the respective review committee;
C. reports from previous internal reviews of the program (if applicable);
D. previous Annual Program Evaluations;
E. results from internal or external resident surveys, if available; and,
F. any other materials the Special Review panel considers necessary and appropriate

The Special Review panel will conduct interviews with the Program Director and Coordinator, key faculty members, at least one peer-selected resident from each level of training in the program, and other individuals deemed appropriate by the committee. The Chair of the department and other individuals as determined by the panel also could be interviewed.

Special Review Report:
The Special Review panel shall submit a written report within 12 business days of the special review to the DIO and GMEC that includes, at a minimum, a description of the review process and the findings and recommendations of the panel. These shall include a description of the quality improvement goals, any corrective actions designed to address the identified concerns, potential resources needed, and the process for GMEC monitoring of outcomes. The GMEC may, at its discretion, choose to modify the Special Review Report before accepting a final version.

Monitoring of Outcomes:
The DIO and GMEC shall monitor outcomes of the Special Review process, including actions taken by the program and/or by the institution with special attention to areas of GMEC oversight, including:

A. the ACGME accreditation status of the Sponsoring Institution and its ACGME-accredited programs
B. the quality of the GME learning and working environment within the Sponsoring Institution, its ACGME-accredited programs, and its participating sites;
C. the quality of educational experiences in each ACGME accredited program that lead to the measurable achievement of educational outcomes as identified in the ACGME Common and specialty/subspecialty-specific Program Requirements;
D. the ACGME-accredited programs' annual evaluation and improvement activities; and
E. all processes related to reductions and closures of individual ACGME-accredited programs, participating sites, and the Sponsoring Institution.

DOCUMENT CHECKLIST FOR SPECIAL REVIEW

Section 1

Please provide the Review Panel Members the following documents by Date:

1. The specialty-specific application questions
2. A list of faculty and resident scholarship updated over the past six months
3. Sample documents demonstrating resident involvement in patient safety and QI
4. Current block diagram
5. Program manual with all program-specific policies, such as Supervision, Clinical and Educational Work Hours, Resident and Faculty Wellbeing, etc.) which includes competency-based, educational level-specific goals and objectives for all rotation/assignments
6. Conference schedule reflecting required didactics for the past and current academic year
7. Program Evaluation Committee (PEC) meeting minutes over the past year, a written description of the PEC, and a list of its members
8. Written description of Clinical Competency Committee (CCC) and membership
9. Sample duty hour compliance data demonstrating your monitoring system
10. Most recent APE inclusive of action plans resulting from the APE
11. 3 collective strengths and 3 areas for improvement submitted collectively by the residents directly to the DIO only.

Section 2

Please provide the following documents to Review Panel Members 48 hours prior to the site visit. On the day of the site visit, please have a binder with hard copies of the following documents readily available for the Review Panel.

1. Sample of completed annual confidential evaluation of faculty by residents
2. Signed PLAs
3. A sample of a signed resident contract
4. Files of any trainees who have transferred in or transferred out of the program, or have resigned or been dismissed in past three years
5. Completed evaluations of residents for rotations
6. Multi-source evaluations (360 degree) and/or any other specialty assessments (eg. simulation, journal club, others)
7. Completed milestone reviews, semi-annual reviews, summative reviews
8. Program evaluations completed by faculty and by residents

Sample Schedule for Day of the review where team will meet with:

Program Director and Coordinator	90-100 Minutes
Residents	60 Minutes
Faculty	60 Minutes
Document review and analysis	90 Minutes
Closing meeting with Program Director and Coordinator	60 Minutes

Follow up regarding findings and recommendations with program director and coordinator within 7-10 business days. A report will be created as defined by the Special Review procedure and will be reported to the GMEC for review and approval and will define monitoring recommendations.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-019
Subject: Disruptive Physician	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 3

SCOPE

This policy applies to all Noorda-COM residents, fellows, and faculty participating in Graduate Medical Education programs and at its participating sites.

PURPOSE

1. This policy affirms Noorda-COM's commitment to cultivating and maintaining a system of shared accountability designed to respond to resident and faculty behaviors in a fair and just manner.

2. Noorda-COM is committed to ensuring its ACGME-accredited programs provide a professional, respectful, and civil environment that is psychologically safe and free from unprofessional behavior including mistreatment, abuse, and/or coercion of residents, other learners, faculty members, and staff members (See IS-021 Professionalism and IS-006 Prohibition of Discrimination, Harassment, and Retaliation Policies).

3. Noorda-COM sponsored programs must develop and implement a process for educating residents and faculty members about unprofessional behavior, and a confidential process for reporting, investigating, monitoring, and addressing such concerns.

DEFINITIONS

Awareness conversation: Discussion that any person can have with another person in which the first describes an observed behavior by the latter that is not consistent with the standards and expectations for professional or ethical conduct. It is usually held for minor or first-time policy violations.

Disruptive behavior: Behavior that includes and is not limited to words or actions that impair communication between team members and therefore have the potential to create an unsafe or hostile environment for patients, families, or team members or to interfere with patient care or clinical operations. It includes behavior that interferes with collegial respect that is critical to a safe and productive training environment.

POLICY

It is the expectation that all residents, fellows, and faculty behave in a courteous, cooperative, and professional manner.

1. Addressing and/or reporting disruptive behavior

    A. Awareness conversation - When any resident or faculty member observes a disruptive

behavior for which timely, direct feedback would likely prevent a recurrence, they can, if comfortable doing so, conduct an "awareness conversation" to address the behavior. They may contact their program director or DIO for guidance or assistance in such discussions or request that the behavior be addressed by another person. If the individual chooses not to engage in an awareness conversation with the person engaging in disruptive behavior, that person is strongly encouraged to report their observations using the process below.

B. Reporting disruptive behavior
    1. All students, residents, and faculty are responsible for promptly reporting disruptive behavior, other than minor instances addressed by an awareness conversation, to their residency program director or the DIO (Noorda-COM).
    2. The sponsoring institution prohibits retaliation will not take any adverse action against individuals who report disruptive behavior in good faith. Any person who believes they have been subjected to retaliatory action should report their concerns immediately to the DIO. This may be done confidentially online on the Noorda-COM GME Website.
    3. The individual who is reporting a disruptive behavior may remain anonymous and will be asked to provide the following:
        a. Date and time of the incident
        b. Name of the person exhibiting the behavior
        c. Information on who was involved including patients andthe circumstances that precipitated the situation
        d. A factual and objective description of the behavior
        e. Identification of others who might have observed the incident
        f. Any action taken to remedy the situation
    4. All reports will be treated as confidential to the greatest extent possible and consistent with applicable laws.
    5. If the behavior appears to pose an immediate threat of harm to any individual, Security should be called immediately.
    6. If the person who reported the incident is concerned their report has not been appropriately handled, they should escalate the concern to the DIO of Noorda-COM immediately.

2. Organizational Response

A. The program director or DIO will review each complaint of disruptive behavior and investigate the event thoroughly and as quickly as practical by verifying the details of the event and speaking with any witnesses.

B. The response to disruptive behavior may take a variety of forms depending on the severity of the behavior and whether this is a recurring event. The response could include informal counseling, formal corrective counseling with reporting to the GMEC, discontinuation of residency status or faculty status in the program, or referral for a fitness for duty evaluation. In the case of a hospital medical staff member, disciplinary action may also be taken in accordance with the hospital's Medical Staff By-Laws.

C. Documentation of the organizational response will be provided to the person reporting the event. Copies of this letter, investigation, and subsequent action will be maintained in the Noorda-COM GME office.

3. Corrective Action

A. A single confirmed incident warrants a formal discussion with the offending practitioner by the Program Director or the DIO who will review the event and this policy with that person as well as hear their recollection of the event. The possible results of continued disruptive conduct will be discussed with the practitioner and the expectation that they are required to behave professionally and cooperatively. A written documentation of that meeting will be generated and forwarded to the DIO.
B. If there is a second instance of disruptive behavior, the same process as described above shall occur. However, this second meeting shall constitute a formal warning. A letter will be sent to the practitioner following the meeting after a presentation to the Noorda-COM GMEC. If there is a pattern of disruptive behavior (defined as three verified incidents), the matter will be referred to the Noorda-COM GMEC for final action and resolution of the matter. Any action or recommendation becomes a part of the resident or faculty member's permanent file. More formal action may be pursued at this juncture if warranted, such as severance from the teaching program.
C. Nothing herein shall be deemed to prohibit formal corrective action because of a single incident should it be determined that the seriousness of the incident justifies such action. Temporary suspension of faculty or resident privileges may be appropriate pending the completion of this process depending on the seriousness of the reported offense.

4. The Noorda-COM GMEC shall be fully apprised of any reports of disruptive conduct and any meetings and warnings that may pursue and determine whatever action is necessary to terminate the unacceptable conduct. They will retain all reports or meeting minutes related to the reported disruptive conduct.

5. Examples of disruptive behavior include (but are not limited to):
   A. Verbal or physical attacks that are personal, irrelevant, or beyond the bounds of fair professional conduct; includes shaming, blaming, sarcasm, derogatory and disrespectful language
   B. Impertinent and inappropriate comments - made in the patient's medical records or written or verbal statements to patients or other team members impugning the quality of care given or attacking a particular team member or hospital policies
   C. Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply a lack of intelligence or skill
   D. Refusal to accept or begrudging acceptance of assignments, refusal to answer questions or reasonable requests for information, delayed response to legitimate calls for assistance
   E. Inappropriate outbursts of anger, such as throwing objects, raising one's voice in anger or yelling at other healthcare professionals, trainees, students, staff members, or Noorda-COM GME personnel
   F. Inappropriate touching or contact, or sexual innuendo
   G. Racial, ethnic, or sexual jokes or comments

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-020
Subject: Transitions of Care	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 2

PURPOSE

The purpose of this policy is to establish training and operational standards intended to ensure the quality and safety of patient care. Transitions of care between providers are vulnerable to error, and a clear delineation of the training program and provider responsibilities surrounding this activity promotes and supports Noorda-COM's institutional culture of safety.

DEFINITIONS

Transitions of Care: The hand-off of responsibility for patient care from one resident to another, most commonly at the time of check-out to on-call teams, however, the same principles apply to other transfers between one clinical care setting to another or the scheduled change of providers (e.g., the end- of-month team switches)

Hand-off: Transfer of essential information and the responsibility for the care of the patient from one health care provider to another

POLICY

1. All residents and core faculty members must receive training on performing effective transitions of care.

2. Program faculty will evaluate residents' competency performing a transition of care/handoff initially and periodically.

3. In collaboration with the GMEC and Sponsoring Institution, programs will formally evaluate residents' competency performing a handoff on predetermined dates in the first half of the academic year and at the second portion of the academic year.

4. Programs will monitor resident handoffs using a structured, standardized process that is routinely followed, such as IPASS.

SPONSORING INSTITUTION RESPONSIBILITIES

1. Ensure programs are evaluating trainees are performing effective, structured patient hand-off processes to facilitate continuity of care and patient safety through:
    a. Annual program site visits performed by the DIO
    b. Review of program's transition of care policy
    c. Reviewing ACGME resident and faculty survey results about information not being lost during shift changes, patient transfers, or the hand-off process
    d. Reviewing the Sponsoring Institution's internal annual survey results
    e. Reviewing residents' transition of care evaluations twice a year, and
    f. Sharing findings with the GMEC for oversight purposes.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-021
Subject: Professionalism	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 2

PURPOSE

The purpose of this policy is to set institutional standards for the education of residents/fellows and faculty regarding their professional and personal responsibilities for the safety of their patients.

DEFINTION

Psychological safety: An environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

POLICY

1. Programs, in partnership with Noorda-COM, will provide a professional, equitable, respectful, and civil environment that is psychologically safe and free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of residents/fellows, other learners, faculty, and staff. The program director, in participation with the Noorda-COM, must provide a culture of professionalism that supports patient safety and personal responsibility.

2. Program-specific learning objectives relating to professionalism must be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and educational events. These objectives should not be accomplished without excessive reliance on residents/fellows to fulfill non-physician obligations and ensure manageable patient care responsibilities.

3. The sponsoring institution and its program(s) will:
    a. educate residents/fellows and faculty on professional responsibilities of physicians including their obligation to be appropriately rested and fit to provide the care required by their patients
    b. educate residents/fellows and faculty about unprofessional behavior and the confidential process for reporting, investigating, monitoring, and addressing unprofessional conduct in a timely manner.
    c. monitor residents'/fellows' and core faculty members' fulfillment of educational and professional responsibilities including scholarly pursuits.
    d. Provide formal educational activities that promote patient safety-related goals, tools, and techniques.

4. All residents/fellows and faculty must demonstrate an understanding of their personal role with:
    a. Providing patient-centered and family-centered care
    b. Safeguarding the safety and welfare of patients entrusted to their care, including reporting unsafe conditions and adverse events
    c. Ensuring their fitness for work by managing their time before, during, and after clinical assignments and recognizing when they, their peers or other health care team members are impaired from illness, fatigue, and substance abuse.
    d. Pursuing lifelong learning
    e. Monitoring their patient care performance improvement indicators

f. Accurately reporting clinical and educational work hours, patient outcomes, and clinical experience data.

5. Residents/fellows will conduct themselves professionally by:
    a. Respecting patient privacy and autonomy
    b. Being accountable to patients, society, and the profession
    c. Demonstrating humanism and cultural proficiency by treating all people with respect compassion, and dignity and being responsive to diverse patient populations without exception
    d. Proactively developing a plan to manage their health and personal and professional wellbeing
    e. Appropriately disclosing and addressing conflicts or duality of interest.

6. Residents/fellows and faculty will demonstrate responsiveness to patient needs that supersedes their self-interest and recognize that in certain circumstances, patients' best interests may be served by transitioning those patients' care to different qualified and rested providers.

7. Residents/fellows and faculty will accurately complete required patient care documentation in a timely manner compliant with program, hospital, institutional, and all applicable state and federal policies, rules, and regulations.

8. Residents/fellows demonstrate a commitment to professionalism by adhering to ethical principles and sign an attestation to follow the sponsoring institution's Code of Professional Conduct.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-022
Subject: Accommodation for Disability Policy	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 2

PURPOSE

The purpose of this Accommodation for Disabilities Policy is to reasonably eliminate or reduce disability-related barriers in the learning and workplace environment. This policy is written in accordance with Noorda College of Osteopathic Medicine's Accommodation for Disability policy found in Section 7 of its employee handbook.

POLICY

It is the policy of Noorda-COM to provide reasonable accommodations for disabilities consistent with all applicable state and federal laws, policies, rules, and regulations for qualified individuals with a disability unless hardship or a direct threat will result.

1. Any resident/fellow with a disability who requires an accommodation should submit a written request directly to their program director and to Human Resources.
2. The accommodation request should specify the accommodation the resident/fellow needs to perform the job.
3. Upon receipt of an accommodation request, the Program Director and the program's associated Human Resource Director will meet with the resident to discuss and identify the precise limitations resulting from the disability and the potential accommodation that the program might make to help the resident/fellow to perform essential job functions.
4. Noorda-COM will determine the feasibility of the accommodation considering the various factors, including, but not limited to, the nature and cost of the accommodation, outside funding, financial resources available, and the accommodation's impact on the College, including its impact on the ability of other employees to perform their duties and on Noorda-COM's ability to conduct business.
5. If the requested accommodation is reasonable and will not impose an undue hardship or a direct threat, Noorda-COM will make the accommodation in accordance with applicable law. Noorda-COM may propose an alternative to the requested accommodation or substitute one reasonable accommodation for another and retains the ultimate discretion to choose between reasonable accommodations.
6. Individuals with disabilities who are covered under this policy include applicants seeking admission to residency/fellow programs and current residents/fellows.
7. Residents/fellows are expected to fully cooperate in the accommodation process. The duty to cooperate includes making every effort to provide Human Resources with current medical information. Residents/fellows who do not meaningfully cooperate in the accommodation process will waive the right to accommodation. The accommodation process is in the Noorda-COM Employee Handbook. Residents/fellows who have questions about the process or seek

additional information may contact Noorda-COM Human Resources at 1-385-375-8672.

8. Noorda-COM Administration and/or the Human Resources Director will inform the resident/fellow of its decision on the accommodation request or how Noorda-COM proposes to make an accommodation. If the accommodation request is denied, employees will be advised of their right to appeal the decision by submitting a written statement explaining the request to the Noorda-COM Dean or President. If the request on appeal is denied, that decision is final.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

POLICY		Policy No: IS-023
Subject: Moonlighting	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 3

PURPOSE

This is a Noorda-COM policy establishes parameters and processes necessary for determining resident/fellow involvement in moonlighting.

DEFINITION

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

POLICY

Appointments to Noorda-COM's graduate medical education (GME) training programs are full-time professional education commitments on the part of trainees. This commitment extends to the full 52-week term of each trainee's appointment period. Accordingly, trainees are not to engage in any remunerative professional work (moonlighting) or accept fees for services rendered to patients during the training program unless they have written approval from their program director and DIO.

1. PGY-1 residents/fellows are not permitted to moonlight.
2. All PGY-2 and above residents/fellows who wish to moonlight must be in good standing in their training program.
3. No resident/fellow may be forced to moonlight.
4. Individual programs may prohibit their residents/fellows from moonlighting.
5. Internal moonlighting on a resident/fellow's specialty service is prohibited.
6. Residents/fellows may not engage in moonlighting during regular clinical and educational work hours or while on call.
7. The resident/fellow must have the explicit written and prior approval from their Program Director and DIO before accepting any moonlighting opportunity.
8. Any written approval by the program director and DIO allowing a trainee to moonlight is valid for the academic year when it is granted, unless limited or revoked sooner.
9. A Program Director or DIO has the discretion to permit, prohibit, limit, or revoke permission for moonlighting as they deem appropriate. The Program Director and DIO's decision concerning this approval/non-approval is not subject to appeal.
10. The professional activities must be of educational value and cannot be used to fulfill a training requirement of the current training program.
11. All residents/fellows who engage in moonlighting activities:
    a. must be fully licensed to practice medicine;
    b. must have state and federal (DEA) licenses to prescribe (use of an affiliate hospital's DEA number is not valid for activities outside the scope of the residency training program); and
    c. must carry individual malpractice insurance coverage (see IS-007 Liability Insurance Policy).
12. Time spent by residents/fellow in internal and external moonlighting must be counted toward the 80-hour maximum weekly limit.

13. The resident/fellow is responsible for reporting and logging all hours worked, including all internal and external moonlighting hours, on a weekly basis (unless otherwise indicated by the program director or program policies).
14. Moonlighting is a privilege. Moonlighting must not interfere with the ability of the resident/fellow to achieve the program's educational goals and objectives and must not interfere with the trainee's fitness for work nor compromise patient safety.
15. Regardless of the total number of hours worked, recurring episodes of excessive fatigue, interference with the resident's/fellow's achievement of the goals and objectives of the educational program, or any adverse effect on patient safety shall trigger reevaluation of the approval to accept supplementary employment and may result in the rescission of approval for moonlighting activities.
16. Residents/fellows who moonlight and violate the ACGME's 80-hour rule or fail to report any hours worked, whether regular work hours or internal or external work hours, will be deemed to have voluntarily relinquished their moonlighting approval and may be subject to other disciplinary action up to immediate suspension or termination.
17. Violation of this policy may result in disciplinary action up to termination.

PROCEDURE

1. Residents/fellows who wish to engage in practicing medicine outside of their formal training program must submit a written request to their Program Director.
    a. The request must detail the planned location, date, hours.
    b. The trainee must demonstrate they have adequate professional liability coverage for moonlighting.

2. Individuals approved to moonlight must:
    a. Apply for and be granted clinical privileges as appropriate in the facility requesting their clinical services;
    b. Not exceed the ACGME 80-hour maximum weekly limit;
    c. Accurately log all moonlighting hours in the residency management system (EXAAT, New Innovations, etc.); and
    d. Notify program director and sponsoring institution when moonlighting activity is terminated.

3. The Program Director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding of their personal role in the: provision of patient- and family-centered care; safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; assurance of their fitness for work, including: management of their time before, during, and after clinical assignments; and, recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team.

    The Program Director must:
    a. Notify the resident/fellow writing about their moonlighting request's approval or denial.
    b. Place a copy of the written decision in the trainee's evaluation file;
    c. Ensure moonlighting will not interfere with residency/fellowship training;
    d. Monitor and ensure that moonlighting hours worked are counted in the total of weekly work hour limits for patient care activity; and
    e. Decide on initial approval, renewal, and cessation of approval based on the

trainee's ability to meet clinical and educational work hours requirements, the trainee's achievement of program goals and objectives, or patient safety.

4. Sponsoring institution has the discretion to permit, prohibit, limit, or revoke permission to moonlight.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

Noorda-COM

POLICY		Policy No: IS-024
Subject: Grievance and Due Process	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 3

PURPOSE

This policy provides resident an avenue for due process when an Action is taken and outlines a process for submitting and processing resident grievances.

DEFINITION

Action: An Action refers to a decision to not promote a resident to the next PGY level, to not recommend a graduating resident to sit for a specialty board examination, to suspend a resident other than for contractual or employment obligations, to not renew a resident's contract, and/or to terminate a resident's participation in a residency program. Actions may require disclosure to others upon request, including but not limited to privileging hospitals, licensure, or specialty boards. Due Process, as described within, applies to Actions that are taken because of academic deficiencies and/or misconduct. (See Academic Improvement Policy and Professional Conduct and Misconduct Policy)

DUE PROCESS FOR ACADEMIC MATTERS

A review of the program's decision to take an Action for academic matters must be requested by the resident. A written request for review must be submitted to the Designated Institutional Official (DIO) within fourteen (14) calendar days of learning of the Action. Upon a request for review, the DIO will first determine whether the matter is reviewable under this policy and if so, shall appoint a Review Committee. The Review Committee will be composed of two (2) GME faculty members and one (1) resident from a department or departments different than the requesting resident. The committee will determine whether the resident received appropriate notice of deficiency and an opportunity to correct it, and whether the decision to take the Action was thoughtfully and deliberatively made. The Review Committee will make a recommendation in this regard to the Noorda-COM DIO who will render a decision. This decision will be immediately effective, binding, final, and not subject to further appeal.

Prior to the Review Committee meeting, the Office of Graduate Medical Education (OGME) will provide a copy of the resident's due process file (see Elements of a Resident Due Process File below) to the committee members. The resident and program director are at liberty to submit any additional relevant documentation to OGME for distribution to the committee members by the given deadline. Patient and peer identifiers shall be removed from any documents. The committee will review the trainee's request for review, the trainee's due process file, and any additional documentation provided (materials).

The review meeting will be scheduled in a timely manner. If the resident fails to attend without good cause, they will have been considered to have withdrawn the request for review. If the program director fails to attend without good cause, the meeting will proceed. The meeting will be attended by the three (3) committee members, the resident, program director and a representative of OGME or

their designee. As this is an academic process, no attorneys or legal advisors will be allowed to attend. The resident may have a faculty advisor or other support person present if they so choose. This support person will not be permitted to actively participate unless requested by the chairperson of the Review Committee. The chairperson of the Review Committee will preside over the meeting, make introductions, and verify that all committee members have reviewed the Materials in advance.

The resident will be given an opportunity to describe the reason they believe the Action was unwarranted and the basis for the request for review. The program director will then have an opportunity to respond to or clarify issues raised in the resident's request for review. The committee members will have an opportunity to ask final questions of the resident and program director. The committee may interview others as they see appropriate to aid in the decision-making process. If the committee identifies such individuals in advance, they will be invited to attend the meeting. Alternatively, the committee may identify individuals they need to interview after the meeting and before their deliberations. On conclusion of the committee meeting and after the committee members have had a chance to interview any other individuals they identify; the committee will deliberate without the program director and resident but with the attendance of an OGME representative.

The committee will make a written report with their recommendations, along with a discussion of the rationale for the committee's decision. The OGME will be responsible for forwarding the written report along with a copy of the Materials to the DIO (and the CEO of the employing hospital if the resident is not a Noorda-COM employee). The DIO will review the committee's written report and Materials and render a decision either upholding, overturning, or modifying the Action.

DUE PROCESS FOR MISCONDUCT MATTERS

A review of the decision to take an action for misconduct matters must be requested by the resident. The review process will be the same as that for academic matters (outlined above) with the following exception: The Review Committee will not determine whether the resident received appropriate notice, had an opportunity to be heard regarding the matter at hand, and whether the decision to take the action was thoughtfully and deliberatively made.

The procedures as outlined above shall not preempt the Medical Staff By-laws or personnel codes of the hospitals and/or clinics and shall not preempt or limit any right of the program or hospitals/clinics under the Resident Contract/Agreement Policy or the Impairment Policy to immediately suspend a resident.

EXCEPTIONS

If a resident returns to work following treatment of an impairing condition, they will return on a Conditions of Reinstatement Letter. If they are terminated for violating any of the conditions regarding substance use, monitoring parameters, or information sharing with the monitoring body, such termination is binding and will not be eligible for review.

Residents employed by an affiliated hospital may be required to pass a post-offer drug test as specified by the hospital's substance testing program as a prerequisite of employment. A resident who fails to successfully pass the post-offer drug test shall not have the right to grieve the failure pursuant to this policy.

RESIDENT COMPLAINTS

This refers to some cause of distress (such as an unsatisfactory working condition) that is felt by the resident to present a reason for complaint, but does not involve an Action that is eligible for due process. Complaints must be dealt with in as confidential a manner as possible, and without fear of retaliation. A complaint or incident should be reported to the resident's Chief Resident or attending physician. If the Chief Resident or attending is unable to help the trainee effectively resolve the issue, or if the complaint or incident involves the Chief Resident and/or attending physician, the resident should take the problem to the Program Director for resolution. If satisfactory resolution is still not achieved after the Program Director has become involved, the resident may provide a written complaint report to the DIO.

The DIO will review the written complaint report and meet with the resident to ensure that steps as outlined above for Complaint Matters were followed. The DIO may then convene other individuals deemed necessary to perform a reasonable inquiry and problem-solving process, including but not limited to the complainant's Program Director, hospital/clinic administrators, other residents or faculty, and/or human resources or Title IX personnel. The DIO and other appropriate participants will investigate all the issues associated with the complaint and will provide a final and binding decision to the resident, unless precluded by confidentiality (i.e. if a complaint culminates in a personnel action against a resident, faculty or staff member).

Attachment A Elements of a Resident Due Process File See Resident File Standards for details of each Section			
These elements of the resident's file are included in a Due Process File		**These elements of the resident's file are not included in a Due Process File – May be submitted upon request of resident or PD**	
		Section 1	Applications (If this section is requested, only LORs in which the resident did NOT waive their right to view the letter will be included)
Section 2	Most recent resident contract and all contract renewal letters		
		Section 3	License
Section 4	Certification and credentials- ALL		
Section 5	Required training- ALL		
Section 6	In-service / In-training Exams- ALL		
Section 7	Evaluation Documentation -ALL		
Section 8	Rotation Information / Goals & Objectives - ALL		
		Section 9	Leave Time Documentation
Section 10	Scholarly Activity / QI - ALL		
		Section 11	Post residency / Verifications
Section 12	Deficiencies / Discipline Matters - ALL		
Section 13	Miscellaneous		

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

POLICY		Policy No: IS-025
Subject: Academic Improvement and Due Process	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 2

PURPOSE

This is a Noorda-COM policy outlines a process for improving academic performance and providing residents due process in the event an adverse action is taken.

DEFINTION

Adverse Action: An action that may result when continued remediation efforts have been unsuccessful. These actions may include suspension, denial of certificate of completion, non-renewal of agreement, or dismissal from the program.

POLICY

Each program director is responsible for assessing and monitoring a resident's/fellow's academic and professional progress in the areas of ACGME's six core competencies and adherence to program, institutional, and hospital policies and procedures.

Failure to perform adequately in any of these areas may result in corrective action, up to and including termination. If a resident is not progressing appropriately, the program has a responsibility to inform the resident of the deficiency and provide them with an opportunity to correct the deficiency. At times it is possible and appropriate for the program to provide extra assistance or educational experiences for the resident to aid in this. It is ultimately the resident's/fellow's responsibility to take the steps necessary to meet expectations.

PROCEDURE

Notice of Deficiency

1. **Structured Feedback:** All residents/fellows should be provided routine verbal and written feedback that is consistent with their educational program. Some examples of feedback techniques include verbal feedback (from supervising faculty and program director), rotation evaluations, semi-annual evaluations, summative evaluations, and input from patients, ancillary staff or the program's clinical competence committee. Feedback regarding serious deficiencies should be outlined for the resident, either in an evaluation form, a letter of concern, or other performance improvement plan.

2. **Letter of Deficiency**: If the program director determines that the deficiency is significant enough to warrant something more than routine feedback, a letter of concern, or other program level performance improvement plan, the program director may elect to issue a "Letter of Deficiency."

   This letter provides the trainee with a) notice of the deficiency; and b) an opportunity to correct the deficiency. As much as possible, a Letter of Deficiency should describe the observed deficiency(ies) and the expected academic standard. A Letter of Deficiency is considered a remediation/performance improvement plan. The Letter of Deficiency must include a timeline for reassessment or reevaluation.

All Letters of Deficiency must be cosigned by the program director and the DIO/chair of the GMEC.

The program director will continue to provide the resident with feedback consistent with the Letter of Deficiency. At each designated period of reassessment, the program director will notify the trainee and the DIO/Chair of GMEC in writing that the Letter of Deficiency has been continued or resolved.

3. Failure to Correct the Deficiency (actions)

If the program director determines that the resident/fellow has not satisfactorily corrected the deficiency and/or improved overall performance to an acceptable level, the program director, with input from the clinical competence committee and consultation with the DIO, may elect to take further action which may include one or more of the following steps:

a. Non-promotion to next PGY level
b. Repeat of rotation(s) that extends the required period of training
c. Non-renewal of resident's/fellow's contract
d. Suspension (other than for contractual or employment obligations)
e. Termination from the program

A decision not to promote a trainee to the next PGY level, not extend a resident's/fellow's defined period of training, not renew a resident's/fellow's contract, and/or to terminate the resident's/fellow's participation in a program may require disclosure to others upon request, including but not limited to privileging hospitals, licensure, or specialty boards.

If a resident is subject to an adverse action, they must be notified of this in writing, such notification must be signed by the program director and the DIO/chair of GMEC. Any resident who is not being promoted, or whose contract is not being renewed should be notified of this in writing pursuant to the time period set forth in the resident agreement.

4. Reporting Non-Renewal or Dismissal

The non-renewal or termination of fully licensed trainee's contract must be reported to the Utah's Division of Professional Licensure Board of Physician and Surgeon.

5. Below are the various actions that may be taken

a. Suspension
    i. A resident/fellow may be suspended from all program activities and duties by the program director or the DIO.
    ii. Program suspension may be imposed for program-related conduct that is deemed to be grossly unprofessional; incompetent; erratic; potentially criminal; noncompliant with hospital policies, procedures and code of conduct, federal healthcare program requirements, or conduct threatening to the well-being of patients, other residents/fellows, faculty, staff or the resident/fellow.
    iii. All suspensions must be reported to the DIO.
    iv. Suspension must not exceed 60 calendar days without additional review and may be coupled with or followed by other actions.
    v. Suspension may be with or without pay.

b. Non-Renewal of Agreement
    i. Programs will provide a written notice of intent to residents/fellows when their agreement will not be renewed, when that trainee will not be promoted to the next level of training, or when that resident/fellow will be dismissed.

ii. Programs will provide residents/fellows written notice of intent no later than 4 months prior to the end of the resident's/fellow's current agreement or when the primary reason(s) for non-renewal occurs within those four months, programs will provide as much notice as is feasible
iii. A copy of the notification, signed by the program director and resident/fellow must be sent to the DIO.

c. Denial of Certificate of Completion
   i. A resident/fellow may be denied a certificate of completion of training because of overall unsatisfactory performance during the final academic year of residency/fellowship training. This may include the entire year or overall unsatisfactory performance for at least 50 percent of rotations during the final academic year.
   ii. In most situations, the resident/fellow should be notified of this pending action as soon as possible.
   iii. A copy of the notification, signed by the program director and resident/fellow, must be sent to the DIO.

d. Dismissal
   i. The DIO or a designee must review all dismissals.
   ii. The resident/fellow does not need to be on suspension or remediation for this action to be taken.
   iii. Prior written notice will not be provided to the resident/fellow when it is determined that the seriousness of the act requires immediate dismissal.
   iv. Serious acts may include, but are not limited to, the following:
      a. Professional incompetence
      b. Serious neglect of duty or violation of program or clinic/hospital rules, regulations, policies, or procedures
      c. Action or inaction reasonably determined by the program or clinic/hospital to involve moral turpitude or that is contrary to the interests of patient care, the primary site, or participating sites
      d. Conviction of a felony or other serious crime as determined by the program
      e. Conduct the program reasonably determines to be prejudicial to the best interest of the program or clinic/hospital and patient safety
      f. Presenting to work under the influence of alcohol or drugs
      g. Unapproved absence from the program
      h. Failure to progress satisfactorily in the program's educational and clinical program
      i. Total disability as defined in the program's employment policies and procedures, or inability to perform duties required for a designated period of time per the program's employment policies and procedures
      j. Failure to maintain a medical license
      k. Falsification of medical records

6. Due Process and Request for Review

A resident who is subject to an adverse action may request a review of the decision as described in the Grievance and Due Process Policy. A copy of the Due Process and Resident Complaint Policy should be given to any resident who is subject to an Action.

NOORDA COLLEGE of OSTEOPATHIC MEDICINE

POLICY		Policy No: IS-026
Subject: Misconduct Matters and Due Process	Approval: 07/12/2023 Last Revision Approved:	Page 1 of 4

PURPOSE

This is a Noorda-COM policy outlines a process to address allegations of disruptive behavior or misconduct.

DEFINITION

Disciplinary Actions: Actions that are reserved for serious acts requiring immediate action, such as suspension or dismissal. The residency/fellowship programs are under no obligation to pursue remediation actions prior to recommending a disciplinary action. All disciplinary actions will become a permanent part of the resident's/fellow's training record.

POLICY

Each program director is responsible for assessing and monitoring a resident's/fellow's professional progress in the areas of ACGME's six core competencies and adherence to program, institutional, and hospital policies and procedures.

Any individual who observes disruptive behavior or misconduct by a resident/fellow should report this to the program director or to the complainant's supervisor who will then report it to the program director. Documentation of the behavior should include 1) the date, time and location of the questionable behavior; 2) a description of the behavior limited to direct factual observations; 3) circumstances that precipitated the situation; 4) actual or expected consequences, if any, to patient care; 5) record of any action taken to remedy the situation and; 6) the name of the individual who is making the report, and other witnesses.

PROCEDURE

1. **Receipt of complaint.** Upon receipt of a complaint regarding conduct of a trainee, the program director should conduct an inquiry, as follows:
   a. Meet with the complainant or otherwise review the complaint.
   b. If the program director deems the complaint to have merit, meet with the resident to advise the trainee of the existence of the complaint, to give the trainee an opportunity to respond to the allegations and to identify any potential witnesses to the alleged disruptive behavior or misconduct.
   c. The program director will consult with others as appropriate based on the issues and the people involved (i.e. DIO/Chair of GMEC, legal counsel, administrators of appropriate hospital or clinic, human resources personnel, etc.).
   d. Behaviors or incidents occurring at a hospital site will be addressed by the program director in conjunction with the appropriate hospital personnel, according to the code of conduct policy of the appropriate hospital. If the behavior or incident occurs at a site that is not the resident's employing hospital or clinic, the CMO/CPE of the employing hospital will be

notified.

e. Incidents involving inappropriate sexual comments or behaviors will be addressed by the program director in conjunction with appropriate hospital and/or Noorda College of Osteopathic Medicine staff/Title IX staff, according to the sexual harassment and Title IX policies. Behaviors which indicate the presence of impairment in the resident will be addressed according to the impairment policy. These may proceed simultaneously.
f. Upon consensus of the program director, DIO, Noorda-COM human resources personnel, and appropriate hospital administrator, the trainee may be removed from duty (with or without pay) pending the outcome of the inquiry.

2. **Outcome of Inquiry:** If the inquiry results in a finding that no inappropriate behavior occurred, no action will be taken against the trainee. If the trainee was suspended during the inquiry, they will be reinstated with full benefits and pay.
   a. If the inquiry results in a finding that disruptive behavior occurred that does not reach the level of misconduct, it may be addressed in accordance with the Academic Deficiency Policy as a professionalism deficit. As such, the program may take one or more responses including, but not limited to:
      i. A verbal or written warning
      ii. Issuance of a Letter of Deficiency
      iii. Education regarding appropriate behavior

   b. Or the program may take one or more Actions (as defined in the Academic Improvement Policy):
      i. Non-promotion to the next PGY level
      ii. Denial of credit for previously completed rotations
      iii. Repeat of rotation(s) that extends the required period of training
      iv. Suspension
      v. Non-renewal of contract
      vi. Termination from the GME program
      vii. Denial of Certificate of Completion

   c. If the inquiry results in a finding that a trainee participated in misconduct, the program director (in consultation with the DIO, hospital administrator, human resources personnel, legal counsel, or other individuals) shall determine what response is appropriate to remedy the situation. Determination as to whether an inappropriate behavior constitutes misconduct, versus disruptive behavior, is at the discretion of the program director. A program is under no obligation to offer any resident a second opportunity to engage in misconduct, especially in the patient care setting. The program may take one or more Actions including, but not limited to:
      i. Suspension
      ii. Non-renewal of contract
      iii. Termination from the GME program

   d. The non-renewal or termination of fully licensed trainee's contract must be reported to the Utah's Division of Professional Licensure Board of Physician and Surgeon.

3. Below are the various actions that may be taken
   a. Suspension

i. A resident/fellow may be suspended from all program activities and duties by the program director or the DIO.
ii. Program suspension may be imposed for program-related conduct that is deemed to be grossly unprofessional; incompetent; erratic; potentially criminal; noncompliant with hospital policies, procedures and code of conduct, federal healthcare program requirements, or conduct threatening to the well-being of patients, other residents/fellows, faculty, staff or the resident/fellow.
iii. All suspensions must be reported to the DIO.
iv. Suspension must not exceed 20 calendar days without additional review and may be coupled with or followed by other actions.
v. Suspension may be with or without pay.

b. Non-Renewal of Agreement
   i. Programs will provide a written notice of intent to residents/fellows when their agreement will not be renewed, when that trainee will not be promoted to the next level of training, or when that resident/fellow will be dismissed.
   ii. Programs will provide residents/fellows written notice of intent no later than 4 months prior to the end of the resident's/fellow's current agreement or when the primary reason(s) for non-renewal occurs within those four months, programs will provide as much notice as is feasible
   iii. A copy of the notification, signed by the program director and resident/fellow must be sent to the DIO.

c. Denial of Certificate of Completion
   i. A resident/fellow may be denied a certificate of completion of training because of overall unsatisfactory performance during the final academic year of residency/fellowship training. This may include the entire year or overall unsatisfactory performance for at least 50 percent of rotations during the final academic year.
   ii. In most situations, the resident/fellow should be notified of this pending action as soon as possible.
   iii. A copy of the notification, signed by the program director and resident/fellow, must be sent to the DIO.

d. Dismissal
   i. The DIO or a designee must review all dismissals.
   ii. The resident/fellow does not need to be on suspension or remediation for this action to be taken.
   iii. Prior written notice will not be provided to the resident/fellow when it is determined that the seriousness of the act requires immediate dismissal.
   iv. Serious acts may include, but are not limited to, the following:
      a. Professional incompetence
      b. Serious neglect of duty or violation of program or clinic/hospital rules, regulations, policies, or procedures
      c. Action or inaction reasonably determined by the program or clinic/hospital to involve moral turpitude or that is contrary to the interests of patient care, the primary site, or participating sites
      d. Conviction of a felony or other serious crime as determined by the program

e. Conduct the program reasonably determines to be prejudicial to the best interest of the program or clinic/hospital and patient safety
f. Presenting to work under the influence of alcohol or drugs
g. Unapproved absence from the program
h. Failure to progress satisfactorily in the program's educational and clinical program
i. Total disability as defined in the program's employment policies and procedures, or inability to perform duties required for a designated period of time per the program's employment policies and procedures
j. Failure to maintain a medical license
k. Falsification of medical records

4. **Due Process and Request for Review**

A resident who is subject to a disciplinary action may request a review of the decision as described in the Grievance and Due Process Policy. A copy of the Grievance and Due Process Policy should be given to any resident who is subject to a disciplinary action.