GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)

POLICY AND PROCEDURE MANUAL

LOS ANGELES GENERAL MEDICAL CENTER/ UNIVERSITY OF SOUTHERN CALIFORNIA

Effective Date: June 1, 2024

TABLE OF CONTENTS

SECTION 5: COMPENSATION AND BENEFITS

SECTION 6. COUNTY EMPLOYMENT POLICIES

SECTION I: GME MISSION, INSTITUTIONAL SPONSORSHIP AND STRUCTURE

I. Mission Statement

The mission of Graduate Medical Education at USC/LA General Medical Centerl is to train the future generation of physician leaders to provide humanistic, equitable, world-class individual and population-based healthcare to our diverse Los Angeles community through modeling excellence and innovation in patient care and care delivery, teaching, and scholarship.

II. Introduction

This Graduate Medical Education Committee (GMEC) Policy and Procedure Manual provides residents and faculty with the major policies and procedures for resident participation in Graduate Medical Education at the ACGME designated Sponsoring Institution: University of Southern California/Los Angeles General Medical Center. Residents/fellows are both learners and employees of the Los Angeles County Department of Health Services or the University of Southern California. As such, all residents are responsible for remaining compliant with the policies and procedures governing their academic training programs and the policies of the appropriate employer. Each participating educational site has their policies and procedures electronically available on the intranet or internet. All learners and supervising faculty are advised to reference the appropriate web site to familiarize yourself with site specific policies. This manual also includes the guidelines and procedures for discipline and due process in the event that a program takes an action that is averse to the resident.

The GMEC has adopted the following definition of Graduate Medical Education from the introduction to the ACGME Common Program Requirements Effective July 1, 2023:

Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.

Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable,

quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

III. The Sponsoring Institution: University of Southern California/ Los Angeles General Medical Center (USC/LA General)

The Accreditation Council for Graduate Medical Education (ACGME) has designated the Sponsoring Institution as USC/LA General , which conducts its major teaching efforts at LA General Medical Center and Keck Hospital of USC. The LA General Medical Center is a public facility that is owned and operated by the County of Los Angeles to provide care for patients residing in Los Angeles County including those that are medically indigent and those otherwise without access to health care. LA General is a Level 1 Trauma Center and a regional Burn Center. Keck Hospital of USC is a non-profit, private facility owned and operated by the University of Southern California. These two institutions provide residents with the majority of their educational experiences and are complemented by rotations at other participating sites throughout Los Angeles.

IV. Organizational Commitment to Graduate Medical Education

USC through the Keck School of Medicine (KSOM) and LA General Medical Center both recognize the importance of the Graduate Medical Education (GME) programs to their respective missions. Accordingly, LA General Medical Center and the KSOM have a contractual relationship to provide the support and resources for GME as detailed in the Medical School Affiliation Agreement (MSAA) between the Department of Health Services (DHS) and the University of Southern California (USC). The MSAA identifies the USC employed physician responsibilities for graduate medical education and patient care services at LA General Medical Center and other participating sites. Oversight authority is delegated to the Designated Institutional Official (DIO) who also serves as the Senior Associate Dean Graduate Medical Education. The DIO reports to the Chief Medical Officer, LA General Medical Center and to the Dean, Keck School of Medicine. The DIO is the Chair, Graduate Medical Education Committee (GMEC), which is a standing committee of the Attending Staff Association (ASA), which is the Organized Medical Staff structure. The DIO is a member of the ASA Executive

Committee and as Senior Associate Dean GME is a member of the Dean's Executive Council of the Keck School of Medicine.

V. Accreditation for Patient Care

LA General Medical Center and the Keck Hospital of USC are accredited by the Joint Commission, as are all the major affiliating institutions participating in USC/LA General's residency training programs.

VI. Graduate Medical Education Committee (GMEC)

1. Membership and Reporting Structure:

    a. Membership:
        1. Designated Institutional Official (DIO):
            a. The DIO must be a voting members of the DIO.
            b. The DIO serves as the Chair, GMEC
        2. Program Directors:
            a. All accredited ACGME specialty program directors are voting members of the GMEC
            b. The GMEC must appoint a minimum of one (1) fellowship director as voting members of the GMEC
        3. Peer-selected, voting residents/fellows from ACGME-accredited programs
            a. Four (4) peer-selected residents will be appointed by the resident union (CIR)
            b. Six (6) peer-selected residents/fellows will be appointed as voting members chosen from programs with the largest complement of residents not otherwise represented by the CIR Programs with the highest complement of residents
            c. Two (2) other peer-selected resident/fellows
        4. Quality Improvement or Safety Officer or Designee
        5. Program Coordinators (peer-selected)
        6. KSOM Students: one third-year and one fourth-year

    b. Reporting Structure: The GMEC is a standing committee of and reports to the Executive Committee of the LA General Medical Center Attending Staff Association. The GMEC communicates the needs of the educational programs to the Dean, the DHS Governing Body, and the Medical Staff through direct reports by the DIO and through the Executive Committee of the LA General Medical Center's Attending Staff Association.

2. Subcommittees and Additional Members
    a. Subcommittees that address required GMEC responsibilities must include a peer-selected resident/fellow
    b. Subcommittees must report their actions to the GMEC
    c. Standing subcommittees and Temporary Subcommittees:
        (1). Sexual Assault/Harassment, Fairness and Equity (SAFE)
        (2). Wellness

(3). D.E.I.
(4) Additional standing subcommittees can be appointed by the GMEC by majority vote
(5) A temporary subcommittee can be appointed by the GMEC by majority vote and must have a defined purpose, beginning and ending date

3. Meetings and Attendance
    a. GMEC meetings occur monthly with at least one resident/fellow in attendance
    b. The GMEC must maintain meeting that document execution and compliance with all required GMEC functions and responsibilities and ACGME Institutional, Common, and Program specific requirements.

4. Responsibilities
    a. Oversight of:

(1) ACGME accreditation and recognition status of USC/LA General and each of its ACGME-accredited programs:

(2) the quality of the GME learning and working environment within USC/LA General , each of its ACGME-accredited programs, and its participating sites;

(3) the quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the prevailing ACGME Common and specialty-/subspecialty-specific Program Requirements;

(4) the ACGME-accredited programs' annual program evaluations and Self-Studies;

(5) ACGME-accredited programs' implementation of institutional policies for vacation and leaves of absence including medical, parental, and caregiver leaves of absence, at least annually

(6) all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and USC/LA General ; and

(7) the provision of summary information of patient safety reports to residents/fellows, faculty members and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided

    b. Review and Approval of:
        (1) Institutional GME polices and procedures;
        (2) GMEC subcommittee actions that address required GMEC responsibilities;
        (3) Annual recommendations to USC/LA General 's administration regarding resident/fellow stipends and benefits;

(4) Applications for ACGME accreditation of new programs;
(5) Requests for permanent changes in resident/fellow complement;
(6) Major changes in each of its ACGME-accredited program' structure or duration of education, including any change in the designation of a program's primary clinical site;
(7) Additions and deletions of each of its ACGME-accredited programs' participating sites
(8) Appointment of new program directors
(9) Progress reports requested by a Review Committee
(10) Responses to Clinical Learning Environment Review (CLER) reports;
(11) Request for exceptions to clinical and educational work hour requirements
(12) Voluntary withdrawal of ACGME program accreditation or recognition
(13) Requests for appeal of an adverse action by a Review Committee
(14) Appeal presentations to an ACGME Appears panel;
(15) Exceptionally qualified candidates for resident/fellow appointments who do not satisfy USC/LA General 's resident/fellow eligibility policy and/or resident/fellow eligibility requirements in the Common Program Requirements

5. Annual Institutional Review (AIR):
    a. Institutional Performance Indicators
        i. The most recent ACGME Institutional Letter of Notification
        ii. Results of ACGME Surveys of residents/fellows and core faculty members
        iii. Each of its ACGME-accredited programs' ACGME accreditation information, including accreditation and recognition statuses and citations
    b. The DIO must submit an annual written executive summary of the AIR to USC/LA General 's Governing Body that must include:
        i. A summary of institutional performance indicators for the AIR; and
        ii. Action plans and performance monitoring procedures resulting from the AIR

6. Special Review Process
    a. The Special Review Protocol (See Appendix A) must include
        i. A variety of criteria for identifying underperformance of USC/LA General's ACGME-accredited programs that includes, at a minimum, program accreditation statuses of:
            (1) Initial Accreditation with Warning
            (2) Continued Accreditation with Warning
            (3) Probationary Accreditation
            (4) Egregious Violation of Requirements
            (5) Proposed Withdrawal of Accreditation
            (6) Required Reduction in Complement
        ii. A Special Review Report that in a timely manner describes the quality improvement goals, the corrective actions and the process for GMEC monitoring, including timelines.

VII. Institutional Agreements (Master Affiliation Agreements)

When resident education occurs in a major participating institution, USC/LA General continues to have responsibility for the quality of that educational experience and must retain authority over the residents' activities. A major participating institution is defined by the ACGME as "an institution to which residents rotate for a required experience and/or those that require explicit approval by the appropriate RRC prior to rotation".

Current institutional agreements (master affiliation agreement) must exist with all participating sites. The institutional agreement provides the contractual basis between the sponsoring and participating institutions for exchange of residents. The content of the institutional agreement must address issues such as responsibility for training, supervision and evaluation of residents, salaries and fringe benefits, coverage for professional liability, emergency health care services at the outside facility, reimbursement for the cost of salaries and fringe benefits for the residents, worker's compensation insurance, compliance with the policies and procedures of the Medical Staff of the participating institution, indemnification, record keeping and a number of other issues.

For residents employed by the County of Los Angeles, there is a "boiler plate" affiliation agreement that has been approved and mandated by the Board of Supervisors. Copies of executed affiliation agreements between County of Los Angeles and other institutions for physicians in postgraduate training are on file in the Office of Graduate Medical Education.

Before agreeing to a recurring exchange of residents going to or coming from other institutions, the Program Director is responsible to have a properly executed affiliation agreement in place to cover the exchange of residents. The Office of GME will assist the Program Directors to accomplish the required affiliation agreement(s).

VIII. Letters of Agreement

The ACGME requires that each accredited program shall establish appropriate letters of agreement between the USC/LA General and the participating institution(s) which must be renewed at a minimum every ten (10) years and approved by the DIO. These letters of agreement are required for recurring exchanges of residents (bilateral or unilateral) and even for the occasional, non-recurring elective rotation if it is one month or longer. Even if the program meets the ACGME's requirements to be considered an integrated program wherein the faculty of a department supervise the residents at all the training sites, letters of agreement are still necessary because the participating institution must commit its resources to support the residents.

A letter of agreement that fulfills the Institutional Requirements of the ACGME should:

1. Identify the officials at the participating institution or facility who will assume administrative, educational, and supervisory responsibility for the resident(s);
2. Outline the educational goals and objectives to be attained within the participating institutions;
3. Specify the period of assignment of the residents to the participating institution, the

financial arrangements, and the details for insurance and benefits;
4. Determine the participating institution's responsibilities for teaching, supervision, and formal evaluation of the residents' performances; and
5. Reference the participating institution's policies and procedures that govern the residents' education while rotating to the participating institution.

RRC Program Requirements may establish additional requirements for letters of agreement for a residency program. Program Directors are responsible to review their Program Requirements when preparing letters of agreement.

IX. Institutional Resources-DIO

1. The DIO must have sufficient support and dedicated time to effectively carry out educational, administrative and leadership responsibilities.
2. The DIO must engage in professional development applicable to responsibilities as an educational leader.
3. The DIO must have sufficient salary support and resources for effective GME administration.

X. Institutional Resources-Program Administration

1. USC/LA General , in partnership with each of its ACGME-accredited programs, must ensure and commit to in writing the availability of adequate resources for resident/fellow education, including:
    a. Support and dedicated time for the program director and associate/assistant program director(s) to effectively carry out educational, administrative, and leadership responsibilities, as described in the Institutional, Common, and specialty-/subspecialty specific Program Requirements.
    b. Support for core faculty members to ensure both effective supervision and quality resident/fellow education.
    c. Support for professional development applicable to program directors' and core faculty members' responsibilities as educational leaders;
    d. Support and time for the program coordinator(s) and other required administrators to effectively carry out responsibilities; and
    e. Resources, including space, technology, and supplies, to provide effective support for each of its ACGME-accredited programs.

XI. Resident/Fellow Forum

1. USC/LA General must ensure availability of an organization, council, town hall, or other platform that allows all residents/fellows from within and across USC/LA General's ACGME-accredited programs to communicate and exchange information with other residents/fellows relevant to their ACGME-accredited programs and their learning and working environment.
2. Any resident/fellow from one of USC/LA General's ACGME-accredited programs must have the opportunity to directly raise a concern to the forum.
3. Residents/fellows must have the option, at least in part, to conduct their forum without the DIO, faculty members, or other administrators present.
4. Residents/fellows must have the option to present concerns that arise from discussions at the forum to the DIO and GMEC.

XII. **Resident Salary and Benefits:** USC/LA General , in partnership with its ACGME-accredited programs and participating sites, must provide all residents/fellows with financial support and benefits to ensure that they are able to fulfill the responsibilities of their ACGME-accredited program(s).

XIII. **Educational Tools**

1. Communication resources and technology: Faculty members and residents/fellows must have ready access to adequate communication resources and technological support.
2. Access to medical literature: Faculty members and residents/fellows must have ready access to electronic medical literature databases and specialty-/subspecialty-specific and other appropriate full-text reference material in print or electronic format.

XIV. **Support Services and Systems**:

USC/LA General must provide support services and develop health care delivery systems to minimize residents'/fellows' work that is extraneous to their ACGME-accredited program(s)' educational goals and objectives, and to ensure that residents'/fellows' educational experience is not compromised by excessive reliance on residents/fellows to fulfill non-physician service obligations. These support services and systems must include:

1. Peripheral intravenous access placement, phlebotomy, laboratory, pathology and radiology services and patient transportation services provided in a manner appropriate to and consistent with educational objectives and to support high quality and safe patient care;
2. Medical records available at all participating sites to support high quality and safe patient care, residents'/fellows' education, quality improvement and scholarly activities; and,
3. Institutional processes for ensuring the availability of resources to support residents'/fellows' well-being and education by minimizing impact to clinical assignments resulting from leaves of absence.

XV. **Vendor Policy:** See County Policy 141: Vendor Visiting Policy

SECTION 2: RESIDENT ELIGIBILITY, RECRUITMENT AND SELECTION

1. Each residency program shall select from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Programs must not discriminate with regard to gender, sexual orientation, race, age, religion, color, national origin, disability (see American Disability Act), veteran status or any other applicable legally protected status.

2. In selecting from among qualified applicants for GY-1 positions, all sponsored programs participate in the National Resident Matching Program (NRMP)

3. In selecting from among qualified applicants for positions above the GY-1 level, all of the sponsored programs participate in an organized matching program, where available, such as the National Resident Matching Program (NRMP).

4. Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:

a. Graduates of allopathic medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME.)
b. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
c. Graduates of medical schools outside the United States and Canada who meet the requirements of the Medical Board of California for residency training and meet one of the following qualifications:
    i) Have received a currently valid certificate from the Intealth (Educational Commission for Foreign Medical Graduates) or
    ii) Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.

5. Exceptions: An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed above but who does meet all of the following additional qualifications and conditions as identified in ACGME Common Program Requirements III.A.3:
    i) evaluation by the program director and residency selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of this training; and,
    ii) review and approval of the applicant's exceptional qualifications by the GMEC; and,
    iii) verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification
    iv) applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. .

6. Candidates invited for an Interview: All those invited for an interview must be informed, in writing or electronic means, of the terms, conditions, and benefits of their appointment including financial support, vacation, parental, sick, and other leaves of absence, professional liability, hospitalization, health, disability, and other insurance provided for the residents and their families; and the conditions under which USC/LA General provides call rooms, meals, laundry services or their equivalents.

SECTION 3: APPOINTMENT, NON-RENEWAL, NON-PROMOTION, AND PROGRESSIVE DISCIPLINARY PROCEDURES (SEE SECTION ON DUE PROCESS)

Initial Appointment and Reappointment

The initial appointment is made for one year unless otherwise specified. Reappointment for subsequent years leading to the completion of the residency program is expected and contingent upon satisfactory performance and progress in the residency program as determined by the program director in collaboration with the program's clinical competency committee. Residents will be informed of their program's evaluation and promotion policies.

Non-Renewal of Appointment

Those residents who will not be retained for the succeeding training year will be so informed in writing no later than four months prior to the end of this agreement. If the primary reason (s) for non-renewal occurs within four months prior to the end of this agreement, residents will be notified of intent not to renew as circumstances will reasonably allow prior to the end of this agreement. Residents participating in resident training who do not receive written notice of non-renewal in a timely manner will be renewed for the next postgraduate training year. Residents receiving notice of non-renewal may appeal through the Due Process procedure described in this section.

Non-Promotion to Next Training Level

Residents who will not be promoted to the next level of training for academic reasons will be notified in writing no later than four months prior to the end of this agreement. If the primary reason (s) for non- promotion occurs within four months prior to the end of this agreement, residents will be notified of intent not to promote as circumstances will reasonably allow prior to the end of this agreement. Residents receiving notice of non-promotion may appeal through the Due Process procedure described in this section.

Periodic Evaluation (See Section on Evaluation)

Each resident will undergo periodic evaluation by his/her residency program. Each resident should understand the details of these evaluations, the criteria used, the periodicity of evaluations, those individuals responsible for making evaluations, etc. It is Medical Center policy that the resident may review his/her evaluations.

Due Process

Due process is an established course of proceedings utilized by an individual or group for responding to allegations regarding their behavior and/or academic performance. All County employees are entitled to due process. The right to due process includes entitlement to a full exposition of the reasons and conditions for disciplinary action and the utilization of established grievance procedures. The integrity of grievance procedures as they apply to residents are protected by ACGME Guidelines for Academic Due Process and the Memorandum of Understanding between the County and the CIR. Within the training program, there are two pathways a resident can take to respond to allegations regarding academic performance or non-academic

behavior.

Guidelines for Academic Due Process: A resident should consult these guidelines if he/she receives, or suspects, notification from his/her department of failure to meet academic standards. Notification to the resident that disciplinary action will be undertaken shall include specification of the standard(s) violated or not fulfilled through the residents' action(s) and/or performance. Further, in the case of academic performance, the notification will describe the course of action the resident should undertake to remedy the deficiency. The guidelines for the grievance procedure mandate that prior to the implementation of any disciplinary action leading to termination, a hearing must be convened that allows the resident to present his/her position to department representatives. Following a decision, the resident may appeal, as a final step, to the Medical Director/Chief Medical Officer at the Medical Center.

Should the resident choose to appeal, an independent committee will be appointed, with the specific role of reviewing the matter and making recommendations to the Medical Director/Chief Medical Officer, whose decision is final. The Guidelines are available electronically and can be obtained in the office of the Medical Director/Chief Medical Officer or the Office of Graduate Medical Education.

CIR Memorandum of Understanding -- Grievance Procedures**:** The CIR Grievance Procedures are found in Article 14 of the CIR Memorandum of Understanding. These procedures may be utilized when a resident is threatened with discipline or termination, and if provisions in the CIR Memorandum of Understanding (MOU), such as compensation and benefits, governing personnel practices, and working conditions, have not been granted. The MOU also provides for a Pre-Termination Hearing for the resident. The CIR grievance procedure is a three-step process that may end in binding arbitration. Copies of the CIR Memorandum of Understanding are available in the offices of the Medical Director/Chief Medical Officer, Graduate Medical Education, or Human Resources at the Medical Center, or from the CIR.

SECTION 4: LICENSING REQUIREMENTS

It is the ultimate responsibility of the trainee to obtain the appropriate licensing as a contingency of employment.

For information on licensing requirements:

Allopathic physicians visit the Medical Board of California at https://www.mbc.ca.gov/

Osteopathic physicians visit the Osteopathic Medical Board of California at https://www.ombc.ca.gov/

MEDICAL BOARD OF CALIFORNIA (Allopathic Physicians)

Postgraduate Training License (PTL) (Medical Board of California)

A Postgraduate Training License is issued to an individual who has graduated from an approved medical school, passed all required examinations, has not received either a minimum of 12-months credit (for U.S. or Canadian medical school graduates) or 24-months credit (for international medical school graduates) of Accreditation Council for Graduate Medical Education (ACGME)-accredited postgraduate training if completed in the United States and its territories, or the Royal College of Physicians and Surgeons of Canada (RCPSC) and/or The College of Family Physicians of Canada (CFPC)-accredited postgraduate training if completed in Canada, and is enrolled in a Board-approved California residency program.

To meet the minimum examination requirement for a PTL, you must have taken and passed Steps 1 and 2CK of the USMLE or all parts of the Licentiate of the Medical Council of Canada (LMCC). To transition from a PTL to a physician's and surgeon's license, you must have taken and passed all steps of the USMLE.

Applying for a Postgraduate Training License (PTL)

An applicant may apply for a PTL if they have graduated from a Board-approved medical school (Business and Professions Code (BPC) section 2084), passed all required examinations, enrolled in a California ACGME-accredited residency program, and have not received either 12-months credit (U.S. or Canadian medical school graduates) or 24-months credit (international medical school graduates) of Board-approved postgraduate training.

A PTL is valid for 36 months for all United States, Canadian, and international medical school graduates (BPC section 2064.5(b)) only while enrolled in a California ACGME-accredited postgraduate training program. The PTL is not renewable. A PTL must be obtained within 180 days from beginning a postgraduate training program in California, otherwise, the resident must cease all clinical service at that time until a PTL has been issued by the Board.

The Board may issue a PTL for up to 90 days after a resident has received credit for either 12 or 24 months of Board-approved postgraduate training and continues enrollment in a California ACGME-accredited postgraduate training program. If a Physician's and Surgeon's License is not obtained by the PTL expiration date, the physician must cease all clinical services in California.

The program director may request an extension of the PTL due to a resident's status change. The program director is required to submit a Program Status Update/Change Form, Forms PSU1-PSU2, to the Board within 30 days of any status change. Changes that may affect the PTL expiration date include, but are

not limited to, probation, remediation, leave of absence, transfers, resignation, or termination prior to the program's anticipated end date.

Expedited and Priority Review

The Board may give your application for a PTL priority or expedited review if you:

- Have served as an active-duty member of the United States Armed Forces and were honorably discharged;
- Are going to provide abortions within the scope of practice of your medical license;
- Are a spouse of, domestic partner of, or in another legal union with, an active-duty member of the United States Armed Forces who is assigned to a duty station in California under official active-duty military orders;
- Were admitted to the United States as a Refugee, granted asylum, or have a Special Immigrant Visa Status.

You must submit the required documentation with your application to receive priority review. Please review additional requirements and required supporting documents on the Priority Review and Expedited Application Process on the Medical Board of California Website.

Transition to a Physician's and Surgeon's License

A PTL holder who receives either 12 months (U.S. and Canadian medical school graduates) or 24 months (international medical school graduates) credit of Board-approved postgraduate training with at least four months of general medicine training, may apply for a Physician's and Surgeon's License through the transition process.

To allow sufficient time for processing and remediating deficiencies, the Board strongly encourages you to submit your online Application to Transition from a Postgraduate Training License to a Physician's and Surgeon's License, utilizing BreEZe Online Services, six months prior to receiving 12/24 months of credit from a Board-approved postgraduate training program.

To be eligible for a P&S License, you must have:

- Attended and graduated from a U.S., Canadian, or an international medical school approved by the Board pursuant to Business and Professions Code (BPC) section 2084;
- Received credit for either 12 (United States and Canadian medical school graduates) or 24 (international medical school graduates) months of board-approved postgraduate training (BPC section 2096); and
- Passed all required examinations (BPC section 2170).

Board-approved postgraduate training is training accredited by the Accreditation Council for Graduate Medical Education (ACGME) if completed in the United States and its territories, or the Royal College of Physicians and Surgeons of Canada (RCPSC) and/or The College of Family Physicians of Canada (CFPC) if completed in Canada.

If you have received credit for 12/24 months of Board-approved postgraduate training in another state or in Canada and are accepted into a California ACGME-accredited postgraduate training program, you shall obtain your P&S License within 180 days after beginning your postgraduate training program. If you do not obtain your P&S License, you must cease all clinical service at the end of the 180 days. All clinical service thereafter shall constitute unlicensed practice and you will be subject to disciplinary action. (BPC section 2065(g))

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA (Osteopathic Physicians)

Postgraduate Training License (PTL) (Osteopathic Medical Board)

A Postgraduate Training License (PTL) must be obtained from the Osteopathic Medical Board of California (Board) within 180 days after beginning your American Osteopathic Association (AOA) or Accreditation Committee for Graduate Medical Education (ACGME) accredited postgraduate training program in California. If the PTL is not issued within 180 days of commencing AOA/ACGME-accredited training in California, all clinical activities must cease until the license is issued. Training beyond the 180 days is considered unlicensed practice of medicine and you can be subject to disciplinary action.

The PTL will be valid until 24 months after a resident has received 12 months credit of Board approved postgraduate training, for graduates of medical schools in the United States approved under Business and Professions Code (BPC) section 2084 and section 2084.5. After which a full and unrestricted Physician's and Surgeon's License must be obtained in order to continue practicing medicine in California.

ELIGIBILITY

You must have received your education and graduated from an osteopathic medical school accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA). https://osteopathic.org/accreditation/

- Applicants must have their AOA/ACGME accredited program submit proof of enrollment in a 12-month postgraduate training program; where they will receive at least four months of general medicine and have direct patient care

responsibility.

- Submit proof of completion of the National Board of Osteopathic Medical Examiners (NBOME) COMLEX- USA Exam (Levels 1-2). CCR Title 16 Section 1611 (d)

- Disclosure of a United States Social Security Number (SSN) or an Individual Taxpayer Identification Number (ITIN) is mandatory prior to the issuance of a license. Section 30 of the Business and Professions Code (BPC) authorizes collection of an SSN or ITIN. Section 31(e) of the BPC allows the California Department of Tax and Fee Administration and the Franchise Tax Board to share taxpayer information with the Board.

OSTEOPATHIC PHYSICIAN AND SURGEON'S INITIAL CERTIFICATE

You must obtain an Osteopathic Physician and Surgeon's (P&S) Certificate (certificate/license) from the Osteopathic Medical Board of California (Board) prior to practicing medicine in California. A licensed physician and surgeon may diagnose, prescribe, and administer treatment to individuals suffering from injury or disease. Physicians are authorized to administer and prescribe medication, use devices to sever or penetrate tissues, and to use all methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions.

You must submit your P&S Certificate application online using the BreEZe Online Services portal. Each page of the online application will time out after approximately 15 minutes. To help with the completion of the application, review the "Application Preparation" section to complete each page within the 15-minute time limit, otherwise the system will time out and you will lose your information. Please allow 30 business days to pass before reaching out to the Licensing Unit to inquire on the status of your application.

ELIGIBILITY

- You must have received your education and graduated from an osteopathic medical school accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA). https://osteopathic.org/accreditation/

- To meet the postgraduate training requirement for licensure, you must submit proof of 12 months (1st year) postgraduate training credit reflecting completion of at least four months of general medicine, where there was direct patient care responsibility.

- Submit proof of completion of the National Board of Osteopathic Medical Examiners (NBOME) COMLEX- USA Exam (Levels 1-3); the Federation

Licensing Examination (FLEX) in lieu of COMLEX-USA (Level 3). CCR Title 16 Section 1611 (d)

Dental Resident Requirements

If your training was part of the MD-integrated Oral and Maxillofacial Surgery (OMFS) postgraduate training program, then you must provide evidence of receiving credit for at least 24 months of postgraduate training accredited by the Commission on Dental Accreditation (CODA) to meet the initial renewal requirement. CODA-accredited postgraduate training must be part of an oral and maxillofacial surgery postgraduate training program after receiving a medical degree from a combined dental and medical degree program.

The current program director or the designated institutional official (DIO) must provide a signed and dated Certificate of Completion of ACGME/RCPSC/CFPC Postgraduate Training (Form PTA-PTB) or Certificate of Completion of CODA Postgraduate Training (Form CODA1-CODA2), directly to the Board to verify completion of required training. The Board recommends the program provide this documentation as soon as you complete the required training, rather than waiting until your license expiration date. This will help avoid any delay in processing.

Drug Enforcement Agency (DEA) Controlled Substance Permit

Licensed residents are required to obtain and use their assigned DEA registration number. A copy of this DEA license must be on file in the Office of Graduate Medical Education, in MyEvaluations and the appropriate departmental office. A resident can apply and be issued a controlled substance permit once he or she has obtained a postgraduate training license. For more information, visit the DEA Website https://www.deadiversion.usdoj.gov/

Program Security

It is the Medical Center's obligation to provide the opportunity for continuation and completion of any academic training program for which a resident physician covered under the CIR Memorandum of Understanding is accepted.

In the event of the termination of any residency program for any reason whatsoever, the Medical Center shall make every reasonable effort to place any affected residents in another accredited residency program. The Department of Health Services (DHS) shall make every reasonable effort to place any affected residents in the following order: at another DHS facility; at another accredited program within the Southern California area; or at another accredited program in California or the United States.

SECTION 5: COMPENSATION AND BENEFITS

Salary

Salary and other benefits shall be provided as established by the Los Angeles

County Board of Supervisors, by way of County ordinance and or through an applicable Memorandum of Understanding with the Committee of Interns and Residents (CIR).

Committee of Interns and Residents (CIR)
The Committee of Interns and Residents (CIR), a local affiliate of the nationwide Committee of Interns and Residents (CIR), member AFL-CIO, is the legal bargaining representative for all residents employed by the Los Angeles County. Economic standards, health benefits, program security, due process rights, and other standards of employment are established through the Memorandum of Understanding that is negotiated between the Department of Health Services and CIR. Copies of the Memorandum of Understanding are available through the offices of the Medical Director/Chief Medical Officer, Graduate Medical Education, or Human Resources, or through the CIR.

A periodic membership fee or the equivalent (for residents who chose not to join CIR/CIR) will automatically be deducted (monthly) from each resident's payroll check.

Living Quarters
Living quarters are not provided. The County will provide an annual housing allowance as established by the Los Angeles County Board of Supervisors, by way of County ordinance and or through an applicable Memorandum of Understanding with the Committee of Interns and Residents (CIR).

Laundry
County issued scrubs will be laundered free of charge.

Meals
Three meals per day are provided to residents while they are on duty in a County institution.

Professional Liability Insurance
The County is self-insured and provides liability coverage while working in a County facility. This coverage during the period of employment continues even after leaving County Service ("tail coverage"). Malpractice coverage is provided for residents during rotations to affiliating institutions that are designated as part of the resident training program. Professional liability coverage details will be provided to trainees prior to the start date of resident/fellow appointments; and, written advance notice of any substantial change to the details of professional liability coverage if applicable.

Insurance
The County offers a cafeteria-style benefit program under Internal Revenue Code 125. The program called CHOICES permits flexibility and tax saving advantages for health insurance costs as well as the initiation of spending accounts, health care reimbursements and dependent care reimbursement. The CHOICES program includes health, dental, life, and accidental death and

dismemberment options. If the resident does not enroll in a CHOICES plan within sixty (60) days of employment, he/she must wait until the next open enrollment period to enroll. Coverage is effective sixty to ninety (60 to 90) days after enrollment.

Please understand clearly that this delay of 60 to 90 days in the effective date for your health insurance means that you and any dependents will NOT have health insurance coverage AT THE FIRST RECOGNIZED DAY OF YOUR RESIDENCY OR FELLOWSHIP PROGRAM unless you have your own health insurance AS PER COUNTY CODE, CHAPTER 5.33 SECTIONS 5.33.030A (2) AND 5.33.060A.

These benefits are subject to negotiated change. Enrollment counselors are available on registration and/or orientation days to provide assistance.

Residents who have health, dental, and life insurance coverage prior to beginning County employment should continue this coverage until the CHOICES coverage begins (60 to 90 days after enrollment in the CHOICES plan). For residents who are not able to continue prior coverage, “gap” insurance may be purchased to cover this period.

Health Insurance: Residents are entitled to enroll in one of several programs approved by the County. Dependents are eligible for enrollment. Depending on which plan is selected, a minimal fee is charged.

Dental Insurance: Several dental plans available to choose from.

Life Insurance*:* A term life policy is provided at no cost. Additional life insurance may be purchased for the resident and his/her dependents.

Accidental Death and Dismemberment Insurance: The County offers Accidental Death and Dismemberment coverage as an employee option. This coverage includes the resident, as well as dependents, for a maximum of $250,000 or 10 times the resident’s annual salary, whichever is less.

Disability Insurance: The County provides Long-Term Disability Insurance, administered through the CIR. This coverage is automatic and is provided at no cost to County-employed residents and fellows who are on the County payroll as of July 1. This policy provides group and individual coverage with no sign-up requirements, plus conversion rights. Further information may be obtained by contacting the CIR office.

Vacation

In lieu of other vacation and holiday allowances, persons employed as full-time Physicians, Postgraduate (first through seventh year) who are assigned to a County hospital for any one annual contractual period shall receive 192 hours to be used solely for time off. The 192 hours (i.e., 24 eight-hour workdays) will be posted to the Physicians, Postgraduate (first through seventh year) effective the first day of the employee’s individual contract year. Upon completion of each Physician, Postgraduate year (first year through

seventh year), any remaining hours shall be eliminated from the employee's record unless the Physician, Postgraduate has contracted to another consecutive year of training with the County of Los Angeles.

If the Physician, Postgraduate has contracted to another consecutive year of training, at the end of that consecutive year of training the Physician Postgraduate will have the option to be compensated for a maximum of 80 hours (10 eight hour workdays) of the remaining hours or to request a maximum of 80 hours (10 day eight hour workdays) of the remaining hours be deferred (i.e., carried over) to their next contract year.

The Physician, Postgraduate may defer 10 working days each year the resident contracts to another consecutive year of training with the County of Los Angeles. Whenever the sum of a Physician, Post Graduate deferred leave time exceeds 60 days, the resident shall be compensated for accumulated deferred leave time in excess of 60 days.

Sick Time

Sick time is accrued to a maximum of eight (8) days per year. Residents who have worked at least 12 consecutive months of continuous service and who have not used any sick leave are afforded the opportunity for "cash reimbursement" of up to 24 hours of unused sick leave. The two time periods are from January 1 to June 30 and from July 1 to December 31.

A "Certification for Cash Reimbursement for Unused Sick Leave" form must be submitted for the appropriate time period for which the resident wishes to receive reimbursement. Forms are available in departmental office and must be approved and signed by the resident's supervisor.

Leave of Absence

Should a leave of absence be necessary or desirable for a resident, it is the resident's responsibility to discuss the impact of the leave on the successful completion of the residency program. Any resident contemplating a leave of absence should discuss the issue with his/her program director. The resident must be given reference to the appropriate accrediting bodies to be knowledgeable regarding any constraints placed on training time by either the Program Requirements of the Accreditation Council for Graduate Medical Education, by the training program's specialty board at the American Board of Medical Specialties, or by the Medical Board of California.

Professional Leave

The County does not offer professional leave to residents.

Parental and Caregiver Leave

A resident may take sick leave and vacation as parental/caregiver leave. In compliance with the Family and Medical Leave Act, 12 weeks of unpaid leave may be taken as medical leave, parental leave or to provide care for children, parents, or certain relatives.

ACGME Medical, Parental, and Caregiver Leave (Effective July 1, 2022)

Residents/fellows will be provided with a minimum of six weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program, starting the day the resident/fellow is required to report (IV.H.1.a.)

Residents/fellows will be provided with at least the equivalent of 100 percent of their salary for the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken (IV.H.1.b)

Residents/fellows will receive 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 (IV.H.1.c)

Health and disability insurance benefits are ensured for residents/fellows and their eligible dependents during any approved medical, parental, or caregiver leave(s) of absence (IV.H.1.d)

The policy for submitting and approving requests for leaves of absence is available in the Office of Graduate Medical Education and is available for review by residents/fellows at all times upon request. (IV.H.1.e; IV.H.1.f)

Effect of Leave on Duration of Training and Board Eligibility

Absence from the training program for any reason, including leaves described in this section, may affect the overall duration of the residency training necessary to meet the ACGME or Specialty Board criteria for completion of training. The resident's program will provide written policy in compliance with its Program Requirements concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program and information relating to access to eligibility for certification by the relevant certifying board. Information regarding Board eligibility can be found at: www.abms.org.

Call Rooms

When on duty overnight, residents are expected to use the designated Call Rooms of the Medical Center that are provided at no charge.

Parking

Parking at no cost is provided, but not guaranteed, in designated areas by the Medical Center. If hospital parking is used, the resident assumes the responsibility for any loss or damage to his/her vehicle and/or its contents, i.e., personal liability coverage. Violation of parking rules will result in citations, and repeated violations will result in termination of the resident's parking privileges.

Travel Expenses

There are no provisions for the reimbursement for travel or other expenses

when assigned to an affiliate hospital, clinic, or other designated training facility as part of the training program.

Specialty In-Service Training Examinations
If required by the Residency Program, residents must take prescribed specialty/subspecialty specific in- service training examinations at specified times. These examinations are given at no cost to the resident.

Loss or Damage to Personal Property
The County assumes no liability for loss or damage to personal property that is suffered by its employees or affiliates while at the Medical Center.

Pagers
Pagers will be provided to all residents. A replacement fee of $100 will be charged. The fee may be waived if the loss is due to conditions identified in the Memorandum of Understanding with the County.

Counseling and Support Services
Counseling and support services are available through the Office of Graduate Medical Education at no cost to the resident on an appointment basis and at the Medical Center. Consult Graduate Medical Education for more details.

SECTION VI. COUNTY EMPLOYMENT POLICIES

Live Scan
Employment with the Department of Health Services is contingent upon passing a Live Scan criminal background investigation, a review, verification, and clearance of prior work history.

Social Security Numbers
A Social Security Number is required for County employment.

Physical Examinations
Incoming house staff must receive clearance of a pre-employment medical examination before beginning training. Annual reexamination is a condition of continuing employment.

SARS-CoV-2 (COVID-19) Vaccination and Booster Requirement
Residents must show proof of the SARS-CoV-2 (COVID-19) vaccine and booster prior to beginning training as a contingency of employment.

INS I-9 Documentation
For employment purposes, Federal Law requires the County to obtain documented proof of employment eligibility to work in the United States from all employees upon registering with the Human Resources office.

Visa Status
It is the responsibility of residents who are not U.S. citizens to have a valid J-1 visa or J-1 visa renewal before beginning or continuing training at the Medical Center. It is the resident's responsibility to obtain the necessary documentation. Failure to have a valid visa or visa renewal will result in suspension of employment without pay and/or termination from the

residency program.

Pay Procedure
Residents are responsible for submitting their own timecard twice a month in order to receive their paycheck or direct deposit paystub. County employees are paid monthly on the 15th of every month. However, if the resident signs up for direct deposit, paychecks are deposited directly to his/her bank account on the 15th and 30th of each month.

The first payday for GY-1 residents commencing employment on June 24 will be on July 15 for the six days worked in June (June 24-30). The next regular payday will be August 15 for the entire month of July unless the resident is on “direct deposit”. Residents registered for “direct deposit” will be paid for the first 15 days of July on July 30. Residents wishing to sign up for direct deposit should bring a blank check with the word “VOID” written on the face to registration/orientation. If the resident has a credit union checking account, a form must be completed instead of writing “VOID” on the blank check.

The direct deposit request form must be submitted by June 30 for those residents starting on June 24 in order to receive a check on July 30. For residents starting July 1, the form must be received by July 14.

Professional Activities Outside the Educational Program
The County limits outside employment to 96 hours per month. However, each residency program establishes individual policies regarding outside employment. It is the responsibility of the resident to be aware of the program’s policy. Annually, residents must complete a “Report of Outside Employment” form provided by the Human Resources office.

Electives
Residents may only engage in rotations assigned by the program director for which there is a Master Affiliation Agreement and Letter of Agreement. Rotations outside of non-County facilities require the receiving facility to provide malpractice insurance.

Sexual Harassment and Exploitation Policies
Sexual harassment is an illegal and prohibited behavior. It is a violation of the Federal Civil Rights Act of 1964, Title VII, as well as Los Angeles County Department of Health Services and Medical Center policies. The Medical Center also strictly prohibits unlawful harassment because of race, religious creed, color, national origin, ancestry, physical handicap, medical condition, marital status, sex, or age. Actions by any County employee that are in violation of these policies shall be subject to immediate and appropriate disciplinary action (up to and including discharge). Detailed procedures for residents who feel that they have been harassed or sexually harassed are available through the Medical Director or Chief Medical Officer’s Office or the Office of Human Resources or the Office of Graduate Medical Education.

Substance Abuse Policy
It is the policy of the Medical Center's graduate medical education programs that the abuse of drugs, including alcohol, by residents is unacceptable because it adversely affects health, safety, security, and progress in the training programs. Further, it jeopardizes public confidence and trust.

Using, possessing, selling, or being under the influence of illegal drugs by residents is unlawful, dangerous, and is absolutely prohibited in the workplace. Further, the use of alcohol in the workplace or the misuse of alcohol or prescribed drugs to any extent that impairs safe and effective performance by residents is prohibited. Violation of any element of this policy shall result in disciplinary action, up to and including termination.

The Medical Center's Graduate Medical Education Committee recognizes drug and alcohol dependency as treatable illnesses. Residents with dependency problems are encouraged to seek assistance through their program director, the Director of Graduate Medical Education, or Mental Health Services for Physicians in Training. Information obtained regarding a resident during participation in counseling or psychological services will be treated as confidential, in accordance with Federal and State laws.

Services Rendered
Any form of payment to residents for services rendered to patients as part of their training program is not permitted.

Loyalty Oath
As a condition of employment, County employees must be willing to take a Loyalty Oath that reads as follows:

"YOUR NAME, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter."

Soliciting Business for Attorneys (Capping)
It is illegal for County employees to solicit business for attorneys, on or off County property. To do so is illegal under Sections 6151, 6152, and 6153 of the Business and Professions Code of the State of California.

Conflict of Interest
It is illegal for a person employed in a full-time position in the County Service to engage, outside of his/her regular working hours, in any gainful profession, trade, business or occupation whatsoever for any person, firm, corporation or governmental entity, or be so engaged in his/her own behalf, which profession, trade, business or occupation is incompatible or involves a conflict of interest with his/her duties as a County Officer or employee, or with the duties, functions or responsibility of his/her appointing officer or of

the department by which he/she is employed.

SECTION VII. RESTRICTIVE COVENANTS

Residents shall not be required to sign non-competition guarantees or restrictive covenant.

SECTION 8: MAINTENANCE OF PERSONAL AND ACADEMIC RECORDS

The administrative offices of the programs will be responsible to maintain personnel records and academic records for all residents enrolled in the department's residency program(s). These records shall include:

1. Dates of training
2. Credentials of the residents:
   a. Copies of diploma(s)
   b. California Medical Licenses
   c. ECFMG certificate, if applicable
   d. Visa documents, if applicable
   e. Training certificate(s) issued to the resident
3. Curriculum Vitae (CV)
4. Academic Records
   a. Evaluations of resident performance on assigned rotations
   b. Semiannual feedback from Program Director to each resident
   c. Final summative evaluation of the resident
   d. Disciplinary action, if any, and outcome and /or resolution.
   e. Schedules of residents assignments per rotation at USC/LA General and participating institutions.

SECTION 9: GENERAL RESPONSIBILITIES FOR RESIDENTS

1. The resident must take advantage of all aspects of the educational opportunities that are listed in the Medical Center Responsibilities (see section II below).
2. The resident must comply with the Accreditation Council for Graduate Medical Education (ACGME) Institutional, Common Program and their Specialty/Subspecialty Program Requirements.
3. The resident must comply with the requirements for licensure by the Medical Board of California (MD graduates) or the Osteopathic Medical Board of California (DO graduates). Residents who fail to become licensed within the period provided by California law will be terminated from their training program. The resident is responsible for maintaining a current, valid license at all times as appropriate for their year of training.
4. Licensed residents are required to obtain and use their assigned DEA registration number. A copy of this DEA license must be on file in the Office of Graduate Medical Education and the appropriate departmental office.
5. Outside employment must be approved in writing by the Program Director and must

not interfere with the requirements of the residency program and the performance of the resident. Permission for outside employment can be revoked at any time.

6. The resident must complete all medical records within 14 days. This includes, but is not limited to, admission history, physical examination, progress notes, orders, operative reports, radiologic reports, and written and dictated discharge summaries. Failure to comply with this requirement may result in disciplinary action with documentation that becomes a part of the resident's permanent record and may be conveyed to future employers, medical staff offices, or hospital privileges committees.
7. The resident must return all patient charts to the Medical Records Department and films to the Radiology Department in a timely manner. Failure to comply with this requirement may lead to disciplinary action.
8. The resident must adhere to all applicable County policies and procedures.
9. Residents are expected to participate in institutional, departmental, divisional, and interdisciplinary quality assurance/improvement and patient safety activities. Any breach of confidentiality concerning these activities may result in disciplinary action.
10. Residents should contact their program, the Office of Graduate Medical Education, Human Resources and/or the Committee of Interns and Residents (CIR) for any questions regarding policies affecting their appointment.

SECTION 10: MEDICAL CENTER RESPONSIBILITIES

The Medical Center agrees to provide each resident with the opportunity to:

1. Participate in safe, effective, and compassionate patient care under supervision, appropriate with the resident's level of advancement and responsibility.
2. Participate fully in the educational and scholarly activities of the program and as required, assume responsibility for teaching and supervising other residents and students.
3. Participate as appropriate in Medical Center programs and medical staff activities and adhere to established practices, procedures, and policies of the Medical Center and affiliating institutions.
4. Have appropriate resident representation on Medical Center committees and councils, whose actions affect the resident's education and or patient care.
5. Submit to the training program director at least annually confidential written evaluations of the faculty and of the educational experience.
6. Have training in BCLS and ACLS; and specialized training in PALS, NALS, and ATLS as applicable to the specialty.
7. Have electronic access to their academic and personnel files during their training period.

SECTION 11: EVALUATIONS:

The following evaluation requirements are aligned with the prevailing ACGME Common Requirements for residents effective July 1, 2023. Refer to www.acgme.org for more specific residency/specialty and sub-specialty fellowship requirements.

V.A. Resident Evaluation

V.A.1. Feedback and Evaluation

V.A.1.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)

V.A.1.b) Evaluation must be documented at the completion of the assignment. (Core)

V.A.1.b).(1) For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)

V.A.1.b).(2) Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)

V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)

V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)

V.A.1.c).(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)

V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.1.d).(1) meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)

V.A.1.d).(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)

V.A.1.d).(3) develop plans for residents failing to progress, following institutional policies and procedures. (Core)

.

V.A.1.e) At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)

V.A.1.f) The evaluations of a resident's performance must be accessible for review by the resident. (Core)

[The Review Committee may further specify under any requirement in V.A.1.-V.A.1.f)]

V.A.2. Final Evaluation

V.A.2.a) The program director must provide a final evaluation for each resident upon completion of the program. (Core)

V.A.2.a).(1) The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)

V.A.2.a).(2) The final evaluation must:

V.A.2.a).(2).(a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)

V.A.2.a).(2).(b) verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)

V.A.2.a).(2).(c) be shared with the resident upon completion of the program. (Core)

V.A.3. A Clinical Competency Committee must be appointed by the program director. (Core)

V.A.3.a) At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)

V.A.3.a).(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)

V.A.3.b) The Clinical Competency Committee must:

V.A.3.b).(1) review all resident evaluations at least semi-annually; (Core)

V.A.3.b).(2) determine each resident's progress on

achievement of the specialty-specific Milestones; and, (Core)
V.A.3.b).(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)

V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a Core faculty member, and at least one resident. (Core)

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b).(1) review of the program's self-determined goals and progress toward meeting them; (Core)
V.C.1.b).(2) guiding ongoing program improvement, including development of new goals, based upon outcomes;
and, (Core)
V.C.1.b).(3) review of the current operating environment to identify strengths, challenges, opportunities, and threats as

related to the program's mission and aims. (Core)

V.C.1.c) The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core). Other data to be considered for assessment include:

- Curriculum
- ACGME letters of notification, including citations, Areas for Improvement, and comments
- Quality and safety of patient care
- Aggregate resident and faculty well-being; recruitment and retention; workforce diversity, including graduate medical education staff and other relevant academic community members; engagement in quality improvement and patient safety; and scholarly activity
- ACGME Resident and Faculty Survey results
- Aggregate resident Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance.
- Aggregate faculty evaluation and professional development

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.1.e) The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)

V.C.2. The program must complete a Self-Study only if required by the ACGME and submit it to the DIO. (Core)

V.C.3. One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

[If certification in the specialty is not offered by the ABMS and/or the AOA, V.C.3.a)-V.C.3.f) will be omitted.]

V.C.3.a) For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those

taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

V.C.3.b) For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

V.C.3.c) For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

V.C.3.d) For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

V.C.3.e) For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)

V.C.3.f) Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)

SECTION 12: THE LEARNING AND WORKING ENVIRONMENT (adopted from ACGME Common Program Requirements effective with reference to the prevailing ACGME requirement effective July 1, 2023)

A. INTRODUCTION

The Los Angeles General Medical Center (Formerly USC/LAC+USC Medical Center) places patient safety as a top priority. Physicians (residents and faculty) have a personal responsibility to appear for duty appropriately rested and fit to provide the services required by their patients. We promote patient safety and resident well-being in an educational environment that is supportive and safe. We endorse a culture of professionalism that supports patient safety and personal responsibility. All residents and faculty must understand and accept:

a) assurance of the safety and welfare of patients entrusted to their care.

b) provision of patient- and family-centered care.

c) assurance of their fitness for duty.

d) management of their time before, during, and after clinical assignments.

e) recognition of impairment, including illness and fatigue, in themselves and in their peers.

f) attention to lifelong learning.

g) the monitoring of their patient care performance improvement indicators; and,

h) honest and accurate reporting of clinical and educational hours, patient outcomes, and clinical experience data.

All physicians must be responsive to patient needs. This need supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

All residents and faculty are educated regarding the signs and symptoms of resident fatigue and sleep- deprivation as well as standards of professional conduct.

Clinical and Educational Work Hours

The Los Angeles General Medical Center (Formerly USC/LAC+USC Medical Center) maintains a clinical and educational work hour policy that ensures effective oversight of institutional and program-level compliance with ACGME clinical and educational work hour requirements. The Institution, the resident training programs, and the Graduate Medical Education Committee regularly assess compliance with ACGME clinical and educational hour requirements as per policy County Policy #551.1.

B. POLICIES AND PROCEDURES IN THE LEARNING ENVIRONMENT

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a).(2) Patient Safety Events
Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(2).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(2).(a).(i) know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core)

VI.A.1.a).(2).(a).(ii) be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a).(2).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a).(3) Quality Metrics
Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.a).(3).(a) Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)
[The Review Committee may further specify]

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

Background and Intent: Each patient will have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.

VI.A.2.a).(2) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

[The Review Committee may specify which activities require different levels of supervision.]

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident-patient interactions, training locations, and resident skills and abilities, even at the same level of the educational program. The degree of supervision for a resident is expected to evolve progressively as the resident gains more experience, even with the same patient condition or procedure. The level of supervision for each resident is commensurate with that resident's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables.

VI.A.2.b) Levels of Supervision
To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

VI.A.2.b).(1) Direct Supervision:

VI.A.2.b).(1).(a) the supervising physician is physically present with the resident during the key portions of the patient interaction; or, [The Review Committee may further specify]

VI.A.2.b).(1).(a).(i) PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a). (Core)

[The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]

VI.A.2.b).(1).(b) the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

[The RC may choose not to permit this requirement. The Review Committee may further specify]

VI.A.2.b).(2) Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

VI.A.2.b).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

VI.A.2.c) The program must define when physical presence of a supervising physician is required. (Core)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)

VI.A.2.d).(1) The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d).(2) Faculty members functioning as supervising

physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)

VI.A.2.d).(3) Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core). At a minimum these guidelines must include:

a. Code Blue, Code White, Code OB, Rapid Response Team (RRT) activation, or Code Stroke activation
b. Transfer to ICU
c. Any unexpected critical result
d. Unanticipated patient death
e. Unanticipated transfusion of blood products
f. Attending staff (any) request that the attending be contacted
g. Patient and/or family requests to speak to the supervising attending
h. For any urgent questions residents might have about their patient/patient care

VI.A.2.e).(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with USC/LAGMC, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by

their patients. (Core)

Background and Intent: This requirement emphasizes the professional responsibility of residents and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of residents, faculty members, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies. This includes recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested practitioner.

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished without excessive reliance on residents to fulfill non-physician obligations; (Core)

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

VI.B.2.b) ensure manageable patient care responsibilities; and, (Core) [The Review Committee may further specify]

Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

VI.B.2.c) include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing

professional relationships. (Core)

VI.B.3. The program director, in partnership with USC/LAGMC, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, residents, and faculty.

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)

VI.B.5. Programs, in partnership with USC/LAGMC, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)

VI.B.5.a Residents, Faculty and Staff members are encouraged to report and any persons in a supervisory position are required to report any issues referenced in VI.B.5 to the GMEC's subcommittee for Sexual Assault/Harassment, Fairness and Equity (SAFE), Human Resources and/or to the DIO through the hotline (323-409-LINE), email or cell phone or to the CEO, CMO, Dean, Program Director, Faculty, Ombudsperson or to the ACGME Office of Resident Complaints or the ACGME Office of the Ombuds.

Background and Intent: Psychological safety is defined as 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. The ACGME is unable to adjudicate disputes between individuals, including residents, faculty members, and staff members. However, information that suggests a pattern of behavior that violates the requirement above will trigger a careful review and, if deemed appropriate, action by the Review Committee and/or ACGME, in accordance with ACGME Policies and Procedures.

VI.B.6. Programs, in partnership with USC/LAGMC, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training. Residents and faculty members are at risk for burnout and depression. Programs, in partnership with USC/LAGMC, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.

VI.C.1. The responsibility of the program, in partnership with the USC/LAGMC, must include:

VI.C.1.a) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.b) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

Background and Intent: This requirement emphasizes the responsibility shared by USC/LAGMC and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after safety events.

VI.C.1.c) policies and programs that encourage optimal resident and faculty member well-being; and, (Core)

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise. The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

VI.C.1.c).(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments,

including those scheduled during their working hours. (Core)

VI.C.1.d) education of residents and faculty members in:

VI.C.1.d).(1) identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)

VI.C.1.d).(2) recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)

VI.C.1.d).(3) access to appropriate tools for self-screening. (Core)

Background and Intent: Programs and Sponsoring Institution are encouraged to review materials to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available in Learn at ACGME (https://dl.acgme.org/pages/well-being-tools-resources). Individuals experiencing burnout, depression, a substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions and may be concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness/well-being programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

VI.C.1.e) providing 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. (Core).
Reporting: In the event a resident/fellow or faculty is suspected of impairment, it is the responsibility of other residents/fellows and faculty to report such suspicion to the program director, DIO, and human resources who will be responsible for following the impairment policy.

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement. The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

VI.D. Fatigue Mitigation

VI.D.1. Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies. Strategies that may be used include but are not limited to strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness;

maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

VI.D.2. The program, in partnership with USC/LAGMC, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities: The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core). [Optimal clinical workload may be further specified by each Review Committee]

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. It is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

VI.E.2. Teamwork Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core) [The Review Committee may further specify]

Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with USC/LAGMC, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-off process.(Outcome)

VI.F. Clinical Experience and Education Hours

Programs, in partnership with USC/LAGMC, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

Background and Intent: The terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These terms are used in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that residents’ duty to “clock out” on time superseded their duty to their patients.

> VI.F.1. Maximum Hours of Clinical and Educational Work per Week: Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks. Work from Home: While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day’s cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident’s supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical

work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

Background and Intent: There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This occurs within the context of the 80-hour and the one day-off-in-seven requirements. While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

VI.F.2.b) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

VI.F.2.c) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted

as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as “one (1) continuous 24-hour period free from all administrative, clinical, and educational activities.”

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient’s family; or to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return

beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

VI.F.4.c) Exceptions: the GMEC does not allow exceptions.

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core). Moonlighting must be approved in writing by the program director and can be revoked at any time in there is interference with the resident's fitness for work, compromise of patient safety or academic underperformance.

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core). Moonlighting can not exceed 24 hours per week or 96 hours per month. County malpractice only covers moonlighting performed in Los Angeles County owned and/or operated facilities.

VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

VI.F.6. In-House Night Float
Night float must occur within the context of the 80-hour and one day-off-in-seven requirements. (Core) [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

VI.F.7. Maximum In-House On-Call Frequency
Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every third-night limitation, but must satisfy the requirement for one day in seven free

of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core) [The Review Committee may further specify under any requirement in VI.F.]

Background and Intent: As noted in VI.F.1., clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This acknowledges the often-significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.
In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

SECTION 13: RESIDENCY CLOSURE/REDUCTION/DISASTERS/DISRUPTION

1. Residency Closure/reduction
    - **a.** Notification: In the event that USC/LA General Center intends to reduce the size of a residency program or to close a residency program or the Institution, USC/LA General as the Sponsoring Institution will inform the following as soon as possible:
        - **i.** ACGME
        - **ii.** GMEC
        - **iii.** DIO
        - **iv.** All affected residents/fellow
        - **v.** Resident/Fellow Union(s)
    - **b.** Responsibilities:
        - **i.** In the event of such a reduction, closure, USC/LA General in collaboration with the County of Los Angeles and/or Keck School of Medicine will make every effort to allow residents already in the program or the Institution to complete their education.
        - **ii.** If any resident(s) are displaced by the closure of the Institution, a program (s), or a reduction in the number of residents, every effort will be made to allow residents already in a residency/fellowship training program in USC/LA General to complete their education or assist the residents/fellows in identifying and enrolling in an ACGME accredited program in which they can continue their education.
        - **iii.** USC/LA General will make every effort to ensure that salaries and benefits are provided by USC/LA General while in residency/fellowship training or salaries and benefits are paid by

the Sponsoring Institution to which the residents/fellows are transferred but only until completion of training in the specialty/sub-specialty in which they were currently training.

2. Residency Disruption/Disaster
    a. Notification: In the event of a disruption in training as a result of a disaster, other causes of interruption in patient care or other unforeseen circumstances, USC/LA General will notify as soon as possible the following:
        i. ACGME
        ii. GMEC
        iii. DIO
        iv. All affected residents/fellow
        v. Resident/Fellow Union(s)
    b. Responsibilities
        i. USC/LA General will continue to provide resident salaries and benefits.
        ii. USC/LA General will make every effort to continue resident/fellow assignments within USC/LA General, one of its participating sites and/or another ACGME Sponsoring Institution that can provide equivalent training.

SECTION 14: GUIDELINES FOR DISCIPLINE AND GRIEVANCE RESOLUTION FOR RESIDENT PHYSICIAN

C. POLICIES AND PROCEDURES TO BE USED FOR DISCIPLINE AND GRIEVANCES

These guidelines are intended to assist resident physicians and resident training Program Directors in carrying out appropriate disciplinary procedures whenever performance or behavioral problems arise and to ensure that due process is afforded all parties in the event of disputes over personnel policy or practice.

Residents Employed by County of Los Angeles	*Residents Employed by University of Southern California*
1. ***County of Los Angeles Personnel Policies*** All resident physicians employed by the County of Los Angeles work under the overall policies described in this document. Issues such as working conditions, harassment, discrimination, employees' behavior, absenteeism, illness, insubordination, etc. are covered in a General manner in this manual. Residents alleged to have problems in these areas should be handled in accordance with the procedures outlined herein. A copy is available for reference in the Office of Graduate Medical Education.	1. **University of Southern California Personnel Policies** All resident physicians employed by the University of Southern California work under the overall policies described in this document. Issues such as working conditions, harassment, discrimination, employee behavior, absenteeism, illness, insubordination, etc. are covered in a General manner in this manual. Residents alleged to have problems in these areas should be handled in accordance with the procedures outlined herein. A copy is available for reference in the Office of Graduate Medical Education.
2. **Memorandum of Understanding (MOU) between the Los Angeles County Committee of Interns and Residents (CIR) and the County of Los Angeles** This document addresses issues specific to the resident physician such as vacation time, leave of absence, and educational leave, etc. Resident salaries and other similar specific issues are addressed in this document. A copy of the CIR MOU is available for reference in the Office of Graduate Medical Education. The GME staff and the LA GENERAL Office of Human Resources can assist a resident with specific questions.	2. **Resident Physician Contracts** Issues such as vacation time, leave of absence, educational leave, and resident salaries, fringe benefits, and other conditions of employment are addressed in the Resident Physician Contract between USC and the residents employed by USC.

3. Physician Postgraduate (Resident Physician) Personnel Policy and Procedure Manual and LA GENERAL Medical Center Medical Staff Manual. These documents describe specific areas of professional responsibility with which both resident physicians and Medical Staff Physicians must comply. Examples of these areas include specific patient care issues, licensure requirements, on-call duties, and maintenance of medical records. As employees of Los Angeles County assigned to the LA GENERAL Medical Center, residents are expected to adhere to these policies.	**3. Medical Staff Manuals and Policy and Procedure Manuals of Facilities to which Residents are assigned** Specific areas of professional responsibility with which both resident physicians and medical staff physicians must comply are described in Medical Staff Manuals and Policy and Procedure Manuals of facilities to which residents are assigned as part of the educational curriculum of their residency program. Examples of these areas include specific patient care issues, licensure requirements, and on-call records. As physicians practicing under the direction of faculty in each of the facilities, residents are expected to adhere to these policies of the healthcare facilities.

1. Department Resident Training Policy Manual

Based upon ACGME requirements for accreditation of residency training programs, each department with a training program must have a document that outlines basic academic standards that its residents must maintain in order to achieve satisfactory completion of the program. In any dispute about the medical knowledge, clinical judgment, quality of patient care or professional conduct of the resident, the resident should consult his/her specific departmental training policy manual.

D. PROCEDURES FOR DISCIPLINE AND DUE PROCESS

1. Purpose and Intent

These guidelines state the General practices and policies of LA GENERAL Medical Center and the University of Southern California regarding resident discipline. These guidelines are designed to assist Program Directors and managers in determining when and how to impose discipline and to inform residents of the Medical Center's and Keck School of Medicine's policies and practices in this area. To the extent feasible and practical, the intent is to have a single policy and procedure for discipline of residents. Where the policies of the two institutional sponsors, LA GENERAL Medical Center, and Keck School of Medicine, cannot be resolved into a single policy, the separate policies are shown side by side.

The purpose of discipline is to ensure the quality of care for patients and resident adherence to acceptable and reasonable standards of performance and conduct.

The application of these guidelines requires the consideration of many factors and the use of good judgment. While these guidelines list factors to be considered in discipline matters, they should be used in consultation with the Director of Graduate Medical Education and/or the Office of Human Resources.

2. Non-disciplinary Action

Not all inappropriate behavior will require the imposition of discipline. In some cases non-disciplinary actions such as counseling may be appropriate. The purpose to non-disciplinary action is to inform the resident of a potential problem and to help correct the problem before it becomes significant.

Some examples of non-disciplinary actions are: counseling the resident about work and or performance problems before they become significant, i.e., leaving the work area without permission, not answering pages, unexcused absences or re-training to improve performance. Non-disciplinary actions should occur as soon as possible after the unacceptable behavior or poor performance is first noted.

3. Disciplinary Action

A. Unacceptable Off-the-job conduct

Normally, employees cannot be disciplined for misconduct that occurs while off the job.**esidents Employed by LA GENERAL Medical Center.** Any unacceptable behavior or conduct by residents while off duty in which common sense dictates as unprofessional or which may affect or reflect negatively on the resident's department, the Medical Center, the Department of Health Services, or the County of Los Angeles, may subject a resident to discipline. Off-the-job conduct may also subject a resident to discipline when it is deleterious to the Civil Service system or County government without being specifically related to a particular job. For example, a resident who falsifies a resume, or cheats on a Civil Service examination application, is subject to disciplinary action, including termination.	**Residents Employed by the Keck School of Medicine.** Any unacceptable behavior or conduct by residents while off duty, which common sense dictates as unprofessional or which may affect or reflect negatively on the resident's department, the Keck School of Medicine, or the University of Southern California, may subject a resident to discipline.

B. Unacceptable On-the-Job Conduct

Unacceptable on-the-job behavior encompasses failure of a resident to perform his/her assigned duties so as to meet stated or implied standards of performance.

Unacceptable behavior or conduct may include, but is not limited to, qualitative as well as quantitative elements of performance, such as failure to exercise sound judgement, failure of a resident to follow instructions or to comply with policies and procedures of his/her employer (County and Medical Center or University of Southern California, as the case may be), failure to report information accurately and completely, failure to deal effectively with the public, and failure to make productive use of human, financial and other assigned resources.

C. Progressive Discipline

The paramount concern and overriding consideration in all discipline matters is the potential for harm to patients and quality of care for the patient.

Considerations regarding the circumstances surrounding any misconduct and the likelihood of its recurrence are also relevant. The imposition of discipline should be consistent with the concept of progressive discipline, if appropriate.

The degree of discipline imposed must be determined by the specific circumstances of each case. The disciplinary steps from least to most severe are: preliminary warning, final warning, institutional probation and termination. The most severe disciplinary sanction, termination can be imposed upon a single incident, if appropriate. It is not necessary to impose every level of discipline before imposing a given level.

D. Non-Progressive Discipline

Circumstances in some situations may require bypassing progressive discipline.

Conduct, which may not be appropriate for progressive discipline, is conduct that a resident should know to be unacceptable without specific notice from the resident's employer. This includes behavior such as dishonesty, illegal conduct, or any conduct that places the Medical Center or other facility, to which the training Program Director may assign the resident, in violation of any state, federal law or court order.

The seriousness of the conduct, the frequency of its occurrences, and the attitude of the employee regarding the conduct are among factors that may require non-progressive discipline.

These acts may result in termination without consideration of prior service or imposition of previous discipline.

4. Multiple Violations

There are situations in which separate and distinct violations may occur within a single incident. All violations should be considered in determining the appropriate level of discipline to be imposed.

5. Steps for Discipline

The imposition of the proper discipline stems from a determination of the facts, an evaluation of whether the facts reflect the employee misconduct, a judgement on the significance of the misconduct and the proper disciplinary

action response. The determination of the facts always involves an investigation by the Program Director.

Residents employed by LA GENERAL Medical Center.	**Residents Employed by the Keck School of Medicine.**
Conducting an investigation may also require management to involve one of the following: the Office of Graduate Medical Education, the Office of Human Resources staff, the Department of Health Services Inspections and Audits Division, the County Department of Auditor-Controller, the County Sheriff's Department or other local, state, or federal law enforcement agencies. Allegations of resident misconduct involving patient care shall be reported to the chief of Staff/Medical Director of the facility where the incident occurred. The Chief of Staff will decide whether the investigation of the alleged misconduct should involve others in addition to the resident's Program Director. Please note: Involving anyone else except the Office of Graduate Medical Education and the Office of Human Resources is to be coordinated through the Office of Human Resources. The extent of the investigation is determined by the nature and seriousness of the allegations, performance problem or misconduct. An evaluation of the facts shall be done prior to the imposition of any discipline. Any alleged misconduct must be analyzed and investigated. Misconduct may result from violation(s) of Civil Service Rules, County policies, departmental policies, Medical Center policies, state or federal law, local ordinances, court orders, or implied or specified standards of professional behavior.	Conducting an investigation may also require management to involve one of the following: the Office of Graduate Medical Education, the Office of Human Resources staff, and other investigative agencies that may be appropriate to the circumstances of the incident. Allegations of resident misconduct involving patient care shall be reported to the Chief of Staff/Medical Director of the facility where the incident occurred. The Chief of Staff will decide whether the investigation of the alleged misconduct should involve others in addition to the resident's Program Director.

Disciplining an employee should be an impartial step taken with the intent of correcting the misconduct or poor performance before it becomes more severe or an incorrigible pattern. Discipline should be imposed as soon as possible after the incident or problem occurred.

Finally, the judgment of whether discipline is appropriate should be based upon several factors.

Residents Employed by LA GENERAL Medical Center.	**Residents Employed by the Keck School of Medicine.**
a. Seriousness of the offense, the impact, actual or potential, upon the Medical Center and/or the community; b. The length of service and overall performance of the resident; c. The attitude and the culpability of the resident; and d. Previous discipline and the length of time since imposed.	a. Seriousness of the offense, the impact, actual or potential, upon the University and /or the community; b. The length of service and overall performance of the resident; c. The attitude and the culpability of the resident; and d. Previous discipline and the length of time since imposed.

6. Levels of Discipline

When a Program Director identifies a resident performance problem (academic or other professional performance inclusive of behavioral issues) that could lead to failure to meet acceptable standards by the end of the academic year, the department should give the resident ***written*** notification of the deficiencies and to outline a plan of correction.

The following process should be followed in monitoring the competency of any resident. In most, but not every instance, all steps should be used in sequence. The ***recommendation for immediate removal from the job*** (summary suspension) should be reserved for issues of gross professional misconduct such as abandonment of patient care, forging prescriptions, and similar misdeeds.

A. Preliminary Warning

A written Preliminary Warning is normally issued when an incident and/or deficiency impact upon departmental operation, either academic or non-academic, or when prior actions have not corrected the pattern of behavior or performance. Examples of problems that may lead to such action include but are not limited to: unexcused absences, deficiencies in medical knowledge

and/or clinical judgment, failure to seek help when needed, etc.

The written warning must state that it is a “preliminary warning” letter and contain the following elements:

1. Describe or document the misconduct and its lack of acceptability;
2. The written warning must detail the deficiencies in behavioral, academic and/or clinical performance for or on which the resident failed to meet the acceptable standards and the impact this deficiency had on this performance.
3. Identify previous counseling or discipline;
4. Reference the expectations for future performance or conduct;
5. Identify the disciplinary consequences of repetition, continuation, or lack of improvement.
6. Incorporate the resident’s stated reasons for his or her action; and
7. Request the resident to sign and date the document. This acknowledges only that the resident has received the document. If the resident refuses to sign, the Program Director should request that another management employee be present to witness the refusal of the resident to sign for the document. The Program Director should amend the document to include a notation that the resident refused to sign. The Program Director, and the management representative, should then affix their signature and date to the document directly below the notation.

A resident is entitled to file a written grievance at any step during this process (See Grievance Procedure).

B. Final Warning

A written Final Warning usually is the second phase of progressive discipline. The elements of the letter of Final Warning are the same as the letter of Preliminary Warning.

The written warning must state that it is a letter of “final warning” and contain the following elements:

1. Describe or document the misconduct and its lack of acceptability;
2. The written warning must detail the deficiencies in behavioral, academic and/or clinical performance for or on which the resident failed to meet the acceptable standards and the impact this deficiency had on this performance.
3. Identify previous counseling or discipline;
4. Reference the expectations for future performance or conduct;
5. Identify the disciplinary consequences of repetition, continuation, or lack of improvement.
6. Incorporate the resident’s stated reasons for his or her action; and

7. Request the resident to sign and date the document. This acknowledges only that the resident has received the document. If the resident refuses to sign, the Program Director should request that another management employee be present to witness the refusal of the resident to sign for the document. The Program Director should amend the document to include a notation that the resident refused to sign. The Program Director, and the management representative, should then affix their signature and date to the document directly below the notation.

A resident is entitled to file a written grievance at any step during this process (See Grievance Procedure).

C. Institutional Probation

If the resident has not corrected the problems and/or areas of deficiency outlined in written warning(s), then the Residency Program Director may initiate the process of placing the resident on Institutional Probation, However, if the problems are sufficiently severe, this step can be initiated directly per section 3.C-D.

The following elements must be included in the written notice to Resident Physician with regard to Institutional Probation.

1. Specific reason(s) for placing the resident on Institutional Probation (i.e., in what areas specifically is the resident deficient).

   The written notification must detail the deficiencies in behavioral, academic and/or clinical performance in which the resident failed to meet acceptable or reasonable standards.

2. Specific dates of the probationary period. The duration of the period for performance improvement must be specified and reasonably associated with the deficiency. A probationary period is usually for six (6) months.

   Under no circumstances can the dates be retroactive (i.e., the beginning of the probationary period cannot be prior to the date the resident receives his/her written notification nor can the probationary period be indefinite or unreasonable.

3. Program of Remedial Action and Education including Academic and/or Behavioral issues.

   A program of corrective action shall be stated for the resident to follow. The residents should be provided with ongoing ***written*** feedback, particularly on continued deficiencies.

When necessary, this will include the appointment of one or more faculty to work with the resident on a regular basis, using a planned individualized format. This format may include supervision of history and physical examination, close follow-up and care of certain patients, tutorial sessions, etc.

During the probationary period the Program Director or faculty designed to supervise the resident's remedial training and/or review the resident's behavioral issues will meet periodically with the resident for counseling. At minimum, such counseling shall occur at least at the mid-point and at the end of the probationary period. These counseling sessions will be to inform the resident of his/her progress in resolving the deficiencies. A written confirmation of these counseling sessions will be given to the resident within five (5) business days after the counseling sessions.

4. Specific expectations the resident must meet to be taken off probationary status and the consequences that will follow if the resident fails to meet these expectations.

5. Request the resident to sign and date the document. If the resident refuse to sign, the Program Director should request that another management. Employee be present to witness the refusal of the resident to sign for the document. The Program Director should amend the document to include a notation that the resident refused to sign. The Program Director, and the management representative, should then affix their signature and date to the document directly below the notation.

Prior to giving the resident written notice of Institutional Probation, the Program Director shall submit the letter to the Office of Graduate medical Education for review as to appropriateness of the form of the letter. Copies of the letter notifying the resident of placement on probation and any subsequent written notification of any actions taken regarding the probation must be filed immediately with the Office of GME.

A resident is entitled to file a written grievance at any step during this process (See Grievance Procedure).

D. Termination (Dismissal/Release)

1. Nonacademic Reasons

If a Physician is to be recommended for termination for nonacademic reason, the following procedure must be followed.

Residents Employed by LA GENERAL Medical Center.	**Residents Employed by the Keck School of Medicine.**
a. A recommendation shall be submitted in writing by the Program Director to the Director of Graduate Medical Education. b. The Director of Graduate Medical Education will review the recommendation along with documentation provided, and if appropriate, submit a written recommendation for termination to the Director of Human Resources, LA GENERAL Medical Center, and the Chief of the Medical Staff. c. The Office of Human Resources will review the recommendation along with the documentation provided, and if appropriate, assist the Department Chair in proceeding with the termination (e.g., investigation, writing the termination letter, etc.) d. The termination letter will specify the reasons for the resident's release and detail the appeal process available to the resident. The appeal process, known as "liberty interest," affords the resident the right to respond to this termination action either orally, in writing or both.	a. A recommendation shall be submitted in writing by the Program Director to the Associate Dean for Graduate Medical Education. b. The Associate Dean for c. Graduate Medical Education will review the recommendation along with the documentation provided, and if appropriate, submit a written recommendation for termination to the Dean, Keck School of Medicine. d. The Dean, Keck School of Medicine, or designee will review the recommendation along with the documentation provided, and if appropriate, assist the Department Chair in proceeding with the termination (e.g., investigation, writing the termination letter, etc). e. The termination letter will specify the reasons for the resident's release and detail the appeal process available to the resident. The appeal process affords the resident the right to respond to the termination action either orally, in writing, or both.
A resident is entitled to file a written grievance at any step during this process (See Grievance Procedure).	A resident is entitled to file a written grievance at any step during this process (See Grievance Procedure).

2. Academic (Professional Knowledge and Clinical Judgment) Reasons

   When termination of a resident physician is necessary for academic reasons, the following procedure must be followed.

Residents Employed by LA GENERAL Medical Center.	**Residents Employed by the Keck School of Medicine.**
a. The resident is notified, in writing, that his/her dismissal from the Residency Program is being recommended. This notification must detail the reasons for this recommendation and notify the resident he/she is entitled to a departmental pre- termination hearing.	a. The resident is notified, in writing, that his/her dismissal from the Residency Program is being recommended. This notification must detail the reasons for this recommendation and notify the resident he/she is entitled to a departmental pre-termination hearing.
b. A departmental pre-termination hearing with the resident must be held and the resident is entitled to have representation at this hearing. However, the Program Director or Department Chair must have five (5) working days advance notice of such intention to be represented. The pre-termination hearing will be held with the Training Program Director and/or the Department Chair.	b. A departmental pre-termination hearing with the resident must be held and the resident is entitled to have representation at this hearing. However, the Program Director or Department chair must have five (5) working days advance notice of such intention to be represented. The pre-termination hearing will be held with the Training Program Director and/or the Department Chair.
c. If after the pre-termination hearing, the recommendation for the resident's termination remains, a written recommendation is forwarded to the Chief of Staff. A copy of this recommendation is forwarded to the resident notifying him/her this decision may be appealed to the Chief of Staff.	c. If after the pre-termination hearing, the recommendation for the resident's termination remains, a written recommendation is forwarded to the Dean, Keck School of Medicine. A copy of this recommendation is forwarded to
d. The resident may appeal this recommendation by submitting a written appeal letter to the Chief of Staff within ten (10) business days from receipt of the letter	d. the resident notifying him/her that this decision may be appealed to the Dean. e. The resident may appeal this recommendation by submitting a

recommending dismissal. e. The Chief of Staff shall appoint a Residency Review Committee to review this recommended action. The Director of Graduate Medical Education, who shall be a nonvoting member, shall chair this Residency Review Committee. The membership shall consist of (5) persons: three (3) staff members and two (2) senior level residents, none of whom shall be a member of the resident's department. f. The resident shall have the right to appear before the Residency Review Committee with representation if so desired. However, the resident must notify the Chief of Staff at least five (5) business days in advance of such intent to be represented. g. The Residency Review Committee shall submit a written report of its findings and recommendations to the Chief of Staff within fifteen (15) business days from the hearing date. h. The Chief of Staff's decision shall be rendered, in writing, to the resident, within ten (10) business days of receipt of the Residency Review Committee's recommendations. i. If the Chief of Staff sustains the resident's dismissal from the Residency program, the Chief of Staff will notify, in writing, the Office of Human Resources to proceed with the termination of the resident.	written appeal letter to the Dean within ten (10) business days from receipt of the letter recommending dismissal. f. The Dean shall appoint a Residency Review Committee to review this recommended action. The Associate Dean for Graduate Medical Education, who shall be a nonvoting member, shall chair this Residency Review Committee. The membership shall consist of five (5) persons: three (3) faculty members and two (2) senior level residents, none of whom shall be a member of the resident's department. g. The resident shall have the right to appear before the Residency Review Committee with representation if so desired. However, the resident must notify the Dean at least five (5) business days in advance of such intent to be represented. h. The Residency Review Committee shall submit a written report of its findings and recommendations to the Dean within fifteen (15) business days from the hearing date. i. The Dean shall render his decision, in writing, to the resident, within ten (10) business days of receipt of the Residency Review Committee's recommendations. j. If the Dean sustains the resident's dismissal from the Residency program, the Dean

j. The Office of Human Resources will review the documentation provided, and, if appropriate, write a termination letter notifying the resident that he/she is being dismissed from County service. k. The termination letter will specify the reasons for the resident's release from County service and detail the appeal process available to the resident. The appeal process, known as "liberty interest" gives the resident the right to respond to this termination action either orally in writing, or both. l. Please note: The resident may not be taken off duty until the effective date of termination detailed in the termination letter. A resident is entitled to file a written grievance at any step during this process (See grievance Procedure).	will notify, in writing, the resident of his/her termination. The Dean's decisions are final and without further appeal.

7. Management's Role

Before any potential disciplinary action is considered, the following points should be followed:

1. Investigate and consider all sources of relevant information (facts, not opinions);
2. Verify information;
3. Consult with all applicable parties.
4. Analyze the facts thoroughly and objectively;
5. Summarize the matter in writing;
6. Determine if the level of discipline is appropriate; and

Residents Employed by LA GENERAL Medical Center.	**Residents Employed by the Keck School of Medicine.**
7. Consider other factors, such as the liability or potential liability incurred by the Medical Center or County, the jeopardy to public safety, and the harm or risk of harm to persons or property. If, at the time a disciplinary action is being contemplated, the department is uncertain regarding the appropriate action to take, or if a resident is uncertain regarding his/her due process rights, either party should contact the Office of Graduate Medical Education for assistance. Residents may also wish to contact the JCIR.	7. Consider other factors, such as the liability or potential liability incurred by the University of Southern California, the jeopardy to public safety, and the harm or risk of harm to persons or property. If, at the time a disciplinary action is being contemplated, the department is uncertain regarding the appropriate action to take, or if a resident is uncertain regarding his/her due process rights, either party should contact the Office of Graduate Medical Education for assistance.

GRIEVANCE PROCEDURE

Residents Employed by LA GENERAL Medical Center.	**Residents Employed by the Keck School of Medicine.**
The resident may appeal all actions through formal grievance procedures. The resident may obtain grievance forms from the Office of Graduate Medical Education, the Office of Human Resources or JCIR and initiate such procedures. To be considered timely, the resident must file a grievance with the Program Director and send a copy to the Office of Human Resources within ten (10) business days from receipt of the document/action being grieved. If the grievance is filed in an untimely manner (i.e. exceeds ten business days,) the Program Director and the Office of Human Resources are not required to accept it. However, if the grievance is filed timely and denied, the resident may file the grievance at the second level with the Department Chair. If the second level grievance is filed timely and denied, the resident may file the grievance at the third level at the Medical Center Office of Human Resources. **It is imperative that Management responses to grievances at all levels be given within the ten (10) business day time frame, even if the grievance is denied, due to the requirements of the JCIR MOU. Failure to respond in a timely manner at any level automatically results in the granting of the grievance.**	University residents may use the University's Staff Grievance Procedures in effect when a grievance is filed. The current Staff Grievance Procedures may by found on the University website (http://policies.usc.edu)

SECTION 15: USC/LA GENERAL MEDICAL CENTER GRADUATE MEDICAL EDUCATION COMMITTEE SPECIAL PROGRAM REVIEW PROTOCOL

A. PURPOSE

The Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements since July 1, 2014 require that the Sponsoring Institution's Graduate Medical Education Committee (GMEC) must demonstrate effective oversight of its underperforming ACGME programs through a Special Program Review (SPR) process. This process must include a SPR protocol that establishes criteria for underperformance and results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes.

B. SPECIAL REVIEW PROCESS

a. The DIO, acting on behalf of the GMEC, will notify the Program Director in writing of the intent to conduct a SPR based on one or more criteria for program underperformance as identified in this protocol.
b. The DIO or designee will appoint members of the SPR Committee appropriate to the nature of the review based on the principle of minimizing conflicts of interests.
c. The Program Director will be responsible for submitting all requested documentation and for scheduling all interviewees as requested by the DIO, GMEC and the SPR Committee.
d. The SPR interviews will be completed by the SPR Committee within 90 days of notification of the program director or at discretion of DIO.
e. The SPR Committee will submit a written report to the GMEC that describes the quality improvement goals, corrective actions and process for GMEC monitoring of outcomes. The report must be reviewed by the DIO and reviewed and approved by the GMEC at the following GMEC meeting unless otherwise approved by the GMEC.
f. The Program Director must submit a written SPR Corrective Action Plan within the time period designated on the report after receiving the GMEC approved Special Review Report that must be reviewed and approved by the GMEC. Exceptions must be approved in writing to the DIO. The report must be verbally presented by the Program Director at the GMEC meeting. The need for and timing of additional monitoring and reports to resolve areas of uncorrected program underperformance will be documented in GMEC minutes.

C. CRITERIA FOR PROGRAM UNDERPERFORMANCE

1. ACGME Letter of Notification of Accreditation indicating:
   a) Initial or Continued Accreditation with Warning
   b) Probationary Accreditation or any other adverse accreditation as per ACGME policies and procedures
   c) Proposed Withdrawal
   d) Egregious Violation of Requirements
   e) Required reduction in complement.
2. Inquiry from ACGME Office of Resident Affairs
3. Annual ACGME Resident/Faculty Survey or GMEC Resident Survey identifying compliance less than the national mean for 50% of the questions.
4. Trending data from Annual ACGME or GMEC Resident or Faculty Surveys indicating concerns in the learning environment not satisfactorily addressed in the annual program evaluation.
5. Annual Program Evaluation and Improvement Plans that fail to satisfactorily address current citations, areas for improvement, resident engagement in quality improvement and patient safety, scholarly activity, faculty development, board certification passing rates and/or recommendations from Special Reviews.
6. Two or more changes in Program Directors during the length of the training program.
7. Request from the Designated Institutional Official
8. Request from the Program Director
9. As per majority vote of the GMEC for all other circumstances
10. Special Circumstances unrelated to underperformance
    a) Within the year prior to an ACGME Full Site Visit
    b) New programs with initial accreditation within 18 months of first training year
    c) New program director within 18 months of tenure.

D. SPECIAL REVIEW COMMITTEE MEMBERSHIP

1. Committee membership must include:
   a) The DIO or designee
   b) One Program Director or Associate Program from a Department other than the Department of the program under review
   c) One Faculty member from a Department other than the Department of the program under review
   d) One resident/fellow from a Department other than the Department of the program under review.
2. Special Circumstances regarding committee membership
   a) Membership may include additional GME Leadership personnel, Program Directors, Associate Program Directors, and Residents and/or Faculty, Safety/Quality Officers, Program Coordinators or USC or LA GENERAL administrators at the discretion of the DIO and/or GMEC.
   b) The requirement for membership as per IV.A.2 and IV.A.3 may be waived at the discretion of the DIO and/or GMEC depending on criteria for underperformance providing the rationale for such a waiver is documented in the GMEC minutes, and approved by the GMEC.

E. SPECIAL REVIEWS MATERIALS

1. The following documents must be reviewed for each special review:
   a) Documentation supporting program underperformance
   b) Most recent Letter of Notification
   c) Most recent ACGME Resident and Faculty Survey
   d) Most recent GMEC Resident and Faculty Survey
   e) Most recent Annual Program Evaluation and Improvement Plan
   f) Program Requirements in effect at the time of underperformance
2. Additional documents appropriate to the criteria for underperformance as determined by the Special Review Committee and as documented in the report.

F. SPECIAL PROGRAM REVIEW INTERVIEWS

1. Interviewees at a minimum must include:
   a) Program Director (Program Coordinator is optional)
   b) Representative faculty as determined by the program director.
   c) All or peer-selected residents as follows:
      1) Resident/fellow complement $\leq$ 10: all residents available the day of the interview
      2) Resident/fellow complement >10: a minimum of three peer-selected residents from each year of training
2. Special circumstances
   a) The SPR Committee may waive or reduce the requirement for one or more faculty representatives at the discretion of the Special Review Committee providing the rationale for such a waiver is documented in the GMEC minutes and SPR Report reviewed and approved by the GMEC.
   b) The Special Review Committee may request more than the minimum faculty or residents and/or Department Chairperson
3. Individuals or Groups to be interviewed (preferred order)
   a) Peer-selected Residents/Fellows in a single group or divided by training year or individually as determined by the SPR Committee without faculty or the program director present
   b) Faculty in a single group, multiple groups or individually as determined by the SPR Committee without residents or program director present.
   c) Chairperson at the discretion of the SPR Committee or Program Director
   d) Program Director and program coordinator for evaluation of issues resulting in underperformance and formative feedback from SPR Committee members.
4. Outcomes for interviews
   a) Assess the level of understanding of program underperformance
   b) Assess validity of program underperformance
   c) Identify corrective action plans to date
   d) Assess effectiveness of corrective actions plans to date
   e) Engage interviewees regarding additional corrective action plans
   f) Reconcile any discordance between groups
   g) Provide formative feedback to program director, as appropriate
   h) Acquire and review sufficient documentation including interview comments to create a SPR Report as per approved template (see attached).

SPECIAL PROGRAM REVIEW REPORT

I. Program
Accreditation Status:
Resident complement approved/current:
Effective date of accreditation:
Approximate date of next ACGME site visit:
Date of Special Review Interviews:
Date Special Review Report Approved by GMEC:
Date of Corrective Action Report Due to GMEC:

I. Membership of Special Program Review Committee by name and title including year of training for any resident/fellow members:

II. Participants including names and year of training for residents or fellows interviewed peer-selected residents/fellows or all residents/fellows in programs available at time of Special Program Review with ≤ 10 residents:

Residents or Fellows

Program Faculty

Program Director and Program Coordinator

III. Documentation Required
Documentation supporting program underperformance (see Section V)
Letter of Notification
ACGME Resident and Faculty Survey
GMEC Resident and Faculty Survey
Annual Program Evaluation and Improvement Plan
ACGME Program Requirements
Updated ADS
Optional Documentation as per underperformance criteria:
Board Passing Rates
Block Diagrams
Case logs
Conference Schedule
Evaluation tools
Goals and Objectives
Milestone Data
QI/PS projects and outcomes
Program Policies
Resident/Faculty Call Schedules
Resident files
Wellness program
Other (identify)

IV. Format of Interviews

V. Circumstance(s) requiring Special Review

VI. Letter of Notification and status of corrective action(s)

VII. Sexual Assault/ Sexual Harassment/Safety/Fairness/Equity (SAFE) Evaluation

VIII. ACGME and/or GMEC Resident/Faculty Surveys

A. Overall Evaluation of Program
Special Program Review Committee Evaluation:
B. Resources
Special Program Review Committee Evaluation:
C. Professionalism
Special Program Review Committee Evaluation:
D. Patient Safety and Teamwork
Special Program Review Committee Evaluation:
E. Faculty Teaching and Supervision
Special Program Review Committee Evaluation:
F. Evaluations
Special Program Review Committee Evaluation:
G. Educational Content/Teamwork
Special Program Review Committee Evaluation:
H. Diversity and Inclusion
Special Program Review Committee Evaluation:
I. Clinical Experience and Education
Special Program Review Committee Evaluation:

IX. Quality of Annual Program Evaluation and Improvement Plan:

X. Concerns identified by the Special Program Review Committee from materials reviewed and interviews that must be addressed to the GMEC in a written corrective action plan:

1. **(ACGME Requirements for Graduate Medical Education Training in**
2. **(ACGME Requirements for Graduate Medical Education Training in**
3. **(ACGME Requirements for Graduate Medical Education Training in**
4. **(ACGME Requirements for Graduate Medical Education Training in**
5. **(ACGME Requirements for Graduate Medical Education Training in**

XI. Summary Statement:

XII. **Recommendation for submission and GMEC monitoring of the program director's corrective action plan to concerns identified in Section XI of this report:** the program director must submit a written corrective action plan to each of the X concerns identified in Section XI of this report by XX/XX/XXXX to be presented, reviewed, discussed, and approved by the GMEC at its meeting on XX/XX/XXXX.

CONFIDENTIALITY OF SPECIAL REVIEW DOCUMENTS

The Special Program Review is a peer-review activity conducted by the GMEC functioning as a Subcommittee of the Attending Staff Association and its Executive Committee. Each Special Program Review Committee member will be required to sign a statement of confidentiality. Each report will indicate the following:

The information contained in this document and any attachment is privileged and confidential under state law, including Evidence Code section 1157 relating to medical professional peer review documents and Government Code Section 6254 relating to personnel records.

Adopted by the Graduate Medical Education Committee Steering Committee	March 23, 1999
Approved by the Executive Committee Attending Staff Association, LA GENERAL Medical Center	May 5, 1999
Approved by the Executive Council Keck School of Medicine of USC	June 9, 1999
Revision adopted by the Graduate Medical Education Committee Steering Committee	November 28, 2000
Revision approved by the Executive Committee Attending Staff Association, LA GENERAL Medical Center	December 6, 2000
Revision approved by the Executive Council Keck School of Medicine	January 17, 2001
Revision adopted by the Graduate Medical Education Committee Steering Committee	June 23, 2003
Revision approved by the Executive Committee Attending Staff Association, LA GENERAL Medical Center	July 7, 2003
Revision approved by the Executive Council Keck School of Medicine	November 2, 2003
Revision adopted by the Graduate Medical Education Committee Steering Committee	June 27, 2007
Revision approved by the Executive Committee Attending Staff Association, LA GENERAL Medical Center	July 11, 2007
Revision approved by the Executive Council Keck School of Medicine	July 10, 2007
Revision adopted by the Graduate Medical Education Committee Steering Committee	May 26, 2010
Revision approved by the Executive Committee Attending Staff Association, LA GENERAL Medical Center	June 2, 2010
Revision approved by the Executive Council Keck School of Medicine	June 1, 2010
Revision adopted by the Graduate Medical Education Committee Steering Committee	May 25, 2011
Revision approved by the Executive Committee Attending Staff Association, LA GENERAL Medical Center	August 1, 2011
Revision approved by the Executive Council Keck School of Medicine	July 31, 2011
Revision adopted by the Graduate Medical Education Committee Steering Committee	May 24, 2017

Revision approved by the Executive Committee Attending Staff Association, LA GENERAL Medical Center	August 1, 2017
Revision approved by the Executive Council Keck School of Medicine	July 1, 2017
Revision approved by the Executive Committee Attending Staff Association, LA GENERAL Medical Center	June 2, 2021
Revision approved by the Executive Committee of the Keck School of Medicine	June 30, 2021
Revision approved by the Executive Committee Attending Staff Association Los Angeles General Medical Center	June 2024
Revision approved by the Dean’s Executive Council of the Keck School of Medicine of USC	June 2024