



## RESIDENT/FELLOW POLICY MANUAL

2019-2020

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# **Kern Medical DEPARTMENT OF MEDICAL EDUCATION**

This *Resident/Fellow Policy Manual* is provided as a guide to, and summary of, the various policies, benefits, and services available and applicable to Graduate Medical Education (GME) Trainees (Residents and Fellows) as of the date published. It also summarizes the rights and responsibilities of GME Trainees. The policies, benefits, and services described in this guide may be changed or discontinued. Documents summarizing various policies, benefits, and services are issued, amended, and revised from time to time with or without prior notice. Trainees are encouraged to consult the various booklets, summaries, and governing documents as appropriate, and to contact the Department of Medical Education for more detailed and up-to-date descriptions.

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Except as provided in the applicable grievance or dispute resolution procedure, information contained in any handbook, guide, manual, or document prepared for or relating to Graduate Medical Trainees is for informational purposes only and shall not be construed as a contract. Agreement to the terms of the applicable grievance or dispute resolution procedure, as may be periodically amended and which is available upon request from the Department of Medical Education, is a condition of employment/training.

# RESIDENT POLICY MANUAL

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# **WELCOME TO KERN MEDICAL**

On behalf of the Medical Staff, we welcome you to Kern Medical and wish you every success. We believe that each house officer is integral to Kern Medical's growth and prosperity, and we know you will take pride in being a member of our team.

This manual was developed to describe some of the expectations of our residents and fellows and to outline the policies, programs and benefits available to you. All residents should familiarize themselves with the contents of this manual as soon as possible, for it will answer many questions about employment with Kern Medical.

The Graduate Medical Education Committee through the Director of Medical Education and his professional staff are committed to deliver a top-quality educational experience for you. Input from residents is always welcomed and solicited on a continuous basis especially through the Resident Advisory Council.

## **KERN MEDICAL**

Since 1934, Kern Medical has been training residents and healthcare professionals in this community. Kern Medical is a 222-bed acute care teaching hospital that serves an area of over 750,000 square miles. The hospital is owned and operated by the County of Kern. As an academic teaching hospital, Kern Medical trains more than 108 residents per year specializing in Emergency Medicine, Family Practice, Internal Medicine, Obstetrics and Gynecology, Psychiatry, Child & Adolescent Psychiatry, and Addiction Psychiatry. Over 80 full time faculty physicians participate in graduate, undergraduate, and mid-level professional education at Kern Medical. Kern Medical provides care for over 15,500 inpatients annually, while the clinics provide care and services for over 125,000 patients.

## **INSTITUTIONAL COMMITMENT TO GRADUATE MEDICAL EDUCATION**

Kern Medical is affiliated with the University of California School of Medicine at Los Angeles (UCLA), and recognizes the importance of the graduate medical education (GME) programs. Upon completion of residency, graduates will receive certificates from Kern Medical and their respective affiliated medical schools.

Each residency program (individually and collectively the "Program") shall, upon satisfactory completion of the Program and satisfaction of the Program's requirements and the residents' responsibilities contained herein, furnish to each resident a Certificate of Completion of the Program within one (1) month of each resident's satisfactory completion of his or her training Program or part thereof.

The Director of Medical Education who is the Designated Institutional Official (DIO), is charged with overseeing all residency programs in cooperation with departmental chairpersons and residency program directors. Through the Graduate Medical Education Committee (GMEC), the DME provide oversight to graduate and undergraduate medical education programs. Two peer-selected residents, namely the Chair and Co-Chair of the Resident Advisory Council, sit on the GMEC as voting members to participate in discussions and approve policies relevant to the

medical education environment. Kern Medical is accredited by The Joint Commission (TJC) as are all of the major affiliating institutions participating in the residency training programs.

## **GRADUATE MEDICAL EDUCATION AND ACCREDITATION**

The Accreditation Council for Graduate Medical Education (ACGME) is composed of representatives of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. A federal and public representative is included, as well as a resident representative.

Accreditation, a voluntary effort of all parties involved in graduate medical education, ascertains that residency programs at Kern Medical meet the general and specific requirements of the ACGME. Accordingly, Kern Medical residency programs have a commitment to ensure that residents have the opportunity to:

- Develop a personal program of learning to foster continued professional growth with guidance from the teaching faculty.
- Participate in safe, effective, and compassionate patient care, under supervision, commensurate with level of advancement and responsibility.
- Participate fully in the educational and scholarly activities of the residency-training program and, as required, assume responsibility for teaching and supervising other residents and students.
- Participate, as appropriate, in institutional programs and medical staff activities and adhere to established practices, procedures, and policies of the institution.
- Participate, as appropriate, through peer-nominated representation on institutional committees and councils whose actions affect resident education and/or patient care.
- Participate in periodic written feedback to evaluate the quality of the teaching by the faculty for each service rotation or other agreed-upon block of service time. Residents determine whether the evaluation remains anonymous and every effort is made to keep it confidential.
- Participate in periodic feedback for the overall curriculum, i.e., residents will be asked to evaluate whether the curriculum and program are meeting the written goals and objectives for the residency program and provide input to the curriculum established for the program.



# SECTION I: POLICY MANUAL ORGANIZATION

## PURPOSE

The purpose of this manual is to supplement the Human Resource and Kern Medical Administration Policies and Procedures as they pertain to residents. Revisions of the policy manual are made by the GMEC. Copies of the Kern Medical Resident Policy Manual are provided to new residents during resident check in. The Resident Policy Manual is also available on the Kern Medical intranet site at: <http://kmcintranet/services/medical-education/>. Policies and Procedures can be accessed from any computer at Kern Medical. The Kern Medical Resident Policy Manual may be subject to change and revisions after it is placed at the website above.

## RESIDENT RESPONSIBILITIES

Residents are expected to abide by the policies and procedures in this manual. When required, residents will follow the directions set forth by the Program Director, Residency Review Committee (RRC), ACGME, TJC, and Kern Medical Administration. These policies include, but are not limited to, legible and timely completion of patient medical records, reports, operative and procedure logs, faculty and residency program evaluations, and/or other documentation as determined necessary to fulfill the responsibilities for further graduate training.

Kern Medical is committed to providing an environment that fosters scholarly activity and residents are expected to comply with all of the terms and provisions of law and ethical standards relating to the practice of medicine, including:

- All laws and regulations dealing with government programs and private insurance or prepaid health plans
- All applicable rules, regulations, bylaws, policies, and procedures established by the residency program, Kern Medical, the medical staff, or any other facility at which residents practice medicine in connection with the residency program
- The standards required for maintaining accreditation by JTC, ACGME, RRC, and any other relevant accreditation organization

Residents' best efforts should be made to provide safe, effective, and compassionate patient care with a courteous and respectful attitude toward patients, colleagues, faculty, and visitors at Kern Medical. Always cooperate with any and all quality assessment and improvement, corporate compliance and cost-containment measures in the provision of patient care consistent with the policies of Kern Medical and the residency-training programs.

## **ETHICS AND CONDUCT\***

The success and reputation of Kern Medical is built upon the principles of fair dealing and ethical conduct of its representatives. Therefore, it is an expectation that all staff/residents make the “extra” effort to ensure a professional, gracious, and overtly hospitable environment for patients, visitors, and colleagues. It is our goal to maintain an atmosphere of personal and institutional excellence where outstanding performance is expected.

The resident shall use his or her best efforts to provide safe, effective, and compassionate patient care and present at all times a courteous and respectful attitude toward all patients, colleagues, employees, and visitors at Kern Medical and other facilities and rotation sites to which the resident is assigned.

Likewise, Kern Medical will comply with all applicable laws and regulations and expects its directors, officers, and employees to conduct business in accordance with the letter, spirit, and intent of all relevant laws and to refrain from any illegal, dishonest, or unethical conduct.

In general, the use of good judgment, based on high ethical principles, will guide you with respect to lines of acceptable conduct. If a situation arises where it is difficult to determine the proper course of action, discuss the issue openly with your immediate supervisor and, if necessary, with your program director or contact the Medical Education Office for further advice and consultation.

\*AMA Principles of Medical Ethics page

# SECTION II: RESIDENT APPOINTMENT AND PROMOTION

## RESIDENT/FELLOW APPOINTMENT

For all purposes, the terms resident, resident physician, and fellow are referred to as “resident”. All first year residency positions are offered through the National Residency Matching Program (NRMP). The resident shall provide documentation for certification of eligibility in the residency-training program as follows:

- A completed residency application.
- An official medical school transcript, impressed with medical school seal and an original medical school diploma.
- A letter from the Dean of the medical school from which the resident graduated.
- A minimum of two letters of reference.
- Proof of employment eligibility. If the resident is not a U.S. citizen, he or she must have an active, non-expired visa that allows for clinical training or evidence of permanent U.S. immigrant status. This visa must remain active during the entire period the resident participates in the residency-training program.
- A current and valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) if the resident is a graduate of a foreign medical school (regardless of citizenship status).
- Successful completion of USMLE Steps I and II as required by all US residency programs participating in the National Residency Match Program.
- A permanent license to practice medicine in the State of California and/or a postgraduate “Evaluation Status Letter” from the Medical Board of California or Osteopathic Medical Board of California, as appropriate.
- Such other and future information that Kern Medical may request in connection with the resident’s certification of eligibility.

Any document not printed in English must be accompanied by an acceptable original English translation performed by a qualified translator. Each translation must be accompanied by an affidavit of accuracy acceptable to Kern Medical.

It is the responsibility of the resident to ensure that all necessary documents including those regarding proof of employment, licensure or training status, and ECFMG certification are current and valid at all times. Failure to do so will result in immediate termination from the residency-training program.

Available resident positions are dependent upon the current number of positions authorized by the ACGME and Hospital Administration. Residents who transfer from another residency-training program must provide adequate verifiable statements of previous educational experiences and performance evaluations to the Program Director prior to acceptance into any program.

Individuals with residency appointments are not members of the medical staff and cannot admit or treat patients independently. All appointments are for one year or less, and must be reviewed annually.

## **POSTGRADUATE TRAINING REGISTRATION (PTAL)**

- Each resident must have a Postgraduate Training Registration Form (PTAL) completed and filed with the State of California Medical Board before commencement of training.
- A resident must be a graduate from a medical school recognized by the Medical Board of California, or no PTAL will be issued. International Medical Graduates who have fulfilled the prerequisites will be issued a Postgraduate Training Authorization Letter (commonly referred to as the California letter).
- The PTAL must be issued no more than a year prior to the start date of residency training.
- Any resident without a PTAL is an unauthorized trainee engaging in the unlicensed practice of medicine, a misdemeanor criminal offense.
- The law exempts ACGME trainees from licensure while they complete their training to qualify for a California medical license. U.S. and Canadian medical school graduates are exempt from licensure for 24 months and International Medical Graduates are exempt for 36 months. The trainee's exemption is reduced by all previous training time spent in ACGME or RCPSC (Canadian) accredited training programs regardless of circumstances for which the training was discontinued.

## **BASIC LIFE SUPPORT (BLS)/ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION**

To assure that all residents get certified on the first day of duty, the Department of Medical Education pays the American Hospital Association the fees for certification, which subsequently provides the books and materials for the classes as part of that fee. The cost of re-certification shall be the responsibility of the residents.

The Department of Medical Education requires proof of Basic Life Support and Advanced Cardiac Life Support certification. Graduate Medical Trainees must be certified when they arrive at Kern Medical and must re-certify every two (2) years. Upon completion of the re-certification courses, the resident must provide a copy of the life support cards to the Department of Medical Education.

## **RESIDENT CHECK-IN**

Newly hired residents must attend an employee check in. Residents will not be paid for time spent in the days of employee check in. Residents cannot be placed on the payroll until they have attended this session.

During or prior to check in, residents will receive a copy of the Resident Policy Manual. By signing and returning the last page of this booklet to the Office of Medical Education, the resident or fellow signifies that he or she has received a copy and will read the Resident Policy Manual. Check in continues thereafter for the Summer Core Lecture series.

## **SCREENING DURING CURRENT EMPLOYMENT**

Subsequent to the commencement date of the individual Graduate Medical Education Agreements, residents shall submit to periodic (post-appointment) health examinations and tests, which may include tests for drug use or alcohol abuse, as are deemed necessary by the Program to ensure that the resident is physically, mentally, and emotionally capable of performing essential duties or are otherwise necessary to the operation of the Program. Residents agree to meet applicable standards for immunization in the same manner as all Kern Medical personnel. The results of all examinations shall be provided to the Kern Medical employee health department. Residents agree to comply with Kern Medical's requirements concerning resident health status.

## **INTERNATIONAL MEDICAL GRADUATE (IMG) VISA STATUS**

Kern Medical will accept resident applicants from U.S. citizens who are graduates of U.S. medical or osteopathic schools, or a foreign medical school accepted by the Medical Board of California. Permanent residents and valid J1 or H1B visas are accepted provided there is proper documentation of ECFMG certification and eligibility to work on a non-expired visa. Residents who require visas must obtain premium processing at their own expense in order to present a valid visa prior to July 1<sup>st</sup> when the residency begins.

## **PROMOTION OF RESIDENTS**

Reappointment or promotion to the next level of training is at the sole discretion of the residency-training program and is expressly contingent upon several factors, including but not limited to the following: (a) satisfactory completion of all training components; (b) the availability of a position; (c) satisfactory performance evaluation; (d) full compliance with the terms of the Graduate Medical Education Agreement (GMEA) and the Kern Medical Resident Policy Manual; (e) the continued accreditation of Kern Medical and the residency-training program by the ACGME; (f) the financial ability of the County and Kern Medical ; and (g) furtherance of the residency-training program's objectives. When non-reappointment is based on closure of the residency-training program or the hospital, there will be no further appeal or review allowed.

The Medical Education Office will request promotion decisions from the Program Directors on or before February 28<sup>th</sup> each year. Any written notice of intent not to renew a resident's agreement will be provided to a resident or fellow at least four (4) months before the term (or agreement) ends.

## **USMLE STEP III**

Residents must take the USMLE Step III exam before completing the first year of residency, if not already completed prior to arrival at Kern Medical. Residents who do not pass their USMLE Step III prior to the end of the term (agreement) of their second year of residency will not receive a renewal of resident agreement. They may apply to return when they receive their California licensure. It is the residents' responsibility to submit their application in a timely fashion to ensure that adequate time is allotted for verification processing through the Graduate Medical Education office. We ask that at least six (6) weeks be given for verification processing. The resident will be responsible for any fees incurred through the USMLE application process.

## LICENSURE

### MEDICAL BOARD OF CALIFORNIA LICENSURE

The resident agrees to obtain a regular license to practice medicine in the State of California as soon as s/he is eligible to do so. The resident shall immediately notify the residency-training program of: (a) any notice or other information relating to the resident's license to practice medicine; (b) any notice or other information regarding any decision or action adverse to the resident's Drug Enforcement Administration (DEA) registration number; or (c) any information which the resident has reason to believe may lead to (1) a claim against the professional liability insurance maintained by the County on the resident's behalf or (2) termination, modification, or suspension of the resident's license to practice medicine in the State of California.

California law provides that medical graduates in the first postdoctoral year may practice during that year without a California license, but must register with the Medical Board of California, which is accomplished at check in by completion of the L3 form.

The law further provides that a resident in the second or subsequent postdoctoral year may be appointed and may practice in an approved hospital, provided that such a resident shall qualify for and take the next succeeding examination for the physician and surgeon certificate, or qualify for such a certificate by one of the other methods specified in the California Business and Professions Code (e.g., USMLE or reciprocity with another state). Graduates of international medical schools must complete two years of U.S. residency training prior to receiving a California medical license.

Residents who are graduates of U.S. medical schools are required to possess a valid license for the practice of medicine issued by the State of California (unless exempted by the State of California by virtue of having a valid license in another state) prior to the end of the resident's 24<sup>th</sup> month of graduate training in the United States. Residents who are graduates of international medical schools are required to be fully eligible for or actively pursuing licensing prior to the end of the resident's 24<sup>th</sup> month of graduate training in the United States and possess a valid license for the practice of medicine issued by the State of California by the end of the resident's 36<sup>th</sup> month. Copies of the license and DEA certificate (if applicable) must be provided to the Medical Education Office.

If an individual in the third postdoctoral or subsequent years (following completion of "internship" and one year of residency in California) does not have a valid California medical license, the Program Director of the residency-training program will request that resident have no patient contact until a license is received. Continuation in the program is at the discretion of the Department Chair, Program Director, the DME, and Associate Director of Medical Education.

Those who have completed the first post-doctoral year are urged to seek full licensure by the 31<sup>st</sup> day of December of the year prior to when licensure is required. It may take six months or longer for the processing of an initial California physician's license application. The forms to apply for licensure can be obtained from the Medical Board of California [<http://www.medbd.ca.gov>].

## **DOCTOR OF OSTEOPATHIC MEDICINE LICENSURE**

Those who have completed the first postdoctoral year are urged to seek full licensure by the 31<sup>st</sup> day of December of the year prior to when license is required. It may take six (6) months or longer for the processing of an initial California physician's license application. Doctor of Osteopathic Medicine licensure follows the same time guidelines of allopathic medicine licensure. The forms to apply for licensure can be obtained from the Osteopathic Medical Board of California [<http://www.ombc.ca.gov>]

## **MAINTENANCE OF MEDICAL LICENSURE**

If a medical license expires prior to completion of residency training, the resident is responsible for re-licensure at least six months prior to the expiration date shown on the current license. The resident will be responsible for any fees relating to initial licensure and renewals.

## **SUSPENSION OR TERMINATION OF CALIFORNIA MEDICAL LICENSURE**

Resident appointment may be terminated if the resident's California license to practice medicine is suspended or terminated. Residents are obligated to report that fact to the residency Program Director immediately and the Department of Medical Education. In the event of suspension or termination of California medical licensure, no further appeal or review will be provided.

## **RESIGNATION**

Residents may terminate their appointment at any time after giving 90-day advanced written notice and have discussed the matter with the residency Program Director, unless waived by the residency Program Director. Upon termination of appointment, the resident shall receive compensation up to the effective date of such termination, unless financial obligations are owed to Kern Medical.

## **CHECK OUT PROCEDURE / RETURN OF MATERIALS**

At the time of termination in the Program or in the event of termination of the Program, residents shall: (a) return all Kern Medical property, including, without limitation, equipment, keys, pagers, paper, and personal digital assistant (PDA) equipment; (b) complete all necessary records; and (c) settle all professional and financial obligations.

# **SECTION III: RESIDENT\* EVALUATION, ADVANCEMENT, DUE PROCESS, SUPERVISION, AND FATIGUE**

\*For the purpose of Section III, all fellows are referred to as residents.

## **RESIDENT EVALUATION AND ADVANCEMENT**

At the end of each rotation, faculty and supervising physicians will evaluate a resident's performance and progress in training. Non-cognitive skills and behaviors are observed and measured as an integral part of the evaluation process. Evaluations measure performance against predetermined standards. Clinical and academic competencies are inseparable and will be discussed and written in semi-annual evaluations performed by a Program Director.

Each residency-training program at Kern Medical uses formal evaluation methods and forms, as well as various observations and examination results that are best suited to the program specialty to determine the performance of the assigned residents. At least twice each year program directors conduct a formal evaluation of residents, including a review of all evaluations on file and other pertinent data. A discussion with the resident regarding his/her progress including pertinent information will be entered into the resident's permanent file.

A program competency committee for each residency-training program, which involves the Program Director, faculty mentor, and chairperson, will discuss a resident whose performance is marginal or unsatisfactory. Special observation or remediation may be arranged as needed.

Program goals predetermined by the RRC ensure the quality of graduate medical education at Kern Medical. The resident must exhibit clinical performance and competence consistent with the level of training and satisfactorily complete all assigned rotations, didactic series, applicable examinations, as well as completion of projects that are outlined by the program in order to gain advancement into the next program year. The resident is expected to progressively increase his or her level of proficiency relevant to the development of pertinent skills of the specific program.

The program will, upon satisfactory completion of the program and satisfaction of the program's requirements and the resident's responsibilities contained in the GMEA, furnish to the resident a Certificate of Completion of the Program.

## **REMEDICATION AND PROBATION**

Remediation is used as an academic tool to correct deficiencies noted in a resident. Remediation is designed within a timed period of probation. Any resident found to struggle with an academic and/or behavioral problem as evidenced by rotation evaluations; performance in rounds, clinical management, or in-service examinations agrees to participate in the remedial process as stated below.



Remediation is an initial course of action to correct deficiencies pertaining to a resident's action, conduct, or performance, which if left uncorrected, may lead to non reappointment or disciplinary action, but which are not yet serious enough to form an independent basis for corrective action, termination, or summary suspension.

In the event the resident's performance, at any time, is judged by the Program Director to be unsatisfactory or noncompliant, the Program Director will notify the resident in writing of the nature of the unsatisfactory or noncompliant conduct or performance "Letter of Deficiency". It is expected that the resident personnel will receive routine structured feedback in order to identify and correct the issue. A remediation plan will be developed that outlines the terms of remediation and the length of the remediation process. If the house officer satisfactorily resolves the deficiency(ies) noted in the Letter of Deficiency, and continues to perform acceptably thereafter, the period of unacceptable academic/behavioral performance does not affect the house officer's intended career development. However, failure of the resident to comply with the remediation plan may result in termination or non-renewal of the resident's appointment.

Remediation is not subject to any grievance or appeal procedure. If the resident's failure to comply with a remediation plan results in termination or non-renewal of the resident's appointment, such determination will be subject to the program's grievance or appeal procedures.

## **DEFICIENCY NOTICE**

The resident is informed in writing of the specific problem or deficiency by the Program Director. A meeting is arranged between the resident, his or her rotation attending staff, faculty, the Program Director, and the chair of the department where the plan for improvement is discussed or formulated. The plan may include the following, as deemed appropriate:

- The resident may be given specific reading assignments related to the deficiency or asked to research case-specific material from the library, text, or online sources related to the patients he or she is managing.
- The resident may be given extra time to spend reading by reducing clinic duties until the resident has come to the expected level of knowledge.
- The faculty will provide closer supervision of the resident. The resident is expected to present all clinic cases to the attending faculty and discuss them in detail. If appropriate, the number of cases seen by the resident may be reduced to facilitate teaching.
- An elective month in the second or third year may be utilized for intensive reading and discussion purposes.
- A repeat rotation or additional time may be planned if the problem or deficiency relates to a specific rotation or specialty. The Program Director will pre-arrange with the chief of the specialty service to inform him or her about the purpose of the rotation in order to make provisions for extra supervision of the resident.
- If the problem or deficiency includes behavioral issues, the resident may be asked to attend specific training sessions related to these issues, such as the art of caring or anger management and/or engage in an active therapeutic counseling relationship to address these issues.
- In unusual circumstances, a leave of absence may be granted to the resident with prior approval of the specialty board.

## **PROBATIONARY STATUS**

After an appropriate plan is formulated a written plan will be prepared that outlines the exact remedial measures and time frame for re-evaluation and follow-up. The resident will meet with the Program Director to review and sign the document, which places him or her on probationary status.

- If, after the specified time frame, the problem or deficiency has been resolved, probationary status is ended.
- If, after the specified time frame, the problem or deficiency has not been resolved but the resident has shown significant effort toward resolution by complying with assigned remedial measures, then a new plan for improvement and time frame will be formulated.
- If, after the specified time frame, the problem or deficiency has not been resolved and the resident has not shown effort toward improvement or compliance with remedial measures, the Program Director will file a written complaint within ten days with the Chief Academic Officer.

## **RESIDENT DISMISSAL**

The resident's continued participation in the residency training program is expressly conditioned upon satisfactory performance of all program elements by the resident, which will be determined in the program's sole discretion. The resident may be dismissed or other corrective action may be taken for cause, including but not limited to: (a) unsatisfactory academic or clinical performance; (b) failure to comply with the policies, rules, and regulations of the program, Kern Medical , or other sites where the resident is trained; (c) revocation or suspension of license; (d) theft; (e) acts of moral turpitude; (f) insubordination; (g) use of professional authority to exploit others; (h) conduct that is detrimental to patient care; and (i) unprofessional behavior.

The residency-training program may take any of the following corrective actions: (a) issue a warning or reprimand; (b) impose terms of remediation or a requirement for additional training, consultation or treatment; (c) institute, continue or modify an already imposed suspension of the resident's summary suspension; (d) terminate, limit, or suspend the resident's appointment; (e) not reappoint the resident based upon the resident's unsatisfactory performance; (f) dismiss the resident from the residency-training program; or (g) take any other action that is deemed by the program to be appropriate under the circumstances.

Notwithstanding any provision of the GMEA to the contrary, the resident's appointment will be terminated automatically and immediately upon the suspension, termination, or final rejection of the resident's application for his or her California professional license. In the event of such a suspension, termination, or final rejection, the resident is obligated to report that to the Program Director immediately.

If the resident's appointment is terminated, the Program Director will recommend to Kern Medical whether or not to extend credit to the resident for participation in the program. The Program Director is not obliged to recommend that such credit be extended and Kern Medical is not obliged to extend any such credit.

## **GRIEVANCE OR APPEAL PROCEDURES (DUE PROCESS)**

The program will provide a fair and consistent method for review of a resident's performance. The program's disciplinary and fair hearing procedures are set forth below and in Exhibit "B" of the GMEA.

If a dismissal, summary suspension, or other corrective action other than a warning or reprimand or imposition of a remediation plan is initiated during the term of the GMEA, the process will proceed as follows:

- The resident will be notified in writing that the program is considering corrective action.
- Upon such notification, the resident will have ten (10) calendar days to meet with the Program Director and present written evidence in support of his or her position or response to the reasons for the action set forth by the program. Failure to contact the Program Director in writing within the required time frame (i.e., 10 calendar days) will result in a waiver of the right to appeal.
- After the above-referenced meeting, if the Program Director believes that corrective action is warranted, action may be taken. The resident will be notified of such action within five (5) calendar days.
- The resident has the right to appeal corrective action taken by the program. A written request for an appeal hearing must be submitted to the DME within ten (10) calendar days of the time the resident is informed of the action. The resident's compensation will continue during the appeals procedure.
- Within thirty (30) calendar days of the written request for an appeal the DME will convene a hearing panel. The DME will extend the time for convening a hearing panel for fifteen (15) calendar days upon the request of either party. The hearing panel will consist of two (2) physician faculty members and one (1) senior resident. One hearing panel member will be appointed to chair the panel.
- Either party may challenge the appointment of a hearing panel member, in writing, to the DME no later than five (5) days after publication of the panel appointment. The DME will rule on the validity of the challenge. The challenge must specify reasons that would prevent the individual from being unbiased with respect to the matter involved. If the DME determines the challenge to be valid, a substitute hearing panel member will be made and the process will resume accordingly.
- The hearing is not an evidentiary hearing and court rules and the rules of evidence will not apply. Each party may have an advisor or legal counsel present at the hearing for the purpose of advising the party, but the advisor or counsel may not participate directly in the hearing. The resident will inform the DME at least five (5) calendar days in advance of the hearing of the identity of his or her advisor.
- At the hearing, the resident will have the right to: (a) present written and verbal evidence; (b) present witnesses on his or her behalf; (c) rebut evidence provided by the program; (d) have the hearing recorded by tape recorder or other means at his or her expense; and (e) have a copy of the transcript of the hearing prepared at his or her expense, all under the procedures established by the hearing panel.
- To prevail at the hearing, the resident must demonstrate to the hearing panel that the corrective action imposed by the program was based upon factors that are inappropriate or irrelevant to academic performance or professional conduct.

- Within ten (10) calendar days of the conclusion of the hearing, the panel will submit its recommendation to the DME. The hearing panel may request an extension of not longer than ten (10) days, which shall be granted by the DME. The DME may accept, set aside, or modify the recommendation of the hearing panel. The DME will inform the resident and the Program Director of his or her disposition within fifteen (15) calendar days of receipt of the recommendation of the hearing panel. The decision of the DME will be final and binding, and may not be appealed.

## **SUMMARY SUSPENSION AND PROCEEDINGS**

The Program Director, the Chief Academic Officer, or their designees, will have the authority to summarily suspend, without prior notice, all or any portion of the resident's appointment granted by Kern Medical, whenever it is in good faith determined that the continued appointment of the resident places the safety or health of Kern Medical patients or personnel in jeopardy or to prevent imminent or further disruption of Kern Medical operations. All summary suspensions will be reviewed in accordance with the fair hearing process set forth in Exhibit "B" of the GMEA.

## DUE PROCESS PROCEDURE FOR RESIDENTS\*

\*Fellows are referred to as Residents

The resident receives written notification that the residency-training program is considering corrective action.



Within ten (10) days of the written notification, the resident meets with the program director to present written evidence in support of his or her position.



The program director decides whether corrective action is warranted.



The resident is notified within five (5) days if the program director believes corrective action is warranted.



The resident may appeal by submitting written request within ten (10) days to the DME.



Within thirty (30) days of written request for appeal, the DME convene a hearing panel consisting of two (2) physician faculty, and one (1) senior resident, with one (1) member appointed to chair the hearing panel.



Either party may challenge the appointment of a hearing panel member, in writing to the DME within five (5) days after the publication of the panel appointment. The DME shall rule on the validity of the challenges. The challenge must specify reasons that would prevent a hearing panel member from being unbiased. If the challenge is found to be valid, a substitute member shall be made and the process will resume.



Hearing is not an evidentiary one and court rules and rules of evidence will not apply. Each party may have an advisor or legal counsel present for the purpose of advising the party, but the advisor or legal counsel may not participate in the hearing. The resident must inform the DME at least five (5) days in advance of the hearing of the identity of his or her advisor.



At the hearing, the resident may present written and verbal evidence, present witnesses on his or her behalf, rebut evidence provided by the residency-training program, have the hearing recorded by tape recorder or other means at the resident's expense, have a copy of the transcript of the hearing at the resident's expense



Within ten (10) calendar days of the conclusion of the hearing process, the panel will submit its recommendation to the DME. The hearing panel may request an extension of not longer than ten (10) days, which shall be granted by the DME. The DME may accept, set aside or modify the panel's recommendation.



The DME will inform the resident and the program director of his or her disposition of the panel's recommendation within fifteen (15) calendar days of receipt of the hearing panel's recommendation. The decision of the DME will be final and binding upon the parties, and may not be appealed.

## **RESIDENT SUPERVISION**

### **FACULTY OVERSIGHT**

The GMEC is responsible for providing oversight to residency programs to ensure that residents are appropriately supervised.

- Residents will be supervised by teaching faculty in a manner fostering progressively increasing responsibility according to their level of education, ability, and experience.
- On-call schedules for teaching faculty are structured to ensure that supervision is readily available to residents on duty, as the teaching faculty must determine the level of responsibility accorded to each resident as stated under the Supervision of Procedural Competency.
- Each residency program establishes policies on the supervision of residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines are communicated to all members of the program's teaching faculty and to residents by the Program Director.

### **SUPERVISION OF PROCEDURAL COMPETENCY**

Residents must be instructed and evaluated in procedural techniques by a licensed independent practitioner, i.e. attending physician, who is certified by their training Program Director as competent to independently perform that procedure or who has been credentialed by Kern Medical to perform that procedure.

The Program Director is responsible for identifying the number of procedures, which must be completed successfully prior to the resident receiving the designation of competence in that procedure. For procedures performed by residents in multiple departments, there should be uniform policy for the minimum number of procedures necessary to achieve competence.

### **FACULTY SUPERVISION OF RESIDENT INPATIENT CARE**

Inpatient care supervision of residents by the teaching faculty includes the following:

- A faculty physician is always on-call with a resident. There is a faculty physician available in obstetrics and gynecology and the emergency department 24 hours a day. The faculty is available to the resident to discuss cases seen in the emergency department, as well as complicated problems in the hospital. If needed, faculty physicians in the department will come to the hospital or to the emergency department to evaluate the patient with the resident. A call schedule is made on a regular basis listing which faculty physicians are on-call.
- The assigned teaching faculty, which may include the Program Director, conducts regular morning rounds daily on all hospitalized patients to discuss their management, referral, and discharge as well as provide structured didactic discussion of challenging patient cases.

## **DOCUMENTATION OF FACULTY SUPERVISION FOR INPATIENT CARE**

The documentation of inpatient care supervision includes the following:

- The supervising teaching faculty's name is available on a regular schedule or roster for service rotations and night/emergency call.
- The supervising teaching faculty's name is placed in the medical record at the time of admission.
- A daily faculty note is written in the chart of patients in the hospital.
- Each department has its own documentation requirements for residents.

## **FACULTY SUPERVISION FOR AMBULATORY PATIENT CARE**

Please refer to your individual department for additional information about ambulatory patient care policies. In general:

- The teaching faculty is personally present at the clinic.
- The teaching faculty is personally available for consultation and guidance.
- PGY-1 residents are required to present their work to the teaching faculty.
- The teaching faculty may review other residents as appropriate and write a confirmatory note.
- Chart audit may be used to confirm the process of supervision.

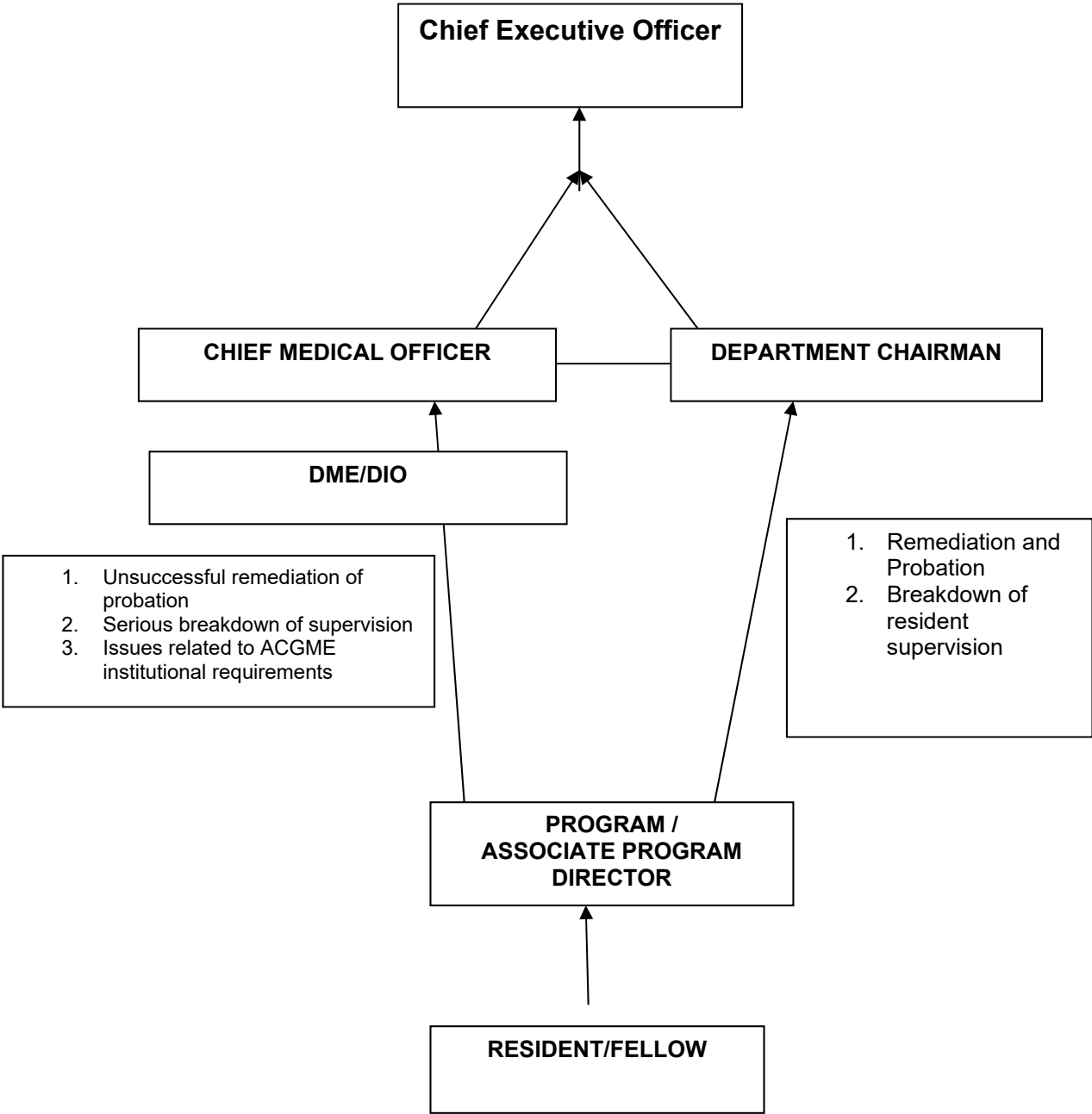
## **HANDLING CRITICAL INSTANCES OF BREAKDOWN OF SUPERVISION**

When the institution becomes aware of critical instances of breakdown of supervision, the plan for response is as follows:

- Notice of breakdown of supervision may be brought to the attention of the resident's Program Director. The responsible medical staff chair/Program Director is requested to investigate the incident and resolve the issue.
- When a documented incident involving a serious breakdown of supervision is identified, the DME instructs the department chair to convene a conference of the teaching faculty and residents. They can identify the factors which have produced the problem, discuss methods by which similar future events may be avoided, and identify specific remedies for correction of the supervisory process.

The DME will provide final decisions in the event that a faculty member is repetitively involved with a lack of supervision.

# CHAIN OF COMMAND FOR RESIDENTS





## **FATIGUE PREVENTION, IDENTIFICATION, AND MANAGEMENT**

The Accreditation Council on Graduate Medical Education requires all training programs to “...educate *faculty and residents ...to recognize the signs of fatigue...and adopt and apply policies to prevent and counteract the potential negative effects*”. Examples of such policies include, specific duty hour requirements such as maximum of 80 duty hours per week, in-house call no more frequently than one in three nights, a minimum of one 24-hour period off each week, a minimum of 10 hours free between consecutive duty periods, and duty periods of no more than 24 hours with up to an additional 6 hours for continuity or education. Every ACGME-accredited residency program in the United States must adhere to these regulations, although there are some differences among the specialties.

Accrediting bodies have set “the rules”. These should be construed as minimums.

Programs/Institutions should:

- adhere to Kern Medical ’s duty hour requirements,
- minimize prolonged work (> 24 hours of clinical duties),
- protect periods designed to address sleep debt (i.e. the minimum of at least 24 consecutive hours off each week free from all clinical responsibilities),
- reduce non–essential tasks and enhance learning during clinical time,
- reduce non-essential interruptions (i.e. added ancillary services, triage of phone calls by charge nurse, etc),
- assist residents to identify co-existent medical issues which impair their sleep (i.e. undiagnosed sleep disorder, depression, stress),
- educate regarding awareness and management of fatigue,
- critically appraise the best way to implement shift work,
- provide napping resources, and
- explore options with residents to return home safely.

Kern Medical should provide accessible call rooms with a conducive rest environment. If there are difficulties with call rooms, contact the Department of Medical Education at 62117.

The American Medical Association Council on Ethical and Judicial Affairs considers physicians attending to their own health and wellness, as well as the health of their colleagues, an ethical imperative. Compliance with duty hours is monitored. Residents are urged to report any concern regarding duty hours, fatigue and other issues to the Department of Medical Education, 62117, immediately.

Parallel to the focus on “duty hours” are efforts to increase the awareness of fatigue’s impact on resident well-being, learning, and patient safety. These include dissemination of evidence-based information regarding the prevention, recognition and management of fatigue, and access to national and specialized resources.

## **SYMPTOMS AND SIGNS OF SLEEP DEPRIVATION**

“Too little sleep” may be the most common reason for sleepiness among residents, occurring when residents get less sleep than optimal. Although there is individual variation, most adults

require an average of 8.2 hours of sleep each night. Residents may not have developed “good sleep habits” in college and medical school for adequate sleep even on their nights “off”. Alternatively, the duration of sleep may be optimal but the sleep itself is disrupted. Insufficient time may be spent in the “deeper”, “restorative”, stages of sleep. Though “in bed”, residents may be interrupted by frequent phone calls, pages, the need to follow up on patients, or to supervise more junior residents. Residents may also be interrupted by the interruptions of residents who share the same call space. Even the “anxiety” of call, or anticipation of sleep interruption can impair sleep. Call from home, though not counted in the duty hours, may still put residents at risk due to sleep disruption with frequent phone calls.

Disruption in sleep leads to a sleep debt. Performance can be impaired with two hours less sleep than “normal” per night. Significant sleep debt may occur if sleep is sub-optimal over as few as two to three nights. Adverse health consequences may occur if sleep debt is allowed to accumulate. Sleep debt requires several consecutive full night’s sleep for adequate recovery, depending upon the number of days during which the sleep debt was accumulated, as well as the individual’s susceptibility and ability to “recover”. Though it is difficult to quantify what is “sufficient”, the individual should feel “rested” after their recovery sleep period.

Psychomotor function after 24 hours without sleep is equivalent to a blood alcohol content of 0.08%, a level recognized legally as inebriation. As is true with alcohol, one cannot depend on the individual to perceive his/her own degree of impairment. Studies confirm residents can’t adequately evaluate their own degree of sleepiness. Furthermore, the ability to recognize “sleepiness” declines the sleepier one feels.

Characteristic symptoms of sleepiness may be unrecognized. These include:

- repeatedly yawning and nodding off during conferences,
- “microsleeps”...a few seconds of “sleep” then “awake” resident may not even recognize,
- increased tolerance for risk,
- passivity,
- inattention to details,
- decreased cognitive functions,
- irritability,
- motor vehicle collisions (or near misses),
- increased errors,
- impact on sleep process itself,
- voluntary and involuntary latencies (the time to fall asleep) shorten, and
- increased number of “microsleeps”.

One of the first skills lost is the ability to do something quickly. If you slow down at a task, you may be able to compensate. But if the task requires a quick response, errors are more likely. Time pressure + fatigue is a major risk.

Residency training may disrupt natural circadian rhythm. This problem may be exacerbated as programs implement solutions, such as “night floats” to adhere to duty hour requirements. Night float systems are increasingly used to comply with duty hours. It takes at least a few “nights” to adjust to the night float schedule and another few nights to adjust to a return to “routine hours”. Programs should minimize the short term use of a night float system (for instance a resident who does night float Monday through Thursday and has the weekend “off” to be on their own schedule,

who returns to “night float” for another four nights. With that weekend “off” residents will usually need “to sleep”. Over 90% of individuals never habituate to night float, even if they work them chronically. Night floats should be designed to take advantage of the fact that it is easier to rotations from days, to evenings to nights, rather than vice versa.

Of particular significance for residents, perhaps, is sleep inertia, the confusion and dysfunction that occurs upon awakening from sleep during deep NREM sleep, sleep in the middle of the night, or following a period of sleep deprivation. This may occur after as brief an interval as 30 minutes of sleep. This disorientation may include a period of amnesia for the period of awakening. The impairment from sleep inertia may be greater than that from sleep loss. Opinions in the sleep medicine field differ on the significance of sleep inertia. Residents may be vulnerable to error when awakened during the night. Increased metabolic activity, such as exercise may minimize effects. Although the research evidence is inconsistent and people react with a great deal of individual variability, be aware this phenomenon may occur and may color judgment and responses for the first 10 minutes (and up to 2 hours) following arousal.

To minimize its impact:

- get out of bed,
- stand up,
- turn on the lights,
- try to nap every 12 hours; the earlier in a period of sleep deprivation “on call” the better,
- consider the use of *prophylactic* caffeine.

## **PREVENTION/TREATMENT/MANAGEMENT OF FATIGUE**

It is probably inevitable there will be some sleep loss and fatigue in the course of medical training. However, it must be managed so it does not interfere with patient care and safety, education, and resident well-being. Developing strategies to minimize the effects of sleepiness in physicians is paramount. Learning to recognize and manage fatigue is essential. Anecdotal and empirical evidence exists suggesting that limits on work hours in and of themselves do not guarantee well rested and optimally functioning residents. Work hour limits are difficult to enforce, particularly if residents have workaholic tendencies or if faculty does not support work hour restrictions. In addition, resident behavior outside of the work place is difficult to govern (i.e. moonlighting activities, home responsibilities, etc.). Residents are adults who cannot be forced to be adequately rested.

## **PROGRAM DIRECTORS AND THE MANAGEMENT OF RESIDENT FATIGUE**

Program Directors should directly ask about issues pertaining to getting adequate sleep, resident safety such as post-call driving, and resident concerns about the balance between professionalism and work hour restrictions. Where an individual program has particular issues with fatigue, enlist residents in developing particular program solutions.

Driving home post call is a particular concern for the safety and well-being of residents. It takes four seconds to drive off the road and have a motor vehicle collision. Four-second “micro sleeps” are common in sleepy residents. Some states have adopted laws, which now make a criminal,

(not just civil offense) for motor vehicle collisions after 24 hours without sleep. Other states will probably follow.

For many residents, the ability to manage fatigue will be a necessary lifelong skill.

## **RESIDENTS RECOGNIZING VULNERABILITY AND SYMPTOMS IN THEMSELVES AND OTHER RESIDENTS**

Although there is individual variation, most adults need eight hours of sleep per night. The impact of too little sleep is cumulative. You can't "will yourself" to act against the neurobehavioral effects of sleep loss. Sleepiness is affected by the amount of time since you last slept, whether or not you have any pre-existing sleep debt, as well as the time of day reflecting circadian rhythm. People typically under-estimate their degree of sleepiness. So as with alcohol, by the time you think you're sleepy you're probably profoundly affected. Your performance level will fall especially with tasks that require a great deal of attention. Even if you feel you're not at risk, consider that your colleagues may be. Watch out for your fellow residents.

If it is a boring lecture, noted author Dinges says, "You'll be awake and annoyed but not asleep". If you are nodding off or falling asleep this is a major symptom that you're too fatigued. You're experiencing "microsleep". Your system is making you sleep without you being able to control this phenomenon. This makes you extremely vulnerable for diminished attention and cognition. You can more easily make poor judgments medically and/or sustain a motor vehicle collision when you're driving home post call.

Driving can put you and others at risk. Motor vehicle collisions increase with fewer than 5 hours of sleep. The first ethical principle of physicians "primum non nocere" (first, no harm) applies to all we do as physicians, including driving. It takes four seconds to run off the road. Signs of drowsiness include difficulty focusing on the road or keeping your eyes open, nodding off, yawning, drifting from one lane to another, missing exits, and amnesia for some period of the drive.

- Consider how close you should live to the hospital. It may be appealing to live 30-40 minutes away, but this may increase your risk of driving home post call.
- Avoid driving if you're tired.
- Chewing gum, loud music, opening the windows...these strategies don't work to keep you "awake at the wheel" if you're tired. Instead, don't drive.
- Realize you may not perceive just how tired you are. Even if you feel perfectly well, you are still vulnerable.
- Consider getting a ride home with a friend, use public transportation (when available) or even a taxi. A cab is less expensive than a ticket or an accident.
- Consider taking a nap before driving home post call. Strategically use caffeine.
- Immediately stop driving if you find yourself becoming drowsy. Find a safe location and nap.

Residents should be careful stewards of their time off. There is a temptation to cram way too much into the hours free from programmatic responsibilities. During off hours pursuits include time for professional reading, family and friends, hobbies, and spiritual and community connections. Although all of these are important, protect your recovery time.

You should practice setting reasonable priorities, especially if this is something that you have not had sufficient practice with during your years in college and medical school. It will be an important habit for the rest of your career.

Excessive fatigue can affect every facet of your life. Try to be appropriately selfish about your needed sleep time. You can honestly never, for instance, read enough. Don't short change your sleep to try to "read it all".

Healthy sleep patterns are more likely if you develop a healthy sleep routine. Some of these seem obvious but deserve a reminder.

- Aim for seven to nine hours of sleep per night. This is especially true after a period of sleep loss, such as a busy rotation, is anticipated.
- On the days following your time "on call" and particularly your 24-hour period per week off, make sure you're getting sufficient catch up sleep; at least enough to feel "rested" when you wake up. It's tempting to try to "make up" everything you haven't been able to accomplish due to your busy professional schedule, but make rest a priority.
- Keep to a routine when possible. Going to bed and arising about the same time may help.
- Get adequate exercise but avoid it directly before sleep.
- Eat right. Try not to go to bed hungry, however, eating a large meal within three hours of sleep may keep you awake.
- Make the bedroom comfortable with appropriate mattress, pillow, cooler temperature, sound and lighting level.
- Develop relaxation rituals before sleep such as reading, meditation, or listening to music. Your workday may have been extremely intense. You may come home to additional responsibilities, even enjoyable ones, such as spending time with a significant other or children. Decompressing helps sleep.
- Protect sleep time. Turn off the phone. Ask your family/significant others, friends to help you. Try not to incur a sleep debt from non-work activities.
- Get light exposure when you're awake

Naps can prevent and ameliorate *some* degree of fatigue. However, there are some caveats that should be observed.

- Brief (one to two hours) napping **prior** to prolonged period of sleep loss, such as 24 hours on call, can enhance alertness. Consider a two-hour nap prior to a 24-hour period of expected wakefulness.
- To be therapeutic during a shift, naps should ideally be frequent (every two to three hours) and brief (15-30 minutes);
- Naps work best the "earlier" they are in a period of sleep deprivation. If you can pick just one nap, get it as early in the period of sleep deprivation as possible. Better to "top off the tank" early than wait till very fatigued.
- Time naps during circadian window of opportunity, between 2-5 a.m. and 2-5 p.m.
- Longer naps, such as those more than 30 minutes duration *may* be counter-productive in terms of "sleep inertia". But probably better than "no nap". Instead know how to counter sleep inertia. Get moving, get upright, bright lights, caffeine, etc.
- Utilize quiet, environmentally comfortable locations for naps, ideally where there are no other interruptions such as colleagues dictating or using the computer. Hand over beepers and clinical responsibilities to another colleague when possible.

Finally, residents, as do other individuals, may have a primary, undiagnosed sleep disorder such as obstructive sleep apnea, narcolepsy, and insomnia.

Residents may also display symptoms of “fatigue” or attribute symptoms to fatigue when the etiology is in fact anxiety, depression, stress, burnout, or career dissatisfaction.

Sometimes you’re approached about making a swap of schedules and you certainly want to accommodate a colleague. But consider your own sleep need as part of this decision and you may need to pull in a chief resident or program director to see if you’re the best person to meet this need.

Of particular concern is moonlighting. There are certainly marked financial needs faced by today’s residents and the pressure to meet those needs may force you to sacrifice time needed for rest. Think carefully through the level of debt burden you are comfortable carrying and the consequences of that debt if it adds to your workload.

Using caffeine, a central nervous stimulant, “strategically” can help manage fatigue. **It is not a sleep substitute.** Tolerance quickly develops. If you intend to use caffeine to counteract fatigue, minimize the regular social use of caffeine so that it will be more effective when consumed. Caffeine may modulate symptoms but does not substitute for sleep.

The effects of caffeine generally occur within 15-30 minutes. If you use it just before you drive home its stimulant effects may not kick in until you are home and ready to go to sleep.

Avoid regular caffeine use (the social use of caffeine) if you plan to use to abate sleepiness. Instead use it for its “drug effect” when you are on call only.

- Three to four cups (400-600 mg) brewed coffee is a usual dose, but some individuals may be overly sensitive to this amount. Center for Science in the Public Interest [www.cspinet.org/new/cafechart.htm](http://www.cspinet.org/new/cafechart.htm) Accessed 2-17-04
- Consider using caffeine 30 minutes **prior** to drive home following night call.
- Useful only for temporary relief of sleepiness. (The benefit typically lasts three to five hours).
- Adverse effects include disruption in sleep quality, tolerance, diuresis and irritability.
- Sleep inertia symptoms can be minimized.

substance	Caffeine content
8 ounce cola	23 mg
8 ounces diet cola	35 mg
8 ounces brewed Coffee	135 mg
8 ounces ice tea	40 mg
1 ounce dark chocolate	20 mg
Excedrin, 2 tablets	130 mg
No Doz maximum strength 1 tablet	200 mg

It is important for residents to avoid self-medicating or prescribing casually for colleagues. The Medical Board of California **does not allow** self-prescribing. It is far better for residents, as for patients, to have a regular physician who coordinates their care. Your license can be at risk if you violate the rules of the Board.

Sleep medications to increase sleep (sedative hypnotics) or stimulants should be used only **after** a complete medical/sleep consultation.

- Melatonin induces sleep onset and may be used for circadian rhythm disturbances. There are few data applicable to evaluate its use for residents.
- Sedative hypnotics such as zolpidem (Ambien) and zaleplon (Sonata) and/or behavioral therapy may be prescribed for certain sleep disorders and the military is testing these products for settings of sleep deprivation. They are not indicated for chronic use.
- Adverse medication effects are common and include headache, drowsiness, disorientation, GI disturbance and dizziness.
- Alcohol should not be used to enhance sleep and disrupts optimal sleep quality.
- Avoid the use of over-the-counter stimulants.
- Stimulants such as methylphenidate (Ritalin), dextroamphetamine (Dexedrine), modafinil, and pemoline should not be used unless prescribed by one's own personal physician for an appropriate medical condition.
- Alcohol is a drug with sleep effect. Try to avoid or minimize. Realize the impact of fatigue and alcohol on performance and driving are cumulative.

## **SLEEP DEPRIVATION RESOURCES**

If a resident or faculty member is concerned about a resident having a potential sleep disorder, they can obtain help through their respective Department Chairman.

Sleep loss and sleepiness are pervasive problems during residency training and can account for serious professional errors and personal problems. Symptoms and signs are often difficult to recognize. Whereas there are many ways to deal with the sleepiness and fatigue, the only real treatment is getting adequate sleep. Other management strategies should be individualized, especially if there is an underlying sleep disorder:

1. The SAFER (Sleep, Alertness and Fatigue Education in Residency) program developed by the American Academy of Sleep Medicine (AASM) with representatives from the ACGME and AMA. They have (for purchase) an educational module designed to increase knowledge and awareness about sleep and fatigue among the medical community which includes a slide set, syllabus, and pre and post tests. <http://www.aasmnet.org/safer.htm>
2. Presentations at ACGME Lecture series.
3. Dr David Dinges' Presentations available through the web sites: [www.acgme.org](http://www.acgme.org) and [www.aamc.org](http://www.aamc.org).

# SECTION IV: DUTY HOURS

## DUTY HOURS

Each resident shall perform his or her duties during such hours as the Program Director may direct in accordance with the policies and requirements of the Program, subject to the periodic modification and variation as determined by the Program Director depending upon the clinical area to which a resident is assigned and exigent circumstances. All duty hours shall be in accordance with State, Federal, ACGME and other applicable requirements. The call schedules and schedule of assignments shall be made available to residents. Changes to these schedules shall be available in the office of the Program Director. Residents shall comply with all assigned schedules in a timely fashion

ACGME institutional and program requirements take precedence over all other policy statements and apply to all institutions at which residents rotate.

## REPORTING OF DUTY HOURS

Completion of a time-study survey recorded in **E\*Value** is required from each resident on a continuous basis. Program directors will consistently monitor the duty hours in support of the residents' physical and emotional well-being, prevention of sleep deprivation, and assess resident fatigue based on these records.

## ON-CALL ACTIVITIES

On call duties shall be in compliance with current ACGME duty hour regulations. On-call rooms are provided for residents with nighttime duty hours. Any house officer working in excess of the hours mentioned above, is strongly encouraged to report the situation to their Chief Resident, Program Director, Department Chair or to the Chief Academic Officer as any program accredited by ACGME must abide by the principles and policies as stated above.

## MOONLIGHTING/OUTSIDE (OF TRAINING) ACTIVITY

The resident is considered a professional who has agreed to commit full time effort toward his or her training in the residency-training program, and agrees that all moonlighting (outside activities) will require the prior written approval of the Program Director. The resident, while engaged in activities outside the scope of the residency training program is not covered by the professional liability insurance provided by the county under the GMEA during the performance of such activities.

Residents are NOT REQUIRED to moonlight or to perform temporary special medical activity. Moonlighting/temporary special medical activity may be allowed at the PGY-2 and above level, unless otherwise stipulated by residency department policy. Moonlighting/outside (of training) activities shall not interfere with performance in the residency program, which may be reflected by any of the following:



- Reports of arriving late, leaving early, or decreased clinical work performance due to fatigue resulting directly or indirectly from moonlighting/outside (of training) activities.
- Poor or deteriorating performance in any area covered in the formal evaluation process.
- Deterioration of health or psychological well-being of the resident.
- Any reported deficiencies in performance while on off service rotations.
- Any other deficiency of performance, the correction of which is impeded by moonlighting/temporary special medical activity activities.

Prior to each moonlighting episode, the resident must obtain the signed authorization form from his or her Program Director. The Program Director will evaluate the resident to ensure that no adverse effect, as stipulated above, occurs with respect to resident performance. If the Program Director determines that moonlighting is negatively impacting resident performance, moonlighting will not be allowed and written documentation will be placed in the individual’s department file.

### **CALL ROOMS - LOUNGES**

On-call rooms shall be equipped with functioning computers with intranet and internet access and telephones. On-call rooms are for on-call resident use only, and are not to be used for spouses, children, and guests to spend the night.

On-call rooms shall be kept clean and tidy for the next person on-call. Housekeeping service is available to empty the trash and replace the linens. During the day hours, housekeeping personnel shall be allowed to perform their duties. Concerns with the housekeeping services should be reported to the Program Director immediately.

Resident on-call rooms shall be equipped with a functional lock. Kern Medical shall provide reasonable notice to the Union of any change in location of the on-call rooms. An annual walk-through and survey of the on-call rooms shall be jointly conducted by CIR/SEIU and by the DME or designee to assess the status of the on-call rooms and to ensure ACGME guidelines and Union contract compliance. The walk-through shall take place during the month of October. CIR/SEIU and the Chief Academic Officer or designee shall generate a report of any repairs to be made to the call rooms and present it, through the Chief Academic Officer or designee, to the Hospital’s management for repair.

<u>Department</u>	<u>Call Room</u>	<u>Department</u>	<u>Call Room</u>
RBFM-CSV	4000	OB/GYN	R-4 = 4017
ICU Senior Room	2402	OB/GYN	R-3 = 4011
ICU Junior Room	2403	OB/GYN	R-2 = 4009
Internal Medicine	3011	OB/GYN	R-1 = 4051
Internal Medicine	4003	Pediatrics	4004
		Psychiatry	3012
		Psychiatry	3014

### **RESIDENT LOUNGE**

The resident lounge is located on the fourth (4<sup>th</sup>) floor of the A-wing, Room 4020. The lounge is to be used for relaxation. Please do not use the lounge for parties. Housekeeping service is available to empty trash and tidy the lounge. If the room is in need of cleaning please call 661-326-2117.

# **SECTION V: PHYSICIAN CONDUCT/COUNSELING**

## **RESIDENT IMPAIRMENT**

It is imperative that residents should not have their performance impaired by drugs, alcohol, or other circumstances. For residents who feel they may have such a problem, the Employee Assistance Program (EAP) and the State-sponsored are available. Every reasonable encouragement and support shall be given for this purpose. Call toll-free 24 hours a day, seven days a week: (800) 730-3859 or visit: [members.mhn.com](http://members.mhn.com) and register with the access code: kern

The EAP is available to all eligible residents and their eligible dependents. The purpose of the EAP is to provide evaluation and if appropriate, short term counseling for emotional health issues which may affect work performance or personal life. Through a confidential self-referral process, any resident has an opportunity to discuss personal situations in strict confidence with a professional.

A Chairman or Program Director may also make a formal referral if he/she feels that job performance may benefit from this service. No resident shall be disciplined or terminated for being referred to the EAP or State-sponsored program; however, disciplinary action may be taken for any underlying behavior or clinical performance issue, independent of supervisory referral.

## **SEXUAL HARASSMENT AND DISCRIMINATION**

The County agrees not to discriminate against any resident for his/her activity on behalf of, or membership in, the Union, as stated in the Employer-employee Relations Resolution. Both parties shall comply with all applicable Federal and State laws prohibiting discrimination against any resident on the basis of race, color, creed, religion, age, sex, marital status, physical disability or the resident's inclusion in a legally protected class.

The County and Kern Medical are committed to maintaining a work environment free from sexual harassment. Conduct or behavior that creates an intimidating, hostile, or offensive work environment is strictly prohibited. Any person violating this policy will be subject to corrective counseling up to and including discharge. The resident shall cooperate fully with County policies prohibiting sexual discrimination and sexual harassment and other policies that apply to the program. Kern Medical observes the County's policy of zero tolerance.

Sexual harassment/discrimination is a federal regulation called Title VII of the Equal Employment Opportunity Commission (EEOC) and is not permitted. Harassment by a resident against any individual (e.g., another resident, a medical staff member, medical center employee, or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, age, marital status, ability to pay, sex, or sexual orientation shall not be tolerated.

Sexual harassment is unwelcome verbal or physical conduct which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when:

- Submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment.
- This conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct, which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

Individuals who believe that they have been victims of sexual harassment shall inform their Program Director, the Chief Academic Officer and/or Associate DME, the Chief Executive Officer, the Medical Director, the President of Medical Staff, or the Equal Employment Opportunity Division of the Personnel Department. No individual will be retaliated against for making a complaint or bringing inappropriate conduct to the attention of the medical staff, medical center or County.

# **SECTION VI: GENERAL INFORMATION AND HOSPITAL POLICIES**

## **OUTSIDE ROTATIONS**

When a resident is participating in a rotation outside the hospital, the treatment of patients will be under the supervision of a site education director. Approval of the rotation and its corresponding Program Letter of Agreement must be presented before the GMEC at least two (2) months in advance. The site education director selected by resident and program director will provide a rotation evaluation of the resident at the completion of that rotation. He or she meets periodically with the Program Director to clarify and improve on the rotation description. Kern Medical provides payment for resident salary, benefits, and professional liability insurance if the rotation meets the approval of the GMEC.

## **COST CONTAINMENT**

The resident will do his/her best to apply cost-containment measures in the provision of patient care consistent with the policies of Kern Medical and the residency-training program. The Chairman of each residency will provide guidance to this matter to the respective Program Director as needed.

## **DRESS CODE**

The resident will comply with Kern Medical's Dress Code, including clear display of a Kern Medical identification badge, and present at all times a proper and professional appearance. The resident is expected to maintain a professional appearance while on duty in the hospital. Male residents are expected to wear a shirt, tie, trousers, and white lab coat while on duty. Female residents are expected to wear shirt/blouse, slacks, skirt, or dress and white lab coat while on duty. Tee shirts (underwear variety) are not permitted. No jeans of any color may be worn. No sandals or high heels are allowed and shoes must be enclosed. No shirts with slogans or pictures may be worn. Hair that extends below the shoulders must be contained when working in the treatment area, particularly around sterile trays. For complete Dress Code Policy Information, please refer to the Human Resources policy HRM-HR-508.00 for further details. (<http://Kern Medical net/qr/hr/HRM-HR-508.PDF>).

## **GUIDELINES FOR ABUSE REPORTING**

### **CHILD ABUSE**

Since, January 1, 1985, all persons employed as health practitioners prior to commencing employment are required to sign a statement acknowledging that they know of the provisions of Section 11166 of the Penal Code. Section 11166 of the Penal Code stipulates the provisions for reporting child abuse.

Report all cases of suspected child abuse to Social Services at 326-2865 or the patient's attending physician. During evenings, weekends and holidays, the Nursing supervisor should be contacted instead of the Social Services Department. A designee of the health care team will assume the responsibility of making the referral to Child Protective Services. First, complete a form called the Suspected Child Abuse Report form F8SA. Then place a call to 631-6011 and mail the original form to Child Protective Service, P.O. Box 511, Bakersfield, California 93302 within 36 hours.

## **ADULT/ELDER ABUSE**

California law requires health practitioners to report physical abuse under the following circumstances:

- When the reporter has observed an incident that reasonably appears to be physical abuse.
- When the reporter has observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury, clearly indicates that physical abuse has occurred.
- When an elder or a dependent adult tells the reporter that he or she has experienced behavior constituting physical abuse.

The report must be made immediately, or as soon as possible, by telephone to either the long-term care ombudsman at 661-323-7884 or to the Adult Abuse Protective Services Coordinator at 661-868-1000.

Mail the Report of Suspected Dependent Adult/Elder Abuse form to: Long Term Care Ombudsman, 615 California Ave, Bakersfield, CA 93304 or fax it to 661-868-0923.

## **WHAT IS HIPAA?**

The Health Insurance Portability & Accountability Act of 1996, (HIPAA) amends the Internal Revenue Service Code of 1986. The act includes the following:

- Improved efficiency in healthcare delivery by standardizing electronic data interchange, and
- Protection of confidentiality and security of health data through setting and enforcing standards.
- Standardizing of electronic patient health, administrative and financial data;
- Unique health identifiers for individuals, employers, health plans and healthcare providers;
- Security standards protecting the confidentiality and integrity of "individually" identifiable health information, past, present or future.

# **CONFIDENTIALITY**

## **YOUR RESPONSIBILITY**

Become familiar with the HIPAA guidelines about privacy. No one, physician/staff included, is allowed access to the patient's information unless the job duties require access to the patient information or it is documented that the patient gives verbal, and in some circumstances written, permission for that access. If a private physician does not have staff privileges at Kern Medical, he or she may not have access to the patient's health information, unless it is documented that the patient grants that privilege.

You cannot give out any information to anyone but the patient, the patient's legal representative, the patient's spouse, or a custodial parent, if the patient is a minor, without written permission. If the patient/legal representative/spouse/parent gives permission for information to be released to others, this should be specifically documented in the patient's medical record.

## **BEST PRACTICE**

### **Fax/Mail**

- Double check all fax numbers, and all addresses to ensure you are sending the correct information to the correct individual
- Periodically review and update provider information stored within a database or preprogrammed into fax machines
- Use the PHI Fax Coversheet when sending PHI

### **Minimum Necessary**

- Disclose only the minimum necessary information needed to accomplish your purpose.

### **Voicemail**

- Avoid leaving PHI in a voicemail message
- Say only your name, phone number, and your organization
- Do not leave your department name, or the reason that you are calling

### **Email**

- Always use secure email to send PHI (internally and externally)
- Do not put protected or identifying information in the subject line
- Verify presence of PHI in the email thread before forwarding; if PHI is present, send email securely
- Emails being sent outside of Kern Medical must be encrypted and password protected. The password is sent in a separate email.

### **Access to Information Systems**

- Access to Protected Health Information (PHI) is on a "Need to Know". Only access information if you are treating the patient, have been referred the patient, or have been consulted to come and see the patient.
- Never access patient records, including those of family and friends, unless you have a signed authorization

- Never share your password
- Always remember to logoff

#### Portable Devices

- PHI is **not** allowed on any portable devices to include, iPads, PDA's, thumb drives.

#### Photography

- Photography on personal cell phones **is prohibited** to include EKG or the EMR or other computer screens. Authorization by the patient is required in most instances. Please refer to Photography of Patient Policy ADM-RI-202
- Obtain patient authorization to use images for purposes other than treatment, including for external teaching and publication, because identifiable photos, videos and images (including x-rays and scans) are considered PHI

#### Security of PHI

- All PHI needs to be secure. This means that it cannot be left lying about Kern Medical, in conference rooms unattended, or placed in your car or home.
- PHI is **not** to be removed from Kern Medical campus.

## DOCUMENTATION

Well documented medical records are important, and accurate documentation must be both legible and complete. Legible signatures and completed timely entries are very important. Refrain from the use of phrases like mistake, occurrence report, or error.

## INFORMED CONSENT

It is the resident's sole responsibility to establish the patient's competence to give consent and the resident's responsibility to explain the risk, benefits, and alternatives of the procedure. It is also the resident's responsibility to obtain a verbal consent from the patient/legal representative and to document all of the above.

## NOTIFICATION OF UNEXPECTED OUTCOME

The law requires that the resident notify the patient/legal representative if an unexpected outcome has occurred, such as a complication during a procedure, medication error, etc.

## PATIENT/FAMILY'S BEHAVIOR/VERBALIZATION

If the patient's/family's behavior is hostile or a lawsuit is threatened, please call the Patient Representative at 62812.

## PERSONAL DOCUMENTATION

Please do not keep any personal notes or logs regarding the care of patients. These could be subpoenaed in litigation. After an event occurs and the resident would like to write down some thoughts, or more in depth description, notes should be delivered to the risk management

department who will keep a confidential file. Any questions regarding specific incidents incurred while on duty, even those the resident feels are not truly relevant, may be brought up and documented with risk management to minimize any potential litigation that may proceed as a result.

## **PERSONNEL DATA CHANGES**

It is the responsibility of each house officer to promptly notify Kern Medical's Medical Education Office of any changes in personnel data. Personal mailing addresses, telephone numbers, numbers and names of dependents, individuals to be contacted in the event of an emergency, and other such status reports should be accurate and current at all times.

## **STANDARD OF CARE**

It is important that the standard of care for the medical professional, the specialty, and the community be followed in caring for patients. If the resident's care were to be evaluated by an expert witness, would it meet the standard of care?

## **IDENTIFICATION BADGE**

A Kern Medical identification badge must be worn while on duty that displays the resident's first name, last name, department, and classification. The identification badge should be worn in an easily visible location (e.g., shoulder, chest, and outer layer of clothing, facing forward). The hospital provides each resident with an identification badge on entering the program. The resident is responsible for the cost of any replacement badges.

## **MEDICAL RECORDS**

### **PATIENT RECORDS AND FILES**

The resident will prepare and maintain, or cause to be prepared and maintained, all reports, claims, correspondence and records relating to all professional services rendered pursuant to the Graduate Medical Education Agreement (GMEA). The resident further agrees to prepare and maintain, or cause to be prepared and maintained, all records and reports in accordance with all federal and state statutes and regulations, and policies adopted by Kern Medical.

The resident acknowledges that all patients seen by them within the scope of the program are patients of Kern Medical and that all records and patient files relating to such patients belong to and are the property of Kern Medical. Upon the termination of the GMEA, except as provided in section 9.1 of the GMEA, the resident will have no claim or right to access to Kern Medical's books, records, accounts, case histories and reports, patient lists, patient charts, files, memoranda, accounts receivable, or other records. Notwithstanding the foregoing, upon the termination of the GMEA, the resident will, upon request and for legitimate purposes as determined in the reasonable discretion of Kern Medical, and at reasonable times, be entitled to inspect medical records of patients with whom the resident worked while appointed to the residency training program to the extent permitted by applicable law.



## **TIMELY COMPLETION OF PATIENT RECORDS**

If records are incomplete a physician should log on to the hospital electronic medical record system to check for notification of medical record deficiencies. Some deficiencies (i.e. signatures) can be completed in the hospital EMR while others may require coming in to Health Information Services to complete any signatures that are in a paper format and will be scanned into the hospital records archival system. The hospital has a hybrid medical record which consists of medical records both in paper and electronic format. The state of California requires that there are zero delinquent medical records. All portions of the medical record must be completed immediately upon documentation in the EMR and as soon as the completed data is available for signature.

Residents should refer to their Residency Program policy manual relative to completion of medical records. All completion of medical records will conform to the Medical Staff Rules and Regulations. All hospital associates must also comply with Health Information Services Policy HIS-IM-101 The Legal Medical Record. Failure to accurately complete medical records within the time limits established by the Medical Staff Rules and Regulations and Kern Medical policies will result in a suspension from all clinical duties and the same will be noted in the resident's academic file. Automatic suspension is enacted at the expiration of five (5) business days after the resident is given written notice to complete the record(s). Suspension will continue until all delinquent medical records are completed. Failure to complete medical records after two (2) months from the date the suspension became effective, shall be deemed a voluntary resignation by the resident. A resident physician may be contacted by the HIS department following HIS department policy HIS-IM-101, in order to facilitate completion of a medical record for legal and revenue cycle purposes and compliance is required. A resident will not receive a diploma upon graduation if they have not completed all the medical records which they are responsible for.

## **RESIDENT RECORDS**

The resident authorizes and consents to the release of information by the (1) Program Director, (2) Chief Academic Officer or Associate Director of Medical Education, or (3) other physicians involved with the program evaluation of the resident. Such information may be disseminated to other hospitals, teaching programs, medical associations, medical staff, certification boards, or other such entities or persons seeking to evaluate the resident's professional qualifications. The resident hereby releases such persons from any and all liability, cost, and expense related thereof.

Resident performance evaluations will be provided in accordance with County policy and ACGME requirements:

All residents shall have the right to access and review all documents placed in their individual academic, departmental, and employment files during the term of their appointment, excluding pre-appointment references. Copies shall be provided at the County's expense within five (5) business days where a reasonable need therefore is established. The County will provide records once per year at the County's expense. Residents should make all requests for access and review of their individual files to the Department of Medical Education. Access shall be provided within two (2) business days of the request.

## **PARKING**

Parking is provided in accordance with Kern Medical policy, which may be revised from time to time. Certain parking areas require a parking sticker and gate card. If requested, Kern Medical shall provide escort services for residents when going to and from parking lots and other buildings on the Hospital campus.

## **SECURITY**

The County shall provide a healthy and safe work environment for residents and comply with City, State and Federal health and safety laws.

The County shall make safety training available to all residents who work at Kern County facilities, and/or web-based online safety training for residents. All residents shall receive training on how to de-escalate violent patients.

If at any time the resident feels uncomfortable walking to his or her car alone or the resident needs to report a security issue, please call Security at extension 62056. The Security office is open 24 hours a day to accommodate such needs.

Upon reasonable notice, the Kern Medical Director of Security or designee shall attend regularly scheduled meetings of the Resident Advisory Council to discuss resident safety and security concerns, safety and security initiatives, and changes within the Hospital, recommendations for improvement, and other items and matters related to resident safety and security.

## **ELECTRONIC DEVICES**

Please see Kern Medical Policies No COM-IM-264 attached.

# SECTION VII: COMPENSATION\*

The appointment of a resident shall be based on the resident's appropriate post-graduate year (PGY) level, as depicted in the following chart, which shall be determined as follows:

1. A resident who has not completed at least one year of service in an ACGME accredited training Program or an equivalent Program shall be placed at the PGY-1 level.
2. Residents shall be placed at PGY levels commensurate with their training in the Program in which they are appointed.
3. A year of service in a training Program as herein referred to shall mean a year of service in a training Program that has been certified as having been completed by the appropriate authority.
4. A resident who successfully completes his or her service for a year and is reappointed to serve for an additional year shall be advanced to the next higher PGY level.
5. Residents who have satisfied the eligibility requirements set forth in Exhibit A of the Graduate Medical Education Agreement and who are eligible for employment in the United States shall begin being paid as of the effective date of resident's individual Graduate Medical Education Agreement.

The salary schedule for represented residents shall remain unchanged for the term of the MOU. The following chart depicts the current salary ranges for residents covered by this MOU:

Resident I- Bi-weekly: $1,791.30 \times 26.089 = \$46,733.23$ Annual
Resident II-Bi-weekly: $1,916.69 \times 26.089 = \$ 50,004.52$ Annual
Resident III-Bi-weekly: $2,050.85 \times 26.089 = \$53,504.63$ Annual
Resident/Fellow IV-Bi-weekly: $2,194.43 \times 26.089 = \$57,250.48$ Annual
Resident/Fellow V-Bi-weekly: $2,348.07 \times 26.089 = \$61,258.79$ Annual

The County shall withhold from the compensation paid to each resident applicable State and federal income taxes and other required deductions. The County shall pay the employer's portion of the FICA 1 (Social Security) and FICA 2 (Medicare) contributions, and all other employer taxes and insurance, as applicable and as required by law.

## ELIGIBILITY FOR BENEFITS

Residents who are enrolled full time in a training Program are entitled to full benefits. Residents employed at 0.5 FTE or greater but less than full time are eligible for prorated benefits. Residents employed less than 0.5 FTE are not eligible for benefits. All requests for less than full time status must be approved by and are at the sole discretion of the Department of Medical Education upon recommendation of the Program Director.

\* The county reserves the right to modify or discontinue the plan of benefits set forth herein at any time on a prospective basis only.

Residents are eligible for coverage the first day of the biweekly period coinciding with or following the day they complete one month of continuous service. For further information, please contact the Department of Medical Education or the County Administrative Office Health Benefits Division at (661) 868-3182.

All eligible residents shall be required to pay, by payroll deduction, twenty percent (20%) of the insurance premium for the residents' medical, dental, and vision insurance except for residents who decline the County's health insurance coverage in accordance with the provision provided below.

New residents may decline coverage under the County's health insurance provided that the resident executes a declaration, in a form acceptable to the County, in which the resident: (i) declares that the resident has medical insurance coverage for the resident; and (ii) declines coverage under the County's health insurance program for resident and the resident's eligible dependents. New residents who decline coverage may not enroll in the County's health insurance program until the next open enrollment period. New residents who have not declined coverage shall have the option of obtaining County health insurance for the new resident's eligible dependents. In the event that such residents opt to obtain health insurance for eligible dependents, the resident shall be required to pay, by payroll deduction, twenty percent (20%) of the appropriate premium for dependents. The health insurance program offered to new residents and their eligible dependents shall consist of three components: medical, dental and vision. That program must be accepted or declined in its entirety. It is not permissible to pick and choose among those components.

The County shall continue to provide an annual open enrollment for residents to change plans and/or enroll eligible dependents.

## **VACATION**

- A. During the first four years of consecutive service, each full time resident will be credited with 160 hours of vacation leave (20 working days) for each one-year term of service. Beginning with the fifth year of consecutive service, each full time resident will be credited with 176 hours of vacation leave. Vacation leave shall accrue on the commencement date of the resident's individual Graduate Medical Education Agreement, and shall be pro-rated from the commencement date of each academic year. The academic year begins on July 1<sup>st</sup>. Vacation leave may be taken at any time thereafter.
- B. Part time residents shall earn vacation leave at a rate proportionate to full time residents, based on the number of regular hours worked by the part time resident per pay period in relation to 80 hours.
- C. Vacation is to be taken at the mutual convenience of the resident and the Program Director. The standard vacation increment is a two-week block. (For the purpose of calculating vacation leave, a one-week block is defined as five (5) days and includes Monday through Friday and contiguous weekend days preceding and following the five (5) day block.) This may vary from program to program.

- D. In general, vacation during the month of June will not be granted. Vacation during the month of June will be approved only under special circumstances.
- E. Vacation leave not taken at the expiration of each one-year term of service shall be credited to the next consecutive one-year term of service up to a maximum number of 480 hours. If the maximum accrual amount is reached, the resident shall not earn (accrue) vacation leave until the vacation leave is reduced below the maximum.
- F. A resident shall be paid for accrued and unused vacation leave upon termination of employment.
- G. All vacation leave must be approved in advance by the Program Director.

## **SICK LEAVE**

- A. Each full time resident will accrue sick leave credit at the rate of 2.46 hours per biweekly pay period, for a maximum accrual of 64 hours (eight [8] days) per year. Total unused sick leave accumulated will not exceed a maximum of 321 hours. If the maximum accrual amount is reached, the resident shall not earn (accrue) sick leave until the sick leave balance is reduced below the maximum.

Part time residents shall earn sick leave at a rate proportionate to full time residents, based on the number of regular hours worked by the part time resident per pay period in relation to 80 hours.

- B. Residents may be granted sick leave with pay up to the maximum number of hours of sick leave accrued and under the terms and conditions set forth in the Kern County Administrative Procedures Manual.
- C. Accrued sick leave hours remaining at the expiration of each one-year term of service will be credited to the next consecutive one-year term of service to a maximum of 321 hours.
- D. Residents will not be paid for accrued and unused sick leave upon termination of employment.

## **HOLIDAYS**

Residents shall be entitled to all paid holidays authorized as official holidays for the Authority employees. If a resident is scheduled for and works on an official holiday, the resident shall be granted an alternate day off. The resident shall not be paid for accrued and unused holidays upon termination of employment.

## **RETIREMENT**

Residents are eligible to participate in the Kern County Deferred Compensation Plan (457 Plan) on a pre-tax basis. Residents shall be required to make all contributions if electing to participate in the 457 Plan.

## **WORKERS' COMPENSATION**

The County provides workers' compensation coverage as required by law to protect employees who are injured on the job. This coverage provides payment for medical expenses and temporary disability (in lieu of lost earnings) for workers who are injured in the course of their employment. Temporary disability payments begin on the first day of hospitalization or after the third day following a lost time injury if an employee is not hospitalized. The County finances and administers this coverage under a state approved self-funded program

## **LONG TERM DISABILITY INSURANCE**

Long-term disability insurance coverage may be purchased from Chimienti & Associates through payroll deduction. For further information, please contact the Department of Medical Education or the County Administrative Office-Health Benefits Division at (661) 868-3182.

## **SHORT TERM DISABILITY INSURANCE**

Short-term disability insurance and accident policies may be purchased from Chimienti & Associates through payroll deduction. To arrange this, call (877) 733-1670 X 17 and speak to a specialist. For further information, contact the Department of Medical Education or the County Administrative Office-Health Benefits Division at (661) 868-3182.

## **LIFE INSURANCE**

Eligible residents and their eligible dependents may purchase additional term life insurance coverage from Chimienti & Associates through payroll deduction. For further information, please contact the Department of Medical Education or the County Administrative Office-Health Benefits Division at (661) 868-3182.

## **STATE DISABILITY INSURANCE**

The County has an integrated disability plan with the State. The resident's wages are integrated with the disability payments from the State, which enables the resident to extend his or her sick leave or vacation leave. The resident's wages (sick leave and vacation leave used) are offset by disability payments and the corresponding sick leave and vacation time is restored to the resident's sick leave and vacation balances.

State Disability applications are available from the Kern Medical payroll clerks and the Auditor-Controller-County Clerk. The mailing address, Box 1 on the application form, should indicate: c/o Auditor-Controller-County Clerk, 1115 Truxtun Avenue, 2<sup>nd</sup> Floor, Bakersfield, California 93301. The disability checks will be sent to the Auditor-Controller-County Clerk, where they are

photocopied and used to offset against wages paid for the period covered on the disability check. The checks are mailed to the resident the same day

## **FAMILY SICK LEAVE**

Residents are entitled to use accrued sick leave to take time off for the illness of an immediate family member up to a maximum of ten (10) days per year. Immediate family member is defined in Chapter 1, Section 119 of the county Administrative Procedures Manual.

## **FAMILY CARE LEAVE**

Family and medical leaves of absence (including leave for the birth and care of a newborn, placement of a child with an employee for adoption or foster care, care of a spouse, child, or parent who has a serious health condition or serious health condition of the employee) will comply with State and federal law.

## **PERSONAL LEAVE**

Residents may be granted, upon proper written request and approval of Kern Medical, the Program Director and the Director of Medical Education a leave of absence without pay not to exceed three (3) months for personal reasons. Approval of such leave without pay under this section shall be conditioned on finding that: (i) the situation or condition necessitating leave is not remedial by other means; (ii) refusal to authorize leave will result in personal hardship or suffering for the resident or his or her immediate family; and (iii) the absence of the resident will not substantially interfere with the service of the affected clinical department. All vacation leave and holiday hours must be exhausted prior to the effective date of the leave of absence. Whenever a resident who has taken a personal leave desires to return before expiration of such leave, the resident will notify Kern Medical in writing at least five (5) calendar days in advance of the return. The resident will promptly notify the Program Director and Director of Medical Education of his or her return.

## **LEAVE OF ABSENCE WITHOUT PAY**

- A. If a resident is absent from duty due to illness or disability for a period exceeding accrued sick leave and vacation leave hours, the resident shall not be entitled to compensation for such absence. The resident may be placed on a "leave-without-pay" status during such absence.
- B. If a resident is absent from duty for reasons other than illness or disability for a period in excess of accrued vacation leave or holiday hours, the resident will not be entitled to compensation for such absence. The resident may be placed on a "leave-without-pay" status during such absence. Extended leave for any reason may impact the successful or timely completion of the resident's progress. Residents expressly acknowledge that training after a leave of absence may be required to satisfy the criteria for completion of the Program or eligibility for certification by the relevant certifying board.
- C. The leave of absence may not exceed six (6) months in duration.

## **HEALTH BENEFITS DURING A LEAVE OF ABSENCE**

Any resident taking a leave of absence must complete a Health Benefits Leave of Absence form, which is available from payroll/personnel clerks in the HR department. The County will continue to contribute toward coverage as outlined in the Health Benefits Leave of Absence form. During a Leave of Absence without pay, the resident becomes responsible for his or her benefits portion that is normally paid by the County. For more information, please contact the Kern Medical Human Resources Department or County Administrative Office-Health Benefits Division at (661) 868-3182.

## **JURY DUTY**

Kern Medical policy enables residents to fulfill the civic responsibility of serving on juries or appearing as a subpoenaed witness without loss of pay or benefits. All residents are eligible for this benefit. When a summons, subpoena, or other legal notice for appearance is received the resident should notify the Program Director immediately. In the case of jury duty, the Program Director will approve the absence and consider it an authorized absence with full pay. Proof of appearance, including complete dates of service, must be submitted when the resident returns to work. In those instances, when the resident's continued presence is crucial to the operation of the department, the Program Director is authorized to furnish a letter of explanation (addressed to the Presiding Judge) requesting that the resident be excused. The absences will not be counted as sick pay or vacation regardless of the duration of the jury service.

## **BEREAVEMENT LEAVE**

A resident may be granted the use of up to ten (10) days of accrued sick leave for the death and/or funeral of a member of his or her immediate family. Immediate family member is defined in Chapter 1, Section 119 of the County Administrative Procedures Manual.

## **MILITARY LEAVE**

Military leave is granted in compliance with state and federal law.

## **FELLOWSHIP/POST-RESIDENCY EMPLOYMENT INTERVIEWS**

During the final year of residency training, a resident may take up to five (5) days of paid leave for interviews related to fellowship training or post-residency employment.

## **MISCELLANEOUS**

### **KERN\$FLEX**

The residents covered by this MOU are eligible to participate in the plan known as KERN\$FLEX I, which was developed and is maintained to meet the appropriate requirements of sections 105, 106, and 129 of the Internal Revenue Code of 1986, as amended. KERN\$FLEX I included flexible spending accounts for dependent care expenses, un-reimbursed medical expenses, a premium reduction component for resident contributions to County health insurance programs, and other specified insurance programs.



The administration of KERN\$FLEX I shall be regulated by the Plan Document, as adopted and periodically amended, by the Kern County Board of Supervisors and by applicable State and federal laws.

### **DIRECT DEPOSIT**

The County shall require that all residents receive their pay and qualified expense reimbursement via direct deposit. Residents should contact payroll at (661) 326-2306 to obtain an application

### **UNIFORMS/LAB COATS**

Lab coats are provided upon entry into the Program. Kern Medical shall furnish two (2) lab coats for categorical residents and one (1) lab coat for preliminary residents. Residents are responsible for maintenance of the lab coats. Scrubs will be issued to residents in General Surgery, Emergency Medicine, and OB-GYN, and all residents on rotations in these departments. Scrubs will be issued via a scrubs vending machine. Residents will be given a card that allows access to two (2) sets of scrubs at a time. One (1) set of scrubs shall be issued to Internal Medicine, Family Medicine, and Psychiatry residents.

### **MEAL ALLOWANCE**

Kern Medical shall arrange that the food left over from the food prepared daily for residents be packed, date stamped with preparation dates, and stored at the end of the day so that the food is available for the night meal. Kern Medical shall prepare sufficient food daily to ensure that healthy night meals are available or provide frozen meals for all residents who are assigned to nighttime duty or in-hospital on-call duty.

### **TERMINATION OF BENEFITS**

Resident benefits will end on the last day of the bi-weekly payroll period during which his or her contract ends. Benefits will also end on the due date of any unpaid resident contribution. Check with the Human Resources Department for any additional information related to this matter.

## **PAYROLL AND PAY DAYS**

Each biweekly payroll period begins at 12:01 am on a Saturday and ends on a Friday at 12:00 midnight two weeks later and is identified by the calendar year and a sequence number. All residents are paid biweekly or every other Tuesday. If there is a holiday on that Tuesday or any other day from the end of payroll period to payday, payday may fall on a Monday or Wednesday. Payroll warrants will not be released in advance of paydays, excepting scheduled mailings.

## **CONSOLIDATED OMNIBUS RECONCILIATION ACT (COBRA)**

COBRA requires that Kern Medical offer residents and their families the opportunity for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where coverage under the plan would otherwise end. Residents covered by the County of Kern's health benefits programs have a right to choose this continuation coverage if he or she loses health insurance coverage because of reduction in hours or the termination of employment for reasons other than gross misconduct. The spouse and eligible dependents of a resident, are also covered by the County of Kern's health benefits programs, and have the same right to choose continuation coverage. For further information, please contact the Department of Medical Education or the County Administrative Office-Health Benefits Division at (661) 868-3182.

# SECTION VIII: LEGAL PROTECTION AND WORKPLACE SAFETY

## INFECTION CONTROL AND PRECAUTIONS

Infection Control means doing everything possible to prevent illnesses acquired in the health care facility. In the health care setting, the resident is exposed to germs that can make him or her sick and keep him or her out of work. Since agent and host factors are the most difficult to control, precautions that are needed include:

- Hand washing is the single most effective step in preventing infections;
- Wear gloves any time contact with blood or other potentially infectious materials is likely;
- Mask, face and eye protection are used when splashes or sprays of blood or other potentially infectious material are likely;
- Gowns and protective apparel are used when splashes or sprays of blood or other potentially infectious material are likely.

Sharps is a word used to describe any object that can penetrate the skin such as needles, knives, scissors, razor blades and broken glass. Accidental needle sticks cause most of the cases of exposure to HIV and HBV. To prevent this:

- Never shear or break contaminated needles or other contaminated sharps;
- Never bend, recap or remove sharps from engineered sharps injury protection devices;
- Always place used sharps carefully in the container and make sure they are fully inserted;
- Do not overfill the sharps containers;
- Sharps containers should be closed and sealed so that the container is leak resistant and incapable of being reopened without great difficulty.

These precautions take the guesswork out of protecting yourself and others as you provide essential health care.

## REPORTING ACCIDENTS, ILLNESSES, AND EXPOSURES

To report during the day time 8:00 a.m. to 5:00 p.m., Monday – Friday, excluding holidays, see the Unit Supervisor where the accident occurred for forms to report the incident. During the evening and night hours, or on holidays, contact the Nurse Supervisor (661-326-2685) on duty to report the incident.

It is the **responsibility of the resident to report any and all injuries** that occur while at work. Regardless of the type of injury, the incident must be reported to the Unit Supervisor and Employee Health Coordinator (661-326-2069) on the date of the injury but no later than the next working day.

All injuries, whether treatment is accepted or declined, must be documented and reported. Kern County has designated specific physician sites that provide treatment and evaluation of industrial injuries. To obtain this care, the resident must first acquire the appropriate forms from one of the resources listed above.

If the injury is a needle stick or mucous membrane exposure or an infectious communicable disease, the incident must immediately be reported to the Unit Supervisor and Employee Health Coordinator (no later than 12 hours) for assessment and the need for prophylactic care. The Infectious Disease Specialist on call may be contacted to answer any additional questions.

## **RISK MANAGEMENT/SPEAKING TO THE PRESS**

The resident must report immediately to the Kern Medical County Counsel's Office at 661-868-3638 when any inquiry comes from a private or government attorney or investigator. The resident must contact the Kern Medical Administration by calling 661-326-2102 when any inquiry comes from a member of the press. The resident may communicate with an inquiring attorney or investigator or any member of the press only to refer such attorneys and investigators to the County Counsel's office and to refer the press to Kern Medical Administration. The Human Resources Department receives on a resident's behalf all summons, complaint, subpoena, or court paper of any kind relating to the resident's duties. The Kern Medical Compliance Coordinator and Privacy Officer [661-326-2048] in turn contacts the resident when a subpoena is served and received at the Human Resources Department.

The County Counsel's Office can be reached at 661-326-2018 from Monday through Friday between 8:00 a.m. to 4:30 p.m. when there are questions about a legal question, or patient consent or competency, sentinel event (an unexpected occurrence involving death or serious physical or psychological injury), or when a resident is personally served with a summons or subpoena involving a Kern Medical patient, or any other legal questions.

## **COMPLIANCE WITH LITIGATION**

The resident agrees to cooperate fully with Kern Medical Administration, the Kern Medical Compliance Coordinator, all attorneys retained by the County on behalf of Kern Medical, including, without limitation, the Office of County Counsel, and all investigators, committees, and departments of Kern Medical, particularly in connection with the following: (a) evaluation of patient care; (b) review of any incident or claim; or (c) preparation for litigation, including investigation, discovery and defense, whether or not the resident is a named party to that litigation. The obligations of the resident to cooperate in any investigation, discovery and defense will survive the termination or expiration of the GMEA.

## **SUBPOENA**

If a subpoena is served, residents are required by law to appear, unless a call is placed to the lawyer issuing the subpoena to make other arrangements. The best action to take is to immediately notify the Risk Coordinator when served with a subpoena or Notice to Appear. Prepare ahead of time by reading the chart and being familiar with the case before the deposition or trial.

- Criminal versus Malpractice—The subpoena could involve a criminal case in which the resident treated an involved party or a civil/malpractice action against the resident and/or Kern Medical.
- Deposition—When the resident is required to attend a deposition usually the defense and plaintiff attorneys are present, as well as a court reporter to type notes. If it is a malpractice case against the resident and/or Kern Medical, the County Counsel attorney will meet with the resident to prepare for the deposition.
- Medical Record—In the event of a claim or litigation, the original medical record will be sequestered in the risk management department and a working copy will be substituted in its place in health information systems.
- Placenta—If there is a bad outcome in the delivery of a baby; please notify the pathologist of the outcome, so a thorough evaluation of the placenta can be made, as well as sequestering of the evidence.
- Safe Medical Device Act (SMDA)—If a device is involved in a Potential Risk Event, notify the Risk Coordinator or Biomedical Engineer to sequester the device and begin an investigation. Please safely remove from the patient and do not change any of the settings.
- Trial—If the resident receives a subpoena for a trial the resident will usually be allowed the professional courtesy of being on call. This call status will remain in effect for the length of the trial. The lawyer's office will call and give the resident from one hour to a half-day warning before he or she is expected at the courtroom. Please do not abuse this privilege by not showing up when called. The judge could issue a bench warrant and send a sheriff to bring the resident in. Even if the resident's subpoena does not mention the on call courtesy, call the lawyer's office listed to request this privilege.

# SECTION IX: EDUCATIONAL AND SCHOLARLY ACTIVITY

The resident is expected to participate fully in the educational and scholarly activities of the residency-training program as assigned by the residency Program Director; attend all required educational conferences, assume responsibility for teaching and supervising other residents and medical students; participate in assigned hospital, medical staff, and residency-training program activities.

The resident will develop and follow a personal program of self-study and professional growth under guidance of the residency-training program's teaching faculty.

## SUMMER CORE

From July through the end of August, during weekdays from noon to 1 p.m. in Room 1058 (the main conference room) there are a series of mandatory lectures and training sessions. Summer core courses help transition a medical student to PGY-1 to ascertain his or her knowledge, skills, and attitudes required to perform well in specialty training. This is a program for the acculturation of new residents to Kern Medical.

## ACGME COMPETENCY LECTURE SERIES

All programs will be engaged in teaching the six ACGME competences. To acquaint residents with these, a series of lectures are conducted on the third (3<sup>rd</sup>) Wednesday of each month, year-round, from 7:30 a.m. to 8:30 a.m. in Room 1058 (the main conference room). All residents are required to attend as the educational focus is on three out of the six core competency topics in the Outcomes Project of ACGME. Topics include ethics, socio-economics, medical/legal issues, cost containment issues, communication skills, research design, biostatistics, and systems based competencies of practice. The competencies are better explained in the ACGME website: <http://www.acgme.org/outcome/comp/compFull.asp> but are listed below.

## PATIENT CARE

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

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
- Gather essential and accurate information about their patients.

- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up to date scientific evidence and clinical judgment.
- Develop and carry out management plans.
- Counsel and educate patients and their families.
- Use information technology to support patient care decisions and patient education.
- Perform competently all medical and invasive procedures considered essential for the area of practice.
- Provide health care services aimed at preventing health problems or maintaining health.

## **MEDICAL KNOWLEDGE**

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and the application of such knowledge to patient care. Residents are expected to:

- Demonstrate an investigative and analytic thinking approach to clinical situations.
- Know and apply the basic and clinically supportive sciences, which are appropriate to their discipline.

## **PRACTICE BASED LEARNING AND IMPROVEMENT**

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence and improve their patient care practices. Residents are expected to:

- Analyze practice experience and perform practice based improvement activities using a systematic methodology.
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
- Obtain and use information about the population of patients and the larger population from which patients are drawn.
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
- Use information technology to manage information, access on-line medical information, and support their education.
- Facilitate the learning of students and other health care professionals.

## **INTERPERSONAL AND COMMUNICATION SKILLS**

Residents must be able to demonstrate interpersonal and communication skills. Such skills result in effective information exchange and teaming with patients, patients' families and professional associates. Residents are expected to:

- Create and sustain a therapeutic and ethically sound relationship with patients.
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning and writing skills.
- Work effectively with others as a member or leader of a health care team or other professional group.

## **PROFESSIONALISM**

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population. Residents are expected to:

- Demonstrate self-interest; accountability to patients, society and the profession; a commitment to excellence; and ongoing professional development.
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent and business practices.
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities.

## **SYSTEMS BASED PRACTICE**

Residents must demonstrate an awareness of, and responsiveness to, the larger context and system of health care, and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice.



- Know how types of medical practice and delivery systems differ from one another including methods of controlling health care costs and allocating resources.
- Practice cost-effective health care and resource utilization that does not compromise quality of care.
- Advocate for quality patient care and assist patients in dealing with system complexities.
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance. This project will involve activities developed by your individual department or program, institutional program as well as those specifically developed and/or sponsored by GME.

## **LEARNING THE ACGME COMPETENCIES**

Kern Medical has dedicated teaching faculty and hospital administrators to ensure that residents master the knowledge and skill-set across all specialties to become fully trained and prepared to practice in the specialty which he or she has chosen.

During the program's internal review, faculty will identify the progress made in implementation of competencies within the goals and objectives of the program. Workshops are held for faculty to become better acquainted with the practical methods of incorporating ACGME competencies into residents' experiences.

## **TRAVEL POLICY**

Interns, residents, and fellows are provided a travel allowance when they are in good standing in their training Program as determined by the Program Director, Chairman, and Chief Academic Officer. All reimbursable expenses are pursuant to Chapter 3 of the County Administrative Procedures Manual and the terms of the Administrative Bulletin Number 20.

Three types of intern/resident/fellow travel arrangements are eligible for reimbursement:

- Travel to attend a national meeting within the United States to present a first-author potential publication, abstract, or poster exhibit.
- Travel to attend a national education conference within the United States. Upon return, under the direction of the Program Director, an educational report to the respective clinical department is expected.
- Attendance at mandatory rotations based on ACGME-approved curriculum, unless the host hospital or department provides food, mileage, and lodging.

### Education Benefit Travel

Over the course of the residency, one (1) trip will be reimbursed for a national subspecialty education conference. Up to three (3) trips may be paid if the resident is the first author who is presenting an abstract or poster exhibit at a national meeting. International meetings outside of the United States are not reimbursed.

Interns/residents/fellows must request approval of prospective travel allowance by completing the Kern County Travel Authorization Form six (6) weeks prior to departure. Course syllabus or

meeting brochures must be submitted and reviewed by the Program Director. The anticipated absence must be cleared for non-interference with coverage schedules by the Program Director.

Standard meeting coverage includes airfare, up to two (2) nights lodging for presentation trips, and three (3) nights for educational meetings, related per diem meals, and incidental expenses as set forth in Chapter 3 of the County Administrative Procedures Manual. If more than one (1) trainee attends the same meeting, the hotel room should be shared if gender is the same.

If travel is by auto, a Mileage Claim Voucher (Form No. AC580-111-023) must be used and odometer readings before and after the travel must be noted. Approved mileage rates, parking, and other driving expenses are pursuant to Administrative Bulletin Number 20, which also includes proof of automobile insurance and a valid driver's license.

The resident must provide all original receipts for expenses to be reimbursed and must follow the County Administrative Procedures Manual and Administrative Bulletin Number 13 to be eligible for reimbursement. Receipts should be submitted to the Program Coordinator no later than five (5) business days after travel.

If travel to the requested meeting is not approved, a separate request for personal time without reimbursement may be made to the Program Director. Educational leave is not subject to the ACGME duty hours rule.

### Travel for Outside Rotations

Residents on mandatory rotations to attend Graduate Medical Education Committee approved rotations at other UCLA campuses including Harbor, Olive View, and Ronald Reagan Medical Center and the VA Greater Los Angeles Hospital, may share the two-room Kern Medical /UCLA apartment at no cost to the resident. The apartments are furnished and utilities are paid by Kern Medical. Residents will be provided per diem and mileage reimbursement based on Chapter 3 of the County Administrative Procedures Manual and the terms of Administrative Bulletin Number 20 if not otherwise provided by the host hospital.

## **RESEARCH & SCHOLARLY ACTIVITY**

### **SCHOLARLY ACTIVITY OVERVIEW**

Scholarly activity refers to an oral or written presentation that reflects a thorough and critical collection of knowledge. The audience for scholarly activity on the part of residents may be faculty, peers, medical students or the public.

### **RESEARCH**

Kern Medical holds a Federal Wide Assurance (FWA00016042) which requires ethical and legal conduction for all research reviewed by the Kern Medical Institutional Review Board (IRB) and conducted at Kern Medical. The Institutional Review Board (IRB) is registered with the Federal Office of Human Research Protections (IRB00007680) and, as needed, reports compliance matters to that agency.

Recipients awarded a Federal Wide Assurance have external, federal level, reporting requirements for certain categories of research regulation or protocol violations.

As designated with the FWA, the CEO of Kern Medical is the Designated Institutional Official for research.

As identified in the Federal Wide Assurance (FWA00016042) organizational chart, the Chief Academic Officer for Medical Education and Research, is the Institutional Review Board administrator of record and is the IRB Chair.

Federal and state laws, and their associated body of regulations that create the framework in which ethical and legal human subject research may be conducted, are adhered to at Kern Medical. The laws and regulations that cover medical clinical practice are generated by the State of California and are separate from, and independent of, those governing the conduction of human research. Conducting human research or using patient data for research purposes is a privilege, granted by direct informed consent from an individual patient or their legally authorized representative, or upon approval of a consent waiver from the Institutional Review Board; it is not a right granted to a holders of a health care license.

## **PROGRAM SPECIFIC RESIDENT RESEARCH REQUIREMENTS**

National Residency Review Committees for each postgraduate medical education specialty establish program-specific resident and/or faculty research requirements. You should check with your Program Director during the first year of residency to identify your program's resident-specific research requirements.

## **AN INTRODUCTION TO THE Kern Medical INSTITUTIONAL REVIEW BOARD (IRB)**

An IRB is multidisciplinary group, with membership composition defined by federal and state research regulations. Members fall into one or more categories: scientific, non-scientific, institutionally affiliated, or non-institutionally affiliated; membership composition is defined in federal regulations. The primary purpose of the IRB review is to ensure the protection of the rights and welfare of the human subjects in accordance with ethical, legal, state and federal regulations and accrediting organization's compliance standards. During research review, the IRB may include adequacy of protocol design to determine if the study design will accomplish answering the research question.

The Kern Medical IRB Office is located in the Medical Education Suite, Room 2313. Staff is available weekdays to assist you in identifying appropriate forms for submitting research proposals and in preparing studies for IRB review. The IRB Office can be reached by phone at 661-326-2896

## **ANNUAL RESEARCH FORUM**

The Kern Medical Annual Research Forum is a Kern County spring-time scientific assembly show casing ongoing research achievements at Kern Medical. It features poster and multimedia presentations from each of the six academic departments: Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Psychiatry, and General Surgery, and other

members of the hospital community. The evening event begins with poster sessions, and ends with juried competition PowerPoint presentations for “Excellence in Research” acknowledgments.

All Kern Medical staff who have conducted research projects are eligible to participate in an upcoming Annual Research Forum. A “Call for Abstracts” is distributed to all postgraduate education departments to Chairs, Program Directors and Program Coordinators for distribution to their respective departmental staff at least 6 months prior to the following year’s forum. The abstract submission form, instructions for developing and submitting abstracts and a calendar of associated dates, e.g., applications for research review, due date for abstracts, due dates for posters, etc., accompanies the “Call for Abstracts” announcement.

The Kern Medical Chief Academic Officer, Program Directors and IRB staff also provide support and assistance in helping residents navigate from an idea for research to IRB review and to the scholarly writing essential for submitting an abstract or research article for peer-reviewed publication.

## **RESEARCH DEFINED**

How human subject research is defined is determined by each of two regulation generating departments at the Department of Health and Human Services:

- Office of Human Subjects Protection (OHRP)
- Food and Drug Administration (FDA)

OHRP defines research as investigational activities with human subjects and/or personally identifiable health care information that lead to generalizable knowledge. For knowledge to be considered generalizable, research findings must be published in a peer reviewed scientific publication, or presented to an audience of peers, faculty, medical students or the public where findings can be subject to external critical analysis.

The FDA definition of research generally concurs with OHRP’s and adds focus on clinical studies of drugs and/or medical devices, which the FDA has responsibility to regulate.

Residents participating in research studies, either being mentored in the Principal Investigator role or as a Sub-investigator, should recognize the need to develop scientific writing skills and to pursuing peer-reviewed publication for all Kern Medical supported research.

## **MINIMAL HUMAN SUBJECTS PROTECTION TRAINING REQUIREMENT**

Before any resident, staff member or prospective study team member can participate in a research study, a minimal training requirement must be met. An online training, hosted by the National Institutes of Health, is located at: <http://phrp.nihtraining.com/index.php>. Upon completion of the training, print two copies of the Completion Certificate: one copy must be provided to the IRB Office, the second to your Program Coordinator for placement in your file.

Additional training may be required for HIPAA privacy rights accorded to research subjects and for research-specific informed consent.

## **BEGINNING A RESEARCH PROJECT**

All residents have access to a Residency Program Director, a departmental Research Director and to the Chief Academic Officer for assistance in generating researchable questions, a testable hypothesis and guidance in developing protocols. Preliminary planning is a significant part of the work of conducting a research study. It sets the basis for the quality of the protocol and study findings.

Preliminary planning includes:

- Reviewing medical literature to establish a theoretical basis for the research proposal
- Asking a researchable question
- Stating the hypothesis
- Identifying variables that will answer the research question
- Determining which variables can be controlled by specific data
- Identifying which statistical tests to use to achieve valid results,
- Defining what data can go in each data field
- A written protocol plan
- Contacting the IRB Office (326-2896) for guidance on correct forms, assistance with applications and for review of application drafts.

This planning precedes any actual research activity with patient intervention or patient data acquisition. Research activity can only commence following receipt of written IRB approval.

## **DETERMINING THE RISK CLASSIFICATION OF A PROPOSED HUMAN SUBJECTS STUDY**

Human subject research is defined by Department of Health and Human Services as involving a living individual about whom a research investigator (whether a professional or a student) obtains data through intervention or interaction with the individual or from individually identifiable information

Federal regulations for research define three categories of human subject research. Please contact the IRB office at 326-2896 for guidance regarding risk establishment during the planning stage of your proposed study: Determination of the following categories for study risk is a responsibility of the Kern Medical IRB and requires an application for IRB review:

1. Exempt from IRB Review – studies may be exempt from IRB review when they do not involve human subjects. Studies involving human subjects may be exempt if covered by one or more of six regulatory categories.
2. Minimal Risk studies - the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.
3. Greater than Minimal Risk – federal regulations do not offer a definition of “greater than minimal risk”. By exclusion of studies meeting exemption or minimal risk definitions, all other human subject studies fall into this category.

Additionally, federal law and regulation provide added research protections for special populations: pregnant woman/fetuses, prisoners and children.

Federal regulations also require and IRB to provide protections for the economically disadvantaged, ethnic or religious minorities, homeless and other societal groups that are not cultural or economic majorities.

Federal privacy law and regulations (HIPAA) add privacy requirements to existing research regulations.

State laws and regulations add research protections for AIDS patients.

Institutional policies and procedures further define how research is to be conducted with Kern Medical patients and/or patient data.

## **REVIEW OF RESEARCH BY OTHER THAN THE IRB**

Depending on the complexity and funding status of proposed research, an Administrative Review and/or review by the Research Committee may be necessary. The following policies will guide you in determining if your study has additional review requirements.

COM-RI-113 Administrative review of research conducted at Kern Medical  
COM-RI-114 Research Committee Review of Greater than minimal risk research

## **AN IMPORTANT DEFINITION**

Unauthorized Clinical Investigation: Unauthorized clinical investigation includes any clinical investigation or use of patient data without an IRB approved protocol or a clinical investigation which employs procedures not detailed in an approved protocol and/or in the consent form (N.B., the hospital or surgical consent form is not acceptable for research consent).

## **OFF-SITE ROTATIONS AND KERN MEDICAL RESIDENT RESEARCH ACTIVITIES**

Off-site rotations may include community based medical practices, other hospitals and clinics, all of which care for patients that are not considered County of Kern patients. The Kern Medical IRB may only review studies for the three County of Kern departments that provide patient care services.

When on off-site rotations, the same laws and regulations still apply for the conduction of human research or research use of human data. This means that an external IRB with the authority to review research, for the clinical setting to which you are assigned, must review research proposals. Human research may not be conducted without IRB review.

## **INCLUSION OF PRISONERS OR PRISONER DATA IN RESEARCH REVIEWED BY THE KERN MEDICAL IRB**

The Kern Medical IRB does not meet the federal requirements to qualify as a “Prisoner IRB”. At no time may a prisoner or prisoner data be included in research reviewed by the Kern Medical IRB. This means that if you are conducting an IRB-approved records based study and encounter a period of time when a patient’s records indicate that they were incarcerated or imprisoned, you must exclude data from that period from your research collection activities.

## **THE RELATIONSHIP BETWEEN RESEARCH AND QUALITY ACCURANCE (QA) STUDIES**

Records research is similar in design whether it is for research and QA purposes. Similarities end there.

In California, QA conducted under the auspices of Medical Staff QA is solely for institutional use, to improve care or processes at Kern Medical. The product of this QA is protected when hospital staff or the hospital is sued.

Research does not have protection from discovery if a researcher or a research team member is sued related to their research activities: all research records and findings are “discoverable”.

If considering a combined research/QA study, you must first get the consent of your departmental faculty QA representative and from the Kern Medical QA Committee since QA will lose discoverability protections upon publication or public presentation of study findings.

## **USE OF KERN MEDICAL PATIENT DATABASES FOR RESEARCH**

Kern Medical owns all financial and medical record patient databases; certain Kern Medical departments “own” additional databases, e.g., Cancer Registry, Trauma Registry. IRB approval serves as permission to access the Kern Medical owned data bases. You will need additional permission from the “owner” of any separate registry, prior to accessing that data for research purposes, even if you already have IRB approval for a study.

## **ELECTRONIC DATA BASE SEARCHES FOR RESEARCH**

Members of research teams conducting IRB-approved records research studies may request an electronic database search to identify study-specific patient records that may hold data that can be used for your study database entries.

A form is available at the Kern Medical Intranet site on the initial page with a clickable section marked “[Physician Orders/Forms](#)”

Activating this link will take you to the page with Orders/Forms. In the “Forms” section click on the document listed as [Standard Database Search Request](#).

The form is self-explanatory to complete for fields available for records searches for subjects for IRB-approved studies only. Your IRB study number is required on the document. IRB staff sends a copy of your study approval letter to HIS. HIS maintains study approvals in a database and only study team members for those approved studies may request research-related records searches.

The form, when completed, should be sent by interoffice mail to "HIS Supervisor: Research Search Request" or hand delivered to the HIS File Room.

## **QUESTIONS ABOUT RESEARCH?**

You have the following resources available:

### Departmental

- Program Director
- Research Director
- Senior staff and residents who already have been active in research studies

### Kern Medical

- Medical Library
- Chief Medical Officer/Chief Academic Officer
- Director of Research
- IRB staff

### Internet Resources:

- OVID
- PubMed
- Medline

## **LIBRARY AND MEDIA SERVICES**

The main Medical Library (Dr. Jack H. Bloch) is located on the first floor of the Medical Center and is open from Monday through Friday from 8:00am to 4:30pm. After-hours access is provided but residents must use their ID badge to enter the Library. A printer and photocopier are available for copying purposes and residents are required to observe copyright law. Please contact the library staff at 661-326-2227 for any special article requests or library instruction.

## **HOSPITAL AND MEDICAL STAFF COMMITTEES**

### **RESIDENT ADVISORY COUNCIL (RAC)**

*Goal: "Provision of an organizational system for residents to communicate and exchange information on their work environment and their ACGME-accredited programs. This may be accomplished through a resident organization or other forums in which to address resident issues."*

The purpose of the RAC is to provide a forum for the exchange of information between the residents and administrative managers/supervisors. The RAC will review and discuss items of concern identified by the residents and GME officials and will exchange ideas/suggestions given by administrative managers/supervisors to improve hospital operations.

At least two (2) representatives will be peer selected from each of the following residency training programs to participate as a member on the RAC: Emergency Medicine, Family Practice, Internal Medicine, Obstetrics and Gynecology, Psychiatry, and Surgery. Membership will be for one (1)



academic year, beginning on July 1<sup>st</sup> and terminating on June 30<sup>th</sup>. The DIO and the Associate Director of Medical Education will be guest members.

- Each resident member agrees to attend monthly meetings and Program Directors must allow time free of duty for this function. Meetings will be directed by the peer selected resident chairperson of the council.
- Meetings will be held as directed by the peer selected resident chairperson.
- If a member is unable to attend a meeting, he or she should identify another resident from the program to substitute.
- The members or representatives are responsible for providing information to his or her peers.
- The members or representatives are responsible for collecting opinions and data from their peers.
- The members or representatives may be requested to participate in subcommittees and facilitate the resident reviewer component of internal reviews of programs.
- Two (2) members of the RAC will be peer selected to be voting members of the GMEC.

### **GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)**

The GMEC provides oversight to all aspects of resident education. The committee meets on the second (2<sup>nd</sup>) Thursday of every other month from 7:30 a.m. to 9:00 a.m. in Room 1065 (conference room behind 1058). The Chief Medical Officer/Chief Academic Officer/DIO is the chairperson. The other committee members are:

- Department Chairpersons and/or Training Program Directors
- Chairperson and Co-Chairperson of the RAC or representative
- Chief Executive Officer or designee
- Director of Medical Research
- President of the Medical Staff

All residents who are interested in bringing issues or topics for discussion to hospital committee meetings should contact the Program Director, Department Chair, or the President of the Medical Staff. Other hospital and medical staff committees that have residents as regular members are:

### **QUALITY MANAGEMENT COMMITTEE (QMC)**

This committee meets the 4<sup>th</sup> Wednesday of the month at 7:30 a.m.

### **UTILIZATION REVIEW COMMITTEE (URC)**

This committee meets on the 1<sup>st</sup> Thursday of the month at 7:30 a.m. in Room 3321

### **PHARMACY AND THERAPEUTICS COMMITTEE (P&T)**

This committee meets on the 3<sup>rd</sup> Tuesday of the month at 11:30 a.m. in Room 3048

### **TRANSFUSION COMMITTEE**

This committee meets the 2<sup>nd</sup> Thursday of the month at Noon, six times per year at the discretion of the Chair.

# SECTION X: OTHER INSTITUTIONAL POLICIES

## TRANSITIONS OF CARE/HANDOFFS POLICY

### PURPOSE

To establish protocol and standards within the residency and fellowship programs to ensure the quality and safety of patient care when transfer of responsibility occurs during duty hour shift changes and other scheduled or unexpected circumstances.

The goal is to prevent errors during transitions of care and to minimize the number of transitions between care providers.

### DEFINITION

A handoff is defined as the communication of information to support the transfer of care and responsibility for a patient/group of patients from one provider to another. Transitions of care are necessary in the hospital setting for various reasons. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another. Transition of care occurs regularly under the following conditions:

1. Change in level of patient care, including inpatient admission from an outpatient procedure or diagnostic area or ER and transfer to or from a critical care unit.
2. Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas.
3. Discharge, including discharge to home or another facility such as skilled nursing care.
4. Change in provider or service change, including change of shift for nurses, resident sign-out, and rotation changes for residents. Safeguards exist for coverage when unexpected changes in patient care may occur due to circumstances such as resident illness, fatigue, or emergency.

### POLICY STATEMENT

Individual programs must design schedules and clinical assignments to maximize the learning experience for residents as well as to ensure quality care and patient safety, and adhere to general institutional policies concerning transitions of patient care. Examples of strategies which have successfully minimized transitions include day/night teams, staggering of intern/resident/attending switch times and/or days to maintain continuity, outpatient clinic or teams, etc. All training programs must design call and shift schedules to minimize transitions in patient care. Schedule overlaps should include time to allow for face-to face handoffs to ensure availability of information and an opportunity to clarify issues.

### PROCEDURE

The transition/hand-off process should involve face-to-face interaction with both verbal and written/computerized communication, with opportunity for the receiver of the information to ask questions or clarify specific issues. The hand-off process may be conducted by telephone conversation. The transition process should include, at a minimum, the following information in a standardized format that is universal across all services:

- a) Identification of patient, including name, medical record number, and date of birth
- b) Identification of admitting/primary/supervising physician and contact information
- c) Diagnosis and current status/condition of patient
- d) Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken
- e) Outstanding tasks – what needs to be completed in immediate future
- f) Outstanding laboratories/studies – what needs follow up during shift
- g) Changes in patient condition that may occur requiring interventions or contingency plans

Programs must develop and utilize a method of monitoring the transition of care process and update as necessary. Monitoring of handoffs by the program to ensure:

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

Each residency program must include the transition of care process in its curriculum. Residents must demonstrate competency in performance of this task. Programs must develop and utilize a method of monitoring the transition of care process and update as necessary.

## **PHARMACEUTICAL RELATIONSHIPS & VENDOR INTERACTIONS WITH RESIDENTS [II.B.13]**

In concert with the institutional vendor relation’s policy, ADM MM-100, and in an effort to minimize undue influence on the residents’ health care decision-making, relationships with commercial interests should be limited. For the purposes of this policy, the term “vendor” encompasses all commercial entities that do business with Kern Medical and its faculty, staff and trainees. Although the Medical Education Office acknowledges that relationships with industry representatives may result in promoting intellectual curiosity as well as venues and opportunities for research inquiries, it may also be detrimental and cause changes of behavior that influence medical management of patient care.

When residents are engaged with industry representatives it should be in a structured venue where representatives highlight the therapeutics of Kern Medical ’s approved drug formulary; thereby creating an environment of teaching and learning. Structured venues may consist of a monthly forum-based discussion group between industry representatives, faculty, pharmacists, resident/fellow and ethics personnel. This discussion group would alleviate any one-sided effort to improperly influence medical decision-making and/or affect health care provider behavior through counter dealing. Novel therapeutics and device demonstrations may be presented in a similar fashion.

Housestaff **MAY:**

- Interact with industry representatives only when solicited by Kern Medical to engage in monthly forum-based drug and/or device presentations whereby faculty will be on hand to stimulate discussion in terms of drug efficacy, side effects and contraindications.

- Take part in in-service training, approved by the Value Analysis Committee, as needed to gain proficiency and familiarity with any drug or new devices from a particular industry only when shown to be of particular benefit and use to enhance the quality of patient care.
- Engage in Accreditation Council for Continuing Medical Education (ACCME) sponsored professional meetings that may receive partial industry support in a CME conference.
- Apply for competitive grants for research activities, as these are not considered gifts as outlined by the ACCME guidelines.

Housestaff **MAY NOT** when on duty:

- Accept gifts, defined as items of any value over \$25, and gratuities in a setting other than what the Medical Education Office has set up with industry representatives.
- Receive compensation at any time for listening to or attending industry sponsored activities or for changing a patient's prescription.
- Utilize medications or devices brought to Kern Medical as trial unless approved by Kern Medical administration as stipulated in institutional policy ADM MM-100.
- Solicit industry representatives to obtain samples or devices for personal use or for use by family members.

## **ADMINISTRATIVE SUPPORT IN THE EVENT OF A NATURAL DISASTER [I.B.8]**

Kern Medical is committed to its GME programs and residents. In order to protect and assist residents in the event of a natural disaster, Kern Medical will continue patient care and post-graduate training activities during a disaster if at all possible. If a break in training does occur, Kern Medical will review the situation to decide the best course of action.

Program Directors will immediately notify residents in the event an interruption in training is imminent. If determined that post-graduate training is discontinued for a period of time, Kern Medical will support resident transfer to another ACGME accredited program. While it will be the residents' responsibility to locate interested programs, Kern Medical will provide letters of support for residents who require transfer to another institution. If available, evaluations and other employment documentation will be supplied upon request of the resident and/or receiving institution.

## **CLOSURE OF RESIDENCY DUE TO ADVERSE ACGME ACCREDITATION ACTION [I.D.3] and [II.D.5 a., b.]**

The County shall notify each resident affected and the CIR/SEIU:

- As soon as reasonably possible of a decision to discontinue any training Program for any reason.
- As soon as reasonably possible upon receipt from ACGME, or any other relevant accrediting body of any notification regarding non-accreditation or probation of similar change in the professional status of any training Program.
- As soon as reasonably possible of a decision of a merger, closure, or change in the number of beds that has a substantial impact on any training involved.

For residents continuing in a Program for which accreditation is lost, Kern Medical shall maintain levels of training, continue to provide rotations required for certification, and add ancillary and professional staff to cover losses in resident coverage. Kern Medical shall take reasonable steps to try to gain full accreditation for the Program, to encourage residents to remain in the Program, and to balance the service needs of Kern Medical with the professional goals of the residents involved.

Upon receipt from the ACGME of any confirmation of an adverse accreditation action, Kern Medical will notify and provide a plan of response for the loss to the ACGME within 30 days. Program Directors will notify each affected resident / fellow about the intended plan of action.

If a decision is made to reduce the size or close a program, Program directors will inform the affected resident/fellow as soon as possible. In such cases, the Program Director will allow the resident/fellow already in the program to complete his/her education or assist them in enrolling in another ACGME accredited program at other institutions.

# SECTION XI: APPENDIX

## ABBREVIATION GLOSSARY

ACGME	Accreditation Council for Graduate Medical Education
ADME	Associate Director of Medical Education
AMG	American Medical Graduate
CAO	Chief Academic Officer
CMO	Chief Medical Officer
DEA	Drug Enforcement Administration
DIO	Designated Institutional Official
DME	Director of Medical Education
EAP	Employee Assistance Program
GME	Graduate Medical Education
GMEA	Graduate Medical Education Agreement (aka: resident employment contract)
GMEC	Graduate Medical Education Committee
IMG	International Medical Graduate
IRB	Institutional Review Board
Kern Medical	Kern Medical
MEC	Medical Executive Committee
NBME	National Board of Medical Examiners
NRMP	National Residency Matching Program
PGY	Post Graduate Year
RAC	Resident Advisory Council
RRC	Residency Review Committee
TJC	The Joint Commission
UCLA	University of California, Los Angeles
USMLE	United States Medical Licensing Exam

# **AMA PRINCIPLES OF MEDICAL ETHICS**

## **PREAMBLE**


The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct, which define the essentials of honorable behavior for the physician.

## **PRINCIPLES OF MEDICAL ETHICS**

- I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
- VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
- IX. A physician shall support access to medical care for all people.

Adopted by the AMA's House of Delegates June 17, 2001

<http://www.ama-assn.org/ama>

	<b>Department: Compliance</b>			
	Policy No. COM-IM-264	Effective Date: July 2016	Review Date: July 2019	Page 1 of 3
<b>Title: Portable Data Storage Devices</b>				

**I. PURPOSE:**

To specify the conditions under which the use of portable data storage devices are permissible and supported or explicitly prohibited within the Kern Medical Center (KMC) computing environment.

**II. DEFINITIONS:**

- A. Portable Data Storage Device – A standalone device that may be temporarily attached to a computer system or network and used for data storage, data transport or mobile use of image, audio or other data. This includes portable hard drives, flash memory cards or devices attached via USB or other ports, such as “thumb drive” or “memory key”, audio or video players, such as the “iPod” or personal recording devices, such as external CD/DVD recorders and associated media.
- B. Protected Health Information (PHI) – Health information transmitted or maintained in any form or medium that (1) identifies or could be used to identify an individual; (2) is created by KMC or received from another health care provider, health plan, employer or health care clearinghouse; and (3) relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

**III. POLICY STATEMENT:**

It is the policy of KMC to specify the conditions under which the use of portable data storage devices is permissible and supported or explicitly prohibited within the KMC computing environment.

**IV. EQUIPMENT: N/A**

**V. PROCEDURE:**

- A. Device Issuance or Approval
  - 1. KMC department heads will issue and approve a portable data storage device request prior to the device’s connection to KMC computer systems, networks or other computing infrastructure. KMC department heads will ensure that the portable data storage device for use on KMC systems and networks is limited to cases where a specific business case can be demonstrated and determined that the use does not contravene regulatory requirements.
- B. Device Use
  - 1. Portable data storage devices not supplied or approved by KMC Information Systems (IS) will not be connected to KMC computer systems, networks or other computing infrastructure.



2. PHI will not be recorded or stored on any portable data storage devices supplied by KMC IS, which are used in the performance of KMC business functions.
- C. Device Approval
1. KMC department heads may approve an IS-specified portable data storage device for use on KMC systems and networks only where a specific business case can be demonstrated and where the use of the device does not either contravene regulatory requirements or substantively increase the risk of intentional or accidental disclosure of the information from KMC systems and networks.
- D. Sensitive Information
1. PHI will not be stored on portable data storage devices, with the exception of devices provided by KMC IS for the specific purpose of PHI data backup. Where information classified as restricted, private or protected is stored on a supported device, the data will be protected using permissions and/or encryption appropriate to the information classification. Physical access to the device will be limited to a single authorized individual storing and retrieving the data. Information classified as restricted, private or protected will not be shared among individuals in a group using a portable storage device.
- E. Additional Physical Protections
1. Offsite computers and storage devices used for regular remote access will have additional protections against physical theft or damage comparable to portable computers, through protective physical anti-theft measures, such as isolated rooms and equipment locks.
- F. Additional Physical and Logical Protections
1. Offsite computers and storage devices used for regular remote access will have additional protections against information theft or monitoring comparable to portable computers through such logical access protection measures as volume encryption.
  2. Portable computers and storage devices will have additional protections against physical and information theft or damage while used or transported outside KMC facilities, either through protective physical anti-theft measures or logical access protections, such as volume encryption.
  3. IS will maintain and periodically issue information regarding the current standard for physical and logical protection of portable computers and the use of remote access facilities.
- G. Disconnection
1. Non-approved or personal portable data storage devices will be disconnected from KMC infrastructure and any sensitive KMC or PHI data will be verifiably removed. Violators of this policy may be subject to appropriate disciplinary action up to and including employment termination, termination of agreements, removal or denial of IS service, including systems and connectivity and/or legal penalties, both criminal and civil.
- H. Removal of Improper Data
1. Where sensitive information, such as PHI, has been improperly stored on a portable data storage device, the data will be transferred to a KMC controlled storage, if the data is required for KMC records or medical services and removed from the portable device as soon as reasonably

possible. The removal will be in accordance with policy, COM-IM-234, Information and Media Disposal.

- I. Mobile Computers Subject to Standard Policies
  - 1. Mobile computers and network capable devices supported by KMC IS are subject to the same security controls and policies as standard workstation systems.

**VI. SPECIAL CONSIDERATIONS: N/A**

**VII. EDUCATION:**

- A. Employees will be educated during general orientation regarding information handling, as well as through the KMC confidentiality agreement. Employees are responsible for knowledge and ongoing awareness of the policy. Additional education will be given on a case-by-case basis by the unit as it relates to employee job duties and responsibilities.

**VIII. DOCUMENTATION: N/A**

**IX. ADDENDUMS: N/A**

**X. REFERENCES:**

- A. HIPAA Security Rule – 45 CFR §160.103 Protected Health Information
- B. HIPAA Security Rule – 45 CFR §164.310(d)(1) Device and Media Controls

**XI. KEY WORDS: Portable, Storage, Device**

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