Detroit Education & Research

GME Resident Policy Manual
(updated May 2016)
This Graduate Medical Education (“GME”) Resident Policy Manual (“Manual”) is provided as a guide to and summary of the various policies, benefits, and services available and applicable to GME residents and fellows (collectively “Residents”) as of the date published. It also summarizes the rights and responsibilities of the Residents. The policies, benefits, and services described in this Manual 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.

Residents are encouraged to consult the various booklets, summaries, and/or governing documents as appropriate. Information contained in any handbook, guide, manual, or document prepared for or relating to Residents is for informational purposes only and shall not be construed as a contract.

This Manual is to acquaint you with the policies of Detroit Education & Research (“Detroit E&R”) and the Detroit Graduate Medical Education Program (collectively referred to as “DMC-GME”) and the Detroit Medical Center (“DMC”) hospitals at which you will be rotating. It is important to note that as stated in your GME Agreement of Appointment – i.e. your contract, you are governed by the policies of any hospital at which you rotate. If you wish to have additional information regarding anything addressed in this guide, please feel free to contact the GME office at 313-745-5146.

Please note that pertinent DMC-GME policies and procedures are also available for viewing on the GME website at http://www.dmc.org/gme.
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Section I – Graduate Medical Education Contacts

OFFICE:
Main Telephone Number: (313) 745-5146 or (313) 745-5147
Main Fax Number: (313) 966-0880

DMC MEDICAL EDUCATION ADMINISTRATION

Mark S. Juzych, M.D., Vice-President of Academic Affairs and Designated Institutional Official
(313) 577-7614; mjuzych@dmc.org

Heidi Kromrei, Ph.D., Assistant Vice-President of Academic Affairs and Associate Designated Institutional Official
(313) 993-0736; hkromrei@dmc.org

Bruce Wolf, D.O.; Osteopathic Director of Medical Education
(248) 937-5085; bwolf@dmc.org

Mary F. Martin, Director, GME Operations
(313) 745-3551; mmartin@dmc.org

Terese M. DeClercq, MSF, Director, GME Finance
(313) 966-0515; tdeclerc@dmc.org

Karolina Redziniak, MA Executive Director Student Programs
(313) 966-3053; kredziniak@dmc.org

Lisa Dillon, Ph.D., Academic Director
(313) 993-8112; ldillon@dmc.org

Carol A. Bartley, GME Institutional Coordinator
(313) 993-0937; cbartley@dmc.org

Kavitha Reddy, MBA Financial Specialist
(313) 966-9147; kreddy@dmc.org
DMC MEDICAL EDUCATION STAFF

Lydia Pingilley, GME Operations Coordinator  
(313) 745-5146; lpingill@dmc.org

Greg Czentnar, Financial Coordinator, GME  
(313) 745-5149; gczentna@dmc.org

Kim Canady; GME Associate; Verification Letters A-L  
(313) 993-0931; kcanady@dmc.org

Ryan Dougherty; GME Associate; Verification Letters M-Z  
(313) 993-0034; rdougher@dmc.org

DMC OSTEOPATHIC GME CONTACT INFORMATION

Bruce Wolf, D.O.; Osteopathic Director of Medical Education  
(248) 937-5085; bwolf@dmc.org

Sinai-Grace Hospital  
Adelina (Nina) Orejel; Program Coordinator  
(313) 966-1941; aorejel@dmc.org

Huron Valley-Sinai Hospital  
Tracy Kotwicki, C-TAGME; Graduate Medical Education Manager  
(248) 937-5085; tkotwicki@dmc.org
Section II – Policies

**ACLS\BLS\PALS Certification**

Effective Date: July 1, 2004
Revised Date: 
Approved by: GMEC

The GME office requires proof of BLS certification provided by the American Heart Association for all Residents. ACLS/ATLS/PALS is program dependent. Residents must be certified upon arrival at DMC and must re-certify every two years thereafter until graduation. Upon completion of the initial and re-certification courses, the Resident must provide a copy of the life support cards to the GME Office.

**Responsibility**
GME Committee

**JC Functional Chapter**
Leadership
Accommodations for Residents with Disabilities

Effective Date: March 2012
Revised Date: May 2015
Approved by: GMEC

POLICY
As employees of the Detroit Medical Center, Residents with disabilities have a right to request reasonable accommodations.

PURPOSE
To guide Residents in the procedure for requesting accommodations within the scope of the residency education program.

PROCEDURE

1. The Resident’s request for accommodations must be initiated, in writing, by the Resident to the Program Director, who must in turn notify the Graduate Medical Education (GME) office of the request.

2. The Residency program and GME office, under the guidance of DMC Human Resources, will develop an appropriate plan for accommodations as stipulated in Tenet Policy HR.EHP.06 Disability Accommodation, and applicable law.

Responsibility
GME Committee

JC Functional Chapter
Leadership
**Advanced Standing**

Effective Date: July 1, 2004  
Revised Date:  
Approved by: GMEC

The stipend level of a Resident must be in accord with the level of the Resident recognized by the board or accrediting body of the specialty the Resident is entering. For example, a Resident transferring from Internal Medicine who will not receive any credit from the American Board of Surgery must be appointed at the PGY I level.

**Responsibility**

GME Committee

**JC Functional Chapter**

Leadership
Alertness Management and Fatigue Mitigation

Effective Date: July 1, 2011
Revised Date: October 24, 2011
Approved by: GMEC

Policy

Residency and Fellowship programs sponsored by the Detroit Medical Center shall provide education for program faculty and Residents designed to facilitate awareness, recognition, and appropriate steps to mitigate fatigue and sleep deprivation.

Procedure

1. Each sponsored program must:
   a) educate faculty members and Residents to recognize the signs of fatigue and sleep deprivation
   b) educate faculty members and Residents in alertness management and fatigue mitigation processes, and,
   c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps, exercise, caffeine, or back-up schedules.

2. Each program must have a process to ensure continuity of patient care in the event a Resident may be unable to perform patient care duties.

3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for Residents who may be too fatigued to safely return home.

Responsibility

GME Committee

JC Functional Chapter

Leadership
Compliance

Effective Date: July 1, 2004
Revised Date: November 2014
Approved by: GMEC

Tenet Health Systems (“Tenet”), the parent company of the Detroit Medical Center, is committed to the timely identification and resolution of all issues that may adversely affect employees, patients or the organization. It maintains a national corporate compliance program for that purpose. This program includes:

1. Policies and procedures to guide our compliance.
2. Compliance Officers to oversee the compliance program.
3. Training and education for employees on compliance issues.
4. Monitoring for unlawful or unethical activities within the organization.
5. Reporting mechanisms for unlawful or unethical activities.
6. Written guidelines for dealing with employees and others who engage in unlawful or unethical activities.
7. Responding to detected offenses.

Compliance Hot Line: call toll-free (800) 838-4427

Tenet has established a compliance hotline that serves as a communication channel for employees and other interested parties to report, either anonymously or in confidence, such matters as suspected criminal activity, illegal or unethical conduct, and information security or privacy violations occurring within the company. Calls to the hotline are answered 7 days a week/24 hours a day by qualified and trained personnel. Hotline calls are not recorded or traced.

1. Employees who report problems and concerns via the hotline in good faith will be protected from any form of retaliation or retribution. (HR.ERW.091 - Tenet Employee Conduct and Work Rules; HR.ERW.151 – Ethics and Compliance Training)
2. Tenet Corporate Compliance is responsible for the daily operation of the compliance hotline and for ensuring that appropriate investigations and follow-up of hotline reports are conducted in accord with the company’s internal compliance investigation procedures.
3. If the efforts above do not resolve the issue, Residents may also contact the Designated Institutional Official.
4. If still not resolved, the Resident may contact the ACGME or other Applicable Accrediting Body complaint officer to discuss submitting a formal complaint.

Responsibility
GME Committee

JC Functional Chapter
Leadership
**Call Rooms**

Effective Date: July 1, 2004
Revised Date:
Approved by: GMEC

DMC will provide adequate institutional call room space for Residents who are required to do in-house call or who are too fatigued to drive home.

ACGME Requirements:

Common Requirements - VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home. (Core)

Institutional Requirements -

II.F.2. The Sponsoring Institution must ensure a healthy and safe learning and working environment that provides for:

II.F.2.a) access to food while on duty at all participating sites; (Core)

II.F.2.b) safe, quiet, and private sleep/rest facilities available and accessible for residents/fellows to support education and safe patient care; and, (Core)

II.F.2.c) security and safety measures appropriate to the participating site.

**Responsibility**

GME Committee

**JC Functional Chapter**

Leadership
Communication with an Accrediting Body

Effective Date: July 1, 2004
Revised Date:
Approved by: GMEC

POLICY

All communication with the Accreditation Council of Graduate Medical Education, the American Osteopathic Association, the Council on Podiatric Medical Education, the American Dental Association Commission on Dental Accreditation, or the American Board of Obstetrics and Gynecology (each an “Accrediting Body”) by the Program Director must be approved and include the signature of the Designated Institutional Official (DIO) at the Detroit Medical Center prior to submission.

PURPOSE

To ensure that all communications and documents submitted to an Accrediting Body are complete and accurate.

PROCEDURE

The Graduate Medical Education Committee (GMEC) and DIO must review, approve prior to submission to an Accrediting Body by Program Directors. In addition, the DIO must provide signature to all communications to an Accrediting Body prior to submission for the following:

- All applications for accreditation of new programs;
- Changes in resident complement;
- Major changes in program structure or length of training;
- Additions and deletions of participating sites;
- Appointments of new program directors;
- Progress reports requested by any Review Committee;
- Responses to all proposed adverse actions;
- Requests for exceptions of resident duty hours;
- Voluntary withdrawal of program accreditation;
- Requests for an appeal of an adverse action; and,
- Appeal presentations to a Board of Appeal or the Accrediting Body.

l. Experimentation and innovation: Oversight of all phases of educational experiments and innovations that may deviate from Institutional, Common and specialty/subspecialty-specific Program Requirements, including:
   - Approval prior to submission to the Accrediting Body and/or respective Review Committee;
   - Adherence to Procedures for “Approving Proposals for Experimentation or Innovative Projects” in Accrediting Body Policies and Procedures; and,
   - Monitoring quality of education provided to residents for the duration of such a project.

Responsibility
GME Committee
JC Functional Chapter
Leadership
Corrective Action Procedures

Effective Date: July 1, 2004
Revised Date: July 1, 2011
Approved by: GMEC

These procedures are followed when a Resident is subject to corrective action, as provided by the Graduate Medical Education Agreement of Appointment entered into by the Resident.

1. GENERAL PROVISIONS

1.1. Corrective Action. As used in this document, “corrective action” includes the following actions:

1.1.1. Suspension. This action involves the temporary removal from the residency program (“Program”) for a definite period of time. It does not include a summary suspension, as discussed in Paragraph 3 below.

1.1.2. Reappointment Without Advancement. This action involves reappointment to the Program without advancement to the next training level.

1.1.3. Decision Not To Reappoint. This action involves a decision not to reappoint a Resident following the expiration of the term of his or her current contract.

1.1.4. Termination. This action involves immediate and permanent dismissal from the Program.

1.1.5. Other. Other corrective action includes, but is not limited to, the following:

(a) Placing the Resident on probationary status.

(1) Probation status shall not exceed one year. If the probation exceeds six months, the probation shall include at least one interim review at the approximate midpoint of the probation.

(2) Probation is imposed in accordance with 2.12 and 2.13.

(b) Issuing the Resident a letter of warning, admonition or reprimand which documents the cause for concern and becomes part of the Resident’s permanent record.

1.2. Criteria for Initiation. Corrective action may be based upon the following criteria:

1.2.1. Failure of the Resident to fulfill each and every obligation imposed by the Residency Agreement.

1.2.2. Any action, conduct or health status of the Resident that is adverse to the best interests of patient care or the institutions to which the Resident is assigned.

1.3. Examples. The criteria described in Paragraph 1.2 include, but are not limited to, the following examples:

1.3.1. Breach of professional ethics;

1.3.2. Misrepresentation of research results;

1.3.3. Violation of the rules of the Program, of the institution to which the Resident is assigned or of the law; and
1.3.4. Inadequate medical knowledge, deficient application of medical knowledge to either patient care or research, deficient technical skills or any other deficiency that adversely affects the Resident’s performance.

1.4. **Parties Who May Initiate Corrective Action.** Any of the following parties may initiate corrective action:

1.4.1. Any Detroit Medical Center (DMC) Hospital or other hospital to which the Resident is or has been assigned, or in which duties under the Residency Agreement are otherwise performed;

1.4.2. DMC-GME;

1.4.3. The Department or Section Chief to which the Resident is assigned; or

1.4.4. The Director of a GME Program.

1.5. **Separate Action By A Non-DMC Hospital.** In addition to the corrective actions described in this document, a non-DMC Hospital to which the Resident is assigned for outside rotation may, in accordance with the policies of such hospital, limit, restrict, suspend, summarily or otherwise, or terminate the Resident’s rotation at such hospital. The hospital shall first consult with the CMO, the Chair of GMEC, DMC counsel or appropriate Program Director prior to taking such action. Corrective action may be initiated by DMC-GME based on the Resident conduct giving rise to such action by a non-DMC hospital.

1.6. **Notice.** Any notice required by this document shall be deemed sufficient if the notice provisions of the Residency Agreement are satisfied.

2. **CORRECTIVE ACTION PROCEDURE**

2.1. All requests for the corrective actions described above in Paragraphs 1.1.1 through 1.1.4 shall be in writing, submitted to the Executive Director of DMC-GME, and supported by reference to the specific activity, conduct, deficiency or other basis constituting the grounds for the request. The procedures described below in Paragraphs 2.2 through 2.12 shall be followed for such corrective actions, and the procedure described below in Paragraph 2.12 and 2.13 shall be followed for all other corrective actions.

2.2. The Executive Director of DMC-GME shall investigate the request for corrective action in the manner and to the extent it deems appropriate. The investigative procedure may include consultation with the Resident and/or other parties, as determined in the sole discretion of the Executive Director, and shall be completed no later than thirty days following receipt of the request.

2.3. The Chair of the GMEC shall appoint a Committee of not less than three members of the GMEC. The Chair of the GMEC shall not serve as a member of the Committee, nor shall the Department or Section Chief of the Department to which the Resident is assigned or the individual initiating the corrective action.

2.4. Upon completion of the investigation, the Executive Director of DMC-GME shall forward the request and a written report of his/her investigation and recommendations to the members of the Committee. A copy of the request shall also be sent to the Resident, along with a copy of the Corrective Action Procedures then in effect, and a notice that he or she may request an appearance before the Committee.
2.5. The Resident shall have ten days following the date of the notice described in Paragraph 2.4 above to file a written request for an appearance before the Committee. This request may include the Resident’s written response to the request for corrective action. The request is to be made to the Chair of the DMC-GMEC. The request for an appearance shall specify:

2.5.1. The name of the single physician, if any, who will accompany and represent the Resident;
2.5.2. The names of any witnesses the Resident intends to call.
2.5.3. The rights to representation by a physician and/or to call witnesses shall be deemed waived if the request for an appearance fails to specify the information described in Paragraphs 2.5.1 and 2.5.2.

2.6. If the Resident fails to request an appearance within the applicable time period:

2.6.1. He or she waives any right to such appearance and to any further appellate procedures to which he or she might otherwise have been entitled; and
2.6.2. He or she will be deemed to have accepted an adverse decision by the Committee, which decision shall thereupon become the final decision and shall be implemented.

2.7. The Committee shall consider and decide upon the request for corrective action at its next meeting or as soon thereafter as may be practicable. The following procedures shall be applicable if the Resident has requested an appearance in accordance with the provisions of Paragraph 2.5 above.

2.7.1. The Resident shall be provided fifteen days notice of the time, place and date of the meeting;
2.7.2. The Resident may present witnesses named pursuant to Paragraph 2.5.2;
2.7.3. The party initiating the corrective action may present witnesses;
2.7.4. Either party may cross-examine any witness appearing in-person;
2.7.5. Any party may present evidence of a type on which reasonable persons customarily rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law; and
2.7.6. The Committee shall record its evidentiary proceedings. Deliberations of the Committee shall not be recorded.

2.8. The Resident shall be deemed to have waived his or her rights to appear as well as any appeal rights if, having requested an appearance, he or she fails without good cause to attend the meeting.

2.9. Following the appearance of the Resident and the presentation and examination of all witnesses and evidence, the Committee shall deliberate to determine appropriate action. The Committee may take either the action sought in the initial request for corrective action or such other action that the Committee determines to be warranted.

2.10. The Committee shall notify the Resident and the GMEC of its findings and corrective action decision no later than twenty-one days following the meeting.

2.11. The Resident may submit a written request for reconsideration by the DMC Chief Medical Officer (DMC CMO) of the decision of the Committee within ten days of the date of notice of such decision. The DMC CMO, in his or her sole discretion, may affirm, modify or reverse the decision of the Committee, or return the case for consideration by the full GMEC. The DMC CMO shall notify
the Resident of his or her decision within fifteen days of the receipt of such request for consideration. The DMC CMO’s decision shall be final and binding.

2.12. The procedures described in Paragraphs 2.1 through 2.11 above shall not apply to other corrective action taken by a non-DMC hospital as provided for above by Paragraph 1.5. The decision of the non-DMC hospital shall be final and binding as to the Resident’s outside rotation at the non-DMC hospital.

2.13. If the Program Director determines that the Resident should be placed on probation, the Program Director shall provide the Resident with the following information in writing:

(a) The length of the probationary period, which shall not exceed one year.
(b) The academic or professional deficiency or conduct, or other basis giving rise to the probation.
(c) The criteria which the Resident must meet in order to satisfy the terms of the probation.
(d) The approximate date or dates on which the Resident’s probationary status will be reviewed.

A copy of such written probation notice, including the information provided to the Resident, shall be submitted to the Executive Director of DMC-GME. If the Program Director fails to provide such information, the Resident may request review by the Committee as set forth in paragraphs 2.1 through 2.11.

3. SUMMARY SUSPENSION

3.1. Description. The Resident may be summarily suspended from the Program, based on the criteria listed in Paragraph 1.2, and such suspension shall become effective immediately upon imposition. In the event any corrective action described in Paragraphs 1.1.1 through 1.1.4 is also recommended, summary suspension shall continue pending completion of the corrective action proceedings described in Paragraph 2 above. If no such corrective action is recommended within ten days, or if any corrective action described in Paragraph 1.1.5 is taken, the summary suspension shall terminate upon expiration of the ten-day period or upon the taking of such corrective action.

3.2. Parties Who May Initiate. Summary suspension, as described above in Paragraph 3.1, may be initiated by any of the parties described in Paragraph 1.4.2 through 1.4.4 above.

3.3. Separate Action By A Non-DMC Hospital. As provided in Paragraph 1.5 above, a non-DMC hospital to which the Resident is assigned for outside rotation may summarily suspend or terminate the Resident’s training activities at that hospital, in accordance with that hospital’s procedures. Corrective action may be initiated by DMC-GME based on the Resident conduct giving rise to the Resident’s summary suspension or termination from the non-DMC hospital. If the non-DMC hospital’s suspension or termination of the Resident substantially interferes with the Resident’s DMC training program, DMC-GME may seek dismissal of the Resident pursuant to the corrective action procedures described in Paragraphs 2.1 through 2.11 above.

3.4. Such action may be taken independent of and in addition to any action taken pursuant to in Paragraph 3.1.

Responsibility
GME Committee

JC Functional Chapter
Leadership
**DEA Numbers**

Effective Date: July 1, 2004  
Revised Date: July 1, 2010  
Approved by: GMEC

An individual DEA number is only available and required upon acquiring a permanent medical license and CS-3.

A prescription for a controlled substance must be dated and signed on the date when issued. The prescription must include the patient’s full name and address, and the practitioner’s full name, address, and DEA registration number. The prescription must also include:

1. drug name  
2. strength  
3. dosage form  
4. quantity prescribed  
5. directions for use  
6. number of refills (if any) authorized

A prescription for a controlled substance must be written in ink or indelible pencil or typewritten and must be manually signed by the practitioner on the date when issued. An individual (secretary or nurse) may be designated by the practitioner to prepare prescriptions for the practitioner’s signature.

The practitioner is responsible for ensuring that the prescription conforms to all requirements of the law and regulations, both federal and state.

Residents are required to use DMC DEA numbers. Your 4-digit pager number is added to the end of your home hospital DEA number (see chart below). Incorrect use of DEA numbers can cause DMC to be subject to an audit.

If you are rotating to a hospital outside DMC, you will follow that hospital’s policy regarding DEA numbers.

Faculty or Residents who have applied and received their own DEA number would continue to use that DEA number. They may no longer use the DMC DEA numbers.

Please see new DMC Hospital DEA numbers listed below:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Address</th>
<th>New DEA #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's Hospital of Michigan</td>
<td>3901 Beaubien Blvd, Detroit, MI 48201</td>
<td>FC2397354</td>
</tr>
<tr>
<td>Detroit Receiving Hospital</td>
<td>4201 St. Antoine Blvd, Detroit, MI 48201</td>
<td>FD2397304</td>
</tr>
<tr>
<td>Harper-Hutzel Hospital</td>
<td>3990 John R, Detroit, MI 48201</td>
<td>FH2397289</td>
</tr>
<tr>
<td>Huron Valley-Sinai Hospital</td>
<td>1 William Carls Drive, Commerce Township, MI 48382</td>
<td>FH2397265</td>
</tr>
<tr>
<td>DMC Surgery Hospital</td>
<td>30671 Stephenson Hwy, Madison Heights, MI</td>
<td>FD2397330</td>
</tr>
<tr>
<td>48071</td>
<td>Sinai-Grace Hospital</td>
<td>6071 W. Outer Drive, Detroit, MI 48235</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation Inst of MI <strong>(RIM uses the same DEA # as Harper-Hutzel Hospital)</strong></td>
<td>261 Mack Avenue, Detroit, MI 48201</td>
</tr>
</tbody>
</table>

**Responsibility**

GME Committee

**JC Functional Chapter**

Leadership
Disaster Response Policy

Effective Date: July 1, 2004
Revised Date: July 1, 2010
Approved by: GMEC

In the event of a disaster impacting the GME programs sponsored by DMC, the GMEC has established this policy to protect the well-being, safety and educational experience of Residents enrolled in our training programs.

The definition of disaster will be determined by Accreditation Council of Graduate Medical Education, the American Osteopathic Association, the Council on Podiatric Medical Education, the American Dental Association Commission on Dental Accreditation, or the American Board of Obstetrics and Gynecology (“Applicable Accrediting Body”) as defined in their respective published policies and procedures. Following declaration of a disaster, the DIO and other sponsoring institution leadership will strive to restructure or reconstitute the educational experience as quickly as possible following the disaster.

In order to maximize the likelihood that Residents will be able to complete program requirements within the standard time required for certification in that specialty, the DIO will, as soon as possible, make the determination that transfer to another program is necessary.

Once the DIO determines that the sponsoring institution can no longer provide an adequate educational experience for its Residents, the sponsoring institution will, to the best of its ability, arrange for the temporary transfer of the Residents to programs at other sponsoring institutions until such a time as the DMC is able to resume providing the experience. Residents who transfer to other programs as a result of a disaster will be provided by their Program Directors an estimated time that relocation to another program will be necessary. Should that initial time estimate need to be extended, the Residents will be notified by their Program Director using written or electronic means identifying the estimated time of the extension.

It will be the intent of DMC to provide the appropriate administrative support, to the extent possible, to re-establish a permanent educational experience which meets the standards of the Applicable Accrediting Body as quickly as possible. If this cannot be achieved within a reasonable amount of time following the disaster, DMC will take appropriate steps to arrange permanent transfers of Residents to other accredited programs.

The DIO will be the primary institutional contact with the Applicable Accrediting Body and Institutional Review Committee Executive Director regarding disaster plan implementation and needs within the sponsoring institution. The DIO within 10 days of declaring a disaster will contact the Applicable Accrediting Body to discuss due dates that the Applicable Accrediting Body will establish for the programs including but not limited to program reconfigurations and Resident transfer decisions. Program Directors and Residents will contact the appropriate Review Committee Executive Director with information and/or requests.

In the event of a disaster affecting other sponsoring institutions of GME programs, the program leadership at DMC will work collaboratively with the DIO who will coordinate on behalf of the medical center the ability to accept transfer Residents from other institutions. This will include the process to request complement increases with the Applicable Accrediting Body that may be required to accept additional Residents for training. Programs currently under a proposed or actual adverse accreditation decision by the Applicable Accrediting Body will not be eligible to participate in accepting transfer Residents.
Responsibility
GME Committee

JC Functional Chapter
Leadership
Disciplinary Action
See Corrective Action.
Duty Hours and Working Environment

Effective Date: 9/1/2003

Approved by: GME

This policy applies to all graduate medical education programs sponsored by DMC, to all Residents enrolled in graduate medical education programs sponsored by Detroit Medical Center, and to all Residents assigned to DMC from graduate medical education programs sponsored by other institutions.

This policy incorporates the ACGME and other Applicable Accrediting Body duty hour requirements that are effective July 1, 2011, and includes requirements that programs carefully monitor moonlighting activities (if allowed and approved prior to actual duty by the Program Director) and that program-specific policies be developed and distributed to each Resident.

The following policy has been adopted by the GMEC for all Residents in GME.

1. Duty hours are defined as all clinical and academic activities related to the training program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

2. Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.

3. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

4. Duty periods of PGY-1 Residents must not exceed 16 hours in duration.

5. Duty periods of PGY-2 Residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.

   a. Programs must encourage Residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

   b. It is essential for patient safety and Resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

   c. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

   d. In unusual circumstances, Residents on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

      i. Under those circumstances, the Resident must:
a. Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

b. Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the Program Director.

ii. The Program Director must review each submission of additional service, and track both individual Resident and program-wide episodes of additional duty.

6. PGY-1 Residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

7. Intermediate-level Residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

8. Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

i. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that Residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these Residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

ii. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by Residents in their final years of education must be monitored by the Program Director.

On-Call Activities

The objective of on-call activities is to provide Residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when Residents are required to be immediately available in the assigned institution.

- Residents must not be scheduled for more than six consecutive nights of night float.

- PGY-2 Residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

- At-Home Call

  o Time spent in the hospital by Residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

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

    o Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

- In the course of duty hours, if a Resident feels too fatigued to drive to/from home, they may take a cab and provide the original receipt later for reimbursement.
Oversight & Monitoring

Institution Responsibilities

The GMEC reviews and monitors working conditions, Resident supervision, duty hours for Residents, and ancillary support, and Residents’ participation in department scholarly activity as set forth in the Applicable Accrediting Body Requirements.

The GMEC reviews and approves any proposal to substantially alter the working conditions for Residents including benefits before they are enacted. This is done through the Operations and Technology Committee. The Operations and Technology Committee duties include educating GMEC and other interested parties regarding sources of funding for GME; reviewing existing use of GME Funds; actively participating in the institutional budget process; making recommendations to GMEC regarding use of GME Funds; reviewing requests for affiliation with other training programs/institutions; monitoring agreements with affiliated training programs/institutions; considering GME sizing issues; assisting with monitoring Resident duty hours, moonlighting, supervision and/or other IRC requirements or issues that apply to all training programs.

Program Responsibilities

1. Programs must develop duty hour tracking systems for their programs to assist with appropriate monitoring of compliance with this policy. Program Directors are encouraged to develop and use tracking systems that best meet the needs of their program and Residents. Program Directors shall report their procedure for tracking duty hours to the GMEC for approval.

2. Program Directors shall include information on compliance with the requirements of this policy in an annual report to the GMEC or as specified by the GMEC. Each DMC program must have written policies and procedures consistent with this policy and the Applicable Accrediting Body Program Requirements for Resident duty hours and the working environment. These policies must be distributed to the Residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

3. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create Resident fatigue sufficient to jeopardize patient care.

4. If the complainant is a Resident, a member of the teaching staff, or other internal personnel in the program or institution in question, the following options should be taken before submitting a complaint to the Applicable Accrediting Body:
   a. Contact the Program Director to discuss the problem.
   b. If the issue either involves the Program Director or is not resolved by meeting with the Program Director, contact the institutional GME committee or similar oversight body, the DIO of the sponsoring institution, the GME office or the Resident representative on any of these oversight groups.

5. If the efforts above do not resolve the issue, contact the Applicable Accrediting Body Complaint Officer to discuss submitting a formal complaint. If the complainant is someone outside the institution, the Applicable Accrediting Body Complaint Officer may be contacted as the first option in the process.
6. For further information on filing a complaint directly with the Applicable Accrediting Body please reference its website.

**Communication of Duty Hours Concerns and Issues**

Duty hour issues will be a standing agenda item for every Graduate Medical Education Committee meeting. The GMEC will review, discuss, and resolve issues or problems involving duty hours as they are brought to the attention of the committee by program directors, Residents, or other parties.

The GMEC will require program directors to provide corrective action plans addressing any violation of the ACGME Duty Hour Standards.

Residents are encouraged to discuss concerns or issues with duty hours with their Program Director and Chief Residents. Residents may also report duty hour violations or concerns without fear of reprisal to the Designated Institutional Official or the Associate Designated Institutional Official in the GME Office at any time in person, by telephone, or by e-mail. Duty hour issues brought to the attention of the GME Office will be addressed as quickly as possible with the appropriate program director and will be reported at the next GMEC meeting. Duty hour concerns and issues may also be reported anonymously or confidentially to the Tenet Ethics Action Line (1-800-838-4427 or ethics@tenethealth.com).

**Requests for Exception**

(First approved 05.01.03 by GMEC).

A Program wishing to request an exception to the Duty Hours limitation (up to 10% or a maximum of 88 hours), must submit a written proposal describing the educational rationale for the request to the GMEC.

A Residency Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale. However, prior permission of the GMEC is required.

**Process:**

1. Exceptions to the above standards for reasons of sound educational rationale may be submitted to the Resident section of the GMEC for consideration. The Resident section will then present the proposal along with their recommendations to the full GMEC for approval/denial. If approved, the exception request will then be forwarded on to the appropriate Applicable Accrediting Body. Exceptions approved by GMEC will not be effective until direct notification to the Designated Institutional Official (DIO) from the Applicable Accrediting Body that it was accepted.

2. All duty hour concerns by Residents will be directed to the Resident section of the GMEC for consideration, investigation, and action. The Resident Council of the GMEC will then present the concerns and proposed action to the full GMEC for approval/denial.

**Monitoring Requirements**

Compliance with duty hour requirements is monitored as identified below. Follow-up and resolution of problems identified are the responsibility of the GMEC and DIO.

**Resident Survey:** The ACGME and other Accrediting Bodies survey the Residents about their clinical and education experiences. This survey is not administered in conjunction with a program's site visit, although the information gathered will be used at the time of the program's site visit.
Compliance Hotline: Residents are encouraged to contact the Tenet Ethics Action Line (800.838.4427) to report violations of the Duty Hour requirements.

Program Policies: Copies of program specific policies and procedures are maintained in the GME Office.

Periodic Review of Program Procedures: On a regular basis, Program Directors are requested to report on the procedures they have in place to insure that duty hour requirements are being met.

Web Survey: Residents are required to complete a confidential (only program is identified) web based survey. Included in the survey are questions about program compliance with duty hours and other work environment issues.

Moonlighting
DMC does not require moonlighting. However if a Resident would like to moonlight he/she must meet the below requirements:

1. Residents must devote themselves to the performance of their graduate medical education program (“Program”) requirements. Performance of Program requirements takes precedence over moonlighting. Moonlighting must not interfere with the Resident’s ability to achieve the goals and objectives of the educational Program. Residents must NOT moonlight while on call for a GME program.
2. Interns and Residents on J-1 visas are prohibited from moonlighting.
3. Residents must hold a permanent Michigan medical license (not an educational limited license), a Michigan CS-3 (Controlled Substance) pharmacy license and an independent federal DEA number in order to moonlight.
4. The Resident must receive prior written approval for moonlighting from his/her Program Director. A copy of such written approval, along with a request to moonlight, must be provided to the GME office by the Resident. The Program Director may withhold or withdraw his or her approval at any time, as he or she, in his or her sole discretion, deems appropriate. The GME office must be notified in writing of any withdrawal of approval.
5. The GME office will review all requests for moonlighting and will prepare a roster of approved moonlighters (the “Approved Moonlighting List”) which lists those Residents with the requisite licensure, visa status and program approvals for moonlighting. Only those Residents listed on the List will be permitted to moonlight. The GME office will update the List on a regular basis and circulate it to hospital presidents and their designees, as well as GME program directors and faculty.
6. Internal and external moonlighting must be counted toward the 80-hour weekly limit on duty hours. Residents and Fellows must record their duty hours in New Innovations, including any moonlighting hours. Failure to appropriately record duty hours will result in the revocation of moonlighting privileges.

DMC training programs must have a written policy regarding moonlighting that:

- Identifies whether or not the program allows Residents to moonlight

If program allows moonlighting, policy must also:
Describe eligibility for moonlighting
Set parameters, e.g., maintenance of acceptable performance, hours, location, etc.
State that Internal and External Moonlighting must be counted toward the 80-hour limit.
Describe consequences of not complying with policy
State that PGY 1 Residents, Residents with educational limited licenses, and Residents on J-1 visas are not permitted to moonlight
State that only those Residents listed on the GME Approved Moonlighters Roster may moonlight

The policy must be distributed to each Resident. A copy of the policy signed by each Resident acknowledging receipt must be maintained in the Resident’s program file.

A copy of the program’s moonlighting policy must be provided to the GME office.

Liability coverage for moonlighting activities is NOT provided through DMC-GME. It is the responsibility of the Resident to ensure that appropriate liability coverage is in place for his/her moonlighting activities.

**Resident Request for Moonlighting Activities**
*(GMEC approved 8/25/2008)*

In order for a DMC Resident to moonlight in a DMC-owned hospital or practice, the following criteria must be met:

1. The Resident must be listed on the GME office’s then-current Approved Moonlighting List.

2. Under current ECFMG regulations, J-I visa holders are NOT eligible to moonlight under any circumstances. Moonlighting is considered extracurricular activity which is not part of the training program curriculum for which compensation is provided. Therefore, any activities performed outside of the scope of the program would be considered moonlighting and J-I visa holders would not be eligible.

3. Under current USCIS regulations, H-I B visa holders ARE eligible to moonlight as long as they receive compensation from the employer that has petitioned for their current H-I B visa. Detroit E&R is the employer on the H-I B petition so compensation must be paid by Detroit E&R.

4. Moonlighting candidates MUST hold a permanent Michigan medical license (not an educational limited license), a Michigan CS-3 (Controlled Substance) pharmacy license and an independent federal DEA number in order to moonlight.

5. Malpractice coverage must be provided for moonlighting activities. The GME policy does NOT cover moonlighting activities. Residents who will be moonlighting must have the appropriate DMC Insurance Program request forms (available through New Innovations intranet/knowledge warehouse) sent by their supervisor to:

DMC Insurance Program
Attention: Pamela Jones
Fax: (313) 966-5124
This will provide notification to the DMC Professional Liability Office of the extracurricular activities that will be performed by the Residents so coverage can be provided.

In order for a DMC Resident to moonlight in a non-DMC-owned hospital or practice, the following criteria must be met:

1. The Resident must be listed on the GME office’s then-current Approved Moonlighting List.

2. Under current ECFMG regulations J-1 visa holders are NOT eligible for moonlighting under any circumstances. Moonlighting is considered any extracurricular activity which is not part of the training program curriculum for which compensation is provided. Therefore, any activity performed outside of the scope of the program would be considered moonlighting and J-1 visa holders would not be eligible.

3. Under current USCIS regulations, H-I B visa holders ARE eligible to moonlight. However, if the employer is a hospital or practice other than the DMC, the Resident MUST apply for a dual H-I B with that employer. The H-I B visa that the Resident has with Detroit E&R is not valid for any other employer, including the Barbara Ann Karmanos Cancer Institute and the John D, Dingell VA Medical Center. The Resident would need to contact an attorney to process this request and will be responsible for payment of all fees associated with it. It is the responsibility of the Resident to verify with the attorney that he/she will be exempt from the H-I B cap based on the employer’s status.

4. Moonlighting candidates MUST hold a permanent Michigan medical license (not an educational limited license), a Michigan CS-3 (Controlled Substance) pharmacy license and an independent federal DEA number in order to moonlight.

5. Malpractice coverage must be provided for moonlighting activities by the employer. It is not provided by the DMC.

Responsibility
GME Committee

JC Functional Chapter
Leadership
Educational Commission for Foreign Medical Graduates (ECFMG) Certificate (International Medical Graduates Only)

Effective Date: July 1, 2004
Revised Date:
Approved by: GMEC

The ECFMG (www.ecfmg.org) certificate is required for admission to any residency training program at DMC. See also Eligibility Requirements for Residents.

Responsibility
GME Committee

JC Functional Chapter
Leadership
Eligibility Requirements for Residents

Effective Date: 7/1/2012
Revised Date: 7/1/2008; 5/23/2011; 7/1/2012
Reviewed Date: 7/23/2012

Approved by: GMEC

POLICY

The Detroit Medical Center Graduate Medical Education Office, in cooperation with the Program Directors of Detroit Medical Center Residency and Fellowship Programs, shall be responsible for review and approval of the credentials of all applicants for residency and fellowship at the DMC in order to assure that applicants meet the eligibility requirements for residency and fellowship specified by the DMC Graduate Medical Education Committee, the ACGME, AOA or other Applicable Accrediting Body.

Medical School Requirements

Applicants for residency or fellowship at the Detroit Medical Center must have one of the following qualifications:

1) **Graduate of a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME).** Valid documentation of graduation includes presentation of the original diploma from the applicant’s medical school, or written confirmation from the Dean of the applicant’s medical school that the applicant is expected to graduate during the same year the applicant will start residency. Applicants registered through the Electronic Residency Application Service (ERAS) shall be deemed eligible for appointment. Candidates applying outside of ERAS must be approved in writing by the Detroit Medical Center Vice President of Academic Affairs/Designated Institutional Official before being deemed eligible for appointment.

2) **Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).** Valid documentation of graduation includes presentation of the original diploma from the applicant’s college of osteopathic medicine, or written confirmation from the Dean of the applicant’s college of osteopathic medicine that the applicant is expected to graduate during the same year the applicant will start residency. Applicants registered through the Electronic Residency Application Service (ERAS) shall be deemed eligible for appointment. Candidates applying outside of ERAS must be approved in writing by the Detroit Medical Center Vice President of Academic Affairs/Designated Institutional Official before being deemed eligible for appointment.

3) **Graduate of a medical school outside the United States and Canada who meets one of the following qualifications:**

   a. **Holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates.** Valid documentation of an ECFMG Certificate must be confirmed in writing by the DMC Graduate Medical Education Office before the candidate’s appointment is effective.
b. **Holds a full and unrestricted license to practice medicine in the State of Michigan.** Valid documentation of a Michigan medical license must be confirmed in writing by the DMC Graduate Medical Education Office before the candidate’s appointment is effective.

c. **Graduate of a medical school outside the United States and Canada who has completed a Fifth Pathway program provided by a medical school accredited by the Liaison Committee on Medical Education (LCME).** Valid documentation of completion of a Fifth Pathway program must be confirmed by the DMC Graduate Medical Education Office before the candidate’s appointment is effective.

**Medical Licensing Examination Requirements**

**United States Medical License Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Exam (COMLEX) Requirements.**

All applicants for residency must provide documentation of a passing score on Step 1 of the USMLE or COMLEX level 1 at the time of application.

Candidates for residency must provide documentation of a passing score on Step 2 of the USMLE, including Step 2- Clinical Knowledge and Step 2 Clinical Skills, or the COMLEX-USA Level 2, including Level 2-Cognitive Evaluation (CE) and Level 2-Performance Evaluation (PE), prior to the start of residency and as a condition of employment at the DMC.

All applicants for fellowships must provide documentation of a passing score on Step 1, Step 2 and Step 3 of the USMLE or COMLEX Level 1, Level 2, and Level 3, at the time of application.

**Visa Requirements for citizens of countries outside the United States**

Applicants from citizens of countries outside the United States must provide documentation of a valid visa issued by the United States Department of State allowing the individual to work and study in the United States for the duration of residency or fellowship training.

**Acceptable Citizenship or Visa Statuses**

The following are acceptable work statuses for enrollment:

1. J-1
2. Work authorization
3. Permanent resident
4. F-1/OPT
5. H-1b

**J-1 training visa:** Applicants for residency or fellowship at the DMC should obtain a J-1 visa through the sponsorship of the Educational Commission on Foreign Medical Graduates (ECFMG).

**F-1/OPT Visa:**

Residents who enter the program on an F-1/OPT visa will need to convert this visa to either a J-1 during their first year of training.

**H-1b temporary worker visa:** Applicants for residency or fellowship at the DMC may request sponsorship from the DMC for an H-1b visa. The cost of the application and processing of H-1b visas must be paid by
the department to which the candidate is applying.

**Responsibility of Resident Visa Holders:** It is the responsibility of the Resident to remain in valid visa status at all times.

**Responsibility**
GME Committee

**JC Functional Chapter**
Leadership
**E-Mail**

Effective Date: July 1, 2004
Revised Date: 
Approved by: GMEC

As employees of the DMC, Residents are automatically provided an email account by the DMC. However, a Resident may obtain a WSUSOM or KCC email through his/her Program. The DMC, WSUSOM or KCC address must be the primary email for contact with and from Residents to ensure HIPPA and confidentiality are maintained.

Emails concerning patient information from a DMC, WSUSOM or KCC account must say “SECURE” in the subject line.

**Responsibility**
GME Committee

**JC Functional Chapter**
Leadership
Emergency Operations Plan (1 EC 040)

Effective Date: May 6, 2011
Revised Date: April 25, 2008
Approved by: DMC management

OBJECTIVE
The emergency operations plan is designed to outline an organized process to mitigate, prepare, respond and recover from emergency events that may occur internal or external to the DMC. Response to emergencies will incorporate an all hazard command structure that is in compliance with the NIMS. The all hazard command structure will be organized round 6 components: communication, resources and assets, safety and security, staff roles and responsibilities, patient clinical and support activities and utility management. Response procedures will include response to isolated emergency events as well as multiple emergency events that can adversely impact patient care and the ability to provide care, treatment and services for an extended length of time without the immediate support of outside responding agencies/services. Site specific plans will outline response procedures that will be taken by the staff at the site.

SCOPE
All DMC facilities.

DEFINITIONS
All Hazard: Flexible enough for use in all emergency situations including unforeseen events.

Emergency: Any incident/situation/event that requires responsive action to protect or save lives, protect property and public health and safety, or to lessen or avert the threat of a catastrophe. Emergency event would be but no limited to severe weather, tornadoes, loss of utilities, bomb threats, hostage situations or infant abductions.

Disaster: Any natural emergency which has the severity or magnitude to warrant assistance from local emergency responders.

Catastrophe: Any natural or manmade incident/emergency event that results in extraordinary levels of mass casualties, damage or disruption severely affecting the hospital infrastructure, environment, or ability to provide services. Any event that would extend beyond the capabilities of the hospital and would require assistance from local, state or federal response agencies.

Hazard Vulnerability Analysis (HVA): The identification of potential emergencies and the direct and indirect effects these emergencies may have on the facility. The analysis will evaluate probability, risk and preparedness.

Incident Command System: The combination of facilities, equipment, personnel procedures and communications operating within a common terminology and organizational structure with responsibility for the management of assigned resources to effectively accomplish stated objectives pertaining to an incident.
Mitigation: Activities designed to reduce or eliminate risk to persons or property or to lessen the actual or potential effects or consequences of an incident. Mitigation measures may be implemented prior to, during or after an incident. Mitigation involves ongoing actions to reduce exposure to, probability of or potential loss from hazards.

Mutual Aid Agreement: A pre-arranged agreement developed between two or more facilities to render assistance to each other in the event of an emergency.

NIMS: National Incident Management System. A system mandated by HSPD-5 (Homeland Security Presidential Directive 5) that provides a consistent, nationwide approach for Federal, State, Local and tribal governments, private sector to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size or complexity. Incident Command System is one of the key features of NIMS.

Preparedness: Establishing and delineating authorization and responsibility for emergency actions and making provisions for having the people, equipment and facilities in place to respond when the need arises. Preparedness involves planning, training, exercising, procuring and maintaining equipment and designing facilities for shelter and other emergency purposes.

Recovery: The process of restoring infrastructure, social and economic systems following an emergency.

Response: Carrying out time-sensitive actions to save lives and protect property during an emergency. In addition to managing the response, actions can include fire-fighting, protective actions by law enforcement, warning, evacuation, mass care, emergency public information, search and rescue, health and medical care, resource management and other activities.

POLICY
The Detroit Medical Center (DMC) and its Governing body are committed to providing a safe and healthy environment that is free of recognized hazards for patients, residents, tenants, visitors and staff. The Emergency Operations Plan will comply with all applicable laws and regulations and accepted practices within the safety and healthcare industry. In the event of an emergency/disaster event this plan will outline the actions that will be taken in compliance with NIMS. Site specific plan will outline site response to an emergency/disaster event.

PROVISIONS
The DMC Environment of Care Emergency Management Focus Group and the DMC Emergency Management Committee will provide oversight to emergency management planning and implementation in keeping with the provisions of the DMC Environment of Care Program. Site Emergency Management Committees will develop and implement site-specific emergency operations plans in conjunction with the site leadership and environment of care committee.

The Written Emergency Operations Plan will include the following sections:

1. Emergency Management Planning Activities
2. Response Plans
3. Recovery Plan
4. Managing emergency response (six critical functions)
5. Exercise Design
6. Annual Effectiveness Evaluations (EOP, HVA, Inventory)

Emergency Management Program Planning:

1. **Hazard Vulnerability (HVA):**
   A comprehensive Hazard Vulnerability analysis will be conducted as part of the planning activities at each DMC facility to identify potential emergencies that could affect the need for services or ability to provide those services. The comprehensive risk assessment will be determine by reviewing the hazards that threaten the facility and or community, frequency of the hazards, severity of the situation, likely impact to the facility and community and vulnerability of the facility to the hazard. The events identified will be prioritized according to likelihood of occurrence, risk to the population and property/building and significance of the impact to the facility. The results of the risk assessment will be used to develop mitigation, preparedness, response and recovery plans, determine frequency and type of emergency exercises. The HVA will be an evolving document at the DMC facilities and will be reviewed after each actual or emergency exercise in which the emergency response plan was activated or at least annually by the site emergency management committee. Each DMC facility will submit the results of the site HVA with their local emergency management department for review and incorporation of the local community emergency events that could impact the DMC facility.

   Each DMC facility will communicate capabilities, needs and vulnerabilities that will require assistance from the community partners in the following areas: communication, resources and assets, safety and security, utilities, management of patients and staff during an emergency. The capabilities chart will be used to document discussion with community partners.

2. **Incident Command Systems (ICS) - All hazard:**
   The DMC adopted the all hazard system used by the local responders. This incident command system will be used to manage all emergency incidents, exercises and actual events in accordance with the ICS organization structures, doctrine, and procedures as defined in the National Incident Management System (NIMS). The ICS structure for each site will be outlined in the site emergency operation plans. Depending on the size and scope of the event the ICS organization structure will vary. Each site will designate individuals for the incident commander position. The following schematic describes the incident command system that will be activated for all incidents regardless of the size or nature of the incident: Refer to 1 EC 040 Incident Command System
The ICS system will be activated in all DMC facilities. The job duties of the ICS positions are outlined as follows:

**Incident Commander (IC):** The only position that is always activated in an incident regardless of the nature of the incident. The IC develops the incident objectives on which the incident action plan is based. The IC will be the person that is on site at the time of the emergency and assumes overall responsibility of the incident, disaster or incident. The IC position will be passed upward to the most senior person until the designated IC arrives. See 1 EC 042 Incident Command System

**Command Staff:** Command staff individuals will assist the IC when needed in managing the emergency situation. Depending on the size and the nature of the event the IC can handle the responsibilities of the command staff. If additional support is required the IC will activate the command staff which will consist of Liaison, safety and public information officers. When activated the command staff will assist the IC in developing incident action plan.

**Liaison Officer:** The point of contact for assisting and/or coordinating with the responding agencies.

**Safety Officer:** Ensures responding personnel observe safety procedures and safer practices, identifies unsafe or hazardous conditions that may exist or develop measures to protect the safety of personnel and takes immediate action to stop or prevent unsafe acts. The safety officer position must be appointed whenever there is a hazardous material incident. The safety officer has the authority to stop the emergency response to prevent unsafe acts during an emergency.
Public Information Officer: Provides a valuable interface with the media to disseminate accurate, timely and consistent information. The IC is responsible for the approval of the release of all incident related information.

Large scale events may require additional staff to manage the emergency incident. The IC has the authority of activating the general staff positions of the ICS. The general staff will also assist the IC in managing the emergency incident. The following positions make up the general staff:

Operations Section Chief: The person most knowledgeable about the emergency situation. This person provides information to the IC on how to manage the emergency situation. The Operations Section Chief is responsible for the direct management of all of the incident related operational activities. Individuals are appointed to this position based on the nature of the emergency situation. This opposition manages the tactical operations and coordinated operations.

Planning Section Chief: Responsible for collecting, evaluating and disseminating incident situation information and intelligence for the IC and prepares status reports, displays situation information, maintains status of resources assigned to the incident and develops and documents the incident action plan. This person also identifies any problems that may be encountered in trying to accomplish the goals of the emergency situation.

Logistics Section Chief: Responsible for all support requirements needed to facilitate effective and efficient incident management including ordering resources from, providing facilities, transportation, supplies, equipment maintenance, fuel, food services, communications support, and information technology support. The position obtains whatever is required to accomplish the incident action plan.

Financial/Administration Section Chief: The position is established when the emergency response activities require finance and other administrative support services. The position approves any request that requires additional funds for supplies or equipment not in the facility.

Incident Command Post: The location established by the incident commander and is adjacent to or as close and as safe as possible to the emergency incident. The incident commander, the command staff and the general staff will perform assign task at this location. The incident command post is managed by the incident commander.

Emergency Operations Center (EOC): The designated location in the hospital at which coordination of information and resources required to support the incident commander and incident objectives takes place. The EOC is managed by the Agency Executive (see below) of the hospital. Site and Corporate EOC’s are activated when required. DMC EOC will be activated when two or more site specific EOC’s are activated.

Agency Executive: The Chief Executive Officer/President of the hospital. Responsible for the overall day to day administration of the hospital operations.

Unified Command: Established when a local emergency responder arrives to assist the hospital in the response to the emergency incident. The incident commander of the emergency responder agency will work with the hospital incident commander to establish a common set of objectives and
strategies to resolve the emergency situation.

3. **Four phases of emergency management**: There are 4 phases that are used in emergency management planning for response to emergency incidents/events. Emergency events identified on the HVA will identify the four phases as mitigation, preparedness, response and recovery. The following phases will be identified on separate chart or referenced in the site response plan:

**Prevention/Mitigation**: Activities used to reduce/lessen the severity of the impact to a potential emergency. Mitigation will begin with the identification of the Hazards.

**Preparedness**: Activities to prepare the staff and facility for emergency response. Preparedness also includes inventory of resources response plans, training, ongoing planning and exercises conducted periodically or as required by standard/regulations. Each DMC facility will have a documented inventory of their emergency resources and assets maintained on site. The inventory will include at the minimum PPE, water, fuel, medical and surgical supplies, and medication related to emergency resources.

**Response**: Appropriate actions to protect life and property are identified. Emergency response plans identify actions to be taken when the emergency codes are activated.

**Recovery**: Activities required to restore the organization following the emergency response. Replacement of supplies, resources, finances, staffing and services that may have been impacted by the emergency event.

4. **Emergency code notification**: Criteria used to determine activation of the emergency operation code will consist of the following applicable information received:
   a. Type of emergency event and location of emergency event
   b. Nature of the injuries
   c. Number of injuries
   d. Likely impact on the facility, staffing, and other key support areas
   e. Can the impact be managed through daily operations and management practices
   f. Does the event involve the media
   g. Direction received from DMC Emergency Operation Center
   h. Need for additional staff to assist in the response to the event

Staff will be notified of an emergency operation plan activation when an event has occurred in the facility or in the community. Staff will be knowledgeable of the department response to the activation of the plan, implementation of the 4 phases of response and the activation of the Incident Command System. Each site Emergency Operation Plans will identify who has the authority to activate response and recovery phases of an emergency situation and to whom the staff will report in the hospital’s command structure.

The DMC adopted the emergency code colors that are consistent with the hospitals in the Detroit and surrounding county hospitals. Color codes are used to identify the type of emergency event occurring in the hospital or community. The use of the emergency color code rapidly conveys an alert to the staff to activate department or hospital wide response. In addition to color codes additional alerts are used which will convey to the staff that a hospital specific emergency event has occurred and department response should be activated. The following color codes/alerts are used
<table>
<thead>
<tr>
<th>Event</th>
<th>Code/Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>Code Red (Red)</td>
</tr>
<tr>
<td>Adult Emergency</td>
<td>Code Blue (Blue)</td>
</tr>
<tr>
<td>Bomb Threat</td>
<td>Code Yellow (Yellow)</td>
</tr>
<tr>
<td>Combative Person</td>
<td>Code Gray (Gray)</td>
</tr>
<tr>
<td>Infant Abduction (&lt; 1 Yrs)</td>
<td>Code Pink (Pink)</td>
</tr>
<tr>
<td>Child Abduction</td>
<td>Code Purple (Purple)</td>
</tr>
<tr>
<td>Pediatric Medical Emergency</td>
<td>Code White (White)</td>
</tr>
<tr>
<td>Person with Weapon/Hostage</td>
<td>Code Silver (Silver)</td>
</tr>
<tr>
<td>Radiation Incident</td>
<td>Code Violet (Violet)</td>
</tr>
<tr>
<td>Hazardous Material Spill/Release</td>
<td>Code Orange (Orange)</td>
</tr>
<tr>
<td>Severe Weather</td>
<td>Code Black (Black)</td>
</tr>
<tr>
<td>Neonatal Medical Emergency</td>
<td>Code Brown (Brown)</td>
</tr>
<tr>
<td>Evacuation of Patient Required</td>
<td>Code Evac</td>
</tr>
<tr>
<td>Internal Disaster</td>
<td>Code Triage: Internal</td>
</tr>
<tr>
<td>External Disaster</td>
<td>Code Triage: External</td>
</tr>
<tr>
<td>Newborn Delivery (Outside L&amp;D Area)</td>
<td>Birth Alert (State Location)</td>
</tr>
<tr>
<td>Utility Alert</td>
<td>Utility Alert (State the Utility)</td>
</tr>
<tr>
<td>ED Over Capacity; Bed Shortage, ED Full</td>
<td>Elevator, HVAC, Water Medical Gases, Power, Steam</td>
</tr>
<tr>
<td>Evacuate areas due to ETO Alarm</td>
<td>29 Alert</td>
</tr>
<tr>
<td>Patient Medical Duress</td>
<td>CPD Alert</td>
</tr>
<tr>
<td></td>
<td>Green Alert</td>
</tr>
</tbody>
</table>
5. **Training**: All DMC employees will be trained on communication processes, staff roles and responsibilities, available resources, safety and security measures, patient care activities and support activities and alternative methods for utility failures. The training will be specific to the hospital response procedures. In addition to the hospital specific training all staff will be trained annually on the environment of care net learning module which includes emergency management planning, response and recovery methods. NIMS training will be conducted for designated staff and senior leadership in accordance with the NIMS implementation requirements. Staff receive general education regarding the hospital emergency operation plan during new employee orientation, annual graduate medical education orientation, annual refresher training programs or net learning modules. Emergency code charts are posted throughout the DMC facilities to provide quick reference of the code names and basic staff response.

6. **Graduate Medical Education**: All department chiefs and managers are expected to assure that staff understands their role and responsibilities during an emergency situation. Each department is responsible for developing a plan that addresses the following:
   a. Maintain an up to date phone list of their employees and provide a current roster of supervisors’ home phone and on-call schedule to administer
   b. Ensure adequate safety for those individuals’
   c. Develop specific plans and responses that address their operations during any type of emergency event.
   d. Account for all GME personnel assigned to each department service at the time of the emergency event.
   e. Upon notification of emergency code external/internal triage all GME personnel will report to their designated departments and sign in on the department disaster log. The department chief will forward that information to the site VP of Medical Affairs in the Site EOC. If and emergency code is activated during a time when the department is not staffed and alternative location and process must be established in the department’s emergency plan.

7. **Community Involvements**: The DMC will participate with the designated emergency management response agency for the city, county and/or region in their contiguous geographic area as well as other surrounding areas when required. At least once a year the DMC will participate in a communitywide exercise. Hospitals will interact with the local emergency responders prior to an emergency event to establish a working relationship and to communicate the capabilities and limitation of the hospitals during an emergency event. DMC will have representation on the local emergency planning committees of the appropriate geographic area to participate in cooperative planning with local responders and other healthcare organizations to facilitate the timely sharing of information about essential elements of their command structure and other essential information required during an emergency.

The DMC hospitals are active members of the Region 2 North and 2 South Bio-Defense Regions. The Bio-defense Region is a collaboration of hospitals, health departments, emergency management departments, homeland security departments and other emergency response agencies in Detroit, Wayne, Oakland and other adjacent counties.
8. **Emergency Management Planning Committee:** DMC system and site emergency management committees or working focus groups will meet at least quarterly to develop the comprehensive system and site emergency operations plans. The system and site committees will be a multidisciplinary committee which will include the participation of hospital leaders (including medical staff) who will be responsible for the design, training, implementation, monitoring, exercising, and improvement of system and site emergency response and recovery. The committee will adopt an all hazard approach for emergency events identified on the HVA. Any goals or initiatives of the local and or regional emergency management response agencies will be included in the annual assessment, goals and actions items of the system and site emergency management planning committee. The planning committee will include the following 6 critical function processes for managing emergencies: communication, resources and assets, safety and security, staff roles and responsibilities, utilities and patients. Each site emergency operations plan will document the management processes during an emergency in attachments to the site plan.

The attachments will identify activities and capabilities that will support a level of preparedness for any emergency that may occur at the hospital. The critical components will be organized in chart form for each component and will include current state of readiness for an emergency as well as state of readiness for a disaster that would prevent support from the outside emergency response community for 96 hours. The chart will also include sustainability hours associated with the loss of each critical component to determine the capabilities of the hospital and establish guidelines and actions when the hospital can no longer provide care services. The attachments will be included in the evaluation and critique conducted after activation of any emergency code response and recovery.

9. **Emergency Exercise:** Planned exercises will be conducted and planned by the site emergency management committee. When appropriate the DMC hospitals will plan joint exercises to evaluate system response to an emergency event. Planning and frequency of the exercises will be determined by the emergency management committee. The Hazard Vulnerability Assessment will guide the emergency exercise schedule as well as planned exercises based on nationwide hospital emergency events.

DMC hospitals that offer emergency services or are community-designated disaster receiving hospital will conduct at two exercises a year. One of the two exercises will include an influx of actual or simulated patients. Annually an exercise will be planned to test how the hospitals will perform when the local community cannot be relied on for support. The exercise will be planned to escalate in order to test effectiveness of providing care during a disaster or catastrophe with the infrastructure damaged. Business occupancy facilities will conduct an annual emergency management exercise.

In the planning process all scenarios will be as realistic as possible. An evaluator for the exercise will be identified whose responsibility will be to monitor the hospital performance, be knowledgeable in the goals and expectations of the exercise and objectively document opportunities for improvement. The individual(s) selected will not be a participant or player in the exercise.

10. **Emergency Exercise Critique/Evaluation:** All emergency code activations will be evaluated to identify deficiencies and opportunities for improvement based on the monitoring activities results and observations during the exercise. Critique of the planned exercise will be performed by a
multidisciplinary process that includes representatives from administration, clinical (includes physicians) and support staff. Results of the critique will be documented and may require modification of the emergency operation plan, training of staff, scheduling another exercise if performance is not acceptable, and determination of objectives for the next exercise. Revisions to the emergency operation plan will be reviewed by the site emergency management committee and the site environment of care committee for final approval and final revision to the emergency operation plan.

During planned exercises the hospitals will monitor any revisions to the emergency operation plan as a result of previous exercises, specific hospital objectives of the planned exercise and the will include the following areas:
1) Effectiveness of communication both within the hospital as well as with response entities outside the hospital
2) Resource mobilization and allocation including responders, equipment, supplies, personal protective equipment and transportation
3) Safety and Security measures appropriate to the planned exercise
4) Management of staff roles and responsibilities
5) Utility Management and alternative methods when appropriate
6) Management of patients and support care activities

11. Performance Indicators: Annually the system and site emergency management planning committees or working focus groups will identify monitoring activities applicable to emergency management planning, response and recovery. Results of the identified monitoring measures will be reported quarterly to the site environment of care committee and at least annually to the appropriate system and site leadership committee.

12. Memorandum of Understanding: Memorandum of Understanding has been developed among DMC hospitals if an emergency incident requires the evacuation of any DMC hospital. If evacuation assistance is required from the local emergency responders the request will be made to the by the evacuating hospital’s Agency Executive and communicated to the local community emergency response agency as soon as possible after the decision to evacuate is made. Communication with the local response agency will be established at the time of the emergency situation with notification on the possibility of evacuation. MOAs (Memorandum of Agreement) also exists with DMC vendors for supplies (medical and non-medical), National Disaster Medical System, alternate utility services, food services and equipment. Additional MOU/MOA will be available to the DMC hospitals as a result of participation with the Region 2 North and 2 South Bio-defense network and the local community emergency response agencies. Activation of the MOU guidelines will be communicated to the DMC hospitals from the emergency response agencies.

13. Annual Evaluation of Emergency Operations Plan: The site emergency operation plan will be evaluated for effectiveness at least annually. The annual evaluation will include a review of identified risks, hazards and potential emergencies listed in the Hazard Vulnerability Analysis, the emergency operation plan’s objectives, scope, performance and effectiveness and a review of inventory of supplies, equipment and other items determined to be required for response and recovery. Results of the annual evaluation will be documented and reported to the site environment of care committee and to the appropriate site leadership committee.
templates are designed to document the annual effectiveness review of the EOP.

14. Disaster Privileging for volunteer licensed independent practitioners: Tier 1 MS 026 establishes guidelines for the credentialing of licensed and non-licensed volunteer practitioners in the event of a disaster, mass casualty incident and/or a catastrophic event requiring the activation of the DMC or site emergency operation plan and exceed the clinical resources available in the DMC.

Response Procedures:

1. **Emergency Code Plan(s) Activation:** Each site emergency code plan will identify the authorized person to activate the emergency code plan when deemed appropriate. Initial notification of an external emergency event can be received in the emergency department, site operator/communication department, security, media, administration or front information desk. Department staff has been trained on actions required when the initial information is received and will quickly notify the appropriate person. All site code plans identify how and to whom the information should be communicated for evaluation and determination of the activation of the emergency response operation plan/response. Once it has been determined that the information warrants the activation of the emergency operation plan the staff and administration will be notified by several redundant communication devices. All site code plans identify immediate actions that will be taken upon hearing the activation of the code plan.

2. **Command and Control:** Command and control is a critical emergency response function. This function will begin immediately upon the onset of an emergency incident/event and will continue until the emergency no longer exist and normal operations resume. The DMC adopted the ICS that is consistent with the local emergency responders and will be used for all emergency code activations. The incident commander (IC) will assume control of the emergency according to the site emergency code plans. Each code plan or separate policy will identify the incident commander for each emergency incident identified on the HVA. Transfer of command can occur when the designated incident commander arrives or at the end of an operational period (shift change). The ICS outlined in item #2 of the emergency planning section of this plan will be followed.

   The IC will determine if additional staff, either command or general staff will be required for the effective response to the emergency. The IC along with command and/or general staff will conduct an assessment of the emergency situation and establish immediate objectives that address life safety and incident stabilization. A management meeting will be called with the Agency Executive of the hospital to review the information on the emergency and the immediate objectives implemented. The result of the management meeting will be the setting of the emergency objectives and overall priorities. The incident commander with the help of the command staff/general staff will implement the objectives. Briefings will occur throughout the emergency event until normal operation can be restored.

   If additional support is required from the local community unified command will be used to command and control the emergency incident. The hospital incident commander and the IC from the emergency responder will work together to determine the best and effective objectives to return the hospital to normal operations. The incident commander will determine when the all clear will be announced and the beginning of the recovery activities.
3. **ICS organization structure**: The ICS organization structure outlined in section 2 of the emergency planning section of this policy. The Incident commander will be the first position activated. Site emergency code plans indicate who will assume the incident command position for each emergency event identified on the site HVA. Additional incident command positions will be assigned based on the nature and size of the emergency event. If the emergency event is a hazardous material incident the safety officer position shall be appointed in compliance with the regulatory standards.

4. **Job Action Sheets**: Job Actions sheets are outlined in checklist format to assist the command staff in completing the assigned position activities. The location of the job action sheets are site specific and will be detailed in the site plans for activation of the command center and emergency operation center.

5. **ICS Forms**: Various incident command system forms will be utilized in the command center and the emergency operations center. The forms used will be site specific and can include ICS organization chart, incident action plan and objectives, finance section chief accounting forms, logistics inventory tracking forms, staging area sign in sheet, command center and emergency operation center sign in sheet, pre-printed scripted messages, and various incident facility locations sign in sheets. These forms guide and assist prompt decisions making and will capture specific information that will be helpful in the evaluation of the response and improving of the emergency response plan.

6. **Alternate Care Sites**: The emergency event may create the need to manage an influx of patients beyond the normal operating capacity of the hospital. This influx of patients may have very specialized medical needs. Internal surge capacity has been assessed at each DMC hospital and those locations identified will be utilized to care for the patients. Ongoing communication with local and regional support agencies will be established prior to the activation of the internal surge locations. When the capacity for the internal surge locations are exceeded the hospitals will contact the local community and regional emergency response support agencies for assistance.

**Recovery Phase**

1. **Deactivation of emergency code**: When deemed appropriate the incident commander will announce an All Clear to indicate that the emergency event/hazard no longer poses an immediate threat or impact to the hospital. **Criteria used to determine deactivation can consist of the following actions:**
   a. The number of incoming patients have decreased and patients received have either been treated and released or admitted
   b. Support of additional staff is no longer required
   c. Notification received that no additional patients will be transported to the facility
   d. Local responders have demobilized
   e. Building assessment does not reveal damage to the facility or damage is minimal and will not impact the ability to provide quality care
   f. Local emergency operation centers have returned to normal operations
   g. All clear has been announced by local response agencies
   h. Internal information indicates that initial emergency situation is now under control

Staff will be notified of the All Clear situation by use of various communication devices such as phones, overhead pages, pagers, two-way radios, and/or e-mail. The incident commander will notify the community emergency management departments when
applicable.

2. **Demobilization of Command Center**: Following the All Clear announcement the incident commander will provide instructions to the command center responder to begin the demobilization of the command center. Each responding command center staff will be responsible for the inventory and repackaging and replacement of supplies, apparel, forms, job action sheets and other items that were used in the emergency response activities in the command center. The command center responders will be responsible for the documentation and preparation of the critique information required of the position. The documentation will be given to the incident commander in preparation for the response evaluation session.

3. **Department Responsibilities**: The Department Manager will be responsible for the restoration of operation in their designated department. Restoration activities required in the department shall be conducted and completed as quickly as possible. All staff present will be required to assist as directed. An immediate assessment of ability to resume normal operation in each department will be made. Status reports will be made to leadership if any concerns related with supplies, equipment, continued patient care or staff occurs. The Department Manager will direct the restocking of supplies and repair of equipment request where necessary. An evaluation of the department’s response will be completed on the site specific evaluation/critique form and submitted to the site safety director or designated person. The information will be presented to the site emergency management committee for review/discussion and analysis and a summary presented to the site environment of care committee.

4. **Debriefing**: A debriefing will occur as soon as possible after the all clear is announced by the incident commander. The location of the debriefing will be determined at the time of the all clear announcement. The purpose of the debriefing is to obtain preliminary information on the emergency response. It is not meant to be a detailed accounting of the response but an overview of any immediate issues that need to be resolved and receive information on the after action report guidelines.

**After Action Report**: An after action report will be developed by the site emergency management chairperson or designated person. Every site Department will provide an evaluation report of the department specific response. All designated evaluator(s) will provide the requested information on the exercise evaluation form. The After action report will provide an overview of the exercise, sequence of events, goals of the exercise, identify major strengths, weakness and analysis of the weaknesses, evaluation of the 6 critical function areas, opportunities for improvement and lessons learned. The improvement plan will identify any policy revisions, actions that are required for any opportunities for improvements identified, responsible person, timeline for completion and goals that will be evaluated for the next planned exercise of the same or similar scenario. The After Action Report will be reviewed by the site environment of care committee and site senior leadership. If policy revisions and training is required the after action report should indicate the time frame for the completion of the policy and staff training.

**Responsibility**

Director of Environment of Care

**JC Functional Chapter**
Leadership
Employee/Staff Pertussis and Influenza Vaccination (1 CLN 060)

Effective Date: September 30, 2013
Revised: Yes
Approved by: DMC Management

OBJECTIVE
To improve the safety of our patients, employees and staff by reducing exposure or potential exposure to pertussis and influenza through employee/staff vaccination.

SCOPE
All employees, staff, faculty, and vendors who work at the DMC, CHM, DRH, DSH, HUH, HVS, HWH, KEI, SGH and RIM facilities. This includes (but is not limited to) healthcare and non healthcare staff, medical staff, residents, students, licensed independent practitioners, nurses, patient care associates, therapists (respiratory, physical, occupational), pharmacists, technicians, transporters, dietary personnel, environmental services, social work, volunteers and others, including employees who work remotely and visit any DMC facility.

Employees covered by a union contract should refer to the collective bargaining agreement. This policy applies to union employees except to the extent the policy conflicts with the applicable collective bargaining agreement, in which case the provisions of the collective bargaining agreement on that subject will control.

DEFINITIONS
DMC facilities – all hospitals, ambulatory sites, outpatient clinics and other facilities owned, leased, or managed by the DMC and/or its hospitals whether or not patient care is delivered at the facility.

Tdap Vaccine – A multivalent vaccine that protects against tetanus, diphtheria, and pertussis.

Influenza Vaccine – the approved vaccine(s) against influenza for the current season.

Influenza Season – the dates defined by Corporate Infection Control (CIC) each year based on national and local trends of Influenza reported by the Centers for Disease Control and Prevention (CDC) and Michigan Department of Community Health. In general, vaccination occurs in the fall of each year. Peak Influenza Season is most often fall/winter.

POLICY
All individuals who work in DMC facilities must be vaccinated against pertussis and influenza unless there is a bona fide contraindication validated by Occupational Health Services (OHS). Those whose vaccinations are deferred due to a temporary contraindication must be vaccinated when the vaccine is no longer contraindicated. Those with bona fide contraindications to influenza vaccination validated by OHS shall wear an appropriate mask while providing direct patient care to patients during Influenza Season.

PROVISIONS
1. As of November 30, 2012, all persons who are employed by DMC will receive a one-time vaccination against pertussis (Tdap Vaccine), provide documentation of prior Tdap vaccination, or provide
acceptable documentation of a contraindication validated by OHS. New hires eligible to receive the vaccine will be vaccinated at the time of their pre-placement examination.

2. All persons who work in DMC facilities will receive the Influenza Vaccine each year when the vaccine is available and no later than the annual deadline established by the DMC Vaccination Planning Committee, or provide acceptable documentation of a contraindication validated by OHS.

   a. Newly hired employees and staff will be informed that influenza vaccination (when available) is a condition of employment. This expectation is part of the on-boarding documentation acknowledged by all individuals newly employed. Employees who fail to obtain the seasonal vaccine and any additional influenza vaccination determined to be required when it is available on an annual basis, will receive a Final Written Warning with a suspension of three (3) days for hourly employees or a letter of disappointment with a suspension of five (5) days without pay for salary employees in which the employee shall be compliant by the end of the suspension. Failure to be compliant by the end of the suspension will result in immediate termination. Exceptions to this requirement at time of hire and annually include a bona fide contraindication validated by OHS.

3. Documentation of medical contraindications shall be reviewed and validated by DMC OHS and/or CIC on a case-by-case basis. DMC OHS and/or CIC reserve the right to request additional documentation. Those with temporary contraindications shall be vaccinated when the vaccine is no longer contraindicated. Pregnant women will be offered vaccination consistent with Centers for Disease Control and Prevention/Advisory Committee on Immunization Practices (CDC/ACIP) recommendations. A pregnant woman may defer vaccination until she is no longer pregnant upon written recommendation of her treating physician. Documentation of non-medical contraindications (e.g. religious) will be considered by, and require approval of a DMC exemption committee consisting of DMC CMO or designee and DMC OHS.

4. Vaccinations will be given in accordance with CDC/ACIP recommendations.

5. Occupational Health Services will track employee and medical staff compliance and provide regular reports to supervisors, the infection control committee, Medical Staff Affairs, and DMC management during the flu season for influenza, and as indicated for Tdap. When vaccinated other than by OHS, acceptable documentation of outside vaccination will be required for OHS to track vaccination. If the Influenza Vaccine is declined due to a documented bona fide contraindication, or deferred (upon physician recommendation), then the individual must wear a mask whenever within 6 feet of patients (during Influenza Season).

6. The employee’s or staff member’s direct supervisor, manager or department chief/SIC will be responsible for ensuring compliance with this policy.

7. Failure of an employee to comply with this policy will result in a Final Written Warning with a suspension of three (3) days for hourly employees or a letter of disappointment with a suspension of five (5) days without pay for salary employees in which the employee shall be compliant by the end of the suspension. Failure to be compliant by the end of the suspension will result in immediate termination.

8. Personnel who have an authorized exemption as provided within this policy and are not vaccinated will: a) wear an appropriate mask while providing direct patient care or being within 6 feet of patients during Influenza Season or b) may be re-assigned from high risk areas (ED, ICU, Perinatal, or protective environment patient care areas).
ADMINISTRATIVE RESPONSIBILITY

The DMC EVP/COO has overall administrative responsibility for this policy. The DMC EVP/CMO and The SVP/CNO have day to day operational responsibility for this policy.

APPROVAL

This policy has been approved and is duly authorized by Detroit Medical Center, Children’s Hospital of Michigan, Detroit Receiving Hospital, DMC Surgery Hospital, Harper/Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital. The posting of the policy on the DMC intranet signifies that it is in full force and effect.

NEXT REVIEW DATE: 09/16
SUPERSEDES: 11/01/12

KEY Search Words: Pertussis, Tdap, Influenza, Flu, Vaccination

Please check one:
This policy is:   New □ Reviewed X Revised

Responsibility
DMC management

JC Functional Chapter
Leadership
**Evaluations**

Effective Date: July 1, 2004  
Revised Date:  
Approved by: GMEC

It is critically important that Residents are made aware of performance expectations. A program must be able to document that the goals and objectives of the training program and individual rotations have been provided to the Resident at the beginning of his/her training and prior to each rotation.

A formal written evaluation integrated with the ACGME, AOA or other Applicable Accrediting Body general competencies must be completed for each Resident on at least a semi-annual basis or as required by the accrediting body. The evaluation must be provided to the Resident in a face to face session with the Program Director or his/her designee. It is important that the program maintain documentation of the evaluation and counseling sessions for each Resident.

Prior to the start of each rotation, the goals and objectives of the rotation must be clearly delineated in writing and provided to the Resident. The Resident must receive an evaluation of his/her performance at the end of each rotation. Adequate documentation of the evaluations must be maintained by the program and reviewed through multiple reporting methods including GME reviews.

**Responsibility**

GME Committee

**JC Functional Chapter**

Leadership
Gifts from Vendors (1 CG 015)

Effective Date: August 4, 2014
Revised Date: 
Approved by: GMEC

I. OBJECTIVE:
To further the academic mission of the Detroit Medical Center, this policy limits gifts from vendors consistent with academic medical center policies.

II. SCOPE:
All employees, medical staff, students, volunteers, contractors and vendors of the Detroit Medical Center, Children’s Hospital of Michigan, Detroit Receiving Hospital and University Health Center, the Cardiovascular Institute, Harper University Hospital, Hutzel Women’s Hospital, Huron Valley-Sinai Hospital, DMC Surgery Hospital, Rehabilitation Institute of Michigan, Sinai-Grace Hospital, DMC Education and Research (residents and fellows), CRNAs of Michigan, DMC Medical Group and VHS Detroit Businesses (including DMC University Laboratories) (Covered Persons for purposes of this policy.)

III. DEFINITIONS:
Terms used herein are defined in the Tenet Standards of Conduct.

IV. POLICY:
The following limits are in addition to the limits on gifts and entertainment contained in the Tenet Standards of Conduct.
   a. Covered Persons shall not solicit or accept gifts from vendors, regardless of the nature or dollar value of the gifts.
   b. Covered Persons shall not solicit or accept meals from vendors on Detroit Medical Center premises.
   c. Covered Persons shall not solicit or accept any type of promotional items from vendors, including pens, penlights, paper pads or prescription pads.
   d. Gifts, meals or promotional items provided by vendors must be promptly returned to vendors. Perishable items may be donated to charity.
   e. The term 'vendors' includes any person or entity representing vendors, as well as nonprofit entities created and/or supported by vendors.

V. ADMINISTRATIVE RESPONSIBILITY
The Regional Compliance Director for the Detroit Market is charged with enforcement, interpretation of, or exception to the approved policy.

Responsibility
Regional Compliance Director for the Detroit Market

JC Functional Chapter
Leadership
GMEC Approved Complement of Residents in Program

Effective Date: November 17, 2008
Revised Date: 
Approved by: GMEC

In order to be in compliance with ACGME, AOA or other Applicable Accrediting Body’s approved number of Residents and the DMC GME Strategic Plan budget, the GMEC will review on a semiannual basis (January and September meetings) the status of each program. Programs that exceed the number of approved Residents will be required to submit an explanation to the DIO and the GMEC.

Responsibility
GME Committee

JC Functional Chapter
Leadership
Grievance for GME Residents

Effective Date: May 23, 2011
Revised Date: 
Approved by: GMEC

DMC encourages Residents to communicate matters of concern regarding their residency training programs. In an effort to provide an additional, nonexclusive system of communication, Residents may contact the President of the Resident Council or the Chair of the GMEC to discuss confidential concerns or substantive issues relating to the interpretation and application of program policies, practices and procedures. These Committee representatives have full access to the Committee and any ad hoc committees necessary to explore and address Resident concerns, complaints, or grievances which are not covered under the DMC-GME Corrective Action Procedures for Residents.

The names of the Resident and faculty representatives will be made available to all Residents on an annual basis. Any records regarding these issues will have protected status of peer review.

Responsibility
GME Committee

JC Functional Chapter
Leadership
Sexual Harassment Policy (1 HR 511 and 1 CG 018)

Effective Date: November 1, 2013
Revised Date: November 1, 2013
Approved by: DMC management

OBJECTIVE
To establish guidelines to ensure a work environment free from sexual harassment and to provide a mechanism for assisting individuals who believe that they have been subjected to harassment in contradiction to this policy.

SCOPE
All Detroit Medical Center, Children’s Hospital of Michigan, Detroit Receiving Hospital and University Health Center, DMC Surgery Hospital, Harper University Hospital, Hutzel Women’s Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital medical staff, employees, students, volunteers, contractors, and vendors.

DEFINITIONS
The following examples may represent sexual harassment if the behavior is unwelcomed:

A. OVERT ACTIONS
   1. UNWANTED, UNSOLICITED, OR OFFENSIVE SEXUAL ADVANCES, REQUESTS FOR SEXUAL FAVORS, AND OTHER VERBAL, VISUAL, AND/OR PHYSICAL CONDUCT OF A SEXUAL NATURE CONSTITUTE SEXUAL HARASSMENT WHEN:
      a. Submission to or rejection of such conduct is made either explicitly or implicitly a term or condition of an individual’s employment.
      b. Submission to or rejection of such conduct or communication by an individual is used as a basis for decisions affecting employment, promotion, transfer, selection for training, or performance evaluation.
      c. Such conduct or communication has the purpose or effect of substantially or unreasonably interfering with an individuals work performance or creating an intimidating, hostile, or offensive work environment.
   2. The definition of sexual harassment applies equally to females and males. Both males and females can be victims of sexual harassment, and both males and females can be perpetrators of sexual harassment.

B. SEXUALLY HOSTILE ENVIRONMENT
   1. Sexual harassment includes behavior, which may create a hostile or offensive work environment. A hostile work environment is an environment in which harassment is so persistent that it substantially or unreasonably alters the terms and conditions of employment.
2. Behavior that is of a sexual nature and interferes with an individual’s work performance may constitute a sexually hostile or offensive work environment. While the following list is not exhaustive, it can or should be used as a guide to identify inappropriate behavior:

   a. Sexual propositions, invitations, or other pressures for sex;
   b. Jokes of a sexual nature;
   c. Suggestive or offensive remarks;
   d. Displaying pictures, posters, or cartoons of a sexual nature;
   e. Displaying pornographic materials;
   f. Sexually derogatory sounds and comments;
   g. Whistling in a suggestive manner;
   h. Unwelcome patting, pinching, or touching;
   i. Offensive gestures; and
   j. The sharing of sexually suggestive e-mail messages.

POLICY
It is the policy of The DMC to maintain a work environment free of sexual harassment, including harassment based upon a hostile work environment. The DMC will not tolerate sexual harassment of its employees by supervisors, coworkers or others; nor will harassment of non-employees by any DMC employee be condoned.

All employees are expected to conduct themselves in a manner that will provide a positive work environment that is free of harassment. Sexual harassment by an employee is a serious form of misconduct for which an employee may be disciplined, up to and including discharge.

In accordance with the Non-Retribution/Non-Retaliation Policy (Tier 1 Policy CG 011), no retaliation or reprisals will be tolerated against any individual who in good faith raises a concern or makes a charge about behavior that may violate this policy. Nor will there be tolerance of any form of retaliation against an individual who participates in the investigation of any incident of alleged sexual harassment.

The definitions and provisions enumerated below shall apply unless such definitions or provisions are specified in a contract to which The DMC or an operating unit of the DMC is a signatory. In such cases, the terms of the contract will take precedence over this policy.

**There are two distinct types of Sexual Harassment:**

A. "*quid pro quo*" or **overt actions** of sexual harassment, occurs when one requests or requires another to submit to unwelcomed sexual behavior in return for a beneficial condition of employment; and

B. Harassment based upon a **sexually hostile environment**.

**PROVISIONS**

1. An individual who is affected by harassment is encouraged to report the incident to his/her supervisor immediately, or at the employee's discretion, to the department head or a
representative of the Human Resources Department. The individual may also utilize the DMC Fraud & Ethics Compliance Hotline to report an alleged sexual harassment situation.

2. All reported sexual harassment complaints shall be investigated to provide a fair, prompt and reliable determination about whether this policy has been violated.

3. No individual will be penalized by the DMC or by any person associated with the corporation for acting in accordance with the provisions described in this policy. Any act of retaliation directed against any party involved in the complaint will be treated as a separate and distinct act and will be subject to discipline.

4. When a supervisor or department head is aware of an alleged harassment situation (whether or not there has been a formal complaint), they are responsible for:

   a. Ensuring that the appropriate Human Resources Representative is immediately informed of the situation.
   
   b. Completing and supporting the investigation as advised by Human Resources.

5. When the appropriate representative of Human Resources is aware of a harassment complaint or situation, he/she is responsible for:

   a. Ensuring that the Corporate Audit & Compliance and the employee's department head, as appropriate, have been promptly notified of the complaint, unless the department head is the alleged harasser.
   
   b. Informing the claimant that all information will be handled with sensitivity, and will only be shared with those parties involved in the investigation.
   
   c. Ensuring that the appropriate level of investigation has taken place and that the matter is resolved/corrected in a prompt manner.
   
   d. Ensuring that situations involving visitors, patients, students, volunteers and affiliated persons are investigated by Administration in conjunction with Human Resources.
   
   e. Ensuring that the DMC Medical Staff Bylaws are followed when the investigations involve Medical Staff members.
   
   f. Ensuring that situations involving medical students or medical staff will be coordinated with the appropriate oversight authority including, but not limited to:

   1) Wayne State University or other academic Institution(s),
   2) Graduate Medical Education Office – Wayne State University or
   3) Medical Staff leadership

6. If the investigation indicates that harassment has occurred, the Human Resources representative, in consultation with the individual’s department head will:
a. Take immediate and appropriate corrective action including the prevention of further harassment.

b. Notify the affected employee that action has been taken to correct/resolve the harassment.

7. If the investigation identifies that corrective action is warranted, provisions of The DMC progressive discipline/corrective action policy will then apply.

8. If the investigation indicates that no harassment has occurred, the Human Resources representative, in consultation with the department head, will so notify the affected employee; and in the case of intentional false accusations, take appropriate corrective action.

9. Any employee not satisfied with the outcome of the investigation may utilize the Employee Problem Solving procedure in accordance with Tier I Policy - HR 505.

10. Legal Affairs and/or Corporate Audit & Compliance may consult, provide assistance, or assume direction of the investigation where appropriate.

11. With the exception of disciplinary/corrective action forms, no documentation of harassment situations should be retained in the official personnel file. The DMC Senior Vice President of Human Resources will retain files separately for anticipated litigation.

12. Human Resources is responsible for the development of the procedures required for implementing the provisions of this policy.

ADMINISTRATIVE RESPONSIBILITY

1. The Chief Executive Officer has overall administrative responsibility for this policy. The President/Chief Operating Officer has overall operational responsibility for this policy. The Senior Administrator of each covered operating unit has operational day-to-day responsibility for policy administration and audit for policy compliance.

2. The Senior Vice President of Human Resources has responsibility for all formal written interpretation and revisions of this policy, and for ensuring compliance, as the policy relates to DMC employees and volunteers.

3. The Senior Vice President of Human Resources, in conjunction with the Regional Vice President of Corporate Compliance will review all policy exceptions and will consult with the appropriate officer(s) to reassess the organizational necessity of an exception when such an exception may be considered to be inconsistent with the objective/purpose of this policy.

4. The respective president or head of each operating unit within The DMC has operational day-to-day responsibility for this policy.

5. Authorization for policy exceptions, after legal consultation, can be made by Chief Executive Officer of The DMC, or his/her designee.
6. Any decision or judgment to be exercised pursuant to this policy shall be in the sole discretion of the management of The DMC and/or its operating unit.

7. If any provision(s) of this policy is, at any time during the life of this policy, in conflict with any applicable valid state, federal or local law(s) or regulation(s), such provision(s) shall continue in effect only to the extent permitted by such law(s) or regulation(s). If any provision(s) of this policy is or becomes invalid or unenforceable, such invalidity or unenforceability shall not affect or impair any other provision of this policy.

APPROVAL
This policy has been approved and is duly authorized by Detroit Medical Center, Children’s Hospital of Michigan, Detroit Receiving Hospital, DMC Surgery Hospital, Harper/Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital. The posting of the policy on the DMC intranet signifies that it is in full force and effect.

SUPERSEDES
Sexual Harassment section of HR 504; 7/15/00; May 1, 2003; 04/13/05; 08-15-09; 03/31/11

Responsibility
DMC management

JC Functional Chapter
Leadership
**ID Badge**

Effective Date: July 1, 2004
Revised Date: 
Approved by: GMEC

Identification badges are issued when the Resident begins in the training program. Replacements for lost badges can be obtained in the Parking and Badges office with $10.00 cash replacement fee. Also new hires are required to pay a $10.00 cash fee.

**Responsibility**
GME Committee

**JC Functional Chapter**
Leadership
Impairment and Substance Abuse

Effective Date: July 1, 2004
Revised Date: June, 2010

Approved by: GMEC

Impairment can be due to medical and/or mental illness, including substance use. Assurance of fitness for duty is an institutional, personal and professional requirement. (DMC GME Policy: Professionalism, Personal Responsibility & Patient Safety).

It is the policy of DMC to provide a drug-free workplace by prohibiting the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance or alcohol. (DMC Policy 1 HR 502).

A Resident will be required to undergo a Behavioral Fitness for Duty Evaluation, including drug and alcohol testing any time a supervisor has reasonable suspicion (based on abnormal speech, appearance, odor, attendance, behavior or conduct, etc.) that a Resident’s behavior is unusual/impaired, and could be a result of the use of drugs and/or alcohol. Residents who refuse to be tested for drugs and/or alcohol will be considered to be insubordinate and will be subject to disciplinary action up to and including termination.

When a Resident has been identified, either through the evaluation or through recognition and voluntary reporting, as having a positive drug or alcohol screen, or a substance abuse or dependency problem, the Resident will be referred for a substance abuse evaluation. The Resident will be suspended with pending evaluation. If concerns for abuse/ misuse are identified, the Resident will be referred to the Michigan Health Professional Recovery Program (HPRP).

If HPRP recommends a treatment plan, HPRP will require the Resident to sign a contract stipulating the conditions under which the Resident can return to the training program and care for patients in the State of Michigan. Prior to returning to work, the Resident must provide a copy of the HPRP treatment plan recommendation and signed contract to the DIO. If the HPRP does not recommend its monitoring of and/or a treatment plan for the Resident, then the Substance Abuse Clinician, responsible Program Director, the DMC Medical Review Officer and the DIO will discuss alternative monitoring/and or intervention for the Resident.

The Resident must agree to submit to periodic alcohol or drug screening testing, as appropriate to the impairment, anytime at the request of the DIO, Program Director, or DMC MRO. Similarly, the Resident must agree to undergo medical and/or psychiatric evaluation, as appropriate to the impairment. Failure to comply with such requests will be subject to disciplinary action up to and including termination.

If a leave of absence is involved in the plan, it must meet the criteria stated in the regulations of the appropriate Specialty Board. (For example, if a resident exceeds the maximum time allowed by his/her respective board, then this will result in prolonging his/her training).

All paid and unpaid leave taken by the resident will be in accordance with DMC leave of absence policies.

Indications for urine drug screening for a resident at the DMC include:

- Preplacement evaluation prior to beginning residency/fellowship.
- Return to work after 30 days of absence.
- For cause, as defined by the DMC.
- As part of a monitoring agreement with the DMC.
All urine drug screens that are signed off as “positive” (i.e., no legitimate medical explanation) by the DMC Medical Review Officer (MRO) will result in the following:

- Referral for Substance Abuse Evaluation
- Suspension with pay pending substance abuse evaluation.

Results of the Substance Abuse Evaluation will yield one of the following conclusions:

- No diagnosis of either impairment or substance abuse, recommend case closure by HPRP, return to work without any restrictions. Random drug testing will be performed by the DMC MRO in those cases with a verified positive test even if there is no diagnosis of impairment or substance abuse – e.g. the casual drug user or suspected impairment, but inadequate evidence to make diagnosis
- Diagnosis of substance abuse or dependence, refer to HPRP for recommendations for treatment, monitoring agreement, and aftercare.
- Diagnosis of impairment (as defined by the HPRP and the Bureau of Health Professions/Attorney General); may result in case closure by the HPRP, but will be referred to the DMC for internal monitoring.
- Diagnosis deferred, recommend additional evaluation (i.e., neuropsychiatric testing in the case of suspected medical disorder).

In addition to a Monitoring Agreement with the HPRP, the DMC will require the following:

- Release of information between the HPRP and the substance abuse evaluator, the DMC Department of Graduate Medical Education, and specified MROs at the DMC.
- All urine drug screen results performed by the HPRP specified laboratory will be provided to the DMC MRO and the Substance Abuse Evaluator.
- An MRO-confirmed positive urine drug screen will result in immediate suspension with pay, pending a substance abuse evaluation.
- The Resident will require a return to work & safety assessment, as specified by the HPRP, before returning to work.
- Occupational Health or the substance abuse evaluator may do additional monitoring at his/her discretion.
Leaves of Absence

Effective Date: July 1, 2004
Revised Date: 
Approved by: DMC management

DMC does not maintain a separate policy for maternity/paternity leave. Time off for pregnancy and/or delivery is provided for under the Short Term Illness and FMLA policies as outlined below.

PLEASE NOTE: Depending on the length of the leave and individual board requirements training time may need to be extended as determined by your Program Director.

BEREAVEMENT LEAVE (Governed by Tenet Policy HR.BNC.11):
In the event of the death of a close relative, Residents will be allowed time off with pay. A Resident will receive up to three days paid time off for the funeral of “Immediate Family”. Two additional days may be provided if the funeral site is equal to, or exceeds, 300 miles from the Resident’s residence and the Resident attends the funeral. Bereavement time off must be approved by the Program Director prior to usage and verification must be provided to Program Director after. For the purpose of this policy, “Immediate Family” is defined as: spouse, domestic partner (as defined by Tenet in Criteria for Domestic Partnership Status), children, parents, siblings, grandparents, grandchildren, and corresponding step and in-law relationships or close relative living with the employee. This definition may also include individuals who are not legally related but who reside with the employee.

FAMILY LEAVE OF ABSENCE:
Unpaid family leave of absence is provided in accord with Tenet Policy HR.BNC.07 in order to accommodate specific family care needs.

Under the Family Medical Leave Act (FMLA), you may be eligible to take up to 12 weeks of leave in order to care for a spouse, parent or child who has a serious health condition, to care for a new child or newly adopted child or for yourself for a qualifying serious health condition, as determined under the FMLA Act. You must be employed by DMC for one full year (12 months) and worked 1,250 hours at work (excludes vacations, personal leaves etc.) to qualify for FMLA. The maximum time allowed for job protection is 12 weeks combined in one calendar year.

Except for unforeseen circumstances, notification must be given to the coordinator indicating that a medical need for either self or family is the reason for the consecutive absence or circumstances that the resident cannot be at work or continue the current requirements. The coordinator will complete a FMLA questionnaire and forward to Loss Time Management (LTM). All notifications will be provided to the resident from LTM in writing. Final determination of the FMLA Certification will be provided to the GME Program Director and the resident. Any time taken is not FMLA approved until a determination is received.

A Resident taking time off in order to care for a family member may use paid vacation time. A Resident may not use paid sick time which is applicable only to time off due to Resident’s own illness. If vacation time is exhausted, the leave shall be unpaid.

Health and dental insurance coverage will be paid by DMC for the duration of the approved FMLA.
PERSONAL LEAVE OF ABSENCE:
Approval of personal leaves of absence may be granted at the discretion of the DMC Program Director for up to 90 calendar days. Personal leaves of absence shall be unpaid and all benefits will cease for the duration of the personal leave. The Resident will be provided the opportunity to continue insurance coverage in accordance with the provisions of current law (COBRA).

SHORT - TERM ILLNESS:
Residents will receive payment of stipend for verifiable illness for up to 180 days as follows: 1-90 days at 100%; 91-180 days at 75%. Program Directors will notify the GME office when a Resident is out ill for more than 3 calendar days. For absences in excess of 3 calendar days, physician verification may be required. Illness time does not accumulate.

LONG - TERM DISABILITY:
A long-term disability plan is provided to all Residents employed by Detroit E&R. The plan provides 60% of salary to a maximum benefit of $4000 per month. Long-term disability benefits are payable after 180 consecutive days of disability and are payable as long as the disability continues (maximum to age 65 benefit period). For a detailed description visit www.flynnbenefits.com.

An optional supplemental policy is available at a Resident’s own expense up to a maximum of $1500 per month. For a supplemental application, contact our disability representative Patrick Flynn at (313)745-4935, (248)649-4100, or pflynn@flynnbenefits.com.

Responsibility
GME Committee

JC Functional Chapter
Leadership
**Medical Licensure**

Effective Date: October 1, 2010  
Revised Date:  
Approved by: GMEC

Residents must possess a valid Michigan medical license and controlled substance license (Educational Limited or Permanent Professional). The GME office will assist a Resident in obtaining and/or renewing an educational limited medical license; however, it is the Resident’s responsibility to ensure that his/her medical license is valid at all times.

Any Resident whose license is expired will be removed immediately from **ALL** duty and will be placed on suspension **without** pay. The Resident shall have ten working days to renew or otherwise obtain a valid license. If the Resident fails to obtain a valid license in that time period, corrective action procedures will be initiated to terminate the Resident from employment with Detroit E&R and participation in the DMC GME Program. Note that the Joint Commission does not allow any grace period for an expired license.

License expiration dates may be checked on the State of Michigan website at [http://www7.dleg.state.mi.us/free/](http://www7.dleg.state.mi.us/free/)

**Condition of Employment**

Residents must obtain and maintain a valid license to practice medicine that complies with the applicable provisions of the laws pertaining to licensure in the state of Michigan. Documentation of a valid license must be provided to the GME office by the specified date, which for most Residents is June 30th of each year.

Residents are allowed to have a Michigan Educational Limited License for a period of six years. After that time a Resident must apply for a permanent medical license.

**Obtaining an Educational Limited License**

To obtain an educational limited license in the State of Michigan the one of the following are required:

- **MEDICAL**: A passing score for United States Medical License Exam (USMLE) Step I and II CK & CS or;
- **OSTEOPATHIC**: A passing score for Parts 1, 2 and 3 of the National Board examination or;
- **PODIATRY**: A passing score for Parts 1 and 2 of the National Board Examination or;
- **DENTISTRY**: Official Report of your National Board Scores

**Fingerprint/Background Check**

Effective October 1, 2008, all applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Licenses or registrations will not be issued until this process is complete. Please see the following link for instructions on completing fingerprint/background check requirement and locations [http://www.michigan.gov/documents/cis_fhs_bhserv_mdedimtpkt_74971_7.pdf](http://www.michigan.gov/documents/cis_fhs_bhserv_mdedimtpkt_74971_7.pdf)

**Responsibility**

GME Committee
JC Functional Chapter
Leadership
Medical Staff Bylaws

Effective Date: July 1, 2004
Revised Date: 
Approved by: GMEC

Residents must obey and adhere to the DMC Medical Staff Bylaws which may be accessed at http://www.dmc.org/privileges/.

Responsibility
GME Committee

JC Functional Chapter
Leadership
Military Duty

Effective Date:       July 1, 2004
Revised Date:        
Approved by:         GMEC

Military leaves of absences, and any extensions, will be administered in accordance with DMC policy 1 HR 314A and applicable law.

Depending on the length of the leave and individual board requirements, training time may need to be extended as determined by the Program Director.

Responsibility
GME Committee

JC Functional Chapter
Leadership
**National Practitioner Data Bank (NPDB)**

Effective Date: July 1, 2004  
Revised Date:  
Approved by: GMEC

There will be a check made to identify and discipline incompetent physicians who engage in unprofessional behavior and to restrict their ability to move from state to state without disclosure or discovery of previous damaging or incompetent performance. The NPDB collects information on actions relating to the professional competence or professional conduct of physicians. The check will be conducted on all new applicants to the medical health professional affiliate staff. The departments should notify applicants that employment is contingent on the satisfactory results of these checks.

**Responsibility**  
GME Committee

**JC Functional Chapter**

Leadership
NetLearning Module Oversight and Compliance Tracking

Effective Date: July 1, 2004
Revised Date:
Approved by: GMEC

The GME Department will notify all Residents, Program Directors and Coordinators of deadline for completion of Net Learning Modules via New Innovations Calendar and email announcement. A reminder email will be sent to Residents on July 1st, August 1st, and September 1st. Individual program compliance reports will be sent to Program Directors and Coordinators on July 1st, August 1st and September 1st.

Incoming Residents
Residents who are new to the system are required to complete the modules by the end of the GME Departmental orientation day. Badges and pagers will be released only to Residents who have completed this requirement.

Current Residents
Current Residents are required to complete all modules by the DMC mandated deadline at which time Net Learning Module Access will be closed.
Non-compliant Residents’ practice privileges will be suspended the day following the due date.

Responsibility
GME Committee

JC Functional Chapter
Leadership
**Patient Information Privacy Policy (EC.PS.02.00)**

Effective Date:  September 16, 2013  
Revised Date:  
Approved by:  Tenet management

**Please note:** Any covered person who makes an inappropriate disclosure or use of PHI or who is made aware that an unauthorized use or disclosure has occurred shall immediately contact the DMC HIPAA Privacy Officer to file a detailed report regarding the incident.

Privacy Officer: Cassandra Davis; 313.745.9936

I. **SCOPE:**

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest of greater than 50%; and (3) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Facility”) (collectively, “Tenet”).

II. **PURPOSE:**

The purpose of this policy is to define and limit the circumstances in which an individual’s protected health information may be used or disclosed by Tenet.

III. **DEFINITIONS:**

A. Capitalized terms used herein are defined in the Information Privacy & Security Glossary of Definitions.

IV. **POLICY:**

Members of the Tenet Workforce will use and disclose Protected Health Information (PHI) only as permitted under applicable federal and state laws, Tenet policies, and when required, with the patient’s signed prior Authorization.

Tenet Workforce members with a legitimate “need to know” may only access, use or disclose the minimum information necessary to perform his or her designated role regardless of the extent of access provided.

Members of the Tenet workforce may not use PHI or a patient’s personal information for activities or functions outside of Tenet unless otherwise permitted or required by federal and state laws, Tenet policies, or unless such use has been authorized by the patient. Any use without prior Authorization is considered an inappropriate use and disclosure for purposes of this policy.

B. Required Disclosures
Tenet must disclose PHI to:

1. Individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information. See [EC.PS.02.02. Personal Representatives and Minors Standard](#) for additional information.
2. Health and Human Services when it is undertaking a compliance investigation, review, or enforcement action.

C. Permitted Uses and Disclosures

A covered entity is permitted, but not required, to use and disclose PHI, without an individual’s Authorization and/or as outlined in [EC.PS.02.01 Uses, Disclosures and Minimum Necessary Standard](#), for the following purposes or situations. Tenet Facility staff must use their best professional judgment, and should consult their Compliance Officer as necessary, when deciding to exercise these permissive uses and disclosures.

1. Treatment, Payment, and Health Care Operations (TPO)
   a. Tenet may use or disclose PHI for its own treatment, payment, and healthcare operations purposes.
   b. Tenet may disclose PHI for its own and other covered entities’ treatment and payment purposes.
   c. Tenet may disclose PHI to another covered entity for the health care operations of the other covered entity within the following limitations:
      1. Each entity has or had a relationship with the individual who is the subject of the information;
      2. The PHI exchanged pertains to that relationship;
      3. The purpose of the disclosure is for health care operations that include: quality assessment and improvement activities; population-based activities relating to improving health or reducing health care costs; case management and care coordination; certification; conducting training programs; accreditation; certification; licensing or credentialing activities; health care fraud and abuse detection or compliance.

2. Patient Authorization

Tenet obtains the Authorization of the patient or the patient’s Personal Representative (see [EC.PS.02.02. Personal Representative and Minors Standard](#)) on the Tenet Facility-approved Authorization To Use And Disclose
Health Information Form whenever it desires to use or disclose Protected Health Information (PHI) for a purpose other than TPO, or making a disclosure based on public policy, or except as otherwise provided in Tenet’s policies.

a. Tenet may not condition its provision of health care to the patient on whether the patient’s signs Authorization, unless either:

(1) The health care to be provided is solely for the purpose of creating PHI to be disclosed to a third party and the patient’s Authorization permits Tenet to release the patient’s PHI to such third party; or

(2) The health care to be provided is research-related treatment and the patient’s Authorization is for the use or disclosure of PHI for such research pursuant to EC.PS.02.04. Research Standard.

b. An individual may revoke an Authorization in writing except to the extent that the facility has taken action in reliance thereon; or if an Authorization was obtained as a condition of obtaining insurance coverage.

c. Staff may not disclose information pursuant to an Authorization Form without ensuring the validity of the Authorization Form by following the procedures set forth in Section IV.C.

d. A patient’s compliant Authorization as outlined in EC.PS.02.01 Uses, Disclosure and Minimum Necessary Standard must be obtained for:

(1) Uses and disclosures of PHI to non-health care providers for treatment;

(2) Uses and disclosures of PHI to non-covered entities or health care providers for payment purposes;

(3) Psychotherapy Notes

Tenet will obtain an individual’s Authorization to use or disclose psychotherapy notes with the following exceptions:

(a) Use and disclosure with respect to oversight of the originator of the notes;

(b) For the Tenet Facility’s own training in which trainees, students, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;

(c) To defend itself in legal proceedings brought by the
individual;

(d) To HHS to investigate or determine the covered entity’s compliance with the Privacy Rules;

(e) To avert a serious and imminent threat to public health or safety;

(f) To a health oversight agency for lawful oversight of the originator of the psychotherapy notes;

(g) For the lawful activities of a coroner or medical examiner; or

(h) As required by law.

4. Marketing

Tenet will obtain a patient’s Authorization before using or disclosing the patient’s PHI for Marketing unless an exception exists under this policy or

3. Research

Uses and disclosure of PHI for research generally requires a patient’s Authorization. However, Tenet may use and disclose PHI for research purposes without an individual’s Authorization, provided Tenet obtains:

   a. Documentation that an alteration or waiver of individuals’ Authorization for the use or disclosure of protected health information about them for research purposes has been approved by an Institutional Review Board (IRB) or Privacy Board;

   b. Representations from the researcher that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purpose preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that protected health information for which access is sought is necessary for the research; or

       Representations from the researcher that the use or disclosure sought is solely for research on the protected health information of decedents, that the protected health information sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is sought.

4. Opportunity to Agree or Object
Absent an objection by the patient (and without having to obtain the patient’s Authorization), Tenet may:

a. Disclose to a family member, other relative, or close personal friend of the patient, or any other person designated by the patient, PHI which is directly relevant to such person’s involvement with the patient’s care or Payment related to the patient’s health care;

b. Use or disclose the patient’s PHI to notify (or assist in the notification of) the patient’s family member (or Personal Representative or other person responsible for the patient’s care) of the patient’s location, general condition or death. In connection with this purpose, Tenet may disclose the patient’s PHI to public or private entities authorized by law or its charter to assist in disaster relief efforts in order to coordinate the notification efforts.

c. Use or disclose the patient’s PHI for Facility Directories. Tenet Facilities may rely on an individual’s informal permission to list in its facility directory:

   (1) the individual’s name,
   (2) general condition,
   (3) religious affiliation, and
   (4) location in the facility.

Tenet Facilities may then disclose the individual’s condition and location in the facility to anyone asking for the individual by name, and also may disclose religious affiliation to clergy. Members of the clergy are not required to ask for the individual by name when inquiring about patient religious affiliation.

d. Tenet will not:

   (1) Disclose any portion of the PHI that is not relevant to the patient’s current condition and that could prove embarrassing to the patient; or
   (2) Assume that a patient’s agreement or lack of objection implies agreement to disclose PHI indefinitely in the future.

5. Incidental Use and Disclosure

Tenet may use or disclose PHI which is the result of, or incidental to, an otherwise permissible use or disclosure because reasonable administrative, technical and physical safeguards to limit incidental uses and disclosures have
been implemented. Incidental uses and disclosures are not required to be part of the accounting for disclosures.

D. Prohibition on Sale of PHI or e-PHI

Tenet will not sell (i.e., receiving any remuneration directly or indirectly) PHI or e-PHI without a valid Authorization unless:

1. The sale is for public health activities.
2. The sale is for research activities and the price charged reflects the cost of preparation and transmittal of the data.
3. The sale is for the treatment of the individual.
4. The purpose for the exchange of PHI is related to the sale, transfer, or merger of all or part of a Tenet Facility.
5. The sale is for a business associate function pursuant to a business associate agreement.
6. The sale is to provide an individual with a copy of his/her PHI.
7. The sale is for any other activity deemed necessary and appropriate by the Secretary of HHS.

E. Minimum Necessary

As a general rule, members of Tenet’s Workforce may not use, disclose or request an entire medical record of a patient unless the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure or request.

As outlined in EC.PS.02.01 Uses, Disclosures and Minimum Necessary Standard, when using or disclosing PHI or when requesting PHI, Tenet will, in accordance with applicable law, make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

The use and/or disclosure of PHI include oral, written or electronic information that is used in treatment, payment or healthcare operations.

F. Limited Data Set

Tenet may use and disclose a limited data set for research, health care operations, and public health purposes, provided the recipient enters into a Data Use Agreement (DUA) with Tenet. Tenet’s DUA is maintained on the Law Department’s Contract Arrangements Manual (CAM). Creating a limited Data Set is outlined in EC.PS.02.01 Uses, Disclosures and Minimum Necessary Standard.
G. Public Interest and Benefit Activities

Tenet may disclose protected health information, without an individual’s Authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability as outlined in EC.PS.02.03 Public Interest and Benefit Activities Standard. This would include, for example, the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions. Tenet may also, at the direction of a public health authority, disclose protected health information to a foreign government agency that is acting in collaboration with a public health authority.

V. PROCEDURE:

H. Implementation

1. Information Privacy and Security Program

   a. Tenet Facility

      (1) Tenet Facility’s Compliance Officer will implement the Information Privacy and Security Program (the “Program”).

      (2) Tenet Facility Management will, in coordination with the Compliance Officer, create specific policies and procedures in order for the Tenet Facility to operationalize the Program.

   b. Home Office

      (1) Tenet’s Information Privacy/Security Office will work with the Tenet Facility Compliance Officer and Tenet Facility Management to develop, maintain, and update policies, procedures, and standards for protecting the privacy of PHI and affording patients their rights with respect to their PHI.

I. Training

1. On-Line Training. Participation in on-line training sessions must be documented and maintained in Tenet’s online education system.

2. Classroom Training. Attendance at classroom training sessions held at individual facilities must be documented. This documentation must be maintained by the Tenet Facility’s Human Resources Department or Education Department.

3. Training materials shall be maintained according to Administrative policy AD 1.11 Records Management and its Records Retention Schedule.

4. Training completion documentation will include the time, date, place and
content of each training session, as well as the Workforce members who attended each training session. Tenet will maintain such documentation and make it available for inspection by regulatory authorities, as appropriate.

J. Mitigation

Information regarding any violation discovered by any member of Tenet’s Workforce must be reported promptly to the Tenet Facility’s Compliance Officer. The Compliance Officer is responsible for investigating all reported violations and/or allegations.

A patient, visitor or other individual may report to the Compliance Officer or his/her designee, all alleged or known instances of the Use and/or Disclosure of PHI in violation of Tenet’s Privacy and Security Program.

The Tenet Facility’s Compliance Officer should mitigate, to the extent practicable, any harmful effect that is known to have occurred as a result of a use or disclosure of PHI or violation of a patient’s rights with respect to his/her PHI.

K. Sanctions

The Human Resource department of the Tenet Facility where the potential violation occurred will document the sanctions imposed on the Workforce member and will retain such documentation as required by Administrative policy AD 1.11 Records Management and its Records Retention Schedule.

L. Auditing and Monitoring

1. Tenet’s Audit Services department will review Tenet and Tenet Facilities implementation of and adherence to this policy during the scheduled audit.

2. Tenet’s Privacy/Security Office is responsible for monitoring Tenet’s adherence to this policy.

3. The Tenet Facility Compliance Officer is responsible for monitoring the Tenet Facility’s adherence to this policy.

M. Responsible Persons

Responsibility for the content and administration of the Information Privacy and Security Program resides with Tenet’s Privacy/Security Office. Responsibility for implementing the Information Privacy and Security Program at the facility level resides with the Tenet Facility Compliance Officer and Tenet Facility Management.

N. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance
management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- EC.PS.01.00 Information Privacy and Security Administration Policy
- EC.PS.04.00 Information Security Policy
- Information Privacy & Security Glossary of Definitions
- Human Resource policy HR.ERW.03 Confidentiality of Company Information
- Human Resource policy HR.ERW.15 Ethics and Compliance Training
- Administrative policy AD 1.11 Records Management and its Records Retention Schedule

VII. ATTACHMENTS:

- Attachment A: Patient Information Privacy Standards
PATIENT INFORMATION PRIVACY STANDARDS

**Uses, Disclosures and Minimum Necessary Standard** – The purpose of this Standard is to identify the Minimum Necessary Standards when using or disclosing protected health information or when requesting protected health information from another covered entity. Section 164.502(b)(1) of the Privacy Rule requires covered entities to limit uses and disclosures of, and requests for, protected health information to “the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.”

**Personal Representatives and Minors Standard** – The purpose of this Standard is to ensure Tenet treats an individual’s personal representative as the individual with respect to uses and disclosures of the individual’s protected health information, as well as the individual’s rights under the Privacy Rule.

**Public Interest and Benefit Activities Standard** – The purpose of this Standard is to identify when the Privacy Rule permits use and disclosure of protected health information, without an individual’s authorization or permission, for national priority purposes, including disclosures that are: (1) Required by Law; (2) for Public Health Activities, (3) regarding Victims of Abuse, Neglect or Domestic Violence; and (4) pursuant to Judicial and Administrative Proceedings.

**Research Standard** – The purpose of this Standard is to ensure Tenet meets the HIPAA Privacy Rule’s conditions under which protected health information may be used or disclosed by covered entities for research purposes. Research is defined in the Privacy Rule as, “a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.”

**Marketing Standard** – The purpose of this Standard is to ensure Tenet obtains a patient’s authorization before using or disclosing the patient’s PHI for Marketing unless an exception exists under this standard. Under no circumstances may Tenet use or disclose Highly Confidential Information for Marketing purposes unless otherwise permitted by law or the patient’s signed Authorization Form.

**Responsibility**
Tenet Management

**JC Functional Chapter**
Leadership
Personal Appearance Standards (2 PC 1001)

Effective Date: December 12, 2013
Revised Date: November 1998; May 2001; January 2004; November 2004; January 2006
Approved by: GMEC

OBJECTIVE
To promote a neat, clean, professional, and business like appearance consistent with preserving and enhancing the image of the Detroit Medical Center, while assuring that attire is not hazardous, distracting or offensive to patients and employees

SCOPE
All Detroit Medical Center, Children’s Hospital of Michigan, Detroit Receiving Hospital and University Health Center, DMC Surgery Hospital, Harper University Hospital, Hutzel Women’s Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital personnel in patient care areas. This policy applies to all DSG and other contracted (agency) staff working in with patients or in patient care areas of the DMC

POLICY
All personnel maintain personal appearance standards that are consistent with the professional image of a health care institution, and all infection control, legal, and safety requirements.

Professional business attire is required while on duty and when employees and contract employees represent the DMC at any outside conferences, community outreach functions and other professional and/or education events.

The utilization of specialized safety equipment (e.g. steel-toed shoes, as determined by OSHA regulations is addressed in department guidelines or MODs.

See site, department or discipline specific guidelines for additional guidance.

PROVISIONS
Universal Personal Appearance Standards
1. Clothing should be of appropriate size and fit permitting freedom of movement while maintaining coverage of body. All personal clothing must be
   - Clean, neat, and of appropriate length with finished hems.
   - In good repair and securely fastened (no holes, rips, tears, patches)
   - Well fitting (i.e. neither too tight or too loose) and not excessively revealing nor transparent.
   - Tucking pant legs into socks is not permitted.
2. Lab coats when worn are clean and in good repair
3. Articles of clothing (not limited to jackets and sweatshirts) should not be tied around the waist.
4. Clothing with hoods are not permitted with the hood up.
5. Undergarments must be worn at all times, and color and/or design must not be visible through or above clothing.

6. Socks or hosiery must be worn. Bare legs/feet and fishnet hosiery are not acceptable.

7. Hair is to be neat and clean. Long hair must be so styled and/or restrained so as not to interfere with work performance, safety and infection control. Head coverings mandated by religious beliefs are acceptable unless heard coverings may pose an infection control risk. Hair or head coverings may not obscure vision or come in contact with patient or other surfaces. Styling combs/picks may not be worn in the hair.

8. Mustaches and beards must be clean and neatly trimmed. Chest hair must be covered.

9. Fingernails must be kept short (i.e., not to exceed 1/4 inch past the fingertip) and clean. Chipped nail polish or enhancements such as jewels may not be worn. Nail enhancements of any kind (e.g., wraps, acrylics, gels and stones) may not be worn in the Operating Rooms, Same Day Surgery, Intensive Care Units (for example, ICU, BMT, Burn unit, NICU, PICU, pheresis), step-down ICU units, or other areas where invasive procedures are routinely performed or when procedures require a surgical scrub. (CDC Guideline for Hand Hygiene in Health-Care Settings. MMWR 51[RR16]; 1-44: 2002).

10. Jewelry must not create a hazard to self or others. No visible ornamental piercing except for ears. No bracelets are to be worn by care providers. Latex jewelry (e.g. watchbands, wristbands) may not be worn. Award, service and school pins are acceptable. Use discretion when using other pins or stickers.

11. Visible adornment with tattoos or body paint is not acceptable.

12. Hospital Identification (ID) badges must be worn in a clearly visible location on the upper chest or shoulder area at all times while on DMC property. ID badges must be worn with the photo/name forward and must not be obscured or defaced. (1 EC 021 & 2 FEC 022) Badge holders/lanyards must not interfere with patient care activities and must be worn above waist level.

13. Shoes must be clean and appropriate. Open toed shoes or sandals without heel straps may not be worn in patient care areas.

14. Shoe covers, where required, must be removed when leaving the patient care area (2 POS 012).

15. Makeup should be appropriate for office daytime wear.

16. Scented personal products (including but not limited to perfume, scented make-up and lotions, scented after-shave lotion, scented deodorant) must not be worn due to the health risk to others.

17. Personal headphones and earphones are not to be used or worn during non-break times or in the presence of patients and/or visitors.

18. Personal electronic devices (e.g. cell phones, pagers, netbooks, iPads, Kindles™) must be on vibrating (non-audible) mode. They may not be visible or used during non-break times or in the presence of patients or visitors (1 HR 514).
19. Personal electronic devices may be used for hospital business purposes. However, they may not be used in the presence of patients/visitors unless directly related to that patient’s care. When used in patient care areas staff must perform hand hygiene before and after use of personal electronic devices.

20. No images may be taken with personal devices (e.g. cell phones, cameras, i-pads or tablets) in the workplace.

21. **Non-Direct Care Activities:** Unless otherwise directed, casual business wear may be worn while in orientation, and/or at skills validation class, or other educational offerings. This includes appropriate shoes/hose. If a portion of the day is spent in the clinical area, uniforms, scrubs, or a lab coat must be worn.

22. **Business casual or professional business attire** must be worn while in the hospital including going to and from work site, orientation, and or skills validation class, or other educational offerings unless an exception is documented with Hospital Administration. This includes shoes/hose. If a portion of the day is spent in direct patient care, scrubs, or lab coat must be worn.

23. **Off-Site Functions:** DMC Personal Appearance Standards must be adhered to when employees or contract employees represent the DMC at any outside conferences, community outreach functions, and other professional/educational events.

24. Non-DMC (agency and contingent) staff must adhere to the universal personal appearance standards and those appropriate to their job category.

25. The following types of clothing are **not** permitted:
   A. Jeans or clothing of denim-like material
   B. T-shirts (without hospital-approved design or logos)
   C. Sweatshirts, sweatpants, or jogging suits
      - **Exception:** Staff may wear sweatshirts with hospital approved logo-site specific.
      - **Personal Trainers at RIM wear RIM Logowear warm-up suits.**
   D. Shorts, capris, bib overalls/coveralls
   E. Tank or tube tops or garments with spaghetti straps
   F. Low cut tops or bare midriffs
   G. Military fatigues or fatigue-like scrub wear
   H. Stretch pants, spandex, stirrup pants
   I. Body clinging, see-through or revealing clothing
   J. No garments that reveal undergarments
   K. Exercise apparel, including yoga pants
   L. Mini-skirts or mini-dresses (mid-thigh)
   M. No skirt slits, vents or kick pleat more than 3" above the knee
   N. Excessive or inappropriate jewelry
   O. Sunglasses
   P. Flip flops or rubber clogs with holes (ie Crocs®)

**Direct Patient Care Providers**
[Registered Nurse (RN), Licensed Practical Nurse (LPN), Patient Care Associate (PCA), Patient Service Associate (PSA)]
1. The following attire is considered appropriate:
   A. Traditional nursing uniforms or scrub dress of mid-knee length or below.
   B. Scrub top and pants or skirt. Scrub tops are to be long enough to tuck into pants or skirt, but may be worn either tucked in or not.
   C. In lieu of a scrub top, polo or other collared shirt may be worn or plain colored T-shirt (with hospital-approved design or logos)
   D. Turtleneck, mock turtleneck, plain tank top or T-shirt may be worn under a scrub top but must not be visible below the hemline.
   E. Scrub/warm-up jackets in a coordinating print may be worn with above uniforms or as designated by site.
   F. Each facility may require the wearing of color and/or style of uniform specific to a job category or department. See site-specific guidelines for color designation. The wearing of white uniforms is limited to RNs and LPNs only.

2. Shoes and Hosiery
   A. Shoes must be clean; white, black or colored shoes that coordinate with uniform pants or skirt may be worn.
   B. No “high top” or athletic shoes that rise above the ankle are permitted.
   C. No open toe shoes are allowed by staff working in patient care areas.
   D. White or flesh tone hose must be worn with a skirt.
   E. Hose or socks must be worn with pants.

Specialty Areas
1. Approved hospital provided and laundered scrubs are to be worn in designated areas only. These include, but are not limited to, the Burn Center (DRH), Labor and Delivery, LDRP, Dialysis and Perioperative areas.

2. In the operating room, clean scrubs are to be obtained in the department. Hospital provided scrubs are not to be worn to or from work. Staff must change into hospital provided scrubs prior to having patient contact.

3. Staff in departments that wear green scrubs must wear labs coats over their scrubs. Shoe covers and masks must be removed.

4. Refer to site or department policy for staff assigned to the Rehabilitation Institute of Michigan and Psychiatric areas.

Indirect and Non-Patient Care Providers
(E.g., Patient Unit Clerks, Transporters, Clinic Staff, Ancillary/Support Staff, Sitters)
1. Refer to site or department policies for specific uniform requirements for patient unit clerks and transporters.

2. Non-patient care providers (e.g., clinic staff) must wear business attire and conservative shoes appropriate for business.
3. Refer to site or department policies for specific uniform requirements for ancillary and support staff.

4. Patient Attendant Safety: may wear casual business wear, uniforms or scrubs while engaged in sitting.

Responsibility
1. Each employee is responsible for maintaining an appearance consistent with this policy. It is the responsibility of management to assure compliance with these guidelines.

2. Managers are expected to counsel employees who wear inappropriate or unsafe clothing.

3. Employees arriving at work in apparel deemed unacceptable or unprofessional will be sent home (without compensation) for more appropriate attire.

4. If the employee does not respond to counseling, verbal and written warnings will be issued per the disciplinary policy (1 HR 506).

5. Site managers may make exceptions to the above policy for specific purposes and events.

ADMINISTRATIVE RESPONSIBILITY
The Detroit Medical Center Sr Vice President /Chief Nursing Officer has overall responsibility and authority for administration of policies, procedures and guidelines related to patient care.

APPROVAL
This policy has been approved and is duly authorized by Detroit Medical Center, Children’s Hospital of Michigan, Detroit Receiving Hospital, DMC Surgery Hospital, Harper/Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital. The posting of the policy on the DMC intranet signifies that it is in full force and effect.

Review Date 11/2016
Supersedes 11/98, 5/2001, 1/1/04, 11/01/04; 1/11/06, 07/2010

Changes
- Added: This policy applies to all DSG and other contracted (agency) staff working in with patients or in patient care areas of the DMC
- Added: Lab coats when worn are clean and in good repair
- Added: No images may be taken with personal devices (e.g. cell phones, cameras, i-pads or tablets) in the work place
- Added: Business casual or professional business attire must be worn while in the hospital including going to and from work site, orientation, and or skills validation class, or other educational offerings unless an exception is documented with Hospital Administration. This includes shoes/hose. If a portion of the day is spent in direct patient care, scrubs, or lab coat must be worn
- Flip-flops and leather were added to types of clothing not permitted
- Added: In the operating room, clean scrubs are to be obtained in the department. Hospital provided scrubs are not to be worn to or from work. Staff must change into hospital provided scrubs prior to having patient contact.
- Added: Staff in departments that wear green scrubs must wear labs coats over their scrubs. Shoe covers and masks must be removed

Responsibility
The Detroit Medical Center Management

JC Functional Chapter
Leadership
Photographs of Patients (1 CLN 048)

Effective Date: May 16, 2011
Revised Date: November 2000; November 2001, May 2005
Approved by: DMC management

OBJECTIVE
To protect the privacy of patients, staff and visitors.

SCOPE
DMC medical staff, students, employees, contractors, vendors and volunteers

DEFINITIONS
Photograph: Visual images produced by cameras, video recorders and other devices (e.g. cell phones) capable of recording visual images

Patient Advocate An adult named by the patient as her/his Durable Power of Attorney for Health Care pursuant to MCLA 700.496

Legal Guardian Individual appointed by a Court as the guardian of an Incapable Adult or Minor, and is granted power to make medical decisions on behalf of the Incapable Adult or Minor. The order appointing the guardian and acceptance of guardianship must be included in the patient’s medical record.

Natural Representative Individual who is most knowledgeable about the patient and who can best represent what the patient’s values, wishes and choices would be, given the medical circumstances. A natural representative need not be a family member, but may be a friend, companion or other person who knows the patient well enough to represent the patient’s values and preferences concerning medical decisions (this does not apply to minors).

POLICY
Photographs may be taken of patients with the consent of the patient, parent/legal guardian, patient advocate or natural representative when appropriate.

PROVISIONS
Photographic Limitations
1. Photographs of patients are permitted only for the following reasons.
   A. When the photograph is a part of consented medical treatment (see 1 CLN 006 Informed Consent for Medical/ Surgical Treatment, and Diagnostic Procedure).
   B. When the photograph is part of research and the patient has executed an Informed Consent Form for such research
   C. When the photograph is in connection with childbirth and the patient has secured the prior approval of hospital staff.
   D. When consent for the photograph is obtained on the Photographic/Publicity Release Form by Public Relations and Marketing (PR&M) or other hospital personnel.
2. Prior to obtaining consent, the Photographic Publicity Release Form (See Attachment 1: Photographic/publicity Release Form) must be explained to the patient, parent/legal guardian, patient...
advocate or natural representative when appropriate. The consent form will be retained in the PR&M Department.

3. Prior to taking photos of patients at the DMC, consultants and contractors retained by the DMC must execute a HIPAA Business Associate Agreement.

4. Photographs may not include any other patients, hospital staff or visitors without their individual consent.

5. Only essential hospital equipment may be included in the photograph.

6. Photographs may not be taken of a patient who is unable to consent or who is deemed incompetent (as determined in the Informed Consent Policy, I CLN 006) without the written consent of the patient’s parent/legal guardian, patient advocate or natural representative.

5. The consent for photographing the patient within the limitations described above is retained in PR&M.

6. The patient, parent/legal guardian, patient advocate or natural representative, has the right to rescind consent for photography at any time by notifying the Hospital in writing. (See Attachment 1: Photographic/Publicity Release Form)

7. The right to take such photographs is not absolute and hospital personnel may restrict the taking of such photos as deemed necessary.

8. Photographs shall be stored in such a manner so as to maintain confidentiality and ensure availability when needed.

Medical Photographs

1. If a photograph is requested for medical purposes, such as evaluation of wounds, and the patient has executed a consent form related to such medical treatment, photos taken of the patient are considered to be part of the patient’s care and no additional consent is required. These photos should be retained as part of the medical record (see 1 CLN 006: Informed Consent for Medical/ Surgical Treatment, and Diagnostic Procedure and 2 AMB 013 Patient Medical Photography/Videos).

2. Photos taken in connection with research activities are governed by the Informed Consent Form executed by the patient in connection with such research and no additional consent is required. These photos should be retained as part of the research file.

Responsibility

The Executive Vice President/Chief Business Officer and the Executive Vice President/Chief Medical Officer, have joint administrative responsibility for this policy.

JC Functional Chapter

Leadership
**Post Exposure Prophylaxis (accidental needle stick) (1 CLN 010)**

**Effective Date:** November 15, 2013  
**Revised Date:** August 2000; August 2001; February 2005; January 2008  
**Approved by:** DMC management

**OBJECTIVE**  
To standardize medical care following a Blood or Bodily Fluid Exposure (BBFE).

**SCOPE**  
All Exposed Individuals (as defined below) who present for post-exposure management of BBFEs.

**DEFINITIONS**  
**ART - Antiretroviral treatment**

**BBFE (Blood or Bodily Fluid Exposure)** - Any percutaneous (puncture or cut through skin), mucosal (e.g. eyes or mouth) or non-intact dermal (e.g. abraded skin, chapped skin or dermatitis) exposure to blood or a potentially infectious bodily fluid of another individual (“source”).

**Exposed Individual** - for the purpose of this policy, an exposed individual shall refer to any individual occupationally exposed to blood or potentially infectious bodily fluid of another individual.

**HBV** – Hepatitis B Virus  
**HCV** – Hepatitis C Virus  
**HIV** – Human Immunodeficiency Virus

**Potentially Infectious Bodily Fluid** - Blood, tissue, visibly bloody fluids, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid and inflammatory exudates are considered potentially infectious materials for HIV, HBV and HCV. Materials which are not considered potentially infectious for HIV, HBV and HCV include feces, urine, nasal secretions, saliva, sputum, sweat, tears and vomitus, unless these materials are visibly bloody.

**Source Individual** - the person whose blood or bodily fluid was the source of the exposure.

**POLICY**

1. Upon presentation for post-exposure management of a BBFE, the risk of exposure will be assessed considering the nature and severity of the exposure and the risk level of the source of the blood or bodily fluid. The exposed individual will be appropriately counseled, with care provided according to CDC guidelines and current medical practices, and shall be offered post-exposure prophylaxis if clinically indicated.

2. Attempts will be made to rapidly identify and test the source patient for HIV, HBV and HCV. If HIV positive, attempts will be made to determine the history of antiretroviral drug treatment and/or prior genotypic antiretroviral resistance testing (GART).
3. Baseline testing of the exposed individual will be performed for HIV, HBV and HCV after consent is documented in the medical record. DMC healthcare workers found to be infected with any of these agents will be subject to the DMC HIV/HBV/HCV Infected Healthcare Worker Policy (1 CLN 023). Those found to be infected on baseline will be referred to their personal physician for management.

4. Informed consent will be obtained prior to testing or treatment. The DMC General Consent for Admission and Treatment forms for both inpatient and outpatient provide adequate consent for source individual HIV testing.

5. An infectious disease consultation and/or second level counseling by an infectious disease expert shall be arranged whenever indicated.

PROVISIONS
1. All DMC employees with BBFEs must complete an incident report and report to their designated DMC OHS clinic (or clinic/emergency department providing back up coverage for DMC OHS after hours) for post-exposure management.
2. Exposed individuals whose initial visit was not at their designated DMC OHS clinic must report to the DMC OHS clinic within 72 hours following the incident.

3. Infectious Disease Specialist consultation may be obtained by the treating provider when clinically indicated by paging the on-call BBFE consultant at DMC pager 4052 for DMC Central Campus, DMC Pager 2312 for Sinai-Grace Hospital, and 248-544-6927 for Huron Valley Hospital. Alternatively, expert consultation can be obtained from the National Post-Exposure Prophylaxis hotline (PEPLine) at 888-448-4911.

4. Post-Exposure Management for HIV:
   a. Risk Assessment: Risk for transmission of HIV shall be assessed based upon the exposure material (type of potentially infectious material), the type and severity of exposure, and the source status. The following provide general guidelines for categorizing risk, recognizing that some situations may fall between categories and will require clinical judgment. Consultation with an infectious disease expert shall be sought whenever the clinician is in doubt.
      i. Sharp (e.g. needlestick or other sharp object) percutaneous exposures are considered less severe when the puncture is superficial or results from a solid needle. Exposures are considered more severe when the exposure involves a large bore needle, a deep puncture wound, the needle has been in an artery or vein of the source patient, or there is visible blood on the device.
      ii. Source status shall be classified as follows:
         1. HIV positive.
         2. HIV negative but source individual is at high risk for recent seroconversion or has symptoms consistent with acute retroviral syndrome
         3. Known source; status unknown; no known HIV risk factors
         4. Known source; status unknown; known HIV risk factors
         5. Unknown source; not a setting in which exposure to HIV infected persons is likely
6. Unknown source; setting in which exposure to HIV infected persons is likely
   
b. **Source Testing** – Following a BBFE, source patient testing shall include a rapid HIV test in order to facilitate decision-making regarding ART. If the source has symptoms of acute retroviral syndrome, or is considered to be at high risk for recent exposure, PCR testing for HIV antigen should be performed.
   
c. **Counseling** of the individual potentially exposed to HIV shall include:
      
      i. Risk of occupational exposure based on up to date epidemiologic information from the CDC. Currently, the risk of HIV transmission following a typical percutaneous needlestick exposure is believed to be approximately 0.3% (3 per 1,000). The risk for a typical mucosal exposure is believed to be approximately 0.09% (9 per 10,000), and the risk for a typical exposure to non-intact skin is believed to be less.
      
      ii. Prevention of secondary transmission to others shall be discussed, including safer sex practices, and the need to avoid blood donation, pregnancy and breast feeding, especially during the first 6 to 12 weeks following exposure. No modifications to an exposed individual’s patient-care responsibilities are necessary solely based upon the exposure incident.
      
      iii. Safe work practices and prevention of future exposure.
      
      iv. The benefits and side effects or risks of antiretroviral therapy (ART) for the prevention of HIV transmission based upon up to date information from the CDC. The counseling should include the following:

         1. Current studies suggest that ART may reduce risk of HIV transmission by as much as 80%. As of the publication of the June 29, 2001 MMWR, while many persons have taken ART following BBFE, there have only been 21 cases worldwide of individuals who developed HIV infection despite taking ART (please note that only 3 of these cases received > 3 drugs for PEP).

         2. Known side effects, risks and potential drug (and herbal agent) interactions with ART. This consideration is especially important for individuals who will be placed on a drug such as Kaletra (lopinavir/ritonavir) which contains a protease inhibitor. Such drug interactions may be serious or even life-threatening in some cases. The provider should refer to Appendix 2 and drug packet inserts or consult with a pharmacist when indicated. The individual receiving ART should be advised that evaluation of certain new, severe symptoms should not be delayed.

         3. Individuals taking ART who rely upon oral contraceptives must be advised to use supplemental contraception, as certain prophylaxis regimens may impair the effectiveness of oral contraceptives.

         4. There may be yet unknown side effects of these medications. Data regarding the long-term effects in otherwise healthy persons, including mutagenesis, carcinogenesis, teratogenesis, and fertility are lacking or inadequate.

      d. **Consultation with** and/or counseling by an **Infectious Disease Expert** (see provision 3 above for telephone numbers) shall be arranged when:

         i. Individual is pregnant or breastfeeding.
ii. Source is known positive and is or has been on ART, or has had genotypic antiretroviral resistance testing (GART) performed.

iii. Individual has a pre-existing medical condition which may increase the risks associated with ART (e.g. renal or hepatic disease, bone marrow suppression or disorder).

iv. Individual is taking a drug or herbal remedy (such as St. John’s Wort) that may interact with ART.

v. Individual has previously been treated with ART.

vi. Acute retroviral syndrome or HIV seroconversion is suspected in the source.

vii. Initial presentation is delayed (Over 72 hours from time of BBFE).

viii. Side effects of ART might require altering the ART regimen.

ix. Either the treating clinician or the patient have questions which would be best answered by such a consultation.

e. Treatment with ART

i. When ART is offered, treatment must begin as soon as possible (preferably within 2-4 hours of exposure). The ART regimen may be subsequently discontinued or changed to a different regimen if additional data collected changes the recommendation. The patient should be offered the option to begin the first doses of ART even while pending the results of source testing, especially when testing delays are anticipated.

ii. ART will be recommended and/or offered to the exposed individual for Post-Exposure Prophylaxis (PEP) according to the following guidelines. ART is to be provided for 28 days. It is recognized that clinically justified deviations may occur.

1. No ART will be provided without counseling and informed consent. The individual must agree to compliance with treatment monitoring and the HIV testing protocol.

2. All females of reproductive capacity will undergo a rapid pregnancy test, and if pregnant, the case will be discussed with an infectious disease expert prior to beginning ART. Breastfeeding women will be encouraged to discontinue breastfeeding for at least 6 weeks. The use of ART in pregnant women should be reported to the National Antiretroviral Pregnancy Registry (www.APRegistry.com).

3. If the individual is either known to be positive for HIV or tests positive for HIV on baseline testing, then he or she will be referred to his or her personal physician, and will not be treated with ART.

4. Drugs taken by the exposed individual, including over the counter and herbal remedies, and drug allergies will be documented, and consideration be given to known drug interactions prior to beginning ART.

5. Sharps Exposures shall be managed based upon the following 4 categories of recommendation:

   a. ART not indicated - ART will not be offered by the provider. Circumstances in which ART is not indicated include:

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1. An additional 24/7 resource is the National Clinicians’ Post Exposure Prophylaxis Hotline (PEPline) at 888-448-4911, which is staffed by physicians and pharmacists trained in BBFE management.
i. HIV antibody negative source, unless source is at high risk for recent seroconversion or has symptoms of acute retroviral syndrome.

ii. No exposure (e.g. intact skin, needle not contaminated with blood or potentially infectious material)

b. ART is Optional, but Recommended Against – ART may be elected at the option of the exposed individual. Circumstances include:

i. Known source; Status unknown; No known risk factors

ii. Unknown source; Setting not likely for HIV infected individuals

c. ART is Optional with no recommendation for or against – ART may be elected at the option of the exposed individual. Circumstances include:

i. Known source; Status unknown

ii. Unknown source; Setting is likely for HIV infected individuals

d. ART is recommended: HIV positive source, or source at risk for recent seroconversion, or has symptoms of acute retroviral syndrome (unless known to be HIV PCR negative)

6. Splash Exposures shall be managed based upon the following 4 categories of recommendation:

a. ART not indicated - ART will not be offered by the provider if the source is known to be HIV negative and not at high risk.

b. ART is Optional, but Recommended Against - ART may be elected at the option of the exposed individual. Circumstances include:

i. Small volume; Known source; Status unknown

ii. Large volume; Known source; Status unknown, but no known risk factors

iii. Small volume; Unknown source

iv. Large volume; Unknown source; Setting not likely for HIV infected individuals

c. ART is Optional with no recommendation for or against - ART may be elected at the option of the exposed individual. Circumstances include:

i. Large volume; Known source; Status unknown; Risk factors for HIV present

ii. Large volume; Unknown source; Setting is likely for HIV infected individuals

d. ART is recommended:

i. HIV positive source (or at high risk for recent seroconversion, or symptoms of acute retroviral syndrome)

f. Selection of ART agents

1. The exposed individual should be started on the following standard preferred regimen: Truvada (tenofovir 300 mg plus emtricitabine 200 mg) 1 tablet daily and Isentress (raltegravir 400 mg) one tablet twice a day (unless other agents are clinically indicated due to medical condition (renal failure (dose adjustments) or other relevant history source history of ART treatment, genotypic
antiretroviral resistance testing (GART), drug allergies). Alternative regimens may be found per the US Public Health Services Guidelines or discussed with the ID physician on call for BBFE.

g. Monitoring ART toxicity – Upon beginning ART, baseline tests shall include a CBC, a blood chemistry panel which includes hepatic and renal function tests, urinalysis, and blood glucose. Testing shall be repeated and reviewed by the physician two weeks following the initiation of ART. Symptoms will be reported to the physician, who will provide treatment as clinically indicated. Blood glucose will be monitored weekly for women who are pregnant and receiving protease inhibitor based prophylaxis which is usually preferred during pregnancy. The patient should be informed of symptoms to watch for and report without delay (rash, fever, back or abdominal pain, painful urination, bloody or dark urine, jaundice, and symptoms of hyperglycemia - frequent urination/thirst).

h. Medication intolerance – If the exposed individual is experiencing ART side effects, agents should be offered to ameliorate the symptoms (e.g. antiemetics, analgesics, antispasmodics). If there is medication intolerance to the extent that compliance may be compromised, an infectious disease expert shall be consulted to consider modifications to the ART regimen.

i. Follow up HIV Testing – Follow-up of the exposed HCP should be arranged within 72 hours after starting medications. In addition to the baseline HIV test, the exposed individual will be tested for HIV at 6 weeks, 12 weeks and 6 months. If a provider is using 4th generation HIV Ag/Ab HIV testing can be concluded in 4 months rather than 6 months. If the source was positive for both HCV and HIV, and the exposed individual becomes HCV positive but not HIV positive, then HIV testing will also be performed at 12 months. If the exposed individual should develop an illness compatible with acute retroviral syndrome, then HIV testing will be repeated regardless of the interval since exposure.

j. Any exposed individual who is confirmed positive for HIV infection on baseline testing will be referred to his or her personal physician. Any individual who is confirmed positive for HIV infection on follow up testing will be referred to a specialist knowledgeable in the management of HIV infection.

k. Testing of the source patient: OHS/ED will alert Administrative Manager/Supervisor of unit to contact attending physician to initiate testing (order as HCW exposure). Attending physician is responsible for counseling the patient.

5. Post-Exposure Management for Hepatitis B (HBV):

A. Risk Assessment: Risk for transmission of HBV shall be assessed based upon the exposure material (type of potentially infectious material), the type and severity of sharp or splash exposure, and the source status.

B. Source Testing – When source testing reveals a positive Hepatitis B surface antigen (HBsAg), additional testing for Hepatitis B ‘e’ antigen (HBeAg) shall be performed to better inform the risk assessment.

C. Counseling of the individual potentially exposed to HBV shall include:

i. Risk of occupational exposure based on up to date epidemiologic information from the CDC. The risk for HBV in the exposed individual who has immunity is negligible, and no treatment or special precautions are necessary. The risk for the exposed individual who does not have immunity to HBV of developing clinical hepatitis following a needlestick injury with an HBV
positive source can range from approximately 1% to 30%, depending on whether or not the source carries the Hepatitis B e-Antigen. This risk can be significantly reduced through post-exposure prophylactic treatment.

ii. Prevention of secondary transmission (if exposed to HBV and not immune) to others. The exposed individual should avoid blood, plasma, semen, tissue and organ donation. The CDC does not recommend changes in sexual practices for long-term monogamous partners. Those with multiple sexual partners or in more casual relationships, however, should be counseled to employ safer sex practices (e.g. condoms). The CDC has no recommendations against becoming pregnant or breastfeeding. No modifications to an exposed individual’s patient-care responsibilities are necessary solely based upon the exposure incident.

iii. Safe work practices and prevention of future exposure.

iv. The benefits and side effects of treatment for individuals who do not have HBV immunity.
   1. Multiple doses of Hepatitis B Immunoglobulin (HBIG) vaccine alone initiated within one week following percutaneous exposure will reduce the transmission risk by approximately 75%.
   2. The addition of the Hepatitis B vaccine series following exposure is believed to further reduce transmission risk and will provide the additional protection from future exposures.
   3. Safety of the vaccines. Common side effects include local soreness at the injection site and sometimes mild to moderate fever. These vaccines are safe for use in pregnancy.
   4. A Michigan Vaccine Information Sheet (VIS) shall be provided prior to vaccination.

D. Management of the HBV exposed (source positive for HBV antigen) individual shall include:
   1. Determination of immunity through review of documentation and/or testing for Hepatitis B surface antibody (HBsAb) and surface antigen (HBsAg) if documentation of immunity does not exist.
   2. If the exposed individual is known to be immune to HBV, then no further treatment or testing for HBV is required.
   3. All exposed individuals who have not been vaccinated for HBV will be offered and strongly encouraged to undergo vaccination, regardless of the exposure risk or source status.
   4. If the exposed individual’s immune status is negative or unknown, then treatment shall proceed according to current CDC guidelines (MMWR June 29, 2001 if not superceded by more current guidelines; see page 22, table 3). Treatment shall be based upon consideration of both the exposed individual and source status and shall include HBIG and the Hepatitis B vaccine series as clinically indicated. Treatment should be initiated as soon as possible (preferably at the initial patient presentation). When HBIG and/or the Hepatitis B vaccine series are indicated, they should be administered as soon as possible (preferably within 24 hours). If the exposed individual presents late, HBIG may be given up to 7 days following exposure. HBIG and the HBV vaccine may be administered simultaneously in different sites (the HBV vaccine should be administered in the deltoid muscle).

E. Follow up shall include:
   1. For those who are offered and decline vaccination, follow up testing shall be performed for HBsAg and HBsAb at three months post exposure. For those receiving vaccination, follow up testing shall be performed at 1-2 months after the last dose of vaccine, but not prior to 4
months following HBIG administration. If follow up testing fails to demonstrate immunity, then consideration should be given to additional vaccination in accordance with CDC guidelines.

2. Those initiating the HBV vaccine series will receive their 2nd and 3rd doses of vaccine at 1 and 6 months after the first dose.

3. Those who require a 2nd dose of HBIG shall receive it 1 month after the first dose.

4. Exposed individuals shall report symptoms which may indicate the development of hepatitis (e.g. jaundice, dark urine, nausea, vomiting, right upper quadrant pain, etc.), and present to OHS as soon as possible for follow up evaluation.

5. Any exposed individual who is confirmed positive for HBV infection on baseline testing will be referred to his or her personal physician. Any exposed individual who is confirmed positive for HBV infection on follow up testing will be referred to a specialist knowledgeable in the management of HBV infection.

6. Post-Exposure Management for Hepatitis C (HCV):

A. Risk Assessment: Risk for transmission of HCV shall be assessed based upon the exposure material (type of potentially infectious material), the type and severity of sharp or splash exposure, and the source status.

B. Counseling of the individual potentially exposed to HCV shall include:

1. Risk of occupational exposure based on up to date epidemiologic information from the CDC. The risk to the individual for acquiring HCV infection following a needlestick injury with an HCV positive source is estimated to be approximately 1.8%.

2. There is no known effective post-exposure prophylaxis for HCV, but follow up testing will be provided.

3. The exposed individual should avoid blood, plasma, semen, tissue and organ donation. The CDC does not recommend changes in sexual practices for long-term monogamous partners. Those with multiple sexual partners or in more casual relationships, however, should be counseled to employ safer sex practices (e.g. condoms). The CDC has no recommendations against becoming pregnant or breastfeeding. No modifications to an exposed individual's patient-care responsibilities are necessary solely based upon the exposure incident.

4. Safe work practices and prevention of future exposure.

C. Management and Follow Up of the HCV exposed (source confirmed positive for HCV antigen) individual shall include:

1. If the source was determined positive on an immunoassay test, source status shall be confirmed with qualitative polymerase chain reaction (PCR) testing.

2. Baseline testing of the exposed individual for HCV antibody and ALT.

3. Follow up testing of the exposed individual for HCV antibody and ALT at 3 and 6 months post exposure.

4. Positive HCV immunoassay screening tests will be followed by confirmation PCR testing.
5. Any individual who is confirmed positive for HCV on baseline testing will be referred to his or her personal physician. Any individual who is confirmed positive for HCV on follow up testing will be referred to a specialist knowledgeable in the management of HCV infection.

6. Exposed individuals shall report symptoms which may indicate the development of hepatitis (e.g. jaundice, dark urine, nausea, vomiting, right upper quadrant pain, etc.), and present to OHS as soon as possible for follow up evaluation.

Questions regarding this policy should be referred to the Chief, Division of Infectious Diseases, Hospital Epidemiologist, Occupational Health Services or (for administrative purposes) or for administrative purposes the SVP Human Resources.

REFERENCES


Updated US Public Health Service guidelines for the management of occupational exposures to human immunodeficiency virus and recommendations for postexposure prophylaxis.

Kuhar DT, Henderson DK, Struble KA, Heneine W, Thomas V, Cheever LW, Gomaa A, Panlilio AL; US Public Health Service Working Group

Recommendations for Postexposure Prophylaxis. MMWR September 30, 2005 Vol. 54/No RR-9

Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. MMWR June 29, 2001 Vol. 50/No RR-11

David T. Kuhar, MD; David K. Henderson, MD; Kimberly A. Struble et al. Updated US Public Health Service Guidelines for the Management of Occupational Exposures Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis. Infection Control and Hospital Epidemiology, Vol. 34, No. 9 (September 2013), pp. 875-892

Responsibility

DMC Management

JC Functional Chapter

Leadership
Professional Liability Coverage/Risk Management

Effective Date: July 1, 2004
Revised Date: GMEC

Professional liability coverage is through the DMC Insurance Company, Limited. This policy is a limited claims made policy with extended reporting endorsement (tail coverage).

This coverage does not extend beyond the Resident’s role as a Resident (see detail below). For example, if a Resident wanted to moonlight outside of the training program, the insurance would not extend to cover the moonlighting activities. It would be the Resident’s responsibility to obtain insurance coverage for these types of exposures.

Coverage for DMC Residents for rotations at DMC
Coverage is provided automatically as part of your training program.

Coverage for DMC Residents while outside DMC
Off-site rotation requests forms are required for ALL rotations to Non-DMC owned facilities and must be submitted to GME at least 6 weeks in advance. This form can be obtained from your program coordinator.

Hospitals that have a reciprocal agreement in place with DMC will provide malpractice coverage while DMC trainees are at that location. All other off-site locations that require malpractice coverage will be taken care of on an individual basis. Specific information about agreements can be obtained from the GME office.

Rotation requests, OUTSIDE THE STATE OF MICHIGAN, are reviewed on a case by case basis by the DIO, as well as the Director of Risk Management, and require a letter from the Program Director justifying the need for the rotation. These requests need to be submitted at least 8 weeks in advance of the rotation.

Coverage for Non-DMC Residents rotating through DMC hospitals
Coverage is determined by an affiliation agreement between DMC and the other institution and/or on a case by case basis. A completed Application for Rotation into a DMC hospital must be submitted to the GME Office at least eight (8) weeks prior to the start of the rotation.

Legal Aid and Legal Actions
Legal aid is available to all Residents in connection with any circumstances involving a DMC hospital patient(s). Any development of a medical/legal nature must be handled through the Risk Management Office. If legal papers, a subpoena, an attorney or the court contact a Resident regarding a DMC patient or situation, contact Risk Management immediately. Using the site representatives listed below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Risk Manager Name</th>
<th>Phone #</th>
<th>Pager #</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHM</td>
<td>Kay Vincent-Mosher</td>
<td>313-966-6105</td>
<td>00590</td>
</tr>
</tbody>
</table>
Safe Medical Devices Act

The Safe Medical Devices Act requires that the institution report to the manufacturer and/or to the FDA certain incidents involving the malfunction or failure of medical devices (1) in which a patient sustained serious injury or death, or (2) intervention was required to prevent serious injury or death (DMC Policy 1 CLN 017). If a Resident’s patient is involved in an incident that might be reportable, the Resident must immediately isolate the equipment without changing any settings and contact Engineering, Maintenance or call Risk Management. Residents should not return such equipment to the company or attempt to repair it by themselves.

Responsibility
GME Committee

JC Functional Chapter

Leadership
Professionalism, Personal Responsibility & Patient Safety

Effective Date: July 1, 2011
Revised Date:

Approved by: GMEC

Policy

The program director and institution shall strive to maintain a culture of professionalism that supports patient safety and personal responsibility.

Procedure

1. Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles as demonstrated by:
   a) compassion, integrity, and respect for others
   b) responsiveness to patient needs that supersedes self-interest
   c) respect for patient privacy and autonomy
   d) accountability to patients, society and the profession; and
   e) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
2. Programs and sponsoring institutions must educate Residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.
3. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.
4. The program director must ensure that Residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
5. The learning objectives of the program must:
   a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,
   b) not be compromised by excessive reliance on Residents to fulfill non-physician service obligations.
6. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
   a) assurance of the safety and welfare of patients entrusted to their care;
   b) provision of patient- and family-centered care;
   c) assurance of their fitness for duty;
   d) management of their time before, during, and after clinical assignments;
   e) recognition of impairment, including illness and fatigue, in themselves and in their peers;
   f) attention to lifelong learning;
   g) the monitoring of their patient care performance improvement indicators; and,
   h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
7. All Residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.
Responsibility
GME Committee
JC Functional Chapter
Leadership
Program Closure and/or Reduction in Size

Effective Date: July 1, 2004
Revised Date: October 22, 2012
Approved by: GMEC

The DMC is committed to insuring that Residents enrolled in a DMC-GME Program are provided the opportunity to complete their training at a DMC institution.

The DMC will inform the GMEC, the DIO, and theResidents as soon as possible when it intends to reduce the size of or close one or more programs, or when the Sponsoring Institution intends to close; and,

The DMC will either allow Residents already in the program(s) to complete their education or assist the Residents in enrolling in program(s) accredited by the Applicable Accrediting Body in which they can continue their education.

Responsibility
GME Committee

JC Functional Chapter
Leadership
Promotion/Reappointment/Graduation

Effective Date: July 1, 2004
Revised Date: July 1, 2004
Approved by: GMEC

Programs must clearly delineate, in writing, requirements for promotion/graduation of Residents.

Re-appointment and/or promotion to the next level of training is conditional upon: 1) satisfactory completion of all training components as mandated by the Program and DMC-GME, 2) the availability of a position, 3) satisfactory performance evaluations and documentation of passage of required licensing examinations, 4) full compliance with the terms of the Resident’s GME Agreement of Appointment, and 5) the continuation of the Program’s accreditation by the Applicable Accrediting Body.

Upon completion of the DMC-GME Program, the Resident will be able to enter practice without direct supervision if all requirements for graduation have been met including integration (where required) of the Applicable Accrediting Body general competencies and appropriate outcome measures. Completion of medical records and clearing of any financial obligations to DMC must be included as a prerequisite for graduation from a DMC training program.

Responsibility
GME Committee

JC Functional Chapter

Leadership
Resident Educational Allowance Program / Other Expenses Procedure

Effective Date: July 1, 2013
Revised Date: July 1, 2014

Approved by: GMEC

Effective July 1, 2013, procedures regarding the DMC GME Resident Educational Allowance Program (Resident Educational Allowance) are as follows:

1. $3,120 per FTE resident will be transferred as payroll to each Resident.
   - Each Resident will be responsible for the direct payment of other individual educational expenses associated with residency training.
   - Examples of individual resident educational expenses include but are not limited to: on-call meals, books, educational materials, training materials, conferences, and personal equipment.
   - DMC recommends that each program director and each entity holding an academic services agreement or resident teaching program contract with the DMC notify the program’s Residents by June 1st each academic year of any required personal educational materials or equipment that must be purchased.

2. The Detroit Medical Center GME Office pays from its operating budget the following expenses:
   - Michigan medical licenses
     - “limited educational” for Residents at training levels PGY-1 to PGY-5
     - “permanent” for Residents at training levels >PGY 5 permanent” for Residents at training levels >PGY 5 or for Residents who are required hold a permanent license to sit for board examinations
   - Laboratory coats
   - In-service examination fees

3. Programs requesting residents/fellows to contribute or pay for certain program educational expenses can not request more than the net amount (after tax) received by a resident/fellow. Programs can not request residents/fellows to carry-over expenses to another academic year.

For resident educational expense reimbursement not related to the Resident Education Allowance Program, directors and coordinators will be responsible for assuring that all reimbursable expenses are submitted through Concur by the Program Coordinator or Manager and in accordance with procedures outlined in Tenet Policy TEA AD 2.08 Travel and Other Business Expenses and TEA 2013 Travel and Expense Reference Guide (attached).

Responsibility
GME Committee

JC Functional Chapter

Leadership
I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital and healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Facility”) (collectively, “Tenet”). Conifer employees are subject to the Conifer Travel and Business Expense policy.

II. PURPOSE:

The purpose of this policy is to provide direction for (1) determining what expenses are appropriate for reimbursement; (2) requesting reimbursement, and (3) reviewing expenses submitted for reimbursement by the employee, supervisor, and functional leaders.

III. DEFINITIONS:

A. “Traveler” means a Tenet employee who is traveling.

B. “Travel Arranger” means a person designated to arrange travel on behalf of a Tenet employee.

C. “SVP+ Approver” means the written approval of a Tenet Senior Vice President or above, or, in the case of a SVP or above, their supervisor.

D. “A-Team Approver or Approval” means the written approval at the facility level by the CEO, COO, CFO, CNO, HR Leader, CMO, DBD, HCO or their delegates.

E. “Department Head or Facility CEO or Facility CFO Approver or Approval” means the written approval of a Tenet Home Office Department Head, Hospital or Business Unit CEO or Hospital or Business Unit CFO.

F. “Travel Services” means Tenet’s Travel and Expense Administration Department. The department is responsible for arranging all business travel for Tenet employees and processing expense reports.

G. “Meeting Services” means Tenet’s Meeting Services Department. The department is responsible for arranging meeting for groups greater than 10 attendees and all needs and conference space at Tenet’s Home Office.

H. “eTenet Expense” or “eTenet Travel” means Tenet’s online Concur Travel and Expense system.
Title: TRAVEL AND OTHER BUSINESS EXPENSES

Effective Date: 08-16-13
Retires Policy Dated: 02-15-12
Previous Versions Dated: 09-27-11; 10-01-09; 08-16-09; 02-23-09; 02-18-08; 03-01-07; 04-30-04; 10-01-96

IV. POLICY:

Business travel and expenses are often required in order to accelerate our growth and maximize our performance.

The company recognizes that travel is an inconvenience and requires personal sacrifices of time and lifestyle by the traveler. As such, we believe that employees traveling on business, particularly those who travel frequently, should be reimbursed for all reasonable expenses incurred as a result of travel.

We also acknowledge that it is competitive practice to periodically entertain our partners, vendors, and customers, celebrate successes and/or empathize with losses of our employees. Our policy provides reimbursement for reasonable expenditure related to these situations.

Our policy relies on the employee to use his/her discretion on appropriate expenses, and be accountable for justifying the need of the reimbursed expense.

Tenet will reimburse employees for reasonable travel related expenses incurred while conducting Tenet business. Tenet develops expense-specific guidelines to ensure compliance with applicable laws and regulations, while also supporting the safety and productivity of employees. Tenet will reimburse employees for reasonable business and entertainment expenses with other employees, partners, vendors, and customers, to the extent employees follow the expense guidelines.

Tenet will reimburse employee for reasonable business expenses for day-to-day supplies and/or other expenses that are not available through other processes policies when needed (e.g., color printing when no printers are available).

Receipts are encouraged for all expense items, however, are required for expenses above $25, unless otherwise accommodated in this policy. If receipts are not available or lost, the employee shall contact the vendor for a duplicate or complete an Expenditures Without Receipt form. A notation must be made on the submitted expense report at the time of submitted explaining the missing receipt.

V. PROCEDURE:

A. Reasonable Travel and Business Expenses

Tenet will reimburse employees for reasonable travel expenses. Tenet’s Travel and Expense Administration Department has posted expense guidelines on eTenet to assist employees in determinations of reasonableness. Spending outside of these guidelines can be approved by a SVP+ Approver based on his/her evaluation of the reasonableness of the expenditure.
Tenet will reimburse for Tenet or facility-sponsored business events (e.g., an office or facility holiday party or picnic) or business entertainment that involves entertaining a physician, vendor or customer (e.g., attendance at community function).

Tenet will reimburse for situations related to employee recognition and/or sympathy.

B. Corporate Credit Card

Employees who will require business travel at least three or more times per year or who routinely incur business expenses are encouraged to apply for a Tenet corporate credit card. To do so, employees must gain the approval from their Department Head or Facility CEO, using the corporate card application located on the Travel and Expense Administration department site located under the “Departments” tab on eTenet. Employees must charge all business-related expenses, including air transportation, hotel, auto rental, meals, and miscellaneous expenses to their corporate card, whenever the card is accepted and within practical limits.

**The corporate credit card should not be used for personal expenses.** Corporate credit card holders are responsible for all charges to their corporate card account. They are responsible for timely submission and approval of expense reports, payment and reconciliation of any discrepancies, even if expense reports are filed and submitted by a designated expense delegate. If personal charges are incurred on the card, they must be filed with regular charges in the expense report and tagged as “personal, do not reimburse me.” Personal payments must be made to credit card company directly by the Cardholder, and must be posted on the account prior to due date. If for any reason a replacement card is issued, the Cardholder is responsible for advising Program Administrator of the new credit card number (if applicable) prior to using the replacement card.

Corporate credit card holders who leave the company must reconcile and submit all reimbursable company card charges via the expense system and make payment for any personal charges to the corporate credit card company prior to their departure. Corporate credit cards must be returned prior to or during exit interview and notice of request for account cancellation must be emailed to expenseadmin@tenethealth.com.

C. Meeting and Conference Planning

1. **Meeting Pre-Approval:** Tenet-sponsored conferences or meetings with ten or more participants requiring air travel and/or hotel reservations require SVP or above approval and must be contracted, planned and executed
through Meeting Services. For Tenet-sponsored events where events are scheduled by Home Office leaders, individual approvals are not needed as they are obtained prior to invitation.

Meetings with more than ten participants not requiring air travel and/or hotel reservations require A-Team approval only.

2. **Meeting Planning**: Planning for such meetings should occur at least six months in advance to take advantage of best pricing. The meeting host must complete a Meeting Services Request Form available on eTenet and provide the required information. Meeting Services shall facilitate all vendor management. Communications and invitations to meetings should be sent to participants at least 45 days in advance to ensure participants can book air travel at least 30 days in advance to take advantage of lower airfares. Whenever possible, meetings should be held at a Tenet facility using Tenet-owned equipment. Payment for such meetings will be made by Meeting Services and shall not be made on individual corporate credit cards.

**D. Preparation of Expense Reports**

1. The Concur Travel and Expense system located on the Tools and Applications page on eTenet is used file expense reports. All expense reports must be prepared in accordance with the instructions located in the Expense Policy Reimbursement Quick Start Guide located on the Travel and Expense Administration department site on the Departments tab on eTenet. Expense reports must clearly and accurately document the business purpose of the expenditure and should be accompanied by an original and detailed receipt for each item greater than $25. All employees are required to utilize the Concur Travel and Expense System. For business meals and entertainment, the Concur documentation must include the date and amount, itemization of the expenditure, restaurant name and location, attendee(s) names and titles, and business purpose.

2. Employees can fax, upload or email receipt images via their camera phone to the Concur Travel and Expense System.

3. If an employee loses a receipt, the employee should contact the vendor for a duplicate or must complete an Expenditures Without Receipt Form.

4. Handwritten expense reports will not be accepted, as they can be difficult to read, and are prone for calculation errors. The exception is for employees who are leaving Tenet. Prior to departure these employees must complete a manual expense report for any cash-out-of-pocket expenses through Meeting Services.
expenses and file a final expense report for any outstanding corporate card charges. The expense report must include date of termination and mailing address.

5. Cash out of pocket expense reports should be submitted after the accumulation of expenses is large enough to warrant a report, but at least quarterly. Tenet incurs a fee for every expense report submitted, and thus fewer reports help with our cost management efforts. If expenses have been incurred on the employee’s corporate credit card, the report should be submitted at least within 14-days of the oldest charge date to assure payment posting prior to the end of the monthly billing cycle.

6. Requests for reimbursement of relocation expenses must be submitted on a separate relocation expense form. Contact Relocation Services for forms and instructions.

7. For any expense requiring advance written approval, the approval must be attached with all receipts when the expense report is submitted for approval.

8. Political Contributions shall only be made with the prior written approval of Government Relations. Political contributions are not reimbursable personal expenses and payments should be coordinated by Government Relations.

9. Expenses shall not be reimbursed from petty cash or through the check request process. Tenet reimburses all expenses through direct payment to its credit card vendors or the payroll process.

E. Responsible Parties

Employees are responsible for complying with this policy, submitting their expense reports in a timely manner and reconciling their corporate credit card accounts. If preparation of the expense report is delegated to another person, the traveler is still responsible for the oversight of the preparer and his/her work. Corporate credit card charges must be filed, submitted and approved in a timely manner to assure Tenet payment posting to card accounts within the 30-day billing cycle of the oldest charge date. Airfare charges must be expensed ahead of actual travel dates to assure timely payment of such charges.

Cash-out-of-pocket expenses are reimbursed to employee’s regular paycheck and should be filed within 90 days of transaction date. Department Heads, Facility CFOs and the employee expense report approvers are responsible for monitoring Expense Reports to ensure that their employees are complying with the intent of
Tenet policies and that those expenses are reasonable and have adequate supporting documentation, including detailed receipt for each expense above $25. Expense report approvers are responsible for processing all reports in a timely manner.

Travel Services will submit periodic reports to Tenet's CFO, SVP Human Resources, and VP Audit Services, who review spending activity and compliance to policy. Reports are also available to functional leaders for review of their travel expenses of the employees in their organizations. Detailed travel expense reports are available for supervisors to review for compliance and reasonable business spending. Patterns of seemingly unreasonable travel expenses are investigated, and when justified, could result in performance management.

F. Levels of Approvals

1. Expense reports for Department Heads, Facility CEOs, and salary managers should be submitted to their next higher manager in the reporting chain for approval.

2. An employee cannot approve his/her own expense report.

3. Approvers of electronic expense reports are assigned by the Concur Expense Administrator based upon completion of the eID request for the Expense Approver Role on eTenet. Employees are responsible for completing their expense and travel profile and advising the name of their expense approver via email to expenseadmin@tenethealth.com.

4. Authorization of eTenet Expense Reports follows the Approval Limits in the Administrative Policy AD 2.05, Authorized Financial Approval Limits.

5. Corrected expense reports must be approved prior to processing.

6. Spending outside of the travel guidelines posted on eTenet requires approval by a SVP+ Approver.

G. Processing the Expense Report and Related Forms

Electronic Concur Travel and Expense System Expense reports are audited by the system. Internal program alerts and flags ensure expenses adhere to policies and charges are reasonable. If expenses appear to be out of compliance with policy, the system will flag the report for additional auditing.
Employees should familiarize themselves with the reimbursable and non-reimbursable expense guidelines provided in Expense Policy Reimbursement Reference Guide for Administrative policy AD 2.06 Travel and Other Business Expenses and the Concur Travel & Expense Quick Start Guide located on the Travel and Expense Administration department site located under the “Departments” tab on eTenet prior to filing expense reports or arranging travel.

H. Enforcement

All employees whose job responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy and its related guidelines. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- Travel & Expense Administration Department website
- Tenet Standards of Conduct
- Administrative policy AD 1.05 Hospital Equipment Maintenance
- Administrative policy AD 2.01 Authorized Financial Approval Limits for Capital Expenditures
- Administrative policy AD 2.05, Authorized Financial Approval Limits for Disbursements
- Administrative policy AD 2.50, Cellular Phones, Pagers, Blackberry Devices and Aircards
- Law Department policy L-1 Business Courtesies to Physicians and Immediate Family Members
**Resident Pre-Probation/Probation**

Effective Date: November 17, 2008

Program Directors must adhere to the following protocol for Resident Probation:

1. The Program Resident Education Committee (or equivalent) identifies a Resident performance deficit that requires pre-probation or probation.

2. The Program Resident Education Committee must define the pre-probation or probationary terms, timeline, and conditions including behavioral based outcomes and expectations.

3. The Program Director must notify a Resident of pre-probation or probationary status in writing. The Resident must review the pre-probation or probation terms and sign the letter acknowledging receipt.

4. Documentation of the probation (including the signed letter and all supporting evidence) must be submitted to the Program Chair and DIO.

5. Resident’s failure to meet the defined terms of probation may result in the implementation of corrective action procedures. The probationary status must not exceed one year; violations considered egregious in nature may result in earlier corrective action implementation.

6. At the time of probation, the Resident must be given a copy of the program and institution’s corrective actions policies and procedures.

**Responsibility**

GME Committee

**JC Functional Chapter**

Leadership
**Procedures for Pre-Probation & Probationary Status of Resident**

**PRE-PROBATIONARY STATUS OF RESIDENT**

Residency Education Committee (REC) identifies:
- Resident w/deficiencies

Residency Education Committee (REC) actions:
- Conduct critical review of evaluations and other relevant data
- Determine possible modification of work schedule
- Design remediation plan
- Identify a mentor
- Develop mentoring meeting timeline

Program Director actions:
- Program Director (PD) meet with Resident
- PD provides written document outlining deficiencies with specific action plan to address deficiencies
- PD & Resident sign document
- PD submits copy to GME office and Mentor

Mentor actions:
- Review action plan with Resident
- Conduct regular meetings per established timeline
- Identify any improvements and/or concerns—discuss with Resident
- Submit progress reports to PD

Residency Education Committee (REC) actions:
- Review resident progress reports
- Determine next step below for Resident

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**Step 6a: Successful Remediation**
- If resident met goals identified in remediation,
  - PD documents summary report for inclusion in resident file stating that resident has satisfied all areas of previously identified concerns
  - Place all progress reports, mentor notes, etc. in resident file

**Step 6b: Continued Remediation**
- Repeat Steps 2 - 5

**Step 6c: Probation**
- If the REC recommends a resident be placed on probation,
  - Submit a copy of ALL documentation (progress reports, mentor notes, action plans, etc.) identified above to GME office for review prior to initiating probationary status
  - Initiate Probation protocol listed on next page
PROBATIONARY STATUS OF RESIDENT

GME Administration actions:
- Review documentation provided by PD
- Determine if evidence presented supports Probation status
- Notify PD if they can proceed to place resident on probation

Meet Probation Requirements:
- Place Resident on Probation

Does Not Meet Probation Requirements:
- Send report back to PD/REC for review/further action

Program Director actions:
- Meet with resident
- Provide resident with Probation letter stating that the REC has recommended probationary status and include the following:
  - The probationary terms of the probationary period
  - Expectations for successful remediation
  - Meeting timeline specified between PD/Mentor and Resident
  - Specify evaluation review timeline in terms of probation
- Obtain Resident signature stating that he/she has read and understands the terms of probationary status
- PD sign Probation letter
- Submit copy of letter to GME office for DIO signature
- Provide resident with copy of GME Corrective Action Procedures at the time resident is informed of probation
- Compile meeting notes after every meeting encounter between PD/Mentor and Resident
- Submit a written update to GME office halfway through resident probationary period

Residency Education Committee (REC) actions:
- Determine if resident has met requirements of successful remediation of deficiencies
- Initiate one of the next steps below

Successful Completion of Probation:
- If resident met goals identified in Probation letter,
  - PD documents summary report for inclusion in resident file stating that resident has satisfied all areas of previously identified concerns
  - Place all progress reports, mentor notes, etc. in resident file
  - Submit update to GME

Unsuccessful Probation result(s):
- PD initiate Corrective Action Procedures as identified in GME Policy Manual
- Submit copies of all probation notes, progress reports, evaluations, etc. to GME office

Step 1
Step 2a
Step 2b
Step 3
Step 4
Step 5a
Step 5b
(or)
**Resident Transfer / Verification of Previous Residency**

Effective Date: December 15, 2008  
Revised Date:  
Approved by: GMEC

Residents are considered as transferring Residents under several conditions which include:

- when moving from one program to another within the same or different sponsoring institution;
- when entering a PGY-2 program requiring a preliminary year even if the Resident was simultaneously accepted into the prelim PGY 1 program and the PGY 2 program as part of the match (e.g. accepted to both programs right out of medical school.)

Before accepting a transferring Resident, the receiving Program Director must obtain written or electronic verification of prior education from the current Program Director. Verification includes:

- evaluations
- rotations completed
- procedural/operative experience
- summative competency-based performance evaluation.

A Resident transfer form must be obtained from the GME Office for programs to utilize that includes the following elements:

- Verification of training
- List and duration of rotations
- Professional liability
- Summative competency based performance evaluation
- Procedural / Surgical Experience
- Final recommendation status

**Responsibility**

GME Committee

**JC Functional Chapter**

Leadership
Scrub Attire (2 MRMLOG 412)

Effective Date: April 1, 2011
Revised Date:
Approved by: DMC Management

OBJECTIVE
To promote a professional appearance and provide sanitary attire for patient care activities.

SCOPE
DMC Physicians (including Residents and medical students), all DMC employees and other direct and indirect patient care providers (including contracted staff and students) requiring scrub attire for surgical or invasive procedures who are at high risk for blood and body fluid exposures.

POLICY
1. All personnel will manage scrub attire consistent with this policy, infection control standards, and regulatory and safety requirements.

2. Departments approved for hospital issued seafoam green scrub attire include Operating Room Services, Labor and Delivery, Hemodialysis units, Central Sterile Processing, Angiography, Cardiac Catheterization, Endoscopy, and E.P. Labs.

3. If clothing becomes soiled with blood and/or body fluids while providing care, hospital issue scrub attire may be provided to other patient care providers for the remainder of their workday.

PROVISIONS

Departments Approved for Hospital Issue Scrubs
1. Employees in departments approved for wearing hospital provided scrub attire are provided with a copy of this policy and are required to sign a responsibility memo (Attachment 1). An original of the memo is retained in the employee's personnel file and a copy provided to the employee as a Security pass.

2. Scrub attire should be removed at the end of the day and/or shift and disposed of in hospital soiled laundry hamper.

3. Scrub attire that becomes soiled with blood and body fluids is changed as soon as possible.

4. If scrub attire is worn home, it must be with the written pre-authorization from management. Upon request, the employee will provide Security with a copy of the authorization.

Other Departments
1. Employees who are issued scrub attire on a one-time basis are provided with a copy of this policy and are required to sign a responsibility memo (Attachment 1). An original of the memo is retained in the employee's personnel file.
2. Employees requesting use of scrub attire due to soiling of their personal uniform will report to their supervisor and obtain a signed authorization for issuance of hospital scrub attire.

3. The supervisor will also complete a 2-copy Package Pass (site specific form). The original is maintained by the authorizing supervisor and the copy given to the employee to be presented for issuance of scrub attire.

4. The employee obtains scrub attire from the Linen Department (or other site-designated department). The Linen Department staff (or other issuing individual) reviews the Package Pass and provides scrub attire as requested. Issuance is documented by signatures in the Scrub Log of both the employee issuing and employee obtaining the scrub attire.

5. The employee will return the used scrub attire at the end of the shift or the following workday to a unit/department dirty linen receptacle. The employee copy of the Package Pass is signed and retained by the supervisor verifying return of the scrub attire. (Note: If the supervisor verifying return did not authorize original issuance, he/she will forward the signed Package Pass to the authorizing supervisor.

Security
1. DMC Security Officers/Management may request to view signed written authorization to remove hospital issued scrub attire from premises.

2. If upon request, the employee is unable to provide written authorization, his/her name and department/unit will be forwarded to the site Vice President of Patient Care Services for follow-up.

Responsibility
1. Management is responsible for enforcing the dress code policy and monitoring use of hospital issued scrub attire.

2. Violation of this policy may result in disciplinary action.

Responsibility
Corporate Director of Logistics Management

JC Functional Chapter
Leadership
Selection and Appointment of Residents

Effective Date: July 1, 2012
Revised Date: July 1, 2012
Reviewed Date: July 23, 2012
Approved by: GMEC

Policy

Residents shall be selected and appointed from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. DMC graduate medical education programs shall not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status.

Selection

In selecting from among qualified applicants, the Detroit Medical Center and all of its graduate medical education programs shall participate in an organized matching program, such as the National Resident Matching Program (NRMP). Programs participating in the NRMP must abide by all policies and procedures of the NRMP, including the “all-in” policy that requires all positions to be selected through the NRMP.

If a DMC sponsored graduate medical education program presents evidence that participation in the match places the program at a significant disadvantage in selecting highly qualified candidates, the DMC Graduate Medical Education Committee may approve a waiver of the requirement to participate in an organized matching program.

Positions are occasionally available outside the match process for reasons such as attrition, off-cycle appointments, or unfilled positions in the Match. Candidates for such positions shall be proposed by the Program Director to the Vice President of Academic Affairs/Designated Institutional Official prior to making any offer of a position or contract. The Vice President of Academic Affairs/Designated Institutional Official, in cooperation with the Program Director, shall be responsible for certifying the eligibility and qualifications of any candidate proposed for appointment outside the match process and for assuring that the appointment is made in compliance with the policies and procedures of the NRMP (if applicable).

Appointment

All Residents are provided with a written agreement of appointment/contract outlining the terms and conditions of their appointment to a program. All contracts between the Detroit Medical Center and Residents shall be issued by the DMC Graduate Medical Education Office. The DMC Graduate Medical Education Office shall monitor programs with regard to implementation of terms and conditions of appointment. (IR IV.B)
Benefits and Conditions of Appointment: Candidates for programs within the DMC (applicants who are invited for an interview) will be informed, in writing or by electronic means, of the terms, conditions, and benefits of their appointment, including financial support; vacations; parental, sick, and other leaves of absence; professional liability, hospitalization, health, disability and other insurance provided for the Residents and their families; and the conditions under which the Sponsoring Institution provides call rooms, meals, laundry services, or their equivalents. (IR II.C)

All notices of appointment to a DMC sponsored graduate medical education program shall be signed by the Program Director and the Vice President of Academic Affairs/Designated Institutional Official.

Prospective Residents are subject, but not limited, to providing appropriate credentialing documentation along with submitting to a health examination and supplementary test(s), which could include tests for tobacco, drug and/or alcohol abuse, and receive the required initial and annual immunizations in compliance with DMC/Tenet policy and all applicable federal, state, and local laws and regulations. The results of all examinations will be provided to the DMC’s Employee Occupational Health Services.

Responsibility
GME Committee

References
GME Policy: Resident Eligibility Requirements
GME Policy: Resident Recruitment

JC Functional Chapter
Leadership
Smoke Free Policy

Effective Date: November 3, 2014
Revised Date: 
Approved by: DMC Management

OBJECTIVE
To provide a healthy and smoke-free environment for patients, families, visitors and staff as well as to eliminate second hand smoke from the premises.

SCOPE
This policy shall apply to all staff, students, Residents, physicians, AHP, volunteers, visitors, patients, contractors, and other guests.

DEFINITIONS
Tobacco products include cigar, cigarette, and pipe smoking. E-cigarette (electronic cigarette) includes all battery powered devices that simulate the act of tobacco smoking by providing inhaled doses of nicotine by way of a vaporized solution.

POLICY
As a healthcare leader, Detroit Medical Center is committed to providing a smoke free environment. It is our intent to protect the health and safety of our patients, visitors, volunteers, students, Residents, physicians, staff, AHP, contractors, and other guests. The Detroit Medical Center recognizes both the health hazards associated with the inhalation of tobacco smoke by smokers and non-smokers, the health risks associated with e-cigarettes, as well as its obligation to adhere to laws pertaining to smoking. Therefore, the Detroit Medical Center prohibits smoking of any kind in all of its facilities, grounds, vehicles and all property, whether owned or leased. This includes the use of e-cigarettes.

All staff members, including physicians, students, contracted employees and volunteers are expected to comply with the provisions of this policy and encouraged to actively enforce the policy with patients and visitors in a manner consistent with established hospitality guidelines. Visitors and contractors are expected to observe and cooperate with this policy and its provisions. DMC is committed to offering helpful smoking cessation and treatment resources.

DMC is a smoke-free environment; therefore, smoking is prohibited in all areas of DMC hospitals including private offices, bathrooms, conference rooms, locker rooms, etc (Tenet Policy 1 HR 520).

Responsibility
Human Resources

JC Functional Chapter
Leadership
Employee Use of Social Media (HR.ERW.20)

Effective Date: January 1, 2015
Revised Date: 
Approved by: DMC management

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare entity in which an Affiliate either manages or controls the day-to-day operations of the entity (each, a “Tenet Entity”) (collectively, “Tenet”)

II. PURPOSE:

The purpose of this policy is to help employees with respect to Tenet’s policies regarding public Social Media outlets such as Facebook, Twitter, LinkedIn, Instagram, Pinterest, Tumblr, YouTube, Yahoo Finance, Foursquare, and internal social collaboration features (such as SharePoint) on Tenet’s Intranets.

III. DEFINITIONS:

A. “Confidential Information” has the same meaning as Proprietary Information.

B. “Proprietary Information” means any trade secret, know-how, invention, software program, application, documentation, schematic, procedure, contract, information, knowledge, data, process, technique, design, drawing, program, formula or test data, work in progress, engineering, manufacturing, marketing, financial, sales, supplier, customer, patient, employee, investor, or business information, whether in oral, written, graphic or electronic form.

C. “Public Information” means information that has been released to the public by Tenet.

D. “Social Media” mean content created by people using highly accessible and scalable publishing technologies, tools and platforms facilitating the discovery, participation and sharing of content.

IV. POLICY:

We recognize the common use of Social Media in our employees’ day-to-day lives to stay virtually connected to our friends, family, and colleagues. After all, an interest in social connections is what inspired us to join healthcare and care for patients. As such, we respect our employees’ use of Social Media to the extent is does not interfere with our work, or does not create potential harm to others, including patients and their families, Tenet colleagues, and other individuals that we interact with at Tenet.

This policy applies to employee actions both during work and non-work time and Social Media relates to any Social Media postings regarding work-related content (for example, co-workers, physicians, patients, and Tenet and its affiliates). This policy exists to protect the privacy and confidentiality of others, including Tenet, and the words and actions of Tenet employees may be attributed to, and interpreted as speaking on behalf of, Tenet.

IV. PROCEDURE:

A. Human Resources Leaders
1. Assist Supervisors and/or Administration with investigations of inappropriate use of Social Media related to Tenet business.

2. Review Intranet reports provided by Information Systems.

3. Assist Supervisors with corrective action pertaining to the inappropriate use of Social Media.

B. Supervisor/Leaders

Report any violations or potential problems to Administration, the Information Privacy Security Office, and Human Resources for appropriate corrective action with employees.

C. Information Systems

1. Monitor Tenet Intranet social postings for possible violations of this policy and provide related reports to Human Resources.

2. Assist with promptly removing inappropriate content in violation of this policy from Tenet Intranet sites.

D. Employee Guidelines and Restrictions

1. In considering the use of Social Media sites (both public and internal to Tenet), Tenet employees must observe the guidelines set forth in this policy, and have the responsibilities set forth herein:

2. On all sites (public or the Tenet Intranet), employees may NOT publish any content related to patients and patient care, even if the patient is not identified, and must maintain strict adherence to all laws and policies related to a patient’s personal health information. This personal health information includes any information collected, created or maintained by Tenet or on behalf of Tenet, to facilitate treatment, payment and/or healthcare operations. This personal health information may include, but is not limited to, patient name, demographic information, photos, diagnostic testing results, images, and case information.

3. Employees wishing to establish an official, public, work-related Social Media site must first gain approval from Tenet Entity administration. Tenet Entity administration must then obtain approval for such proposed social media site from the Home Office Corporate Communications department (“Corporate Communications”). Use of the Tenet or Tenet Entity name, logo or photographs to establish official Social Media sites is not permitted without Communications Center’s prior written approval (see Administrative Policy AD 1.20 Requirements for Social Media Community Managers).

4. Employees must not provide medical or health advice on any public Social Media site or Tenet’s Intranets.

5. If an employee communicates about Tenet on a public Social Media site, the employee must disclose the employee’s connection as an employee. Employees should be professional, exercise good judgment on any postings and strive to be accurate and honest in all communications.

6. Tenet employees must not comment under any circumstance on major business or financial developments at Tenet or rumors about such developments, including developments or speculation about Tenet’s earnings or financial prospects, purchases or sales of hospitals and other assets, management changes or other important business matters. In addition,
employees must not post any other Confidential or non-Public Information about Tenet or any companies with which Tenet does business (for example, vendors), nor may employees post Tenet’s Proprietary Information. Employees are reminded that, under Tenet’s Administrative Policy AD 1.17 Fair Disclosure, only authorized Home Office spokespersons are authorized to speak on behalf of Tenet to the investing public with respect to these matters. Unauthorized disclosure of material non-Public or Confidential Information also constitutes a violation of Tenet’s Standards of Conduct and Tenet’s Information Privacy and Security Program. It should be noted that the prohibition against disclosing material non-Public Information on Social Media sites applies even to “anonymous” postings. Under applicable law, internet service providers may be compelled to disclose the identity of “anonymous” posters under certain circumstances.

7. Tenet strongly discourages “friending” of patients on Social Media sites. Staff in patient care roles generally should not initiate or accept friend requests except in unusual circumstances such as the situation where an in-person friendship pre-dates the treatment relationship.

8. Tenet discourages staff in management/supervisory roles from initiating “friend” requests with employees they manage. Managers/supervisors may accept friend requests if initiated by the employee, only if the manager/supervisor does not believe it will negatively impact the work relationship.

9. Tenet’s policies regarding harassment, non-discrimination, retaliation and Internet use apply; therefore, libelous, defamatory, malicious, false, obscene, indecent, lewd, violent, abusive, threatening, harassing, discriminatory, and/or similar comments or conduct is strictly prohibited.

10. Employees should not use work time to update or monitor Social Media sites unless that activity is specifically part of the employee’s work duties.

D. Enforcement

All employees are expected to be familiar with the basic procedures and responsibilities created by this policy. Both public Social Media sites and Tenet’s Intranet sites will be monitored for possible violations of this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

JC Functional Chapter
Leadership
Supervision of Residents

Effective Date: July 1, 2004
Revised Date: October 24, 2011
Approved by: GMEC

Policy and Procedure

Supervision of Residents

1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care.
   a) This information should be available to Residents, faculty members, and patients.
   b) Residents and faculty members should inform patients of their respective roles in each patient’s care.

2. Each DMC sponsored program must demonstrate that the appropriate level of supervision is in place for all Residents who care for patients.

3. Residents participating in patient care must be supervised by faculty physicians, or by other physicians who have been designated by the Program Director as being qualified to provide appropriate supervision, at all times. Supervising physicians shall have clinical privileges for the procedures for which they supervise Residents. The Program Director has primary responsibility for ensuring, directing, and documenting adequate supervision of Residents. Schedules for faculty physicians must be structured to ensure that supervision is readily available to Residents on duty, including weekend and night call schedules.

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

Levels of Supervision

To ensure oversight of Resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

a) Direct Supervision: the supervising physician is physically present with the Resident and patient.

b) Indirect Supervision with direct supervision immediately available: the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

c) Indirect Supervision with direct supervision available: the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
d) Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

**Progressive responsibility**
The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each Resident must be assigned by the program director and faculty members.

a) The program director must evaluate each Resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.  
b) Faculty members functioning as supervising physicians should delegate portions of care to Residents, based on the needs of the patient and the skills of the Residents.  
c) Senior Residents should serve in a supervisory role of junior Residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual Resident.

**Communication**

1. The resident or fellow job description and list of supervision guidelines by resident or fellow post graduate level shall be provided to appropriate medical, nursing, and clinical staff in the settings where the resident or fellow physicians are involved in the provision of patient care. Any restrictions or limitations on a Resident’s participation in patient care shall be communicated in writing to the Resident, to the supervising teaching staff, to nursing administration, and to other appropriate parties prior to the assignment of the Resident to a clinical rotation or as otherwise deemed appropriate by the Program Director.
2. Programs must set guidelines for circumstances and events in which Residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.
   (1) Each Resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
      i. In particular, PGY-1 Residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 Residents progress to be supervised indirectly, with direct supervision available.]
   (2) Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.
3. The hospital shall provide Residents with appropriate systems for communication with supervisors, e.g., paging systems.

**Clinical Responsibilities**
The clinical responsibilities for each Resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. [Optimal clinical workload will be further specified by each Review Committee.]

**Supervision on Outside Rotations**
Supervision of Residents on clinical rotations outside of Detroit Medical Center must be documented.

**Review and Evaluation of Resident Supervision**
Program Directors shall provide an annual report to the Graduate Medical Education Committee on Resident supervision procedures and issues for their program.

The DIO all include a report on Resident supervision issues in the annual medical education report to the Medical Staff Executive Committee and Board of Trustees.

**Responsibility**
GME Committee

**JC Functional Chapter**
Leadership
Managing TB Converters and Reactors (2 OHS 018)

Effective Date: July 1, 2014
Revised Date:  
Approved by: Occupational Health Services

OBJECTIVE
To establish the process for managing TB converters and reactors.

SCOPE
DMC Occupational Health Services (OHS) staff.

DEFINITIONS

TST – Tuberculosis Skin Test.

Certified TB Tester/Reader – Individual trained by OHS to place and read tuberculin skin test studies.

TB Reactor – Someone with a positive TB skin test (TST) and/or positive blood assay for MTB (BAMT; e.g. Quantiferon Gold or T-Spot.TB).

Latent TB Infection (LTBI) – Infection with tuberculosis that is inactive, asymptomatic, and poses no risk to others. This condition is determined clinically by the attending physician based upon risk factors in individuals who are TB Reactors, but are not ill with tuberculosis and have no signs of active tuberculosis.

TB Converter – A TB reactor who previously tested negative for TB on DMC OHS baseline, and subsequently tested positive while working at the DMC. TB conversion is OHSA recordable, only when it follows a known occupational exposure (e.g. conversion is detected on a post-exposure follow-up test).

Two Step TB Skin Test – two serial TSTs to establish a baseline in an individual with no prior TST in the preceding 12 months. This is done to avoid a false negative at the time of the baseline due to the “booster phenomenon”. If the individual has had two documented negative TSTs in the past, two step testing is not necessary even if the most recent one was more than 12 months ago.

If the second PPD in the two-step method is a positive test and a boosted response is suspected, the patient should be considered a tuberculin reactor but not a recent converter, unless there is a clinical history of recent exposure.

Positive TB skin test – A positive TST is determined based upon the extent of skin induration (not erythema) as follows:

1. Baseline testing of newly hired employees, volunteers and staff: 10 mm of induration is considered to be a positive TST except in the following circumstances in which 5 mm of induration will be considered positive:
• Immunosuppressed individuals (HIV positive, organ transplant, taking steroids equivalent to 15 mg/day of prednisone for one month or more).
• Known recent unprotected contact with someone with TB.
• Individuals with fibrotic changes on chest X-ray consistent with prior TB.

2. Serial Screening: An increase in induration of 10 mm or more from baseline within a 2 year period is considered positive on serial screening, or on the first (baseline) test in an exposure investigation. For individuals who are immunocompromised, an absolute size of induration greater than or equal to 5 mm is considered positive, regardless of baseline.

3. Post-Exposure Testing: Following a known exposure, a baseline test is done right away, with a follow up test done 8 to 10 weeks following the end of the exposure period. The initial (baseline) test is interpreted in the same manner as a serial screening test. A positive baseline would not be the result of the exposure under investigation, however. The 8-10 week follow up test would assess the outcome related to the exposure. If the individual’s baseline showed zero induration, then a measurement of 5 mm or more of induration in the follow up test is considered positive. If the baseline showed induration greater than zero mm and less than 10 mm, then an increase of 10 mm or more is considered positive.

POLICY

New TB Converters and reactors will be evaluated by the OHS physician for a determination of LTBI, and if considered to have LTBI, will be strongly encouraged to undergo prophylaxis consistent with current CDC guidelines.

PROVISIONS

1. All positive TST results will be verified by a certified reader.
2. All newly identified reactors (whether or not determined to have LTBI by the physician) will receive a CXR (PA and Lateral views), unless a CXR acceptable to the OHS physician has already been done subsequent to a determination of being a reactor, and will be screened annually with a symptom questionnaire. Reactors will no longer be tested with a TST.
3. Individuals suspected of having active tuberculosis on the basis of CXR findings or symptoms will be referred to an infectious disease expert.
4. TB reactors will be evaluated by a physician to determine whether or not the reactor has LTBI, and hence the need for prophylactic treatment. Some individuals with induration between 10 and 14 mm may not be diagnosed with LTBI if the individual is generally healthy and without risk factors for TB (e.g. has never worked in a “medium risk” facility and had no other risk factors). While such individuals will no longer be tested with a TST, they may be considered clinically negative if so determined by the physician, and thus would not necessarily be recommended for prophylactic treatment. The attending physician may perform other tests such as a BAMT to further evaluate for LTBI.
   a. Individuals diagnosed with LTBI by the physician should be strongly encouraged to begin prophylactic treatment with INH (isoniazid).
   b. Individuals who decline prophylactic treatment should be advised that they can be treated in the future if they desire, and should be reminded annually of the recommendation to begin treatment.
   c. Before beginning treatment for LTBI, active TB must be ruled out.
d. Reactors with the following histories must undergo baseline liver enzyme testing: prior liver disease, hepatitis, excessive alcohol intake, peripheral neuropathy, HIV infection and pregnancy or post-partum within the prior 3 months. Those with hepatic disease or abnormal baseline tests will have liver enzymes monitored monthly.

e. All patients treated for LTBI will be clinically monitored at least monthly for signs of hepatitis (nausea, vomiting, abdominal pain, jaundice, scleral icterus, brown urine, hepatomegaly).

5. The Assessment of TB Skin Test Converter form will be completed for all reactors.

6. New PPD conversion incidents (excluding new hires and new volunteers) will be logged, and reported to Epidemiology.

7. Liver enzymes, effects and symptoms will be monitored as clinically indicated for individuals diagnosed with LTBI and placed on INH for prophylactic treatment.

8. TB test results are confidential like any other clinical data.

9. TB converters following a known occupational exposure incident will be recorded on the MIOSHA log.

REFERENCES

Centers for Disease Control and Prevention. Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005. MMWR 2005;54(No. RR-17)

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4906a1.htm

ATTACHMENT
Assessment of TB Skin Test Converter Form

ADMINISTRATIVE RESPONSIBILITY

The Director, DMC Occupational Health Services will execute administrative responsibility.

The Corporate Medical Director, DMC OHS or designee will execute medical oversight.

APPROVAL

This policy has been approved and is duly authorized by DMC management. The posting of the policy on the DMC intranet signifies that it is in full force and effect.

SUPERSEDES
March 31, 2005

Responsibility
GME Committee

JC Functional Chapter
Leadership
Transitions of Care

Effective Date: 7/1/2011
Revised Date: 10/24/2011
Approved by: GMEC

Policy

Residency and Fellowship programs sponsored by Detroit Medical Center shall design clinical assignments to minimize the number of transitions in patient care.

Procedure

1. Each sponsored program must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Pertinent elements evaluated should include exam findings, laboratory data, any clinical changes, family contacts, and any change in responsible attending physician.
2. Programs must ensure that Residents are competent in communicating with team members in the hand-over process.
3. Each program must ensure the availability of schedules that inform all members of the healthcare team of attending physicians and Residents currently responsible for each patient’s care.
4. Scheduling of on-call shifts should be optimized to ensure a minimum number of transitions. The specifics of these schedules will depend upon various factors, including the size of the program, the acuity of care and number of patients, and the level of resident education.
5. The GMEC will monitor schedules, procedures, and any reports of issues or problems with transitions of care.

Responsibility

GME Committee

JC Functional Chapter

Leadership
Use of the Detroit Medical Center’s Computer System (1 HR 516 and 1 CG 022)

Effective Date: November 3, 2014
Revised Date: 
Approved by: DMC Management

PURPOSE

To clarify the requirements for appropriate, business-like usage of the DMC's computer system, the internet and intranet, data records, E-mail and related information, material and equipment, all in accordance with the DMC Code of Conduct.

POLICY

This policy has been approved and is duly authorized by Detroit Medical Center, Children’s Hospital of Michigan, Detroit Receiving Hospital, DMC Surgery Hospital, Harper/Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital. The posting of the policy on the DMC intranet signifies that it is in full force and effect. Violations of this policy, depending on the severity of the violation, may result in warnings; loss of privileges; disciplinary action; suspension or termination of employment, student status, contractor status, or other relationship to the Detroit Medical Center; as well as the possibility of criminal prosecution.

1) All users of the DMC computer system must behave in an ethical, legal, and morally responsible fashion while using the system. Individuals are responsible for their behavior and actions when accessing the system and the internet.

2) Use of the system, and in particular patient information, internet service, and E-mail, is provided for the support and improvement of the Detroit Medical Center’s business objectives. Access is a privilege, given or withheld by the DMC, as it determines.

3) All use of DMC computers, the internet, and E-mail, is subject to observation and monitoring by the Detroit Medical Center to verify that the use of services is in accordance with DMC policy. There shall be no privacy from the DMC in any individual’s use of any DMC system, computer, E-mail message, or related device.

4) The DMC reserves the right to collect, monitor, examine, copy, store, transmit, print, and use any and all information entering, leaving, residing in, or processed by any and all information systems and components used in the corporate setting, for any and all purposes that the DMC so selects or determines, at its sole discretion.

GENERAL

1. Users must never publicly disclose confidential internal information, whether via the electronic mail or other network service, including any information that may adversely affect The Detroit
Medical Center or Contracted Vendor Service Provider’s business position, customer/vendor relations or public image.

2. Users must assure that all files (data, software, etc.) downloaded from the internet be properly licensed.

3. Users must refrain from wasting company time, in violation of Policy 1 HR 506, minor infraction j, by accessing web and FTP sites that are not business related.

4. Users must not use the Detroit Medical Center computer system for illegal purposes. If not sure of the legality of the action, the user should contact the DMC Legal Affairs Department or the Information Services Department.

5. Users must not use another person’s name, password, security keys, files, or data, or otherwise misrepresent their identity to other users or companies.

6. Users must not use programs or devices to circumvent, subvert or disable any protection measures on the network.

7. Users must not Intentionally engage in any activity that might be harmful to the computer or network systems or any of the information stored thereon.

8. Users must not use the system for commercial or political purposes unless explicitly authorized by the appropriate DMC management.

9. Users must not use Company accounts or equipment to download software not pertinent to the DMC business at hand. Users must not access said software.

10. Users must not upload or download graphics, images or other material that is not related to the business at hand or not otherwise in accordance with company policies.

11. Users must not sell or distribute software or any other material, product, or service through the DMC computer system.

12. Users must not post or upload sensitive or confidential information for access by persons not authorized to access said information by the Detroit Medical Center.

13. Users must not store, post, display, transmit, intentionally receive or exchange pirated software, stolen passwords, stolen credit card numbers, indecent or obscene material or any other information that is inconsistent with The Detroit Medical Center business.

14. Users must not distribute or transmit negative comments or similar attacks against any person or entity.

15. Consistent with the DMC Code of Conduct, users are responsible for reporting any known or suspected violation of this policy to the local management, Information Services Department, or the Compliance Hotline at (888) 8ETHICS.
16. Users should not use a Detroit Medical Center account to electronically transmit (mail) software, messages, files and/or data not pertinent to the Detroit Medical Center's business objectives.

17. Users must not E-mail sensitive information to any public mail service where it can be intercepted by unauthorized personnel.

18. Users must not transmit any message, file, or other material where the content violates the Code of Conduct, DMC Policy, or any federal state, or local law.

19. Users should refrain from the use of external mail services (e.g. AOL, MSN, CompuServe, Juno, etc.) for company correspondence unless specific authorization is granted by Corporate Risk Department and the Information Services Department.

20. Users who provide official support of products or services may indicate their affiliation with The Detroit Medical Center as long as those offerings comply with DMC practices and policies.

21. Users must have approved virus checking software resident and actively executing on their system.

22. Users must protect sensitive corporate information by using authorized encryption and authentication measures where appropriate.

23. Users must treat any information taken off the internet as suspect until confirmed by a separate and reliable information source. This also includes E-mail and news groups.

24. Users may participate in news groups or bulletin board services to exchange technical information and tips regarding products the company uses or other issues affecting the DMC. As a participant in these services you may offer non-proprietary and/or non-confidential suggestions, ideas or information.

25. Users must not send any messages that contain chain letters, inappropriate humor or graphics, or any material which is defamatory, sexually oriented, obscene, threatening, or harassing.

26. Users must not send by Email, copy, or distribute, files that contain copyrighted materials for which required permission to use or distribute was not obtained.

27. User must not treat E-mail transmitted via the internet as a secure method of communication for sensitive information unless utilizing authorized secured transmission protocols.

28. Users must sign a Confidentiality Statement. All patient information, in whatever form you might find it, is confidential and may not be shared or released to anyone. This includes, among other things, grouping data without names, or any unauthorized access to even look at a patient record. Remember, all patient information is hands-off, unless the use of such information is a part of your job.

**USERS MUST BE AWARE OF THE FOLLOWING:**
1. **Erasing a message** from personal files does not necessarily erase all copies of the message as the message may have been forwarded, printed, or archived and thus can remain available for a substantial period of time.

2. E-mail can be connected by gateways to other e-mail systems.

3. E-mail may include attachments in electronic form and may be saved as files in a directory that is not encrypted.

4. Computer viruses can be spread via e-mail systems.

5. E-mail messages can be “blind copied” to other E-mail users. That is, E-mail can be forwarded without all recipients' names showing on the message.

6. Treat all E-mail material as data that can be used in litigation. Do not put any information in E-mail that you would not put on DMC letterhead and sign.

7. Users must secure their workstation when the workstation is left in an unattended mode. Do this by exiting the E-mail account or password protecting the workstation.

8. Users are encouraged to delete all E-mail messages within a reasonable period of time, which also includes messages in the ‘sent’ and ‘deleted’ mail folders.

**RESPONSIBILITY**

**Department Management**

It shall be the responsibility of Department Managers and Supervisors to observe workstations within their purview and intervene when evidence of violation of this policy is observed. Managers are not to attempt to read others’ E-mail, but shall notify Information Services Security department of suspected abuse.

**Information Services Department**

It shall be the responsibility of the Information Services Department to:

1. Implement safeguards where appropriate that ensure the proper use of DMC computers, the internet and E-mail systems, and the protection of DMC information contained therein.

2. Monitor computer traffic and take appropriate actions to secure The Detroit Medical Center’s internal Network from unwanted internet traffic.

3. Investigate allegations of violations and report findings to appropriate DMC management personnel for remedial action.
4. Provide access reports upon request from the appropriate management personnel.

5. Establish guidelines for levels of access to the system.

6. Implement system access for authorized personnel and restrict system access in accordance with established guidelines.

7. Audit compliance with the provisions and intent of this policy.

8. Develop any administrative procedures and forms as necessary in order to execute the provisions of this policy.

Human Resources Department, Corporate Compliance Department, Information Services Department

It will be the responsibility of the Human Resources Department, in conjunction with the Corporate Compliance Department and the Information Services Department, to communicate to department heads, supervisors, and employees and non-employee system users both the existence of this policy and the procedures for implementation.

ADMINISTRATIVE RESPONSIBILITY
Requests for exceptions to this policy are to be submitted to the senior executive of the appropriate operating unit for decision. This person may confer with the senior executive of Human Resources, Corporate Compliance, or Information Services, or their designee as necessary.

APPROVAL
This policy has been approved and is duly authorized by Detroit Medical Center, Children’s Hospital of Michigan, Detroit Receiving Hospital, DMC Surgery Hospital, Harper/Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital. The posting of the policy on the DMC intranet signifies that it is in full force and effect.

Responsibility
DMC management

JC Functional Chapter
Leadership
USMLE/COMLEX Part III or equivalent Policy

Effective Date: July 1, 2012
Revised Date: November 7, 2012
Reviewed Date: January 24, 2011; November 1, 2012

Approved by: GMEC

Residents must pass USMLE/COMLEX Part III or PMLEXUS to be promoted to PGY 3. Residents are required to turn in written confirmation of the results of the appropriate exam to their Program Director. Exceptions to this policy can only be granted by the GMEC.

DMC’s GMEC realizes that the above requirements exceed some specialty board requirements. USMLE/COMLEX Part III or PMLEXUS is required for permanent licensure in most states and GMEC believes this policy is in the Resident’s best long-term interest. If the Resident has difficulty passing USMLE/COMLEX Part III or PMLEXUS, remediation plans should be discussed with the Program Director.

Responsibility
GME Committee

JC Functional Chapter
Leadership
Vacation

Effective Date: 7/1/2011
Revised Date:
Reviewed Date: 8/23/2010

Approved by: GMEC

All Residents are eligible for three weeks of vacation per year, as long as they are compliant with the Program’s Specialty Board’s requirements. It is within the discretion of the Program to determine how many days may be designated as personal time or educational conference time. All vacation time must be approved in advance by the Program Director. Vacation time does not accumulate and cannot be forfeited in order to accelerate a contract end date.

Responsibility
GME Committee

JC Functional Chapter
Leadership
Vendor Relations-Graduate Medical Education

Effective Date: August 25, 2014
Revised Date:
Approved by: GMEC

SCOPE: All Detroit Medical Center Graduate Medical Education Programs, Detroit Medical Center residents and fellows

PURPOSE:

1. To avoid conflicts of interest or the appearance of conflict of interest in all interactions between DMC graduate medical education programs, residents/fellows and Vendors.

2. To articulate the DMC's expectations of Vendors in their interactions with residents/fellows and graduate medical education programs.

3. To establish parameters for seeking and accepting funds from Vendors for conferences, educational programs, and other events.

4. To make clear that, other than as permitted herein, the DMC does not wish to place extra-contractual demands on Vendors.

POLICY:

1. The Detroit Medical Center Graduate Medical Education Committee adopts by reference all of the provisions of the DMC Corporate Policy Number "Ethics of Business Conduct Policy".

2. The DMC expects Vendors to respect the DMC's Ethics of Business Conduct and policies and procedures. It also encourages Vendors to commit in contracts with the DMC and any of its affiliates to adhere to the provisions of the DMC's Ethics of Business Conduct and policies and procedures which address Vendor interaction with DMC facilities and colleagues, including DMC resident physicians and fellows.

3. DMC Graduate Medical Education programs may accept Vendor funding for certain events (e.g. educational events, charitable events, and conferences) only as outlined in this policy, provided that the Vendor's funding and/or participation is not inappropriately offered by the Vendor or solicited by the Graduate Medical Education program and its associated faculty, residents, fellows, and administrators.

4. The DMC goal is to have discounts, rebates, administrative fees (GPO Fees), and any other payments received from Vendors to be structured to comply with the Discount Safe Harbor Regulations and the GPO Safe Harbor Regulations, to the extent practical.
5. Any exceptions to this policy must be approved in writing by the DMC Designated Institutional Official (DIO), the Senior Vice President and Chief Medical Officer, the DMC Chief Executive Officer, and the Chief Ethics and Compliance Officer.

PROCEDURE:

1. The DMC Graduate Medical Education Committee expects Vendors to be familiar with the DMC’s Ethics of Business Conduct and policies and procedures which relate to our resident physicians and fellows and graduate medical education program interaction with Vendors and other business associates.

2. The DMC encourages its Vendors to have an ethics and compliance program, a code of conduct, or other policies and programs demonstrating their commitment to ethical business practices.

3. All DMC Graduate Medical Education Programs shall provide formal education to residents and fellows on interaction with Vendors, including education on ethical conduct, professionalism, and avoiding conflicts of interest.

4. **Gifts:** Residents/Fellows may not accept gifts or compensation from Vendors.

5. **Pharmaceutical Samples:** Residents/Fellows may not accept pharmaceutical samples from Vendors.

4. **Vendor Support of Education Conferences:** vendor support of educational conferences involving DMC graduate medical education programs, residents and fellows may be used provided that the funds are provided to the DMC or to another sponsoring institution and not directly to the resident or fellow. The DMC program director is responsible for ensuring that any educational conference supported by vendor funds has significant educational value to the residents/fellows. DMC must never be subject to any implicit or explicit expectation of providing something in return for the support. Financial support by industry must be fully disclosed by the meeting sponsor. The meeting or lecture content must be determined by the speaker and not by the Vendor.

5. **Vendor Support of GME Events:** Vendor support of GME program events, such as Resident Council Meeting events, Program Graduation events, and resident orientation events may be used provided that the funds are provided to the DMC or to any affiliated organization (e.g. Wayne State University) an directly to the resident or fellow. DMC must never be subject to any implicit or explicit expectation of providing something in return for the support.

Responsibility
GME Committee

JC Functional Chapter
Leadership
Worker’s Compensation

Effective Date: July 1, 2004
Revised Date: 
Approved by: GMEC

Loss Time Management is responsible for leaves of absence, which include:
- Medical
- Educational
- Personal
- Military
- FMLA
- Worker’s Compensation

Contact Loss Time Management at 313.745.2812

Responsibility
GME Committee

JC Functional Chapter
Leadership
Section III – Graduate Medical Education Resident Benefits

Athletic Facilities

The Rehabilitation Institute of Michigan's Brasza Outpatient Center is pleased to offer a state-of-the-art health and wellness facility to the valued employees and patients of DMC. Access to this facility is available to Residents for an annual fee of $120.

Please take some time to look over the website and learn about the many programs and services available at the Brasza Outpatient Center. [http://intraweb/default.aspx?fsrc=/main_dmcinfo/rim_fitness](http://intraweb/default.aspx?fsrc=/main_dmcinfo/rim_fitness)

Beeper

A DMC beeper will be issued to Residents, in most cases, when Residents begin in the training program. Should the beeper malfunction or break, it should be returned to the GME office for replacement. There will be a replacement fee of $100.00 should the beeper be lost or stolen.

Changes in Personal Information

Any change in a Resident’s name, address or phone number must be immediately reported to the GME Office as well as the Resident’s or Fellow’s program office, in order to ensure no delay in receipt of important payroll information and/or documentation.

If the Resident holds a Permanent Michigan License, the Resident must also notify the State Licensing Board of the change go to [www.michigan.gov/mylicense](http://www.michigan.gov/mylicense) or in writing to:

State of Michigan
Board of Medicine
P.O. Box 30912
Lansing, Michigan 48909

Foreign Nationals – Specific Notice:

Federal regulations require all foreign nationals to notify INS (in addition to ECFMG) of any change in the Resident’s residential address. Go to [www.ins.usdoj.gov](http://www.ins.usdoj.gov) to obtain FORM AR-11 to submit an address change to INS.

Changes in Tax Withholding and/or Payroll Deductions

Based on the forms completed upon the Resident’s employment with Detroit E&R, federal, state, and Social Security deductions are taken from the Resident’s paycheck. Theses deductions appear on the Resident’s bi-weekly paycheck stub. To change tax withholding, the Resident will need to submit a new Federal W-4 form or MI-4 form to the GME office.
Employee Assistance Program (EAP)

DMC offers an Employee Assistance Program (EAP) through ComPsych to all Residents. The EAP is designed to help with personal problems or work situations, including problems such as anxiety or depression, alcohol or substance abuse, marital or family problems, legal or financial matters. The EAP telephone number is 844.416.1158.

Discounts

The Employee Activities Committee (EAC) is an organization providing employees of DMC with a variety of services and activities. The EAC is dedicated to enhancing the quality of work life as well as the personal life of DMC employees. This enhancement is accomplished by sponsoring recreational, educational and discount opportunities conducted both on and off site. The EAC welcomes all DMC employees, physicians, volunteers, and family members who are interested in having fun, saving money and supporting local charities. The Discount Directory lists every discount available to Residents as a DMC employee or physician and is found on the DMC Intraweb under “For Our Employees” “Employee Activities Committee (EAC)” in the bottom right hand corner of the site.

Health, Dental, and Vision Insurance

As per the GME Agreement of Appointment and in compliance with Applicable Accrediting Body requirements, all Residents and dependents will have access to medical, dental, and vision insurance as well as life insurance and accidental death & dismemberment coverage for the employee. These benefits are updated annually and specific information will be distributed at that time.

PLEASE NOTE that Residents are responsible for reporting any change in their family's status (e.g. marriage, divorce etc.) by calling My Tenet Benefits at 877.468.3638 within 30 days of the occurrence. A Resident has 30 days to report the birth of a child but it is recommended that the Resident add the child to his/her insurance as soon as possible. If changes are not reported within the required period of time, it will not be possible to obtain coverage for that individual until the next annual Open Enrollment.

Life Insurance and Accidental Death & Dismemberment Coverage

Residents receiving a stipend through DMC have a term life insurance policy and accidental death and dismemberment coverage available effective on the date of the Resident’s appointment. Life insurance benefit is one time the annual stipend up to $50,000. After initial enrollment, any change in beneficiary must be reported to the GME office in person.

Meals for In-House Night Call

Meals and/or access to food/beverage service is provided to all Residents during In-House Night Call. For further information, contact the program coordinator.
Payroll Procedures
A Resident receiving a stipend through DER is paid bi-weekly. The Resident has two options, direct deposited to a bank account or deposited to a Visa debit Card. Direct Deposit forms are available at the Payroll Web Site accessible thru the intraweb, or at the GME office. Paystub info is available online thru Lawson Employee Self-Service link.

Security and Safety
Residents must comply with security and safety policies and procedures at DMC Hospitals (DMC Policy 1 EC 020 and 1 EC 023). DMC hospitals require that identification badges be worn at all times. DMC hospitals will not assume responsibilities for theft or damage for personal property. All DMC Residents and personnel are required to complete safety training through DMC Corporate Quality and GME Orientation.

Student Loans
Student loans are the responsibility of the Resident. For more information, the Resident should contact the lender and access his or her loan information and requirements for student loan reduction of payment or other information as needed. Verification of training may be sought from the GME office at (313) 745-5147.