Northwestern Medicine

Clinical Shadowing/Observation

Resumption Guidelines September 2021

Clinical Observer/Shadowing Programs Overview

Category	Description
Emergent/Urgent	• Observations are limited to those which are directly beneficial to the patient being observed. • Examples include athletic trainers or primary care physicians with a direct relationship with the patient and whose presence is desired by the patient. • Law enforcement officials accompanying the patient would also be in this group.
Educational*	• A individual who will be watching patient care functions for medical or professional education, training, or other approved purposes • Requires proper approvals, supervision and sponsorship. • Must not compromise or interfere with patient care or with the formal training provided to others by the hospital. • Pre-Med Student Internship program is included in this category
Recruitment (Shadow Interview)	• Potential NM candidates for clinical roles (ex. Inpatient RN) • Will occur if the manager interviews a candidate and determines that they would like the candidate to shadow for a couple hours to allow additional staff to meet and interact with the candidate. Also ensures candidate is clear on role expectations. • The manager sets up the time and date for this experience in coordination with recruiter/Talent Acquisition Team
Career Planning / Guidance	• High School (only allowed at RMG/Community sites) and College students who are interested in a career in healthcare (ex. medicine, nursing) may shadow for a couple hours with an experienced clinician. • Candidates of NM Academy Schools would also be eligible for this type of observation • Individuals must be 16+ years of age (for Operating Room observations, must be 18+)

Northwestern Medicine *Out of Scope – Students visiting as part of a EAA/GME agreement.

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Clinical Observer Programs Details

Program Details	Emergent/Urgent	Educational*	Recruitment	Career Planning / Guidance
Eligibility	• Personal relationship with patient • PCP • Athletic Trainer • Law Enforcement	• U.S. Med Students, allied health professionals, residents, or fellows • Attending physicians with privileges • Researcher Faculty • US College Students & International Medical Graduates*	• Candidate under serious consideration for employment at NM	• High School Students (Non-Central sites) • College Students • Potential candidate for a NM Academy School • Participants must be 16+ years of age (for Operating Room observations, must be 18+)
Requirements	• Clinical observer application • Clinical observer approval form • Confidentiality and Non-Disclosure Agreement • Health Clearance	• Clinical observer application • Clinical observer approval form • Confidentiality and Non-Disclosure Agreement • Health Clearance	• Confidentiality and Non-Disclosure Agreement • Health Clearance	• Clinical observer application • Clinical observer approval form • Confidentiality and Non-Disclosure Agreement • Health Clearance

Approval Process	• **ONE** approval required from:
	  • Chair/Chief
	  • Director of department
	  • Academic Affairs
		• Requires approval from **ALL** of below:
		  • Chair/Chief or CMO/CNE
		  • Director of department
		  • Academic Affairs
		  • IP & Occupational Health
			• Hiring manager	• Hospital based – Hospital CMO/CNE (May designate a delegate approver)
				• Physician Office based – RMG/NMG CMO

Duration	• Single day/event	• Five days or less • Chair can approve extension for up to 2 weeks • Formal programs may be longer (ex. interns)	• 2-4 hours (ideally) or • Single Day	• Single day OR • Multiple days

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*Out of Scope – Students visiting as part of a EAA/GME agreement.

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Clinical Observer Programs Details

Program Details	Emergent/Urgent	Educational*	Recruitment	Career Planning / Guidance

Health Screening / Clearance Requirements	• One day - Completed COVID vaccine series plus symptom screening questionnaire (next slide)
	• Must be fully vaccinated (2 weeks post final dose)
		• Multiple Days - All occupational health requirements including completed COVID vaccine series and symptom screening questionnaire (next slide)
		• Must be fully vaccinated (2 weeks post final dose)
			• One day - Completed COVID vaccine series plus symptom screening questionnaire (next slide)
			• Must be fully vaccinated (2 weeks post final dose)
				• Single day
				  • Completed COVID vaccine series plus symptom screening questionnaire (next slide)
				• Multiple days
				  • All occupational health requirements including completed COVID vaccine series and symptom screening questionnaire (next slide)
				• Must be fully vaccinated (2 weeks post final dose)

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*Out of Scope – Students visiting as part of a EAA/GME agreement.

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Single Day Shadowing/Observation Process

Single day observations **DO NOT** require occupational health approval as long as process/documentation is submitted per outline below

1 Observer Application Completed, Approvals Obtained, Stored locally

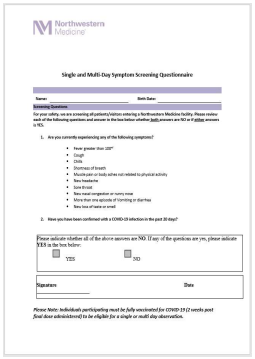
- Application Includes:
  - ✓ Observer information and reason for observation
  - ✓ Site approvals required
  - ✓ Confidentiality and NDA
- Host confirms packet is complete, approvals were obtained, documents stored locally

2 Host Validates Proof of COVID-19 Fully Vaccinated Record Prior to Day of Observation

Acceptable Proof of COVID-19 Vaccination:

- Documentation record from below source:
  - CDC COVID Vaccination Card
  - Pharmacy record (Walgreens, CVS etc.)
  - EPIC immunization record or equivalent hospital EMR
  - Workplace Immunization Record
- Needs to indicate lot number and expiration on record & administration date
- Date of observation must be at least 2 weeks post final vaccination administration date (i.e. fully vaccinated)

3 Host ensures all approvals obtained and captures observers attestation of symptom free upon day of arrival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Single and Multi-Day Symptom Screening Questionnaire

Name: _____ Birth Date: _____

Screening Questions

For your safety, we are screening all patients/visitors entering a Northwestern Medicine facility. Please review each of the following questions and answer in the box below whether both answers are NO or if either answers is YES.

1. Are you currently experiencing any of the following symptoms?
   - Fever greater than 100°
   - Cough
   - Chills
   - Shortness of breath
   - Muscle pain or body aches not related to physical activity
   - New headache
   - Sore throat
   - New nasal congestion or runny nose
   - More than one episode of vomiting or diarrhea
   - New loss of taste or smell
2. Have you been confirmed with a COVID-19 infection in the past 20 days?

Please indicate whether all of the above answers are NO. If any of the questions are yes, please indicate YES in the box below:

☐ YES ☐ NO

Signature: _____ Date: _____

Please Note: Individuals participating must be fully vaccinated for COVID-19 (2 weeks post final dose administered) to be eligible for a single or multi day observation.

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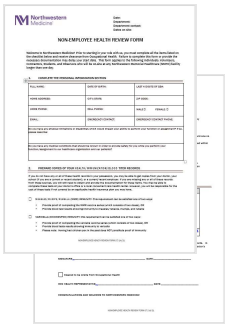
Multiple Day Shadowing/Observation Process

Multi-day observations **DO** require occupational health approval

1 Observer Application Completed, Approvals Obtained, Submitted Online

- Application Includes:
  - ✓ Observer information and reason for observation
  - ✓ Host information including area observed and any PPE requirements
  - ✓ Site approvals
  - ✓ Confidentiality and NDA
- Host confirms packet is complete, approvals were obtained, documents stored locally

2 Multi-Day Required Health Records Submitted to Occupational Health for Review and Approval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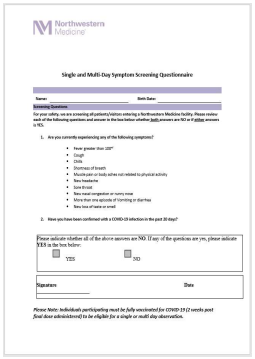
NON-EMPLOYEE HEALTH REVIEW FORM

3 Occupational Health sends clearance report to Host once requirements have been met

4 Host ensures all approvals obtained and captures observers attestation of symptom free upon day of arrival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Single and Multi-Day Symptom Screening Questionnaire

Name: _____ Birth Date: _____

Screening Questions

For your safety, we are screening all patients/visitors entering a Northwestern Medicine facility. Please review each of the following questions and answer in the box below whether both answers are NO or if either answers is YES.

1. Are you currently experiencing any of the following symptoms?
   - Fever greater than 100°
   - Cough
   - Chills
   - Shortness of breath
   - Muscle pain or body aches not related to physical activity
   - New headache
   - Sore throat
   - New nasal congestion or runny nose
   - More than one episode of vomiting or diarrhea
   - New loss of taste or smell
2. Have you been confirmed with a COVID-19 infection in the past 20 days?

Please indicate whether all of the above answers are NO. If any of the questions are yes, please indicate YES in the box below:

☐ YES ☐ NO

Signature: _____ Date: _____

Please Note: Individuals participating must be fully vaccinated for COVID-19 (2 weeks post final dose administered) to be eligible for a single or multi day observation.

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Application for Clinical Observation at NM Checklist

1. ***Letter of Recommendation (a. <u>OR</u> b. is acceptable)***
    a. Letter from the applicant's official training institution confirming the following:
        i. Applicant's good standing
        ii. Purpose of the clinical rotation
        iii. Proposed observation dates
    b. Letter or attestation by Host (requesting faculty member) of the applicant's credentials

2. **COVID-19 Vaccination – Confirmation observer is fully vaccinated**
    a. Acceptable Proof of COVID-19 Vaccination:
        i. Documentation record from one of the following sources:
            1. CDC COVID Vaccination Card
            2. Pharmacy record (Walgreens, CVS etc.)
            3. EPIC immunization record or equivalent hospital EMR
            4. Workplace Immunization Record
        ii. Needs to indicate lot number and expiration on record as well as administration date
        iii. Date of observation must be at least 2 weeks post final vaccination administration date (i.e. fully vaccinated)

3. ***Health Screening Requirements*** (see pages 2-4, requirements vary based on single vs. multi-day observation)

4. ***Copy of Valid Official State or National Picture ID***
    a. Acceptable forms:
        i. State-issued ID
        ii. Drivers' License
        iii. Passport
        iv. Proof of valid visa status for non-United States citizens

5. ***Completed Clinical Observation Approval Observation Application*** *(pages 5-6)*
    a. For observations which are categorized as Educational, the following signatures <u>must be obtained before turning in application*</u>:
        i. Department Chair or Division Chief
        ii. Medical Director of area to be observed
        iii. NM Host (physician or director)

        *NOTE: NMHC Director of Academic Affairs/CMO/CNE signature will be completed *after* application has been turned in and reviewed.
    b. For observations which are categorized as Career Planning/Guidance, only the following approvals are required:
        i. Hospital based – Hospital CMO/CNE
        ii. Physician Office based – RMG/NMG CMO
    c. For observations which are categorized as Recruitment activities, the only required approval is from the Hiring manager.

6. ***Clinical Observer Confidentiality and Non-Disclosure Agreement Signed*** *(pages 7-8)*
    a. *Host to provide PDF copy of policy* (**https://nm.ellucid.com/documents/view/4019**)

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Date: _____
Host Department: _____
Host contact: _____
Requested dates on site: _____

Multi-Day Only: NON-EMPLOYEE HEALTH REVIEW FORM

Welcome to Northwestern Medicine! Prior to starting in your observation with us, you must complete all the items listed on the checklist below and receive clearance from Occupational Health. Failure to complete this form or provide the necessary documentation may delay your observation start date. This form applies to Observers who will be on-site at any Northwestern Memorial HealthCare (NMHC) facility longer than one day.

1. COMPLETE THE PERSONAL INFORMATION SECTION

FULL NAME:	DATE OF BIRTH:	LAST 4 DIGITS OF SS#:
HOME ADDRESS:	CITY/STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	
EMAIL:	EMERGENCY CONTACT:	EMERGENCY CONTACT PHONE:
NM OBSERVER HOST INFORMATION: NM Host Name: NM Host Phone/Email: NM Host Department:		
Do you have any physical limitations or disabilities which would impact your ability to perform your function or assignment? If so, please describe:		
Do you have any medical conditions that should be known in order to provide safety for you while you perform your function/assignment to our healthcare organization and our patients?		

2. PREPARE COPIES OF YOUR HEALTH/IMMUNIZATION/BLOOD TITER RECORDS

If you do not have any or all of these health records in your possession, you may be able to get copies from your doctor, your school (if you are a current or recent student), or a current/recent employer. If you are missing any or all of these records from these sources, you will still need to obtain and provide the documentation for these items. You may be able to complete these tests at your doctor's office or a local convenient care health center. However, you will be responsible for the cost of these tests if not covered by an applicable health insurance plan you may have.

☐ COVID-19 VACCINATION (Provide proof of fully vaccinated – i.e. Two weeks following final dose)

☐ MEASLES/MUMPS/RUBELLA (MMR) IMMUNITY- This requirement can be satisfied one of two ways:

- Provide proof of completing the MMR vaccine series (which consists of two doses), OR
- Provide blood test results showing immunity to measles/rubeola, mumps, and rubella

☐ VARICELLA (CHICKENPOX) IMMUNITY- this requirement can be satisfied one of two ways:

- Provide proof of completing the varicella vaccine series (which consists of two doses), OR

- Provide blood tests results showing immunity to varicella
- Please note: Having had chicken pox in the past does NOT constitute proof of immunity

☐ TETANUS, DIPHTHERIA, PERTUSSIS (TDAP)

- Required for individuals coming into direct contact with NM patients.
- Provide proof of vaccination as an adult (over 11 years)
- Please note: The vaccine must include pertussis. Td vaccine, which is without pertussis, does not fulfill the requirement

☐ SEASONAL INFLUENZA (FLU) VACCINATION- this is a requirement from Sept 1- May 1:

- Our mandatory flu program requires you to obtain the flu vaccine during the current flu season. If previously vaccinated for this year's flu season, please provide documentation of receiving the influenza vaccine.

☐ RESULTS OF TUBERCULOSIS TEST(S)- this requirement can be satisfied one of three ways:

- Provide the documentation of two negative TB skin tests, also called PPDs (one no more than 1 year old, and one no more than 90 days prior to your start date), OR
- Provide the documentation of one negative TB blood test (we'll accept Quantiferon Gold or T-spot) performed within the last 90 days.
- If you've had a positive TB test, provide the report of a normal chest x-ray performed within the past year. The chest x-ray should post date your positive TB test.

☐ HEPATITIS B: Hepatitis B is not required but highly recommended if your role will be in a direct patient care area. If you do have this documentation, please provide proof of immunity which would be either official documentation of the 3 series of immunizations or a positive titer for Hepatitis B.

3. PLEASE EMAIL COMPLETED FORM (INCLUDING YOUR HEALTH/IMMUNIZATION RECORDS) TO THE FOLLOWING OFFICE FOR CLEARANCE:

Downtown Location	West Region	North and Northwest Region
• Northwestern Memorial Healthcare (NMHC) • Northwestern Memorial Hospital (NMH) • Northwestern Medical Group (NMG)	• Central DuPage Hospital (CDH) • Delnor Hospital • Marianjoy Rehab Hospital • Kishwaukee Hospital • Valley West Hospital • Regional Medical Group-West	• Lake Forest Hospital (LFH) • McHenry Hospital • Huntley Hospital • Woodstock Hospital • RMG- Northwest
Email: NMPGCH@nm.org Fax: 312-926-1787	Email: NMOccHealth@nm.org Fax: 630-933-5289	Email: OccHealthNWR@nm.org Fax: 815-363-0136

All records should be faxed at the same time. Please do not fax until you have accumulated all of your required records. In addition, immunization records will not be accepted without this form. If records are being sent directly from your doctor's office, please make sure they have a copy of this form.

SIGNATURE:_____ DATE:_____

☐ Cleared to be onsite from Occupational Health

OCC HEALTH REPRESENTATIVE:_____ DATE:_____

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Single and Multi-Day Observation: Daily Symptom Screening Questionnaire

Name: _____ **Birth Date:** _____

Screening Questions

For your safety, we are screening all patients/visitors entering a Northwestern Medicine facility. Please review each of the following questions and answer in the box below whether both answers are NO or if either answer is YES.

1. **Are you currently experiencing any of the following symptoms?**

   - Fever greater than 100°F
   - Cough
   - Chills
   - Shortness of breath
   - Muscle pain or body aches not related to physical activity
   - New headache
   - Sore throat
   - New nasal congestion or runny nose
   - More than one episode of Vomiting or diarrhea
   - New loss of taste or smell

2. **Have you have been diagnosed with a COVID-19 infection in the past 20 days?**

Please indicate whether all of the above answers are **NO**. If any of the questions are yes, please indicate **YES** in the box below:

☐ YES ☐ NO

Please Note: Individuals participating must be fully vaccinated for COVID-19 (2 weeks post final dose administered) to be eligible for a single or multi day observation.

Observer Signature_____
Date _____

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Application for Clinical Observation at Northwestern Medicine

Please type or print all information clearly.

Name:_____

Affiliation:_____

Position (Check One):

☐ Attending Physician
☐ Researcher
☐ Resident/Fellow
☐ Licensed Allied Health Prof.
☐ Medical Student
☐ Other (specify)_____

Reason for Observation:

☐ Medical/Professional Education
☐ Other_____

Requested Dates for Observation:

Start Date: _____ End Date: _____

Clinical Areas to be observed:

☐ Physician Office: _____
(Please specify)

☐ Diagnostics: _____
(Please specify)

☐ Emergency Department

☐ Inpatient: _____
(Please specify)

☐ Operating Room/Procedural Area:

Case Type _____

Specific Case _____

Case Date _____

Confirmation of COVID-19 Fully Vaccinated: ☐ Yes, Fully Vaccinated for COVID-19

By signing this form below, I agree to abide by all NM regulations, requirements, policies, and procedures.

_____ _____
Applicant Signature Date

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For Educational Observations Only - APPROVED BY:

_____ _____

Department Chair or Chief Date

_____ _____

NM Medical Director of Area to be Observed Date

_____ _____

Host (Physician or NM Director) Date

_____ _____

Central Campus: Director, Academic Affairs, NMHC Date
All other regions: CMO/CNE* per visiting site
**Can designate a delegate to approve*

For observation in the OR, below signature is also required and Observer must be 18+

_____ _____

Director, Surgical Services Date

For Career Planning/Guidance Observations Only - APPROVED BY:

_____ _____

Hospital based Observation – Hospital CMO/CNE*
**Can designate a delegate to approve*
Physician Office based Observation – RMG/NMG CMO Date

For Recruitment Observations Only - APPROVED BY:

_____ _____

NM Hiring Manager Date

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CLINICAL OBSERVER
CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

This Agreement is made and entered into this _____ day of _____, by and between Northwestern Memorial HealthCare (its subsidiaries and affiliated corporations) (together, "NMHC") and _____("Clinical Observer").

The Clinical Observer has requested access to observe NMHC's operations which may involve and expose certain Confidential Information, as defined below.

Accordingly, as a condition of and in consideration of my status as a Clinical Observer, I acknowledge and agree to the following:

1. I acknowledge and agree that in the course of, or incident to, observing operations at NMHC, NMHC may provide access to, or I will otherwise become exposed to Confidential Information. The term "Confidential Information" shall include (a) all information that concerns the business or affairs of NMHC including, without limitation, financial information, business plans, design and construction plans, medical records and other patient, hospital and physician data, know-how, operational information and techniques, and computer software, data, coding systems and documentation licensed to NMHC or owned by NMHC; (b) patient information, including, but not limited to name, address, diagnosis, medical history, discussions with physician, medication, names of family members, diagnostic test results and other medical record content and (c) any other information reasonably identified by NMHC as confidential.

2. I agree to hold the Confidential Information in the strictest confidence, and will exercise at least the same care with respect thereto as I exercise with my own confidential or proprietary information, and will not, without the consent of the owner of the Confidential Information, divulge, copy, release, sell, loan, review, alter or destroy any Confidential Information. Furthermore, I understand that patient privacy and confidentiality is protected from disclosure under state and federal law and I agree to abide by such law and NMHC's Privacy and Confidentiality Policy (NMHC ADM 01.0015).

3. I understand that photography, videography, or audio recording, including with cell phones, during an observation is strictly forbidden except for prior arrangements with Media and then only with the express written authorization of the patient and NMHC support.

4. I may be required to utilize computer systems as part of my Observation. If applicable, I understand that the ID number and passwords issued to me will be a unique code that identifies me for the computer systems. All inquiries and entries that I make will reference my identity and I will be fully responsible for them. Accordingly, I will maintain the confidentiality of my ID number and passwords and not reveal them to others. If at any time I feel the confidentiality of my ID number or passwords has been broken, I will contact my principal contact immediately and request a new ID number and passwords. I further understand that any information I access from the computer systems is strictly confidential and to be used only in the performance of my necessary duties.

5. This Agreement shall be governed by, and construed in accordance with, the substantive laws of the State of Illinois.

6.

Signature page to follow

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7. I agree to waive and release any and all rights and claims for damages that I may have against NMHC, its representatives, employees and medical staff, as a result of my participation as a Clinical Observer. In the event of an injury, I voluntarily assume responsibility for any medical treatment.

8. This Agreement constitutes the entire Agreement between the parties hereto with respect to the subject matter of this Agreement.

I have read and agree to abide by the Privacy and Confidentiality Policy (https://nm.ellucid.com/documents/view/4019) regarding the importance of maintaining security, privacy and confidentiality of all protected health information, information related to business operations, and other sensitive information. Intentional, accidental, or involuntary violation of confidentiality through verbal, written or electronic communications will result in investigation. I understand that non-compliance with this policy may result in corrective action, including immediate termination from the premises, as determined to be appropriate. I agree to cooperate with any investigation regarding possible privacy breaches. Any violation of confidentiality may result in legal action.

Printed Name: _____

Signature: _____

Date: _____