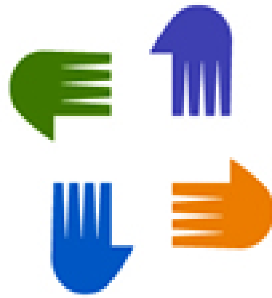

Hennepin County **Medical Center**

Family Medicine Residency Program

POLICY AND PROCEDURE MANUAL
Hennepin County Medical Center
Family Medicine Residency Program

2016-17

HCMC FAMILY MEDICINE RESIDENCY PROGRAM

POLICY AND PROCEDURES MANUAL
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WELCOME

Welcome to the Department of Family and Community Medicine at Hennepin County Medical Center. You have chosen to train for certification in Family Medicine at one of the most experienced, independent, family medicine residency programs, and we are proud that your quest for comprehensive training has led you to our doors.

This handbook highlights the key policies and procedures, resident roles and responsibilities, the ACGME core competencies and duty hour requirements which govern the conduct of this residency program.

As a resident, it is your responsibility to understand and comply with these policies described within. We hope that this manual will be an important and useful reference for you, throughout your training with us.

Allyson Brotherson, M.D, FAAFP
Program Director
Department of Family and Community Medicine
Hennepin County Medical Center

MISSION, VISION AND VALUES

OUR MISSION is to educate Family Physicians to become leaders in Family Medicine and Community Health, and to serve our diverse urban community.

OUR VISION is to be an educational center of excellence for family physicians who are competent in caring for people of diverse cultures, committed to serving their community, and capable of practicing in a wide variety of settings.

OUR VALUES guide and inspire us to do our best as we provide care and medical education. These values include:

Excellence in Medical Care. We provide care that is based on the best medical knowledge and evidence.
Dignity and Compassion. We create a community of healing to care for our patients and nourish our coworkers.
Whole Person. We promote health and healing that addresses body, mind, spirit, family and community.
Cultural Respect. We provide care that is responsive to people's unique cultural characteristics such as race, ethnicity, national origin, language, gender, age, religion, sexual orientation, and physical disability.
Health of All. We value healthy people, families, and communities. We work to optimize the health of all people and to eliminate health disparities.
Physician Wellness. We embrace healthy living for our residents.

SCOPE OF TRAINING

The goal of the family medicine program is to produce fully competent physicians, capable of providing high quality care to their patients.
Family medicine residency programs should provide opportunity for the residents to learn in multiple settings (e.g., hospital, ambulatory settings, emergency rooms, home and long-term care facilities), those skills and procedures that are within the scope of family medicine. Residencies should prepare residents for lifelong learning.

DURATION OF TRAINING

Residencies in family medicine must offer three years of training after graduation from medical school. Residencies must be structured so that a coherent, integrated, and progressive educational program with progressive resident responsibility is ensured.

Educational Standards

Competency requirements are adapted from the standards defined by the Accreditation Council on Graduate Medical Education (ACGME). The ACGME describes six domains of practice in which each resident must achieve competency by the time of graduation from residency training. These six domains or competencies are described below:

ACGME Competencies

The residency program integrates the six core ACGME competencies into the curriculum. Residency training is geared to producing a graduate who is competent in all of these areas. All of our curriculum teaching describes the knowledge, skills and attitudes that all trainees must develop in these six areas and our educational experiences are also defined in this way.

Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

Patient Care

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

Practice-Based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- Identify strengths, deficiencies, and limits in one’s knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems
- Use information technology to optimize learning; and,
- Participate in the education of patients, families, students, residents, and other health professionals

Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
- Communicate effectively with physicians, other health professionals, and health related agencies
- Work effectively as a member or leader of a health care team or other professional group
- Act in a consultative role to other physicians and health professionals; and,
- Maintain comprehensive, timely, and legible medical records, if applicable

Professionalism
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest
- Respect for patient privacy and autonomy
- Accountability to patients, society and the profession; and,
- Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation

Systems-Based Practice
Residents must demonstrate an awareness of, and responsiveness to, the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

- Work effectively in various health care delivery settings and systems relevant to their clinical specialty
- Coordinate patient care within the health care system relevant to their clinical specialty
- Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate
- Advocate for quality patient care and optimal patient care systems
- Work in inter-professional teams to enhance patient safety and improve patient care quality; and,
- Participate in identifying system errors and implementing potential systems solutions

PROGRAM EDUCATIONAL GOALS AND PHILOSOPHY

The residency program also defines its educational goals for each resident in terms of the six competencies.

Patient Care Skills

Graduates must be able to collaborate effectively to provide patient care that is compassionate, appropriate and effective both for the treatment of health problems and the promotion of health. Our graduates will:

- Promote health and healing that address body, mind, spirit, family and community
- Provide comprehensive patient focused care that embraces family and community input
- Promote health by using effective methods of patient education both in the physician relationship and within the health system
- Prevent disease and lessen its morbidity and mortality by using proven primary and secondary prevention techniques
- Recognize patient's psychosocial needs and provide appropriate assistance

Medical Knowledge

Graduates will know and apply current best practice guidelines for the diagnosis and management of common inpatient and outpatient problems. Graduates will:

- Diagnose and manage most acute and chronic health problems using current clinical and best practice guidelines
- Choose among various treatment options by knowing and examining the scientific evidence that supports them
- Demonstrate adequate knowledge to pass the Family Medicine specialty boards

Interpersonal and Communication Skills

Graduates will demonstrate the skills and attitudes that allow effective interaction both oral and written, with patients, families and all members of the health team. Graduates will:

- Demonstrate empathy and respect
- Engage faculty, peers or other health care team providers appropriately to elicit and clarify information
- Transmit medical information appropriately to health professionals, patients and their family members

Professionalism

Graduates will demonstrate the knowledge, behaviors and attitudes necessary to promote the best interest of patients, society and the medical profession. Graduates will:

- Conduct professional activities in an ethical and legally responsible manner
- Provide care that is responsive to the patient's unique cultural characteristics
- Devote attention to the quality of personal and family life in order to sustain healthy relationships with patients and other health professionals

Practice-Based Learning
Graduates will have knowledge, skills and attitudes necessary to evaluate and improve their method of practice and implement techniques to improve their patient care. Graduates will:

- Use practice improvement techniques, evidence based medicine and information technology to improve patient care
- Demonstrate ability to teach and model appropriate patient care, to others on the health care team
- Develop skills and habits of lifelong learning

Systems-Based Learning
Graduates will demonstrate the knowledge, behaviors and attitudes necessary to provide high quality care for patients within the context of the larger healthcare system. Graduates will:

- Understand the nature of system errors and strategies to minimize them
- Understand health care financing and its impact on the quality and availability of patient care
- Appreciate the role of all members of interdisciplinary medical teams and their use in maximizing patient care

COMPETENCY BASED EXPECTATIONS FOR EACH RESIDENT

Residency is a three year training period which trainees must successfully complete before being allowed to write the Family Medicine Certification Examinations. This residency program evaluates each resident's successful achievement in three areas: knowledge, attitudes and skills.

Medical Knowledge requirements:

1. Residents must successfully complete each of the 13 four week block rotations. Residents may need to remediate failed rotation s before being allowed to proceed in their training program
2. All residents are expected to take the in-training examinations conducted by the American Board of Family Medicine. Residents are expected to score greater than the 25 percentile in all areas tested. Failure to do so may result in academic correction
3. Residents are expected to attend the weekly didactics. Wednesday Core Conference attendance is 100% except when excused for rotation responsibilities, vacations or out of country electives
4. All residents must produce a scholarly activity before graduation

Patient Care requirements:

1. Residents will treat patients in a manner that addresses the whole person - being cognizant of the importance of integrating the mind, body and spirit that each patient brings to each encounter
2. Residents will respect and be accepting of patient's values and diverse cultures
3. Residents will perform and develop competence in the performance of medical procedures common to the practice of family physicians

Interpersonal and Communication Skills requirements:

1. Residents will improve and master interviewing techniques

2. Residents will produce a minimum of two videotaped patient encounters for review by the Behavioral Medicine faculty

Practice-Based Learning and Improvement Skills requirements:

1. Residents are expected to have an adult learner mentality, that is, a willingness to embrace knowledge in a motivated fashion. Residents will review new information and incorporate this information into their knowledge base

Professionalism requirements:

1. Residents will embrace the 10 tenets of the residency program's code of professional conduct
2. Treat others as we would like to be treated
3. Be honest: maintain personal and professional integrity; represent the truth
4. Be accountable in our personal and professional lives, as our peers, patients, families and community depend on us
5. Respect age, culture, gender and religious differences
6. Communicate respectfully
7. Be responsible for conflict resolution
8. Be healthy and sober/drug free and ready to learn
9. Be on time
10. Dress appropriately
11. Be altruistic; we are here to help people

Systems-Based Practice and Administrative requirements:

1. Residents will perform their administrative duties in a timely fashion to include:
    a. Complies with the requirements associated with presenting a conference
    b. Completion of all paperwork required by the department (leave/vacation and elective requests) in a timely manner
    c. Completion of outpatient charts within 24 hours after patient's visit; charts and other hospital paperwork in a timely manner
    d. Meeting regularly with faculty advisor
    e. Documentation of required procedures on RMS
    f. Answers departmental pages within 10 minutes of having received call
    g. Follows policies and procedures as set by HCMC (i.e. beepers, leave requests, etc.)

RESIDENTS' ESSENTIAL JOB FUNCTIONS

The following are the tasks required of a resident at the HCMC Family Medicine Residency:

Patient Care:
Take a history and perform a physical examination
Use sterile technique and universal precautions
Perform cardiopulmonary resuscitation
Deliver a baby and repair an episiotomy
Assist at surgery
Move throughout the clinical site and hospitals and address routine and emergent patient care needs
Demonstrate timely, consistent and reliable follow-up on patient care issues, such as laboratory results, patient phone calls or other requests
Perform documentation procedures e.g., chart dictation and other paperwork, in a timely fashion
Manage multiple patient care duties at the same time and prioritize them

Medical Knowledge
Make judgments and decisions regarding complicated, undifferentiated disease presentations in a timely fashion in emergency, ambulatory, and hospital settings.

Practice-Based Learning
Participate in and satisfactorily complete all required rotations in the curriculum.

Professionalism
Demonstrate personal integrity at all times.

Interpersonal Skills and Communications
Communicate with patients and staff – verbally and otherwise - in a manner that exhibits professional judgment and good listening skills that are appropriate for the professional setting.
Present well organized case presentations to other physicians and supervisors.
Input and retrieve computer data through a keyboard and read a computer screen.
Read charts and monitors.

Systems-Based Learning
Demonstrate organizational skills required to eventually care for ten or more outpatient cases per half day.
Take call for the practice or service which requires inpatient admissions and work stretches of up to 16 hours for G1s and 24 hours for G2 & G3s.

BENEFITS:

A(i) Salary and Deferred Compensation
Salary for 2014-2015
G1: $50,844
G2: $52,464
G3: $54,191
(ii) Deferred Compensation
As an alternative to Social Security tax, you may elect to participate in a deferred compensation plan. A percentage of your pre-tax base pay is contributed to your designated investment options in the Minnesota Deferred Compensation Plan.
(iii) Life Insurance
HCMC offers basic life insurance of $50,000 for individual coverage only. The Community Council of Graduate Medical Education (MMCGME) provides coverage. The MMCGME facilities include HCMC, Regions, and Fairview University Medical Center.
(iv) Dental Coverage
Dental coverage is available for purchase by the resident. Both single coverage and family coverage is available
(v) Health Insurance
Medical benefits are provided by Medica.
(vi) Malpractice
Resident physicians are covered for malpractice claims with coverage continuing after the termination of residency for any claim that arose during the course of the residency.
(vii) Life Support Courses at HCMC
Family Medicine residents are required by the RRC to complete certain life support courses at HCMC during their residency. They are as follows:

(i) BCLS/ACLS:	As a G1 resident: done prior to G1 orientation
(ii) ACLS:	Required again during G3 year (if expiration date is prior to G3 year, the resident is responsible for notifying the FM Residency Coordinator)
(iii) APLS:	Required during G1 year, may be asked to take in G2 year
(iv) NRP:	Required during G3 year, may be taken as a G1 or G2
(v) ALSO:	Required as a G1, and a 2nd time during residency, sponsored by the Family Medicine Residency Program

The Residency Program will register and provide payment for the resident to HCMC PRIOR to the start of the course. The residency program also completes the leave request. If unable to attend the course due to illness, etc., the resident MUST notify the Coordinator as soon as possible. This will allow for a replacement to attend the course(s).

For the above listed life support courses residents will be assigned and registered by the residency. Residents will be instructed with details for each course. Course materials must be reviewed before attendance at the course. RESIDENCY REQUIRED COURSES MUST BE PASSED BEFORE COMPLETION OF RESIDENCY. The resident must provide a copy of his/her course certificate. The Department of Family Medicine will pay for first attempts. Subsequent attempts and passing are the responsibility of the resident, including scheduling the retakes with the EMS department, requesting time off via leave request within the due date deadline to the Family Medicine department.

Residents will be responsible for the bill of an assigned course(s) if the resident is registered, the course is paid for, and the resident does not attend and does not provide rationale. The resident must reimburse the department for the cost of a course previously paid for and which the resident does not attend.

Residents are responsible for registration for courses that they have selected on their own. Please note that prior authorization must be obtained from the residency coordinator or designee prior to registering for such a course.

New policies at HCMC have mandated us to follow this procedure **WITHOUT EXCEPTION!**

Department of Family Medicine **CME Money**

Residents will receive five days leave with pay, per year, to attend CME. CME must be approved by the department and certified by the AAFP (American Academy of Family Physicians). CME time does not count as vacation time.

BEFORE YOU MAKE PREPARATIONS FOR YOUR CME YOU MUST SPEAK WITH JESSICA.

CME funds for each resident are available as follows:

A Total of $600.00 During Residency
- To be used during the PGY 1, 2 or 3rd years of training
- Submit to Jessica your original receipts totaling $600.00 within two weeks of attending CME (airline tickets, hotel receipt, registration receipt and car rental receipt). She will prepare paperwork to reimburse you
- You may choose to spend this amount (up to $600) on ABFM board prep materials instead. These materials must be approved in advance and purchased through the department
- If, by the second half of your 3rd year, CME courses/Board Prep materials are not contemplated, any remaining money would be available to purchase medical textbooks or other educational materials totaling 50% of the remaining funds. Submit a list of the books (or other educational materials) to Jessica – they must be purchased through the department. You will not be reimbursed if you purchase books on your own
- **Reimbursement for CME activities, request for books, etc.., must be submitted no later than 90 days before the completion of your residency**

A Total of $75.00 During Residency
- To be used during the PGY 1, 2, or 3rd years of training
- For registration for HCMC conferences or local conferences sponsored by other Twin Cities hospitals
- Original invoice or receipt for registration fee must be submitted to Jessica for reimbursement within two weeks of attending CME

Saturday Clinic
- Residents who hold J visas cannot work for CME money on Saturday mornings
- Residents who need their patient numbers increased may sign up for a Saturday morning clinic, and patients seen will be counted. Residents cannot be paid for a Saturday if counting towards their patient numbers
- G1 residents, beginning in January, may work a Saturday clinic after speaking with Dr. Potts
- Reimbursement is:
  - For the first 5 Saturdays worked, $120.00 per clinic will be paid, plus $25.00 credit for each clinic worked towards additional CME/Board Prep materials
  - The 6th clinic onward is - $130.00 (each clinic worked) plus $50.00 credit for each clinic worked towards additional CME/Board Prep materials

LEAVE POLICIES

VACATION, ILLNESS, AND OTHER SHORT-TERM ABSENCES

American Board of Family Medicine Requirements

Vacation, Illness, and Other Short-Term Absences Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one (1) month per academic year.

Vacation periods may not accumulate from one year to another. Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of the G-2 year and first month of the G-3 year in sequence) and a resident does not have the option of reducing the total time required for residency (36 calendar months) by relinquishing vacation time.

The Board recognizes that vacation/leave policies vary from program to program and are the prerogative of the Program Director so long as they do not exceed the Board's time restriction.

Time away from the residency program for educational purposes, such as workshops or continuing medical education activities, are not counted in the general limitation on absences but should not exceed 5 days annually.

The maximum cumulative amount of time a resident may be away from the program for personal absences including vacation, sick and miscellaneous leave without making up the time must not exceed 30 days for any academic year. Time in excess of 30 days in each PGY year must be made up before the resident advances to the next PGY level, and the time must be added to the projected date of completion of the required 36 months of training
.

HCMC Family Medicine Policy on Vacation, Illness, and Other Short-Term Absences Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of 1 month per academic year.

Allowed vacation:
G1 Residents two weeks paid vacation + one week paid vacation last week in June
G2/3 residents three weeks paid vacation.

Residents have one additional week per year to allow for sick, personal leave, family emergencies (See later under miscellaneous leave)

For vacations the following guidelines should be respected and may result in non – approval if not adhered to:

Vacation Procedure:

A. **Application**

Request for time off must be in writing using the "Leave Request" form available from the Program Coordinator.

VACATIONS MUST BE REQUESTED BY THE DUE DATE ON THE VACATION CALENDAR POSTED IN THE RESIDENT'S LIBRARY, THE APPENDIX AND ON THE INTRANET.

A first-come-first-served basis will be used for granting requests. No leave is approved without the submission of a written leave request.

In approving leave requests, consideration is given to adequate clinic staffing and patient care. *As a result, the residency program must limit the number of residents scheduled out of clinic at any one time to six.*

B. General Rules about Vacations

Residents are encouraged to plan ahead and schedule all vacations by the start of the academic year. A good rule of thumb for scheduling vacations is to take one week of vacation during the first six months of the academic year, and one week from the second six months of the academic year. G2 and G3 residents may consider scheduling one vacation week from their elective period.

A resident cannot reduce the total time required for the residency by foregoing vacation time.

Vacation time is not cumulative from year to year. Any vacation time that is not used by the end of each year cannot be carried over into the subsequent academic year.

C. Exceptions

Vacations are not allowed during the following rotations:

- G1: FMS Night Float and 2 of the 3 FMS Inpatient months.
- G2: Yellow Medicine (ICU), FMS Inpatient rotations, Preventive Medicine.
- G3: FMS Inpatient, Gillettes, when on call on Fridays in Ortho
- Vacation time will NOT be approved during the last week in June or the first week in July for G1s and G2s. Vacation time is not granted in the last two weeks of the third year.
- No more than two (2) consecutive weeks of vacation are allowed.
- No two vacation periods may be concurrent (e.g., last month of the G-2 year and first month of the G-3 year in sequence

Most rotations will not allow time off of major holidays, ie, Thanksgiving (Nov.), Christmas (Dec.), New Year's (Jan.) Memorial Day (May), 4th of July or Labor Day (Sep.)

Many rotations require residents take a full 7 days off at a time and require that time off start on a Monday and end on the following Sunday, returning to work on a Monday. See Residency Coordinator for details.

Vacations during the ABFM examinations

Residents who will miss the ABFM In training examinations because of vacation or leave, must make arrangements to take the examination before they leave on vacation.

MISCELLANEOUS NON ACADEMIC LEAVE

Miscellaneous leave (sick, personal, funeral, emergency)

In case of absence for illness, the resident must call the Program Coordinator, or her appointed designee. Residents should also notify the appropriate coordinator or senior resident for rotations at HCMC or external clinics.

Short periods of sick leave that would not compromise the total one-month away from the program can be handled at the discretion of the Program Director. However, sick time when added to vacation time and any

other personal time away resulting in MORE THAN ONE MONTH away from the program in a PGY year will be considered a medical leave and the days in EXCESS OF ONE MONTH must be made up before the resident progresses to the next PGY level. This will extend your residency, and is a non-negotiable ABFM requirement.

Residents out sick for more than 2 days must have a "return to work" note from their treating physician before reentry.

Days away from the program for other reasons like funeral leave or religious observances may be granted at the discretion of the Program Director. These days will not exceed more than three (3) days at a time. If this leave, when added to vacation time and sick leave, results in more than one month away from the program in a PGY year, the days in excess of one month must be made up before the resident progresses to the next PGY year. Please note that this MAY extend your residency**.**

Please note that miscellaneous leave is for use at times of unexpected emergencies that arise in a resident's life. It is counted in the general limitation on absences, which together must not exceed a combined total of one (1) month per academic year.

Continuity clinic policy during vacations

During any vacation, the resident must notify their team nurse of their absence via inbox messaging.

PARENTAL / ADOPTION LEAVE

Residents must submit requests for parental or adoption leave at least four months in advance of the expected arrival of the child. This is necessary to ensure adequate call and clinic coverage adjustments. As a residency program, we understand that unseen events may complicate pregnancy and decisions about such events will be made on an individual basis.

Maternity leave:

A pregnant resident is expected to inform the Program Director of her pregnancy as early as possible. A resident is allowed six weeks of paid maternity leave under the hospital's disability and family leave (FMLA) policy. As stated before, this leave follows the ABFM's leave policy. Any maternity leave that exceeds the 1 month allowed must be made up before promotion to the next academic year and may prolong residency. **PLEASE NOTE: G1 RESIDENTS DO NOT QUALIFY FOR FMLA**, you must have worked for 12 months in order to qualify for FMLA. (See example)

A resident may elect to reduce the length of residency extension by use of accrued sick and /or vacation time.

G2 and G3 residents may use the Parental- Child elective. (See curriculum manual for details).

Residents are allowed an additional six weeks of unpaid maternity leave under the hospital's disability and family leave policy. Again this leave extends residency if it exceeds the one month rule. Extensions of maternity leave are allowed with the approval of the Program Director.
The same policy applies in the event of an adoption of a child.

For the sake of fairness and equality of calls with other residents, call distribution must be made up on return to residency.

Paternity /Adoption Leave:
A resident is allowed to take two weeks of paid paternity leave for a baby's birth or adoption date in a fashion similar to "maternity leave."
As stated before, this leave follows the ABFM's leave policy. Any paternity leave that exceeds the one month allowed must be made up before promotion to the next academic year and may prolong residency. (See example)

To ensure adequate patient care, the administrators of the residency program may require a resident to take paternity leave in increments.

A resident may elect to reduce the length of residency extension by use of accrued leave.

Parental- Child Elective
G2 and G3 residents **ONLY** may elect to take the Parental-Child elective with minimum continuity clinics around the time of the birth or adoption of a child.

American Board of Family Medicine Leave policy
The maximum cumulative amount of time a resident may be away from the program for personal absences including vacation, sick and miscellaneous leave without making up the time must not exceed one month for any academic year. Time in excess of one month in each PG year must be made up before the resident advances to the next PGY level, and the time must be added to the projected date of completion of the required 36 months of training
Case scenarios
Example1:
A FM resident has used one month of vacation including sick days and leave for religious observances. He now requests 2 weeks of paternity leave. He wants to know the length of time he must extend residency
Answer: 2 weeks
The resident has taken his full allotment of vacation and miscellaneous time. It totals one month. He must extend his time in residency by 2 weeks

Example 2
A FM Resident, a G1 resident, has taken 2 weeks of vacation. She now needs 4 weeks of maternity leave. She chooses to use the remainder of her annual leave allotment, 2 weeks, as part of her maternity leave. For how long is her residency extended? (G1 residents do not receive FMLA)
Answer: 2 weeks

LONG-TERM ABSENCE

Absence from residency education, in excess of one month within the academic year (G1, G2 or G3 year) must be made up before the resident advances to the next training level, and the time must be added to the projected date of completion of the required 36 months of training. Absence from the residency, exclusive of the one month vacation/sick time, may interrupt continuity of patient care for a maximum of three (3) months in each of the G-2 and G-3 years of training. Leave time may be interspersed throughout the year or taken as a three-month block.

Following a leave of absence of less than three months the resident is expected to return to the program and maintain care of his or her panel of patients for a minimum of two months before any subsequent leave. Leave time must be made up before the resident advances to the next training level and the time must be added to the projected date of completion of the required 36 months of training. Residents will be permitted to take vacation time immediately prior to or subsequent to a leave of absence.

In cases where a resident is granted a leave of absence by the program, or must be away because of illness or injury, the Program Director is expected to inform the Board promptly by electronic mail of the date of departure and expected return date. It should be understood that the resident may not return to the program at a level beyond that which was attained at the time of departure. All time away from training in excess of the allocated time for vacation and illness, should be recorded in the Resident Training Management (RTM) system.

ADDITIONAL NOTES ABOUT EXTENDED LEAVES:

Continuation of Benefits and Salary
Residents are referred to the Family and Medical Leave Guidelines in the HCMC Resident Manual for the institutional policy governing extended leaves.

Extension of Residency
The maximum cumulative amount of time a resident may be away from the program for personal absences including vacation, sick and miscellaneous leave without making up the time must not exceed one month for any academic year. Time in excess of one month in each post graduate year must be made up before the resident advances to the next PGY level, and the time must be added to the projected date of completion of the required 36 months of training.

Make Up Time for Rotations
If a resident misses more than 25 % of a given rotation, then the resident will be required to make up the rotation.

Sanctions for Unexcused Absence from the Program
Respect for your patients, and your colleagues, is a cornerstone of being a physician. Processes are in place to define appropriate situations where resident absence from scheduled duties is appropriate, and to allow the program to adjust for such absence. When a resident is absent and does not observe the formal notification process, he/she may impair patient care and also put undue burden on their resident colleagues. Observing this process is viewed as an important measure of professionalism.

For a first event, the resident will lose 1 vacation day and his/her advisor will be notified of a potential lapse in professionalism via email notification.

For a second event, the resident will lose 2 vacation days and his/her advisor will be notified, by letter, as will the program director that a further lapse in professionalism has occurred. A discussion will be held between the resident and advisor at their next advisor-advisee meeting.

For a third event, this further lapse will be recognized by a letter of concern in the resident's permanent file and a meeting with the Program Director to discuss possible probation, at the discretion of the Program Director.

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RESIDENT APPOINTMENTS

RESIDENT ELIGIBILITY, APPLICATION AND SELECTION CRITERIA

To be eligible for a residency program at HCMC, all applicants must meet one of the following qualifications:

a) Graduates of medical schools in the United States and Canada accredited by the American Osteopathic Association (AOA).
b) Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
   i) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG).
   ii) Have full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
c) U.S. citizen graduates from medical schools outside the United States and Canada who cannot qualify but who have successfully completed the licensure examination after successful completion of a specified period of graduate medical education.
d) Graduates of medical schools in the United States and its territories not accredited by the LCME but recognized by the educational and licensure authorities in a medical licensing jurisdiction who have completed the procedures described above.
e) Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school (U.S. or Canadian School).

(ii) General Requirements for the Family Medicine Residency Program
Generally, training positions are offered by participating through the National Resident Matching Program (NRMP).

Applications are accepted only through the Electronic Residency Application Service (ERAS). This service is available to all US Medical Graduates through their Dean's Office. Canadian medical school graduates should contact the Canadian Resident Matching Service. International Medical graduates should contact the Education Commission for Foreign Medical Graduates (ECFMG). Any document not printed in English must be accompanied by an acceptable English translation performed by a qualified translator. Each translation must be accompanied by an affidavit of accuracy acceptable to the Hospital.

(iii) The ERAS application must contain:

- A United States Medical Licensing Exam (USMLE) transcript: All candidates must have successfully passed both Parts I, II and CS of the USMLE for consideration for the residency program.
- International Medical graduates must include an ECFMG certificate (including a current Test of English (TOEFL) certificate) and a copy of a translated medical school diploma.

(iv) To be eligible for the Family Medicine Residency at HCMC, applicants must meet these additional criteria:

a) International medical school candidates must have documented clinical experience in the United States or Canada of at least 6 months. Accepted clinical experience includes some observerships or externships in a primary care specialty, with preference in Family Medicine.
b) Applicants must supply 3 letters of recommendation - at least 2 must come from physicians who can attest to this clinical experience in the United States.
c) Candidates must have completed both USMLE Steps I and II and have no history of failing any of the USMLE steps more than once. There can be no fails on the CS exam
d) Applicants must be able to complete all USMLE Steps within 7 years of passing the first USMLE

examination and before graduating from the residency program**.**

e) Preference will be given to applicants who meet the following additional criteria:

- Graduation from medical school within the last 5 years
- Successfully passing USMLE I and II within 2 attempts
- Successfully passing USMLE CS exam without failure
- Demonstrated commitment to family medicine as demonstrated by letters of recommendation, experience in a family medicine rotation, personal statement

f) HCMC-FMRP is not a transitional residency program. Applicants who desire careers in other specialties should not apply.

g) The Program Director or designee determines which applicants are invited for an interview after a preliminary review of the applicant's credentials is made by the Program Coordinator. Criteria used for this determination include:

- Caliber and reputation of the applicant's collegiate and medical school education
- Grades or grade point average, or other evidence of academic achievement or excellence
- Relative scholastic or class rank, if available
- Letters of recommendation
- Enthusiasm of recommendation of the Dean's letter
- Sincerity and depth in the personal statement
- Other curricular or extra-curricular activities
- Any awards or honors
- Strong references to character

(v) Visa requirements: International medical graduates must possess an EAD authorization, permanent resident status or US citizenship to be considered for a residency position in the HCMC-FMRP. **We will sponsor J-Visas through ECFMG.**

(vi) Invitation to interview:

The Program Coordinator will prescreen all applications for eligibility. Academic records, letters of recommendation (at least one of which must be from a family physician) USMLE scores, post graduate experience, honors, applicant's personal statement and future plans are considered in choosing to interview an applicant.

Applicant interview and credentials review:

Prior to the interview date, the coordinator distributes copies of the applicant's documents to all interviewers, together with a standard evaluation form.

Applicants are interviewed by faculty, residents and the Program Director or Assistant Program Director. Efforts are made to have the applicant interview with members of the Department who might share an applicant's special interest(s). Interview day routinely includes a tour of the Whittier Clinic and the hospital, and lunch with the residents.

Interviewers complete a standard evaluation form for each applicant**.**

(vii) Match list preparation:
At the end of the interview season, the Program Coordinator computes a numerical ranking of the applicants based on the ranking given by the faculty and resident interviewers. The Committee meets before the Match submission deadline to review the individual applicants and the rank order. A final rank list is compiled and reviewed one last time by the entire Committee prior to submission to NRMP.

(viii) Procedures for acceptance of residents after the match:
The selection criteria are the same as those listed above, but some exceptions may be made to the selection criteria if a candidate has an equivalent clinical and /or educational experience to satisfy existing criteria. Written and verbal documentation to this equivalence will be reviewed and approved by the selection committee.

Following the MATCH, the Program submits a request for residency appointment to the Graduate Medical Education Office. A written letter of agreement outlining the terms and conditions of house staff appointment to the residency program is mailed to the new house staff with new employment forms by GME.

Residents who meet the eligibility requirements and are selected by the faculty shall receive a contract confirming their appointment for one-year to the resident staff. Resident appointments are for a one-year time period.

(ix) Ability to be accepted and appointed for training is contingent upon:
- Meeting all ACGME Eligibility Requirements
- Being medically able to begin
- Being physically present on the start date
- GME Resident Agreement of Appointment
- Functioning at the agreed upon level of training
- Obtaining the appropriate visa, if applicable

Participation in GME and Family Medicine Department orientation is MANDATORY.

Resident Transfers/USMLE

(x) Second year applicants are accepted for transfer into the residency if openings occur in that training year. These applicants must have successfully completed at least one year in a previous ACGME Family Medicine training program or one year in an ACGME accredited Specialty. These applicants must meet the criteria outlined above and will be considered and interviewed outside of the NRMP.

Applicants will not be considered for transfer if they have had previous training in more than one residency training program.
Applicants accepted on transfer **must** provide a letter of verification of previous educational training from the Program Director of the residency program from which they are transferring.
Applicants accepted on transfer may receive a maximum of 12 months of advanced training credits based on the ABFM guidelines. Advanced placement credits must be requested by the applicant and must be approved before the Resident Agreement of Appointment is signed.

(xi) USMLE Step 3 Requirement: A trainee accepted into the Family Medicine program must successfully complete Step 3 of the United States Medical Licensing Examination by the end of the first training year. Failure to do so will result in the resident not being offered a contract for continuation to the 2nd year.

Passing USMLE Step 3 is required to obtain a physician license in Minnesota. A full medical license is required for eligibility by the American Board of Family Medicine to sit for the certification examinations in Family Medicine.

Whether selected through the NRMP or outside the match, HCMC FMRP does not discriminate against resident applicants on the basis of race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran's status, or sexual orientation.

NUMBER OF RESIDENTS

The Family Medicine Residency at HCMC is approved for 30 residents by the Family Medicine Residency Review Committee. It is the desire and expectation of the faculty that all first-year residents will complete their three years of training at HCMC.

RESIDENT RETENTION AND CORRECTIVE ACTION

Purpose: To establish procedures for remedial and corrective actions when a resident's academic or non-academic performance is inadequate.

Policy: When a resident's performance is judged inadequate, the resident normally will enter a "Remedial Action Path" that includes, but is not limited to, the following steps: warning, performance improvement, probation, suspension, non-renewal of contract and dismissal. In appropriate situations some of these steps may be omitted.

Rationale: Resident education involves several overlapping areas of responsibility. The primary responsibility is to our patients and to ensure that they receive the highest standard of care. The second responsibility is to teach residents "best practices" for medical care, and to help them learn if they deviate from those "best practices". The third responsibility is to our department and clinic staff to ensure a respectful environment for everyone. These responsibilities mandate that we have methods in place to identify any resident whose performance is not adequate, to protect the well being and safety of our patients, and to give the resident remedies if their performance is substandard.
Inadequacies or deficiencies may occur in both academic and non-academic areas.
(i) Correction for Academic Deficiencies:
Academic deficiencies exist when academic performance is below satisfactory and are grounds for correction. Below satisfactory academic performance is defined as:

- Failed rotation
- "Needs Improvement" in a core rotation, ie, Adult Medicine, Emergency Medicine, Obstetrics, Pediatrics and Surgery, will require repeating the rotation and extension of residency.
- Exam scores below program requirements

Marginal or unsatisfactory performance as evidenced by faculty and rotation evaluations that demonstrate:
    - An insufficient fund of medical knowledge
    - An inability to use medical knowledge effectively in patient care
    - Unsatisfactory clinical diagnosis or judgment
    - Poor interpretation of data
    - Lack of appropriate technical skills
    - Lack of professionalism or collegiality
- Any behavior or performance that compromises patient safety
- Any other deficiency that bears on the resident's academic performance

Procedures
In order to help residents with performance deficiencies while meeting our responsibilities to our patients and co-workers, the following procedural steps shall be followed:

1. Each resident shall be provided with Policy & Behavior Guidelines and Expectations that describe the performance standards of our program, located on the FM intranet page. Periodic updates are offered to residents, in writing, through intra-office memos. These policies summarize the professional standards and expectations from the State Licensure Board, the American College of Graduate Medical Education, (ACGME), Resident Review Committee (RRC), HCMC, and our department
2. Each resident is expected to know and follow these policies in an ethical and professional manner, on all rotations, and in all work settings
3. Residents will be evaluated at the end of each clinical rotation in writing by the designated person on each assigned rotation
4. Each resident's performance shall be evaluated quarterly, by the Program Director, faculty, and key clinical staff. The results of these summary evaluations shall be made available for review with the resident
5. The evaluations in #3 & #4 shall be regularly reviewed by the Program Director along with other "Performance Reports" submitted by concerned faculty, clinic or hospital staff
6. All performance reports shall be evaluated to determine if they represent a singular "error" or if they represent a more serious deficiency
7. If deficiencies are identified, the Program Director and/or resident advisor, acting in a timely manner, shall meet with the resident to discuss the performance report and establish the level of deficiency and the appropriate remedy
8. Corrective action or remediation need not be progressive, and need not follow the order of actions listed below. If in the judgment of the Program Director, the residents' behavior warrants removing the resident from normal duties, suspension or dismissal may be imposed without prior warning

(a) Level I
Written Warning or Letter of Concern:
Definition:
Advice or cautionary notice of undesirable academic performance, behavioral conduct, or administrative deficiency.
If the Program Director deems that only minimal correction is necessary, then a written warning or letter of concern is given.
Process:
1. The actions that may result in a written warning are:
    a. Repeated failure to complete administrative duties- chart completion, failure to answer beepers in a timely manner
    b. Repeated tardiness

c. One “needs improvement” on a single clinical rotation evaluation (other than a core rotation as listed above)
d. Attendance at conferences that fail to meet the minimum requirements
e. Exceeding duty hours or not reporting duty hours
f. Standard scores of less than the 25th percentile in the ITE

2. The notification procedure is as follows:
a. The resident shall be informed by letter of the action resulting in the warning
b. The action is entered in the resident’s file and will remain there until the action is corrected
c. The letter will outline to the resident a clear listing of remediation requirements, if any; date of follow up meeting; and the starting and ending date of warning. Letter may be hand delivered for residents’ signature
d. The warning period shall not add time to the resident’s training
e. Notification of the warning does not become part of the resident’s permanent file and is removed from the training file when the deficiency is corrected

Remediation
Follow up meetings with the Program Director or faculty advisor may be scheduled during the period of remediation.

Evaluation
An evaluation process shall be conducted at the end of the warning period. If the resident has responded or failed to respond to the remediation, the Program Director can take the following actions:
1. Remove the resident from warning status
2. Place the resident on performance improvement or probation
3. The warning letter or letter of concern remains on resident’s training file

(b) Level II
Performance Improvement
Definition:
An individualized action plan that allows for correction of deficiencies without formal probation.
Process:
1. The following examples may result in Level 2 action:
a. Failure of Level 1 Remediation
b. Standard score of less than 10th percentile for the resident’s training year on the Intraining Examination (ITE)
c. Less than satisfactory performance or “needs improvement” in 2 clinical rotation evaluations (other than a core rotation as listed above)
2. The notification procedure is as follows:
a. The Program Director shall meet and review with the resident his/her performance during the warning status, if applicable. During this meeting, the Program Director shall:
i) Review with the resident the written performance evaluations and concerns of the program
ii) Inform the resident that the remediation requirements defined during the warning period were not met, if applicable
iii) Inform the resident about his/her remediation
b. The Program Director shall give written notice to the resident either by hand or certified mail, of the remediation or institution of the performance improvement plan
c. The length of the performance improvement period may vary. The performance improvement period will begin with the date of the notice and shall continue for a minimum period of 1 month but not longer than 3 months. The length of the performance improvement period shall be specified at the outset; and

should be of sufficient duration to give the resident a meaningful opportunity to remedy the identified performance problem(s)

d. The resident shall receive credit for training time, and salary and benefits remain in force during remediation

e. The notification of the remediation shall not become part of the resident's permanent file and is removed from the training file when the deficiency is corrected

Remediation

The mechanism of remediation shall be defined. The resident will be given recommendations for improvement of performance. Examples of mechanisms that may be used to improve the deficiencies include:

1. Clinical and Academic Deficiencies:
    a. Resources for learning, e.g., scientific journals, textbooks, internet resources
    b. Structured educational sessions and tutorials as set by Program Director
    c. Special counseling sessions with faculty mentor or advisor or any trained professional with specific expertise to help in the remediation process
    d. Close observation and feedback from Program Director and training faculty
    e. Alternative training schedules. The resident may be required to repeat rotations or other program specific requirements
2. Technical skill deficiencies:
    a. One-on-one supervision during patient care
    b. Instructional sessions with faculty

Evaluation

Follow up meetings between the resident and the Program Director or academic advisor shall be scheduled during the period of remediation.

Assessment of the resident's performance shall be done at the end of the performance improvement period. If the resident has responded or failed to respond to the remediation, the Program Director may take the following actions:

1. Remove the resident from remediation status with return to good academic standing.
2. Extend performance improvement period for an additional period of 1-3 months with new or remaining deficiencies cited
3. Place the resident on probation

(c) Level III
Academic Probation:

Definition:

A trial period of supervision which is initiated to assist the resident in understanding and correcting academic performance and professional conduct.

If the resident does not achieve remediation during the warning or performance improvement and remediation (Level 1 and 2) status, or if the deficiency is thought to be too severe for warning or performance improvement status, the program may place the resident on probation.

Process:

1. Examples of actions that merit academic probation or Level 3 action are:
    a. Failure of Level 2 remediation
    b. Failure of a single clinical rotation
    c. Less than satisfactory performance or "needs improvement" in 3 clinical rotations (other than core rotations as listed above)
    d. Repeat failure to score more than the 10th percentile compared to residents in the training year on the ITE

2. The notification procedure is as follows:

a. The Program Director shall meet and review with the resident his/her performance during the performance improvement period if applicable. During this meeting, the Program Director shall:

i. Review with the resident, the written performance evaluations and concerns of the program

ii. State to resident that the requirements defined during the remediation period were not met, if applicable

iii. Inform resident about his/her probation

iv. The Program Director shall give written notice to the resident of the probation

b. The length of the probationary period may vary. The initial probationary period will begin with the date of the notice and continue for a minimum period of 1 month but not longer than 3 months. The length of the probationary period shall be specified at the outset and should be of sufficient duration to give the resident a meaningful opportunity to remedy the identified performance problem(s)

c. The resident shall receive credit for training time; and salary and benefits remain in force during probation

d. During probation, the resident will not be allowed to moonlight either internally or externally. The decision to allow the resident to participate in elective rotations will be at the discretion of the Program Director

e. Vacation time or leaves of absence shall not be counted as part of the probationary period. Vacations and leaves of absence during probation shall be granted at the discretion of the Program Director

3. Remediation:

The resident shall be given recommendations for improvement of performance. Examples of mechanisms that may be used to improve the deficiencies include:

a. Clinical and Academic Deficiencies:

i. Resources for learning

ii. Structured educational sessions and tutorials as set by Program Director

iii. Special counseling sessions with faculty mentor or advisor or any trained professional with specific expertise to help in the remediation process

iv. Close observation and feedback from Program Director and training faculty

v. Alternative training schedules (e.g. increased length, repeat or additional rotations)

b. Technical skill deficiencies:

i. One-on-one supervision during patient care

ii. Instructional sessions with faculty

4. Evaluations:

Follow up meetings between the resident and the Program Director or academic advisor shall be scheduled during the period of remediation.

Assessment of the resident's performance shall be done at the end of the probation period. If the resident has responded, or failed to respond to the remediation, the Program Director may take the following actions:

a. Remove the resident from probationary status with return to good academic standing.

b. Extend the Probationary Period with new or remaining deficiencies cited. Academic Probation shall not be extended more than once.

Residents who do not remediate after 2 occasions of Academic Probation may be:

a. Dismissed from the program

b. Placed on suspension

c. Denied promotion to next training level and require further probationary training

d. Subject to non-renewal of contract

e. Recommended for dismissal from residency program

(d) Level IV
Suspension:
Definition:
Suspension is corrective action that temporarily removes the resident from program duties.

Two levels of suspension may be instituted by the Program Director:
1. Summary suspension:
A resident may be summarily suspended, if it is believed that such an action is in the best interest of patient or staff welfare. The Program Director or designee shall notify the resident within 10 days of imposition of the suspension whether the resident will be re-instated, or provide notification of general suspension or probation or termination
2. General Suspension
A resident may merit General suspension for:
1. Failure to achieve remediation during the probation process (Level 3 process) or if the deficiency is too severe for probation
2. Failure to comply with Resident's Duties as set forth in Resident's Contract

Process:
1. The Program Director shall take the following steps:
    a. Meet and review with the resident his/her performance during the probationary status if applicable
    b. Review with resident the written performance evaluations and concerns of the program
    c. Inform the resident that the remediation requirements defined during the probationary period were not met, if applicable
    d. Inform the resident about his/her suspension
    e. The Program Director shall give written notice to the resident of the suspension
    f. The Program Director will notify the resident of:
        i. The appropriate measures to assure satisfactory resolution of the problem
        ii. The activities of the program in which resident may not participate
        iii. The consequences of non-compliance with the terms of suspension
        iv. The requirement for additional training time to compensate for the period of suspension
    g. During the time of suspension, the resident shall be placed on administrative leave with or without pay as appropriate depending on the circumstances. The resident shall not receive credit for training time while on suspension
    h. At the end of the suspension period, the Program Director may take the following actions:
        i. Remove the resident from suspension with return to good academic standing.
        ii. Remove the resident from suspension and have him/her reenter program on probation with new or remaining deficiencies cited
        iii. Extend the suspension period with new or remaining deficiencies
        iv. Deny renewal of contract
        v. Recommend dismissal of resident from residency program.
    i. A resident who successfully re-enters the program after suspension must make up the missed rotations and will have to delay graduation until program requirements are met

(e) Level V
Dismissal/ Termination:
Definition:
Dismissal or termination means the cessation from participation in the training program, even though the resident holds a current residency agreement.

If the Program Director recommends dismissal of the resident because of failure to remediate either while on warning; performance improvement; probation or suspension, or if the Program Director deems the deficiency so grave that patient and institutional risks outweigh the benefits of reprimand, performance improvement, probation, or suspension, then the Program Director may initiate dismissal proceedings against the resident.

Process:
The Program Director shall:

i. Contact the Office of the Medical Director and provide written documentation of the facts leading to the proposed action
ii. Notify the resident in writing of the deficiency and the decision about dismissal
iii. The resident has the right to appeal the decision (see HCMC Resident Manual)

Discipline for Non-Academic reasons:

- Non-academic deficiencies may include, but are not limited to violation of rules of professional responsibility, dishonesty, risks to patient care, violation of institutional standards or law. Behaviors or activities that constitute concern include:
- Conduct that violates professional and ethical standards or which disrupts the operation of Hennepin County Medical Center, the Whittier Clinic, or any other facility at which Hennepin County Medical Center gives medical care
- Refusal to comply with the policies, bylaws, rules or regulations of the Hennepin County Medical Center, the Department of Family Medicine or the Whittier Clinic
- Any action which poses a risk to patient care or orderly administration of the program
- Disregard for the rights and welfare of patients, faculty or other employees of the hospital or clinic
- Performance that presents a serious compromise to acceptable standards of care or that jeopardizes patient care
- Commission by the resident of an offense under federal, state or local laws or ordinances which affect the abilities of the resident to appropriately perform his/her normal duties in the residency program. In addition to any remedial & disciplinary action, any incident or behavior that suggests legal transgression (“breaking the law”), will be reported to the appropriate law enforcement authorities
- Physical abuse or harassment, or the threat of physical abuse or harassment, to any person on the Institution’s premises
- Sexual abuse or harassment, or the threat of sexual abuse or harassment, to any person on the Institution’s premises
- Knowingly furnishing false information to the Institution
- Forgery, alteration or misuse of the Institution’s documents, records, or instruments of identification
- Abuse of chemical substances
- Failure to report to work as scheduled without justification acceptable to the Program Director
- Dysfunctional patterns of communication or behavior, identified by faculty, nursing staff, peers or patients. Dysfunctional communication may include disrespectful or insensitive comments, profanity, inappropriate use of the computer, dysfunctional style of managing conflict or anger
- If in the judgment of the Family Medicine Residency Program, the resident has exhibited non-academic deficiency, the Department will take appropriate corrective action, including but not limited to:

Please refer to the academic remedies – Levels I to V described under academic remediation above.

GRIEVANCE POLICY AND PROCEDURE*

(Closely Adapted from Lynchburg Family Medicine Residency Grievance Policy and Procedure Manual)

Purpose

To provide a mechanism for resolving disputes and complaints which may arise between postgraduate residents (hereinafter referred to as "resident"), and their Program Director or other faculty member.

Policy

Postgraduate residents may appeal grievable (as defined herein) disagreements, disputes, or conflicts with their program using the procedure outlined below.

Definitions

A grievance is any unresolved dispute or complaint a resident has with the policies or procedures of the residency training program or any unresolved dispute or complaint with his or her Program Director or other faculty member.

Covered Grievances:

Under this policy only, the following grievances shall be recognized as subject to the procedures described in this document.

- Disputes or complaints related to unfair or improper application of a policy, procedure, rule, or regulation;
- Unresolved disputes or complaints with the Program Director or other faculty member not related to performance or appointment actions;
- Retaliation as a result of use of this procedure

Complaints based solely on the following actions are not subject to this procedure and thus are considered "not grievable" under this policy:

a. establishment and revision of salaries, position classifications, or general benefits
b. work activity accepted by a resident as a condition of employment or work activity which may reasonably be expected to be part of the job
c. remediation actions taken by the program based on the resident's performance on educational activities such as rotations or the In-Training examination
d. the contents of policies, procedures, rules, and regulations applicable to residents, set by governing bodies such as the ACGME, RRC or the ABFM. Examples are the moonlighting and duty hours policies
e. discrimination on the basis of race, national origin, religion, sex, age, or handicap
f. means, methods, and personnel by which work activities are to be conducted
g. transfer, assignment, and retention of residents within the health system
h. relief of residents from duties in emergencies
i. suspension or dismissal of residents provided in the Policy and Procedure for the Assessment of Performance of Residents, Promotion and Disciplinary Actions, and Formal Grievance Procedure
j. situations listed under d, e, f, g, and h can be questioned under separate agencies within the Health System

Informal Resolution

Step 1:

A good faith effort will be made by an aggrieved resident and the Program Director to resolve a grievance at an informal level. This will begin with the aggrieved resident notifying the Program Director, in writing, of the nature of the grievance within fourteen (14) calendar days of the event or action giving rise to the grievance.

This notification should state the nature of the complaint, all pertinent information and evidence in support of the claim, and the relief requested. Within fourteen (14) calendar days after notice of the grievance is given to the Program Director, the resident and the Program Director will set a mutually convenient time to discuss the complaint and attempt to reach a solution.

Step 1 of the informal resolution process will be deemed complete when the Program Director informs the aggrieved resident, in writing, of the final decision following such discussion. This written response should address the issues and the relief requested.

Step 2:
If the Program Director's final written decision is not acceptable to the aggrieved resident, the resident may choose to proceed to a second informal resolution step which will begin with the aggrieved resident notifying the Council for Residency Affairs (CRA) via the Program Coordinator of the grievance in writing.

Such notification must occur within ten (10) working days of receipt of the Program Director's final decision. This notification should include all pertinent information, including a copy of the Program Director's final written decision, evidence that supports the grievance, and the relief requested.

The program coordinator will set up a meeting of the CRA as soon as possible after receipt of this notification, but not longer than 30 days, to discuss the complaint and attempt to reach a solution. The resident may be accompanied at such meeting by one person- the resident's advisor or resident peer. (Legal counsel shall not be permitted to participate in Step 1, Step 2 or Step 3 discussions.)

Step 2 of the informal process of this grievance procedure will be deemed complete when the CRA provides the aggrieved resident with a written response to the issues and relief requested. If the CRA finds in favor of the aggrieved resident, then the matter is returned to the Program Director and the Program Education committee for review.

Step 3:
If the resident disagrees with the final decision of the CRA, then he or she may pursue further resolution of the grievance. The aggrieved resident must initiate the formal resolution process by presenting a written statement to the Chair of Department of Family Medicine within fourteen working days of receipt of the CRA's final written decision.

The statement should describe the nature of and basis for the grievance and include copies of the final written decisions from the Program Director and the CRA, any other pertinent information. Failure to submit the grievance in the fourteen-day period will result in the resident waiving his or her right to proceed further with this procedure. In this situation, the decision of the CRA will be final.

Formal Resolution
Request for Formal Resolution.

If the resident disagrees with the final decision of the Chair of Department of Family Medicine, he or she may pursue formal resolution of the grievance. The aggrieved resident must initiate the formal resolution process by presenting a written statement to the Director of Medical Education of the Hennepin County Medical Center within fourteen (14) working days of receipt of the Chair's final written decision.

The statement should describe the nature of and basis for the grievance and include copies of the final written decisions from the Program Director, the CRA, the Chair and any other pertinent information. Failure to submit

the grievance in the fourteen-day period will result in the resident waiving his or her right to proceed further with this procedure. In this situation, the decision of the Director of Medical Education will be final.

Confidentiality
All participants in the grievance process are expected to maintain confidentiality by not discussing the matter under review with any third party except as may be required for purposes of the grievance procedure.

Participants in the Council for Residency Affairs will sign an agreement to confidentiality at the start of their 2 year term.

Residents seeking relief under the Grievance Process agree that all documents, actions or discussions pertaining to the grievance issue may be made available to the CRA to assist them in their deliberations.

Amendments
This procedure may be amended any time, or from time to time, in writing, by the Family Medicine Residency.

Residents will be notified of amendments during the monthly resident meeting, via memo in their mailboxes and by posting on the HCMC Intranet.

COUNCIL FOR RESIDENCY AFFAIRS

Purpose
The Council for Residency Affairs (CRA) will serve as an internal appeals committee for residents for resolving complaints which may arise between family medicine residents and the residency program to include:
1. Disputes or complaints related to unfair or improper application of a policy, procedure, rule, or regulation
2. Unresolved disputes or complaints with the Program Director or other faculty member not related to performance or appointment actions
3. Retaliation as a result of use of this procedure

Composition of Committee
1. This committee will be composed of 2 faculty members and 3 residents, and one Chief Resident
2. The Chair of the Department will appoint the faculty members and the Chair of the committee
3. Two residents shall be selected by their peers to be representatives to this committee. The term of appointment shall not be more than 2 years
4. A facilitator and a recording secretary will be provided to assist in the work of the committee. These 2 persons will have no input in the decision making process
5. The final decision of the Committee will be by majority
6. The recording secretary will prepare written documentation of the major deliberations and decisions of the committee
7. The written document will be forwarded to the Program Director and the Chief of the Department of Family Medicine after approval of the members of the committee
8. The committee shall meet on an ad hoc basis as determined by need

DUE PROCESS AND APPEAL

The following actions shall entitle the resident to a hearing and appeal upon timely and proper request from the office of the Medical Director:

Suspension of over 30 days from residency program
Non-renewal of contract
Termination from residency program

<u>The request for a hearing:</u>
Shall be made within 14 days after receipt of the disciplinary action.
Shall be in writing and directed to the Medical Director of Hennepin County Medical Center.
Failure to request a hearing constitutes waiver of all rights to appeal.
The details of the process of appeal are outlined in the HCMC Residents manual under the title Discipline/Dismissal of residents.

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FACULTY

PROGRAM DIRECTOR

Dr. Allyson Brotherson serves as the Program Director. The Program Director:

- monitors licensure requirements
- supervises resident orientation, develops the program of study with each resident, and finalizes all recommendations for modifications of the curricular program
- reviews all forms of resident feedback
- along with the resident's mentor, the Program Director will:
  - define the resident's progress and determine appropriateness of advancement
  - organize the in-training examination program, and will orchestrate the development of programs of remediation
  - monitor resident stress, fatigue, and general well-being
- oversee the Curriculum Committee, and assure that the Committee's decisions are consistent with requirements established by the ACGME for family medicine training programs
- maintain a process of continuous improvement for the individual resident, the program, and the patients cared for by resident services
- meet with each resident biannually, and create a summary statement of the resident's progress
- routinely notifies each resident by February 15th of the academic year of the intent to advance the resident to next level of training
- create a summary document of all graduating residents

CORE EDUCATIONAL FACULTY

Core educational faculty support the Program Director in assuring the creation and implementation of an individualized program of learning that will support each resident's goal of mastery of the Six Competencies as defined by the national accrediting bodies.

Each resident will be assigned an advisor, who will provide individualized attention to the personal and professional development of that resident. The advisor will formally meet with the resident at least three times yearly to review resident progress. The resident's advisor will also serve as the resident's ambulatory clinic supervisor.

A full-time faculty member will be on call at all times, and is available to discuss any patient care issues**. THE CALL SCHEDULE IS AVAILABLE ONLINE AT WWW.AMION.COM.**
Dr. Jerome Potts, Chief of the Department of Family Medicine, handles informatics issues.
Dr. Kimberly Petersen, Associate Program Director, oversees inpatient training and residency clinic scheduling, practice management, and the conference program.
Dr Ayham Moty, is Medical Director of the Whittier Clinic, and oversees evidence-based medicine teaching, and residency research and scholarly activity. He also supervises the ambulatory component of the training program

Faculty rotation liaisons are described in the curriculum manual.

THE CHIEF RESIDENTS

Chief residents are resident leaders, advocates and liaisons to the Family Medicine Program Director, faculty, hospital and medical community. The Chief Resident positions are leadership development positions that involve service in a number of areas including administration, education, leadership, and supervision activities of the residency. The Chief Residents are the administrative representatives for all the residents and serve as liaisons for all the residents' complaints. The Chiefs are the official intermediaries between residents, faculty and staff. The Chiefs assist the Program Director in evaluating residency concerns, developing policies and procedures and determining appropriate disciplinary actions in accordance with due process. The Chief Residents also, by their example foster the professional attitudes and image expected of Family Medicine residents. The Chief Residents report to the Program Director and work closely with the Residency Coordinator, faculty and the Clinic Practice Manager to ensure the smooth operation of the Family Medicine residency.

RESIDENCY PROGRAM COORDINATOR

The residency program employs a full-time Program Coordinator. Melinda Chatelle is responsible for assisting the Program Director with administering policies that govern the function of medical education. The Program Coordinator is responsible for implementing and overseeing strategies to track resident performance and in ensuring compliance to all regulatory requirements.

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THE EDUCATIONAL PROGRAM

CURRICULUM GRID 2014-2015

Block	G1		G2		G3	
1	Family Medicine Inpatient 1.1 (Petersen, Councilman) 16 weeks	Continuity Clinic 1-2 sessions per week	Family Medicine-Inpatient 2.1 (Petersen, Councilman) 8 weeks	Continuity clinic 2-3 sessions per week	Family Medicine-Inpatient 3.1 (Petersen, Councilman) 8 weeks	Continuity clinic 3-5 sessions per week
2						
3			Adult Medicine Medical Intensive Care (Councilman)		Practice Readiness (Brotherson)	
4	Adult Medicine Inpatient (green) (Councilman) 4 weeks		Pediatrics 2.1 (includes Adolescent)		Gillette Pediatric 3.1 (Newman)	
5	Adult Medicine Cardiology Care Unit (Councilman)		Pediatric ED 2.2		Ambulatory Pediatrics 3.2 (Newman)	
6	Pediatrics 1.1 (Newman) 8 weeks		Family Medicine Obstetrics (Karsten)		Gynecology (Pira)	
7			Ambulatory Surgery (Hemmati)		Surgical sub-specialties (Anderson)	
8	FMS – see above		Preventive Medicine (Hasti)		Medical sub-specialties (Councilman)	
9	Obstetrics (Pira)		Dermatology (Brotherson)		Orthopedics (Anderson)	
10	Surgery (Hemmati)		Sports Medicine (Anderson)		Family and Community Medicine /Ambulatory (Sroka/ Petersen)	
11	ED 1.1 (Petersen)		Geriatrics (Ngodup)		Geriatrics Elective Ngodup (4 weeks) AND Elective (Petersen) 8 weeks	
12	Radiology/ Family and Community Medicine (Haddow)		ED 2.1 (Petersen)			
13	Psychiatry/ Neurology (Anderson, Councilman)		Elective (Petersen)			

	G1	G2	G3
		Behavioral Medicine (Anderson, Newman, Sroka, Parker)	Baraza (Brotherson)
		Centering Pregnancy (Hasti, Karsten)	
		Geriatric Medicine (Nursing Home-Ngodup, McTavish) PGY 2,3	
Longitudinal	Wednesday Core conferences (Petersen, chief residents)		
	Outpatient Clinic conference (Faculty TBD. Chief residents)		
	Management of Health Systems (Petersen)		
	Research and Scholarly Activity (Moty)		
	Integrative Medicine (Sroka, Parker)		

Revised 3/10/14

PROGRAM CURRICULUM

The program curriculum describes the general goals and objectives of the training program, as well as the overall evaluation methods to assess competencies including patient care, medical knowledge, professionalism, practice-based learning, and systems-based practice. The program curriculum complements individual rotation curricula. Rotation-specific learning objectives and means to accomplish these objectives are described in the individual rotation curricular document. It is the responsibility of the intern/resident to regularly review the program and specific rotation curricula, and to present the rotation curriculum to the teaching attending on the first day of the rotation so that personal learning objectives may be reviewed in the context of this document. It is the responsibility of the teaching attendings to provide daily formative feedback as well as summative feedback at the midpoint and end of the rotation. It is the responsibility of the intern/resident to use this information, along with other feedback described above, to facilitate a process of continuous improvement. In addition, the resident will provide regular written evaluations of the faculty and program to facilitate continuous improvement of the training program. The resident will regularly reflect on the quality of care provided to his/her patients, and agree to be actively involved in the hospital's and clinic's efforts of continuous improvement in the quality of patient care.

DIDACTIC CURRICULUM

The residency program offers residents a full spectrum of core topics related to Family Medicine during the Wednesday Core Conference time. We continue to tweak parts of the curriculum to keep abreast of the rapidly changing educational environment.

The Behavior Medicine Longitudinal Curriculum runs monthly seminars for the G2's and G3's as well as teaching advanced interviewing and doing video reviews. Behavioral medicine faculty lead 3 seminars with the G1's, and also teach interviewing skills. The G1's use their additional seminar time to do a series on Outpatient Basics focusing on outpatient management of common problems and how to use EPIC as an effective tool in these encounters.

ACADEMIC HALF DAY

The Family Medicine Core Curriculum is taught to all residents. This curriculum is designed to reinforce knowledge gained on clinical rotations in both the inpatient and ambulatory settings. Lectures are provided by Family Medicine faculty members, residents as well as other medical specialists. Topics include Adult Medicine: Allergy and Immunology, Cardiology, Gastroenterology, Hematology, Infectious Disease, Men's Health, Nephrology, Neurology, Pulmonology, Women's Health, and the Older Patient. Other areas include: Care of Neonates, Infants, Children and Adolescents, Care of the Skin, Care of the Surgical patient, Community Medicine, Family Orientated Comprehensive Care, Maternity and Gynecologic Care, Musculoskeletal and Sports Medicine, and Procedural Training.

Team meetings: Recognizing the role of the team in the care of patients and the residents' role as team leader in their future practices, the residency program and the clinic provide many opportunities for interdisciplinary team work. Residents, in their teams, do QI projects, work on improving patient outcomes, and coordinate care for complex patients.

Journal Club is held monthly. Residents, under the tutelage of a faculty member, review evidence based articles and evaluate whether they provide convincing evidence to make practice based changes.

M&M.

Adult Medicine/ Pediatric M&M

Once per block, 2nd year residents, with faculty input, present cases from the Family Medicine Inpatient Service. The cases must meet criteria for challenging or interesting diagnoses or defined adverse events. Challenging or interesting cases include rare or unusual medical cases or those that presented a diagnostic challenge. Adverse events are defined as undesirable, unintended events occurring during medical intervention which may or may not be caused by the intervention. The cases presented must fit one of the following categories:

Mortality (expected or unexpected)
Prolonged LOS
Avoidable admission
Outpatient complications
Procedure complications
Medication errors
Interesting cases
Communication errors/conflicts between consultants and primary care team
System flaws or system issues
Other- did not meet IOM guidelines: i.e. care of patient was not Safe, Timely, Effective, Efficient, Equitable, Patient focused

Board Review – All faculty are involved in conducting board review sessions twice monthly.

Expectations for attendance at Wednesday Core conferences:

- All residents except those on ER shifts, nights, and Yellow Medicine, on vacation, ill or at "away" electives are required to attend the Wednesday Core Conference. Satisfactory attendance is defined as 80 %. Required rotations, illness, vacation and away rotations /conferences are included in the 20% allowance for absence. Attendance is documented for accreditation purposes. Residents may not sign for one another
- In order to qualify for CME travel allowance, 80% of required conferences must be attended
- Each resident must personally sign in at each core conference. This sign-in is the only record that is used to enter a resident's attendance into RMS
- Residents are expected to be on time. Attendance is recorded
- Conference attendance is averaged quarterly

Excused absences from Wednesday conferences

Excused absences from Wednesday conferences include residents on nights, vacation, academic leave, out of state or country electives, residents on MICU and some FMS-A rotations. Residents are expected to attend all or 100% of the remaining conferences. Excused absences account for 20 % of the total conference time.

Unexcused absences are not allowed and vacation days will be deducted for these absences.

Residents falling below the required attendance will receive a Level 1 letter for a first offense. Level 2-3 corrective action for repeat absences. Approval of external CME is contingent on satisfactory attendance at Wednesday Core conference

POLICY ON LIFELONG LEARNING AND USE OF IN-TRAINING EXAM SCORES – ACADEMIC ENHANCEMENT AND PERFORMANCE IMPROVEMENT PLAN

Purpose:
To encourage efficient lifelong learning. To provide guidance for residents regarding interpretation of the ABFM in-training exam scores and to describe the performance improvement plans which may need to be implemented in areas of knowledge deficiency. To achieve a 100 % pass rate for first time takers on the ABFM Certification examination.

Procedure:
It is the goal of the HCMC Family Medicine Residency to create an environment that fosters scholarship and lifelong learning.

The American Board of Family Medicine (www.theabfm.org) administers an In-Training Examination (ITE) annually in October. This exam is absolutely critical to your education. While no exam is ever a surrogate for your abilities as a current and future clinician, the standardized exam is a time-honored, objective method of assessing a fund of knowledge on which clinical knowledge depends. The in-training exam also correlates with future scores on the ABFM Board Certification Exam and is closely monitored by the residency and by the Family Medicine Residency Review Committee for the ACGME. Thus, preparation for the ITE and for the ABFM Boards is important.

This policy describes a plan for lifelong learning that assists residents in longitudinal Board preparation, as well as to help residents meet these benchmarks, or remediate to attain benchmarks on the next ITE.

Plan:

A. Lifelong Learning :
All residents will
Read twice monthly AFP journal and complete each quiz (2 per month).

- Log on to the AAFP website: www.aafp.org.
- You must use your own username and password to obtain access to the site and appropriate CME credit. If you do not remember your username and password, contact AAFP at 800-274-2237
- Sign in to AFP quizzes: AFP CME Quizzes
- Complete the quiz twice monthly
- One of the core teaching faculty will review key questions from the AFP journal once per month during the Structured Board Review
- Report CME from quiz completion on your AAFP CME site
- Print copy of transcript from AAFP website and place in portfolio for biannual review

B. In-Training Examination
The ABFM has identified a set of internal benchmarks for the Intraining examination.
Expected Benchmarks:

Year of Training	ITE Score
G1	390
G2	410
G3	440

Individual education plans are described below to help residents meet these benchmarks or remediate to attain benchmarks on the next ITE.

1. RESIDENT MEETS BENCHMARK FOR YEAR OF TRAINING:
Review your ITE results. Log on to the ABFM website. You will need your username and password. Review your board score, z-score, ITE questions (highlighted questions are the ones that are incorrect). Review your incorrect answers. Use exam answer book for rationale. Focus your study in the content areas where you had difficulty.

Continue current study plan; consider using resources for self-study provided in this document.

Residents may choose to complete 10 board review questions weekly; choose topic areas for board questions based on performance on ITE and focus on areas where performance was suboptimal.

- Log on to the AAFP website: www.aafp.org
- You must use your own username and password to obtain access to the site and appropriate CME credit. If you do not remember your username and password, contact AAFP at 800-274-2237
    - Sign into the Sample Board Questions
        - AAFP Sample Board Review Questions
        - After you complete the board review section you have selected, it will automatically score, have answer explanations, and will list your completion on your CME tracker
            - Print out CME verification from the AAFP website and place in portfolio for biannual review. CME verification is in your CME tracker on the AAFP website

2. RESIDENT BELOW BENCHMARK FOR YEAR OF TRAINING:
Basic Study
All training years:

1. **Review your ITE results**. Log on to the ABFM website. You will need your username and password. Review your board score, z-score, ITE questions (highlighted questions are the ones that are incorrect)
2. Review your incorrect answers. Use exam answer book for rationale
3. Focus your study in the content areas where you had difficulty
4. **Meet with faculty advisor** to discuss results

Level 1 performance improvement
$-0.7 \geq Z$ score ≤ 0
(**Between the 25th and the 50th percentile**):

ADDITIONAL OPTIONAL STUDY
PGY3 only
Complete 10 board review questions weekly; choose topic areas for board questions based on performance on ITE and focus on areas where performance was suboptimal.

- Log on to the AAFP website: www.aafp.org
- You must use your own username and password to obtain access to the site and appropriate CME credit. If you do not remember your username and password, contact AAFP at 800-274-2237
- Sign into the Sample Board Questions
    - AAFP Sample Board Review Questions
        - After you complete the board review section you have selected, it will automatically score, have answer explanations, and will list your completion on your CME tracker
- **Print out CME verification from AAFP website. Give a copy to Peg Sullivan**. Keep a copy for portfolio for bimonthly review

PGY2 and PGY1:
Follow the details of the remediation plan sent to you.

Level 2 performance improvement
Z score < - 0.7
(< 25th percentile)

ADDITIONAL MANDATORY STUDY
PGY3
(Please discuss your plan with your advisor who can help answer questions or work with you on your remediation plan).

Do FP comprehensive questions
Every month, resident will be assigned 50 questions from FP Comprehensive by Dr Petersen.
Resident must meet once per month with a faculty educational consultant (person to be determined) for review of exam questions.
Resident must keep a log that they have completed the assignment. Log must be signed by educational consultant and reviewed with faculty advisor at quarterly evaluation meetings.

PGY2
Follow the details of the Level 2 remediation plan sent to you.
Referrals for exam preparation and test taking strategies (Please discuss with your advisor who will help you to make the arrangements).

PGY1
Follow the details of the Level 2 remediation plan sent to you.

Compliance means:
After in-training exam, meet with faculty mentor to develop IEP (required portions of IEP listed below).
Meet monthly with faculty mentor and review IEP progress.
Completion of Challenger (PGY1 and PGY2) or FP Comprehensive modules (PGY3) as defined.
Completion of all biweekly AAFP journal quizzes (and documentation) on schedule.
Compliance with IEP will be reviewed **quarterly** at resident review.

Failure to comply with this plan may result in academic probation.

PROCEDURE / EXPERIENCE DOCUMENTATION

PROCEDURES LISTED ON PAGES 1 TO 3 OF THIS DOCUMENT ARE REQUIRED FOR GRADUATION FROM THE HCMC FAMILY MEDICINE RESIDENCY

ALL procedures must be documented on New Innovations Residency Management Suite (RMS) to be considered toward residency completion requirements. Proper documentation is critical for future hospital and clinical practice credentialing.

Periodic reports will be generated from the procedure database and placed in the permanent record of each resident. Numbers and types of procedures done by each resident are discussed at resident evaluation meetings and advisor meetings (held periodically).For any questions regarding this policy, please see the Residency Program Director. For technical questions regarding the documentation, please contact the Residency Coordinator/Assistant Coordinator or the Dept. Chief.

Curriculum

1. Didactics:
   Residents will participate in a procedure didactic during Orientation and during the Wednesday Core conference series or in the simulation center.

2. **ACGME- RRC general procedures and experiences (required for certification**)
   General procedures and experiences that the RRC in Family Medicine has indicated are mandatory for successful Board eligibility

Rotation requirements needed for ABFM certification

Procedure	Credentialing target	Recommended time for certification	Forum where experience obtained
Critically ill	15	PGY2	ICU, CMIC
Home visits	2	PGY2	
Adult Inpatient	750 patient encounters	PGY1,2,3	Adult Medicine , FM Inpatient
Pediatric Inpatient	250 patient encounters At least 75 Pediatric ED At least 75 Inpatient Pediatric encounters	PGY1,2,3	Pediatric , NICU, Pediatric ED
Newborn	40	PGY1,2,3	NICU FMS Inpatient PGY1Peds
Continuity patient visits			
TOTAL REQUIRED	1650	PGY1,2,3	WHC
# of patients of total Age <10	165	PGY1,2,3	WHC
# of patients of total Age≥60	165	PGY1,2,3	WHC, Nursing Home
Required by training year	150	PGY1	WHC
Recommended by training year	500	PGY2	WHC, Nursing Home
Recommended by training year	1000	PGY3	WHC, Nursing Home

3. **HCMC-FMRP procedures (required for graduation)**

a. Credentialed procedures with test of independence (required for graduation)

Residents must perform a minimum number of these procedures under supervision **and must demonstrate independence in their performance.** Faculty members must complete competency evaluations on a web based evaluation tool.

Procedures and experiences needed for completion of residency

Procedure	Credentialing target and test for independence required	Recommended time for certification	Forum where procedure learned
Sterile technique		PGY1	Orientation Simulation
Skin procedures			
Skin tag removal Cryosurgery skin Excisional biopsy / Punch biopsy Lesion destruction/removal I&D abscess	3 from each category. (Independence in performance of general skin procedures must be ascertained during Ambulatory Surgery Procedure clinic).	PGY1, 2, 3	Procedure clinic ED Simulation lab
Toenail removal	5	PGY1, 2, 3	ED, Podiatry
GYN procedures			
Pap smears	5	PGY1- Orientation	WHC continuity clinic ‘GYN
Contraceptive device placement IUD or Nexplanon placement	5	PGY1, 2, 3	WHC continuity clinic ,GYN Procedure workshop
Orthopedic procedures			
Joint injections (knees, shoulders)	5	PGY2, 3	Sports medicine Orthopedics

*New procedures added 2014

Independent performance of a procedure includes all of the following criteria:

- Knowledge of the indications and contraindications for the procedure
- Knowledge of potential risks of the procedure and the ability to clearly explain these risks to the patient
- Technical proficiency to complete the procedure
- Ability to anticipate and handle potential complications
- Appropriate documentation of the procedure

b. Procedures with no test of independence but required for graduation

Residents must also seek training in other procedures that will be required for their future practice as family doctors. Residents must also document these procedures on their RPS procedure logger

Procedure	**Credentialing target**	**Recommended time for certification**	**Forum where procedure learned**
Colposcopy	5	PGY3	Colpo clinic, GYN
Circumcisions	3	PGY1, 2, 3	FMS Inpatient
Laceration repair/suturing/ wound closure	5	PGY1, 2, 3	ED Direct care
Orthopedic procedures			
Casts or splints	3		Ortho. Sports medicine , ED
Training experiences			
Continuity Visits to primary hospitalized patients	10	PGY1, 2, 3	HCMC Inpatient
Primary OB	10	PGY3	
Other deliveries	40	PGY3	FMS, Obstetrics
OR ASSIST	3	PGY1	Surgery

4. Elective Procedures

Residents may perform other elective procedures throughout training which they may document. These procedures are recommended but not required for graduation. These will not require test of independence. There are no minimum numbers required for these procedures. These procedures and the numbers completed will be recorded on the resident's final evaluations for licensing authorities and for future employers. The Program will report the number performed and indicate that resident is knowledgeable

The competency rating is as follows:

- **Developing** – Needs to be prompted and coached for every step of the procedure
- **Progressing** Able to perform the procedure with minimal prompting or coaching
- **Independent** Able to perform the procedure with little coaching. Once a resident has achieved independence rating by faculty or senior resident (for OB procedures) no further test of independence is required
-

INTERPRETIVE SKILLS

Residents must develop competency in interpretation of these common tests used in patient care prior to graduation

Skill	Setting	Recommended time for certification
EKG interpretation	Orientation, Core Conference , Cardiology	PGY1
Urinalysis	Continuity clinic	PGY1
X-ray interpretation	Radiology. Sports Medicine, medicine rotations	PGY2
Spirometry	Continuity clinic	PGY2
Fern test	OB, FMS Inpatient	PGY1
NST interpretation		
Electronic fetal monitoring		

The following are the procedures and interpretive skills which residents may learn on each rotation listed below:

Rotation Experience	Procedures	
Adult Medicine	ABG interpretation, Chest X ray interpretation Fluid and electrolyte management Spirometry	Bi pap machine management EKG interpretation Central Line insertion
Pediatric	Cerumen removal Peak flow measurement	Developmental screen interpretation Newborn resuscitation Pediatric X ray interpretation
Obstetrics	Vaginal delivery Vacuum assisted vaginal delivery Amniotomy Insertion of intrauterine pressure catheter with or without amnioinfusion Fetal scalp electrode placement Cervical ripening with Prostaglandins or Foley bulbs Circumcisions	Laceration /episiotomy repair • 1st and 2nd degree • 3rd degree Labor Induction/ Augmentation Management of VBAC Interpretation of fetal monitor
Gynecology	Colposcopy ECC IUD insertion PAP smears	Cervical biopsy LEEP Pelvic and breast examination
Surgery/ Ambulatory Surgery clinic	Aseptic technique Local/regional anesthesia Toenail removal Surgical wound closure Knot tying	Bladder catheterization Minor skin procedures Parenteral nutrition Wound debridement
Emergency Medicine	Anoscopy Burn management Removal of foreign bodies	NG tube insertion Nasal packing Laceration repair
Orthopedics	Cast and application Management of sprains	Closed reduction of fracture Extremity X rays
Sports medicine	Application of braces Performance of musculoskeletal examination	Joint aspiration Rehabilitation of sports injuries

Supervision of procedures:
All procedures must be supervised either by a senior resident or a faculty physician

6/9/14

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RESIDENT PROFESSIONAL BOUNDARY POLICY

Background:
In rural settings, where resources can be limited, it is sometimes common for healthcare providers to "wear several hats" with other people, for example being both the close colleague as well as the patient of another physician. In the Twin Cities there are many options to avoid these complex "dual relationships."
With regards to physicians caring for their own families, all physicians must discern where the line is between being a responsible family member and delegating to a non-family member physician the role of medical provider. In general it is safer to have a non-family member take responsibility for the medical decisions for our family members, so that we can hold on to the role of family member without other complicating responsibilities

Procedure:

- To protect residents from overly complex relationships HCMC family medicine residents must not be the PCP for another HCMC family medicine resident
  - unless there is no non-resident provider available in a timely way (for example if there is no non-resident provider available in direct care when a resident needs moderately urgent care.)
  - In this situation must discuss provision of any medical care for colleagues with attending preceptors/ staff.
- HCMC family medicine residents must not be the PCP for themselves
  - Family medicine residents may have their medical care managed by a non resident providers .
  - Family medicine residents may consider having their primary care needs managed at one of the HCMC Community clinics- Northpoint, East Lake, Brooklyn Park, Richfield, St. Anthony's.
- Under no circumstances should an HCMC resident provider prescribe controlled substances to any resident colleagues or themselves
- Family medicine residents should not provide prescriptions or medical care for their own family members. If a resident believes there are extenuating circumstances that would lead him or her to appropriately provide medical care to a family member s/he needs to discuss this with his/her advisor or Dr Brotherson.
- Family medicine residents may serve as the PCP to a family member of resident colleague**. In taking on the care of the family of a colleague, residents should be particularly aware of the potential conflicts of interest that can arise, and are encouraged to seek closer than usual faculty supervision.**

Questions about how to manage complex situations or to transition out of relationships that pre-date this policy should be discussed with residency behavioral science faculty, advisor or other residency faculty.

RESIDENTS AS TEACHERS

"Intrinsic to the discipline are scientific knowledge, the scientific method of problem-solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values*."* It is a tradition of our profession not only to pursue lifelong learning for ourselves, but also to educate those less experienced in the practice of medicine. As a component of professional development, as well as enhancement of communication skills and reinforcement of medical knowledge, it is expected that all residents in the program will serve as teachers for their peers and junior team members. Teaching skills and techniques will be introduced to the residents during specific teaching workshops and modeled on clinical rotations. Interns will practice teaching skills by mentoring medical students as well as by participating in resident conferences and supporting one another in daily patient-care responsibilities.
Residents will have gradually increasing responsibility in teaching, so that advanced residents will teach second-year residents, interns, and students, as well as their peers. This may occur during routine patient care or in the form of increased responsibilities during resident conferences and teaching rounds.

RESEARCH AND SCHOLARLY ACTIVITY

Residents are expected to participate in research and Scholarly activity during residency. They are expected to complete and share the results and conclusions for scholarly projects, of which at least one must be a practice performance project.

Guidelines for the Appropriate Use of the Internet and Social Networking Sites

Social and business networking Websites (e.g. MySpace, LinkedIn, Facebook, Twitter, Flickr, etc.) are increasingly being used for communication by individuals as well as businesses and universities. As such, it has become necessary to outline appropriate use of these social media networks.

Guiding Principles:

1. Privacy and confidentiality between physician and patient is of the utmost importance.
2. Respect among colleagues and co-workers must occur in a multidisciplinary environment.
3. The tone and content of all electronic conversations should remain professional.
   a. Use salutations
   b. Avoid writing your text in all capitals
4. The individual is responsible for the content of his/her own blogs/posts.
5. Material published on the web should be considered **permanent**.
6. Any information you post on the internet is **public information.**
7. All health care providers have an obligation to maintain the privacy of patient health information as outlined by the Health Insurance Portability and Accountability act (HIPAA)
8. Residents should adhere to all principles outlined in the HCMC Resident manual and the FMRP Policy and procedure manual when interacting on the internet.
9. Internet use must not interfere with the timely completion of job duties.
10. Personal blogging or posting of updates should not be done during work hours or with work computers. (No E-Bay shopping in patient care areas.)
11. It is always inappropriate to "friend" patients on any social networking site or to check patient profiles.
12. Avoid discussing any sensitive, proprietary, confidential, private or financial information about HCMC.
13. Refrain from posting any material that is obscene, defamatory, profane, libelous, threatening, harassing, abusive, hateful or embarrassing to another person or any other entity.

14. Be aware that you may be held responsible for any personal legal liability imposed for any published content.
15. Social networking sites can be the source of cyber bullying, harassment, stalking, threats or unwanted activity. If you are concerned, please contact the Family Medicine Department office.

Patient Information:
Identifiable protected health information (PHI) should **NEVER** be published on the internet. This applies even if only the patient is able to identify him/herself from the posted information. Residents must adhere to all HIPAA principles.

Communication Regarding Hospitals or the University: Unauthorized use of HCMC information or logos is prohibited. No phone numbers, email addresses, web addresses or the name of the department or the hospital may be posted without permission from an authorized departmental individual.
In all communication where you are listed as being affiliated with the Hennepin County Medical Center or Department of Family Medicine, a **disclaimer** must be attached such as "All opinions and views expressed, in my profile (on my page) are entirely personal and do not necessarily represent the opinions or views of anyone else, including other faculty, staff, residents or students in the Family Medicine residency or the Hennepin County Medical Center. Neither the Family Medicine Residency program nor the Hennepin County Medical Center has approved and are not responsible for the material contained in this profile (on this page).

Offering Medical Advice
It is never appropriate to provide medical advice on a social networking site.

Privacy Settings
Residents should consider setting privacy at the highest level on all social networking sites.

Disciplinary Action
Residents discipline follows the Non-Academic Deficiencies/Misconduct/Allegations of Misconduct. Disciplinary action will be determined by the Program Director and will vary depending on the nature of the policy violation.

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CLINICAL

AMBULATORY CLINIC: POLICIES AND PROCEDURES

Family medicine residents spend increasing time in the ambulatory clinic during their residency training Regular opportunities for ambulatory training occur through the continuity clinic experience and direct care at Whittier Clinic, ambulatory block rotations, and in outpatient specialty clinics at HCMC.

Philosophy
The Whittier clinic provides care for a variety of patients.

Patient Care Objectives
• To make available to the community quality health care which takes into account the individual's total need.
• To assure continuity of care by implementing and maintaining a plan of follow-up to include appropriate referrals to other healthcare providers
• To provide effective health education to patients
• To promote cooperation and communication among all members of the health team and allied community agencies to avoid duplication of effort and contradiction of goals
• To provide services in a manner and in a setting that recognizes the patient's dignity
• To provide services with a minimum of waiting time and in a manner that respects the patient
• To provide the same quality of health care to all patients, regardless of race, creed, or socioeconomic situation
• To provide a milieu for the education of medical students and residents in the provision of high quality, cost-effective care

TEAM STRUCTURE AT WHITTIER

The medical providers at Whittier clinic are part of interdisciplinary teams that include chronic care model precepts. Residents practice in the Purple North and Purple South teams. Each team is divided into 3 pods, each led by a core faculty provider and containing residents from each training year. Most pods contain one G3, G2 and G1 each. The team assumes the care of the patients in the panel. Each resident has a panel of patients for whom he/she is the identified primary care provider (PCP).
Teams meet twice monthly with their team faculty leads, registered nurse and medical assistants, interpreters, clerical staff, and social worker to discuss process issues, patient outcomes, quality improvement plans and, to brainstorm around complex patients or problems.

PATIENT PANELS

The resident's patient panel is assigned for the duration of the residency. The initial panel is composed of patients from graduating residents' panels, patients new to Whittier, and UNASSIGNED PATIENTS FROM THE Inpatient Service; or a resident may add family members of his currently assigned patients to his panel at any time.

The resident's panel will increase over the three years in keeping with the increased time spent in the clinic.
Current panel size goals are:
PGY1 62-90
PGY2 250
PGY3 420

In keeping with good medical practice, it is expected that the resident will not care for his own family or write prescriptions for them. No resident will examine or prescribe for a patient without a note being made in the patient's chart.

Assignment of patients to residents by training year
Goal for scheduled and same day visits
At each PGY year goal is 65-75% scheduled
25-35% same day (either their own or team patients)

PROCESS FOR SEEING PATIENTS AT WHITTIER

After being registered, a nursing assessment is performed on each patient, which includes the taking of vital signs. The patient is then escorted to a room and assisted into an exam gown when appropriate. The resident is responsible to review the nursing assessment of each patient, and update the problem list and medication list at each visit. After completing the assessment, the resident presents his/her findings to the attending physician.

The resident returns to the patient for closure. The resident will complete any necessary orders in the record, and a medical assistant and scheduler initiates all tests and follow-up appointments. Residents must complete all clinic notes on the day of the clinic session.

The number of patients scheduled increases with training level. Up to 7 patients are scheduled for interns, and up to **12** patients per upper-year resident. The residents are directly under the supervision of a faculty member. The supervising faculty shares patient care responsibilities with the resident. The attending physician is always present during the clinic sessions.

First-year residents must have one of the precepting attendings see each patient during the first six months of the resident's first year. Second and third-year residents will have an attending available to address any questions. For all residents seeing Medicare patients, consultation with an attending is required before the patient is discharged from clinic.
All cases should be presented to the attending. Consistent dialogue between attending and resident regarding some learning issues on most patients is strongly encouraged. The attending reviews the electronic chart of patients seen in each clinic session.

Residents are expected to be at the office before their first patient. If a resident must be late or cancel a scheduled clinic session, the resident must notify the Program Coordinator or their designee prior to the start of clinic (8:00 am for primary clinic or for Direct Care, 1:00 pm for afternoon clinic, 5:30 pm for evening clinic). The Program Coordinator will notify the clinic scheduler who then notifies the appropriate clinic staff. The resident is responsible for notifying the senior resident/faculty when late/absent from a rotation.
The days when the resident is assigned to Whittier are determined by the rotation to which the resident is assigned**.**

PCP DESIGNATION

Whittier Clinic - Primary Care Provider (PCP) Designation Policy (dated 10-17-2011)
At Whittier Clinic, identification of a patients' Primary Care Provider (PCP) occurs through use of the PCP field in Epic. There are several fields in Epic that are available to designate a PCP. The purpose of this policy is to outline the process for assignment of the PCP-General in Epic. The PCP-General designation implies a continuous and comprehensive relationship between the patient and the provider.

Assigning New Patients a PCP

New patients to Whittier Clinic are registered and scheduled for their first appointment by an agent at the Contact Center. The Contact Center agent helps the patient determine the first appropriate appointment available through use of provider profiles and processes supplied by Whittier Clinic Leadership. The Contact Center agent will change the PCP-General field in Epic to the provider the patient is scheduled to see for their first appointment at the clinic.

Exception: Walk-in patients seen predominantly in Direct Care are registered by a PSC (clerk) on site at Whittier. Direct Care is never identified as a PCP.

Changing a PCP- Initial visit

As part of the patients' first visit at the clinic, the provider will initiate a conversation around establishing primary care. If the patient and provider mutually agree to continue in a primary care relationship, the PCP-General field remains unchanged after the initial visit.

If the provider, patient, or any member of the care team, feel reassignment is necessary after only one visit, then the PCP-General field can be changed by any care team member to the provider the patient is next scheduled with. If the patient does not make another appointment before leaving the initial visit, any of the individuals permitted to change the PCP field (see below list) can then change the PCP field to Unknown PCP or another appropriate designation.

If a patient does not show for the initial visit, it is the responsibility of the provider scheduled to see that patient to ensure their name is removed from the PCP field. PCP Unknown should be designated by one of the individuals permitted to change the PCP field (see list below).

PCP Reassignment Process

If the provider, or any member of the care team, determines a change of PCP is necessary, the following procedure must be completed before changing the PCP-General field in Epic.

The following are the only individuals permitted to change the PCP field in EPIC:

- Faculty Providers (including all preceptors)
- Nurse Practitioners
- Clerical staff at the direction of faculty, preceptor or nurse practitioner
- RNs after discussion and approval by faculty, preceptor or nurse practitioner
- Residents at the direction of preceptor

Exception: Any care team member can change the PCP field from No PCP or PCP Unknown at any point in the patient's clinic based care.

1. All providers and care team members must have a discussion with the patient prior to changing the PCP assignment in Epic. This discussion needs to be documented in an encounter in Epic
2. Any provider currently practicing at Whittier will be at minimum notified by an Epic In- Basket Message, preferably consulted in person, if a patient's PCP field is changed from their name to a new provider
3. Anyone changing the PCP field without speaking with the patient in person (i.e. clerk at the direction of approved providers, preceptor after discussion with resident) is required to either ensure the interaction is documented in Epic or to generate a letter to the patient

Upon a provider leaving a practice, the clinic will implement the transfer of patients' process within a maximum of 1 month of the provider's departure. Exception: graduating resident transfer of care process may take up to two months.

OB PCPs

Only after the RN OB Intake will a patient's PCP through their OB experience be established. It is critical that all providers respect the role of the RN OB Intake and the choices available for how their prenatal experience will be managed.

At the OB Intake, the patient will be offered three choices for their prenatal care. That choice will then be reflected by the PCP assignment in Epic:

1. Patient has PCP at Whittier
   The patient will continue her prenatal care if her PCP provides prenatal care and the patient desires to keep her PCP
2. Patient with no PCP at Whittier

- **Resident provider** – RN reviews OB primary spreadsheet to determine which provider is in most need of deliveries and meets the patient's preference for a prenatal care provider.

  - **PCP field = Identified Provider**

- **Centering Pregnancy –** RN explains option of Centering Pregnancy/ If selected PCP field = Centering Pregnancy

- **Women's Health Nurse Practitioner** – RN explains option of WHNP. If selected PCP field= Identified Provider

At no point should any care team member (other than one of the individuals permitted to change PCPs) change the PCP field for an OB patient at Whittier after the RN OB Intake process has been completed.

Removal of Primary Care Provider in Epic
Any provider can remove their name from the PCP field if the patient has not been seen in the clinic for more than three years. No PCP designation should be used.

EVENING CLINIC

To maximize continuity of care for patients and all residents, to balance staffing at Whittier, and to achieve RRC required numbers of continuity patients (150 for G1's; and 1500 total for G2's and G3's) G2 and G3 residents may be assigned to evening clinics.

1. G2's on the G2 outpatient month will continue being scheduled into evening clinics, 4 per month.
2. Residents who are assigned to back up for FMS will not be assigned evening clinics during the two weeks they serve on back up
3. Residents on electives with evening or out of town obligations may petition to limit their evening clinic assignment based on educational priorities (e.g. adolescent elective has evening clinics at community clinics)
4. The patients seen during these evening clinics will "count" toward the overall goal of 500 patients seen during the G2 year

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SATURDAY MORNING CLINIC

Saturday morning clinic is a voluntary moonlighting experience. Any G2 or G3 (and selected G1's – after the first six months) are welcome to moonlight in our clinic. The clinic hours are from 8:00 a.m. to approximately 12:00 noon.
Once you sign up for clinic you are responsible for finding a replacement if you cannot be there.
You cannot sign up for Saturday clinic if you are post call or on back up call.

The reimbursement for Saturday clinic is $110.00 for the day for G1's. The amount increases to $120.00 and $25.00 in CME money if you are a G2 or G3 and have worked fewer than five Saturday clinics. After working five Saturday morning clinics the amount paid to G2 and G3's is $130.00 and $50.00 in CME money. CME money may be used for travel or educational materials (which will be ordered on a quarterly basis). Prior to scheduling CME or purchasing educational materials, please speak with the Department secretary.

Please speak with the Student Coordinator in the FM dept. with any questions regarding Saturday clinic.

PRIMARY OB DELIVERIES AND WHITTIER CLINIC POLICY

The Department of Family Medicine is committed to residents delivering their primary OB patients with minimal disruption to educational and patient care commitments. The purpose of this policy is to outline the steps to be taken when a resident is assigned to clinic and learns that their primary OB patient is in labor. Patients should be managed over the phone as much as possible.

The primary resident must inform the FMS team and FMS faculty A or B at the time of admission to L&D. The FMS faculty determines when the resident is needed in L&D.

Note the following:
While patients are laboring, residents are expected to continue seeing patients in their assigned FM clinics and leave only when delivery is imminent (i.e., it takes approximately 15 minutes to get to HCMC). The FMS team and L&D RN will monitor the laboring patient for the resident.

When a resident has a patient in L&D and is scheduled in FM clinic, he/she will inform the FMS faculty. The FMS faculty will inform the FM Residency Coordinator (who will inform the clinic scheduler) when delivery is imminent. The FM Residency Coordinator will contact the resident with approval or denial to go to L&D. She will also inform the Whittier preceptors when resident is approved to leave for HCMC.

Patients in clinic will be seen by residents/faculty in clinic (facilitated by the session leader and faculty preceptors). Team clerks will call patients who have not yet arrived to be rescheduled as identified by the team nurse/session leader. Residents will return to clinic in a timely fashion.

Residents assigned to WHC Direct Care clinics are not always allowed to leave these sessions to care for laboring patients. Residents on other HCMC rotations are expected to complete their patient and other care responsibilities to that rotation before assuming management and delivery of their laboring OB patients. Residents are not to abandon their responsibilities on HCMC rotations to care for or deliver their primary OB patients or L&D.

Guidelines for WHC clinic
Residents are to review their clinic schedule (when the tentative is published) against their rotation responsibilities. Should you find you are double-booked you are responsible for notifying Angee Zelaya, clinic scheduler, in order for her to adjust your schedule. Ultimately, residents are responsible for their schedules.

Once the final schedule is published, with very few exceptions, there should be no changes to providers schedules.

EXAMPLE: calling the day before a clinic is scheduled or the morning of a clinic schedule and stating you just noticed you are in clinic but postcall.

LATE TO CLINIC:
Residents are to call Mindy if they anticipate they will be arriving late to clinic. Clinic start times are:
8:00AM for primary clinic
8:00AM for Direct Care – do not look on EPIC for a schedule, look at your clinic schedule to see if you are in Direct Care
1:00PM for afternoon clinic
5:30PM for evening clinic

Residents are to arrive on time to their clinic team area, check in and be prepared to begin clinic. Patients, clinic team members and ultimately the residents are impacted when there is a late arrival to clinic.

Do not leave the team area to go work in the resident room or elsewhere to make phone calls in another area, clinic team members do not have the time to page providers to come to see patients.

Residents late to clinic without notification to Mindy (not a clinic team member or Angee) will:
1st time: receive an email from Mindy
2nd time: be required to meet with their advisor
3rd time: will have ½ day of vacation taken away

CLEAR COMMUNICATION IS IMPORTANT TO THIS PROCESS.

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INPATIENT SERVICE: POLICIES AND PROCEDURES

LIMITATIONS OF RESIDENT SERVICE:

It is the responsibility of the Program Director to ensure that the residency program does not place excessive reliance on the residents to provide for the service needs of the residency. The residency program is charged to ensure that a proper balance between service and education exists. One component of this is the program policy limiting the number of patients for whom residents provide ongoing care.

The Family Medicine Inpatient Service has an ever changing census and provides care for our clinic patients. Faculty members function as supervising physicians and delegate care to residents based on the needs of the patient and the skills of the residents. The Family Medicine Inpatient Service strives to maintain a census of sufficient numbers to ensure that each G1 resident has responsibility for an adequate number of patients.

When in Family Medicine Inpatient Service exceeds the limits delineated above, direct patient care is provided by mid-level providers and faculty physicians.

CALL FOR FMS

FMS – Sick Call/Emergency Policy

A resident unable to attend to his/her call duties due to illness or an emergency (unscheduled absence) must:

- Contact the Family Medicine Residency Coordinator by telephone (612-873-8082). If she is unavailable a message with directions on who to contact will be left for the resident to follow.
- During evening and weekends, the resident must call the back up call resident by beeper or call at home.
- Call the faculty and other resident on call to notify them of the change.

A resident unable to take a scheduled call on the FMS due to illness (including one evening ill) will need to provide a physician note to the residency in order to return to work. The G2/G3 resident will also have to “make up” the call missed. This also applies to emergency leaves. The residency coordinator will keep track of the call day(s) missed.

Back Up Call on FMS

Residents are scheduled for back up call on the FMS, when on a non call rotation, at the beginning of the academic year. If a resident is unable to take back up call due to a vacation or other commitment, the resident scheduled is responsible for finding a replacement and notifying the residency coordinator.

Only G2 and G3 residents are able to be on back up call. He/she is to have his/her beeper on 24 hours a day during the period he/she is serving as the back-up call resident. When listed as back-up call resident, you are expected to be able to take call. Please plan accordingly. Residents are to arrive at the hospital within one hour of notification if call has already begun.

If a resident agrees to switching back-up call with another resident, the resident agreeing to the switch must be sure that they have no commitments that will prevent them from coming in to take call should the need arise.

If the back up call resident is called in during the evening or weekend by a resident who is ill or has an emergent situation, the back up call resident does not have the authority to question the resident calling in, this is the responsibility of the residency. The resident is to prepare themselves to arrive on the service within one hour of notice. Please be sure to notify the residency coordinator in order to receive “guest call” credit for the call.

Residents who do not arrange for call coverage: The residency program will make every effort to avoid assigning residents for call during vacations and other approved time away from the program. It is the resident's responsibility, however, to check the call schedule for such conflicts. If such conflicts are found, it is the resident's responsibility to trade the call day with another resident.

Residents who fail to make this change and leave the call uncovered will be required to take 2 guest calls for every 1 call left uncovered.

Questions regarding backup call should be directed to the chief resident, then the FM Residency Coordinator, then to the Program Director (faculty advisor to the chiefs).

HCMC POST CALL FATIGUE AND CAB VOUCHER POLICY

Purpose:
We recognize that fatigued individuals often are not able to recognize their own limitations. Therefore, we also will provide cab vouchers for residents whose faculty or peers identify them as impaired by fatigue.

Policy:
We are committed to educate faculty and residents to recognize the signs of fatigue, to prevent and counteract its potential negative effects. In order to provide for the well being of residents, all residents who usually drive to work and are finishing in-house overnight call but who are too impaired to drive home safely will have the opportunity to return home using cab vouchers. The maximum voucher amount will be $35.00 per post call date and any additional cab fare will be borne by the resident. The maximum reimbursement will be to the resident's home or to a closer destination if the resident so chooses.

Procedure:
Obtaining a Ride: Residents/fellows may call Yellow Cab directly at 612-888-8889 and indicate that this is a non-patient transport request for Account HCMC GME, account # 1556, and give your name
Reimbursement: The maximum voucher will be $35.00 per call date; any additional cab fare will be borne by the resident.

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HAND-OFF COMMUNICATION

TRANSITION OF CARE POLICY

Responsibilities during Sign-outs:

The primary resident who is caring for the patient is responsible for reviewing and updating the information on the sign-out sheet

The senior resident is responsible for reviewing all information on the sign-out sheet

Faculty is present at hand over sessions and expected to give feedback to residents **Characteristics of handovers:**

Handover sessions should not begin until all appropriate members are present

Hand overs should happen in quiet and controlled environment to limit distractions

Handovers should be concise without any unnecessary information

Evaluation of the handover process:

This process is evaluated by faculty and monitored by the Program Director. Residents are evaluated at a mid-point during the block and receive formal feedback about performance

TEN INDICATORS OF EFFECTIVE SIGNOUTS

- Sign-out should take place face-to-face to facilitate clarification and collaborative cross-checking.
- Start times should be defined. Sign-outs occur at 7:15 am and 8:30 pm and are concise.
- Sign-out should take place in a quiet/secure location. Interruptions and distractions must be minimized. One team member should be assigned to answer pages and telephone calls in and adjoining room.
- The roles and responsibilities of all participants should be clear. In general, interns should "give" sign-out with senior residents listening and/or clarifying. Medical students, when present, should attend but should primarily listen.
- The focus should be on patient safety and effective communication, with an emphasis on synthesis and summation of atient information. These are not attending rounds. It should not be necessary to replicate large amounts of information either verbally or on paper that are already in the patient's medical record.
- The sickest patients should be specifically identified and information should be discussed in a consistent order using the agreed upon structure template.
- All participants should be physically present the entire time.
- Uncompleted tasks should be completed after sign-out has been finished.
- Off-task activities, such as writing notes and putting in orders, should be minimized to promote efficiency and only the essential information should be exchanged verbally. Other information can be written on the sign-out sheet and/or found elsewhere.
- Every sign-out should include a pertinent to-do list and contingency plans for anticipated events. The focus should be on trying to anticipate issues that might arise over the next shift, and what actions might be taken.

DRESS/SCENT CODE (HCMC AND WHITTIER CLINIC)

The dress/scent code policy applies to all employees while at HCMC and at Whittier Clinic. Key concepts of this policy are:

- HCMC nametag must be worn above the waist and visible at all times.
- Only minimal amount of jewelry is allowed for infection control purposes (patient care area policy may be more specific).
- Scented body care products are not allowed. This includes scented cologne, after shave lotions, hair care products, perfume, scented lotions
- Socks or stockings are to be worn at all times; for infection control purposes, toes must be covered
- Clothing and shoes that are clean, in good repair, and appropriate for work are expected.

The following attire is unacceptable while at the work site

- Blue jeans, Shorts, Sweatpants
- Skin-tight clothing, exposed shoulders, or cleavage
- Mini-skirts or mini-culottes
- Open-toe shoes or sandals
- Tee shirts, shirts, sweatshirts with non-department logos or pictures

HCMC white lab coats may be worn at Whittier Clinic .Whittier Clinic lab coats CANNOT be worn at HCMC.

DELINQUENT AND INCOMPLETE CHARTS

Regulatory requirements necessitate the completion of charts prior to the discharge of the patient from the hospital

Medicare requirements also require that the attending physician attest in writing to the principal and secondary diagnoses, and the names of the procedures performed, before hospital billing can be completed.

Medical charting must be completed within five days of discharge.

A list of delinquent and incomplete charts is forwarded to you and the attending provider for PROMPT attention. A complete list is forwarded to the Chief of the Department on a weekly basis.

Any resident with a chart on the delinquent list (over 30 days after discharge) will receive a reminder letter from the Medical Director. If any chart remains delinquent after the reminder, a second reminder is done. Residents who still have delinquent charts after the second reminder will have their cafeteria meal card inactivated, making it impossible to purchase food through their residency account.

BEEPER/PAGER POLICY

Hennepin County Medical Center Policies
Section: Information Management
Subject: Pagers
Policy #100031
Author: Telecommunications

Purpose:
To provide guidelines for issuing and replacing pagers, to reduce cost to the county, and increase individual responsibility and accountability for loaned county property.

Policy:
The Telecommunications Department provides support for pagers 24 hours a day, seven days a week. Hospital personnel shall be issued pagers subject to the following criteria:
Department head or supervisor approval.
B. Employee working a minimum of .5 FTE.
C. Employee in a supervisory or critical position to provide support.

REPLACEMENT OF PAGER:
A. Hospital personnel shall be charged for lost, stolen, or damaged pager.
B. Defective pagers shall be replaced with no charge to hospital personnel.

Procedure:
Requestor shall:
Submit written request to Telecommunications Department. An internet electronic form shall be accessed through the HCMC Home Page by selecting “Forms”, “Telecommunication Form”, “Pager Request”.

Telecommunications staff shall:
A. Fill new pager requests within three business days.
B. Replace defective pagers upon request.
C. Issue a one-day loaner pager if necessary.
Hospital Personnel Staff shall:
A. Report all lost or stolen pagers
to Security, phone number 612-873-3232 and
the Telecommunications Department, phone 612-873-5677.
B. Return loaner pager within 24-hours.
C. Wear pagers at waist to reduce the risk of theft, loss, or damage.

LONG DISTANCE PHONE CALLS

Personal phone calls are your responsibility i.e. you will receive a bill from the department for personal long distance calls.

Business related long distance can be made from the resident’s library. (e.g. patient consultation with an out of state MD, resident recruitment, or for arranging off site rotations).

If you anticipate making a call that is out of the country or for more than 5 minutes, please notify the FM Residency Coordinator. She can then verify the situation, and reason for the call, when long distance charges are reviewed.

COMPUTER USE POLICY

All residents and faculty have signed a confidentiality agreement that they will only use HCMC computers for legitimate business. Viewing pornography while on call is deeply disrespectful behavior, insulting to the entire HCMC community and will not be tolerated.

Anyone found using HCMC computers for viewing pornography will have a letter placed in their permanent file indicating this failure of professionalism. CME privileges will be removed for one year. The identified resident will be interviewed before a panel of faculty and peers to determine if additional consequences (e.g. added call, fines) or academic probation is indicated.

PARKING

(i) Parking at HCMC
Residents receive a parking card during G1 orientation. A deposit is required. Residents are required to turn in the parking card at the end of residency; the deposit is returned to the resident.

(ii) Parking at Whittier
Parking is free at Whittier.

ACGME & INSTITUTIONAL POLICIES

DUTY HOURS AND DUTY HOUR DOCUMENTATION

Resident Duty Hours
Maximum Hours of Work per Week
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.

Moonlighting
Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

PGY-1 residents are not permitted to moonlight.

J1 visa holders CANNOT moonlight in any capacity. This is consistent with the ECFMG requirements.

Mandatory Time Free of Duty
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.

Maximum Duty Period Length
Duty periods of PGY-1 residents must not exceed 16 hours in duration.
Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.

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.
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.
Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
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.
a) Under those circumstances, the resident must:
- i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
- ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Minimum Time Off between Scheduled Duty Periods
a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
b) Intermediate-level residents [as defined by the Review Committee] 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.
c) 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.

1) 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 [as defined by the Review Committee] 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.

a) 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.

Maximum Frequency of In-House Night Float
Residents must not be scheduled for more than six consecutive nights of night float.
[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

Maximum In-House On-Call Frequency
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
This residency program does not have at home call

Documentation of duty hours
Policy:

Residents must accurately log their hours worked and updated in the Duty Hours module of the Residency Management Suite (RMS*). All duty hours for a given month must be entered and approved by the 3rd working day of the following month e.g: January duty hours must be logged and approved by the 3rd working day of February

Cafeteria stipends and parking privileges are contingent on compliance with the logging and approval of duty hours in RMS.

RMS*

This a community wide electronic web-based tool that is used to gather data required for monthly billing to CMS for graduate medical education and reimbursement. The tool assists our institution to track duty hours to meet the requirements for ACGME.

USMLE or COMLEX Step 3 Requirements

Purpose: Completion of Step 3 is vital to a resident's future. The examination is easiest to pass soon after the resident's exposure to their broad-based clinical experiences. Residents who do not pass Step 3 are not eligible for licensure in any state. Those who do not pass Step 3 are not eligible to take Family Medicine Boards. Those who do not pass Step 3 within 7 years of taking Step 1 are required to repeat and pass Step 1, Step 2, and Step 3.

Policy: HCMC institutional policy states that all residents must take and pass the USMLE or COMLEX Step 3 examination by the end of their PGY-2 year. Residents who do not pass will not have their contracts renewed for the PGY-3 year.

FM Procedure: All residents must give a copy of their passing score to the FM Residency **Coordinator by June 15th of their PGY-1 year.** Residents who are off-cycle must provide results two weeks prior to the end of their PGY-1 year. If this copy is not received, a letter will be sent to the resident and no contract for the PGY-2 year will be issued. Residents receiving these letters will need to discuss their situation with the Residency Program Director and develop a plan to remedy their situation.

All residents must complete a leave request in order to take Step 3. Leave requests with short notice may be denied. The resident's first attempt does not count against vacation time. Attempts, thereafter, are charged to vacation time.

MEDICAL LICENSURE

A Minnesota medical licensure may be obtained after successful completion of the PGY1 residency year for US medical school graduates and at the end of the PGY-2 year for graduates of all other medical schools. Beginning in the academic year 2012, **all residents** are required to apply for a Minnesota medical license by the end of the second year of training.

ABFM BOARD CERTIFICATION

Policy for taking the ABFM Certification Examinations:

All PGY3 residents are expected to take the ABFM examinations in APRIL of their graduation year as a condition for successful completion of the HCMC-FMRP residency.

All residents who will complete training by June30th of the year of graduation will be recommended by the PD for eligibility to take the ABFM certification examinations in April of their PGY3 year.

THERE IS NO EXCEPTION FOR RESIDENTS WITH J1 VISAS.

Eligibility for taking the ABFM certification examinations:
All candidates for the American Board of Family Medicine MC-FP Examination for initial certification must have satisfactorily completed three years of training (**a full 36 calendar months with 12 months in each of the G-1, G-2, and G-3 years)** in a Family Medicine residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Successful completion of the HCMC FM residency program includes

- Completion of all ACGME requirements
- Completion of all HCMC-FMRP program requirements including rotation and procedure requirements, chart completion, rotation assignments as well as ABFM certification. All residents will be expected to accumulate 50 MC-FP points to be eligible to sit for the examination. Additionally, at least one Self Assessment Module (SAM) and at least one approved Part IV activity must be included in the 50 points.

Please see the ABFM website for further instructions about completion deadlines

GENERAL SUPERVISION POLICY

A. General Supervision Policy
Purpose: To ensure appropriate supervision for all HCMC Family Medicine residents that is consistent with proper patient care and the educational needs of the residents.

Policy: Residents must be supervised by faculty in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty. Faculty and residents are educated to recognize the signs of fatigue and will prevent and counteract the potential negative effects. The Program Director will ensure, direct, and document adequate supervision of residents at all times. Residents will be provided with rapid, reliable systems for communication with supervising faculty

1. All residents must be supervised by a qualified attending physician. The supervising physician (or his/her qualified designee with oversight from the faculty physician member) must be in the hospital providing direct supervision or indirect supervision with immediate availability to all PGY-1 residents. For PGY-2 and PGY-3 residents, supervising physicians may be in the hospital or immediately available by telephone and within 20 minutes of the hospital.

2. All residents must consult with the supervising physician regarding the assessment and treatment of a patient's illness. Treatment plans must be in accordance with the attending physician's recommendations.

3. All residents, regardless of level of training, must communicate directly with the attending family physician in any clinical circumstance which constitutes a major change in an inpatient's clinical status or any situation which requires more complex medical decision making. Examples of these situations include but are not limited to:

    - Acute deterioration of an inpatient's cardiac, pulmonary, or neurologic status
    - Change in an inpatient's status requiring transfer to the intensive care unit

- Change in an inpatient's code status
- Complex medical decision making for hospitalized patients
- Admission of any patient in active labor
- Acute deterioration of an active labor patient's electronic fetal heart rate tracing

*********For more details –see trigger protocols below********

4. All supervision must be documented in the resident rotation schedules and in the attending physician on-call schedules. In addition, the electronic medical record will accurately reflect both the admitting and the current attending faculty physician.

5. Residents must be supervised in such a way that they are able to assume progressively increasing responsibility according to their level of education, ability, and experience. The level of responsibility accorded to each resident must be determined by the teaching staff.

6. The Department must have resident rotation schedules available at all times to provide to all interested parties.

7. Residents must precept all outpatient encounters. For the first six months, all PGY-1s are required to precept all patients during the visit. The preceptor is required to meet and assess the patient to ensure that safe and competent patient care has occurred. At the end of the first six months, PGY1 residents are assessed for their ability to move from direct to indirect supervision before they are allowed to discharge patients without a face to face meeting with the faculty preceptor.

8. Residents transferring into our program as a PGY-2 must precept their patients prior to completing the patient encounter for the first two months. This does not necessitate meeting the patient face to face, unless requested by the resident or deemed worthwhile by the preceptor.

9. All office and hospital procedures must be performed with direct supervision from attending physician faculty.

10. All supervision must be documented in the resident rotation schedules and by attending physician on-call schedules. Each department will have available at all times such schedules and will provide such to all interested parties.

B. Policy on Trigger Protocols for Urgent Attending Physician Notification

Attending notification guidelines, known as "trigger protocols", identify specific criteria that should trigger a phone call by a resident to an attending physician to inform the attending of a change in patient condition. Expected communication practices when there is a critical change in the patient's condition are that the attending will be notified, ***within 1 hour*** following evaluation. These include:

Inpatient / General

1. Request for admission to hospital/outside facility requesting transfer
2. Transfer to ICU or higher level of care
3. Unanticipated intubation or ventilatory support
4. Development of new significant cardiac changes (e.g. CODE, serious arrhythmia, PE, hemodynamic instability)
5. Development of new significant neurological changes (e.g. CVA, seizure, new onset of paralysis, acute decline in level of consciousness)
6. Medication or treatment errors requiring clinical intervention (e.g. invasive procedure(s), increased monitoring, new medications)
7. Patient, family, or clinical staff request for attending notification

8. Unable to contact patient or unsure of management of “panic” lab result, or patients from community clinics or nursing home patients while on call
9. Unanticipated change in CODE status
10. Death
11. Signing out against medical advice (AMA)
12. Suicide attempt

Obstetrics

13. New triage or admission (call immediately for preeclampsia or pre-term labor)
14. Notification of need for OB consult
15. Fetal tachycardia, category II or III fetal heart rate tracing
16. Patient in active labor
17. Significant adverse changes to vitals (hyper/hypotension, T>100.4, unexpected or unexplained tachycardia)
18. Pre-eclamptic changes (e.g. hyperreflexic, visual changes, increased BP, HELLP)
19. Arrest of dilatation after onset of active labor for ≥ 2 hours

NOTE: This protocol is designed to ensure communication, but ***should not preclude*** communication for any issue short of the above criteria. Any member of the team should feel comfortable to contact the attending of record at any time for questions of clinical management.

Inability to reach the attending should NOT impede needed or emergent clinical care.*

C. Procedure for Labor and Delivery

All Family Medicine faculty physicians are qualified in obstetrics. Family Medicine faculty provide on-site supervision of family medicine obstetric patients for all deliveries. In addition, Family Medicine faculty physicians provide on-site supervision when patients are in active labor, medically complicated or in any way unstable.

At all times there is an obstetrician and a senior resident in an ACGME obstetrics residency on-site for emergency consultations, and to provide c-section or emergency procedures outside the scope of Family Medicine. A resident may request an attending at any time and is never refused. Any significant change in a patient’s condition must be reported immediately to the attending physician.

D. Lines of Responsibility for Residents and Attending Physicians on the Family Medicine Inpatient Service

Attending Physician

Supervision of all orders, procedures and treatment plans
Daily examinations of each patient on service
Daily note written on each patient on service
Organization of teaching responsibilities
Completion of resident evaluations
Monitoring of resident’s academic action plans

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PGY3 (Chief Resident)

Perform the duties of the PGY2 if they are in clinic or unavailable
Direct teaching of residents and medical students
Organize the monthly M&M Conference
Promote teamwork among residents

PGY2
Review all admissions
Assignment of daily activities of the PGY1 residents medical students or extends
Review all OB triage patients
Review of PGY1 daily assessment and plan
Negotiation with attending for final therapeutic plan
Daily examinations of each patient
Daily progress note on each patient on the Inpatient Service
Supervision of PGY1. Review of all laboratory and radiology results
Discussion of therapeutic plan with consulting physicians
Written and verbal sign-out to on-call team each day
Oversees communication via EPIC mail with patient's primary care physician
Carry the team pagers

PGY1
Initial assessment of new patient admissions
Initial assessment of OB triage patients
Daily progress note on each primary patient
Daily examination of each primary patient
Writes all orders on primary patients
Written and verbal sign outs of patients to the on-call team

E.Levels of Supervision for residents
To ensure oversight of resident supervision and graded authority and responsibility, the HCMC Family Medicine Training program uses the following classification of supervision:

Tier 1
Direct Supervision – the supervising physician is physically present with the resident and patient.
Tier 2
Indirect Supervision:
a) 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.
b) 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.
Tier 3
Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident, is assigned by the program director and faculty members.

First year trainees entering the residency program are assigned to Tier 1 supervision in the first 6 months of training. At the end of 6 months, PGY1s are assessed by the residency faculty using the program's Developmental Milestones to ascertain promotion to Tier 2a supervision.

At the end of the PGY1 year, residents take a Supervisor's Examination. Successful passage of this examination results in promotion to determine their suitability to move to Tier 2b supervision and promotion to the second year of post graduate training.

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PGY1 Level of supervision
Ambulatory and Inpatient Standards
(Going from Direct to Indirect Supervision)

Tier 1 Direct Supervision	Tier 2 Direct Supervision (supervision immediately available)
Competency Patient Care **PGY1a** Be able to elicit a medical history that defines the presentation of illness, Be able to perform an appropriate exam on patients presenting with common medical problems Be able to initiate a correct treatment plan based on assessment of common medical problems Beginning to prioritize problems in order to complete daily patient care duties Demonstrate caring and respectful behaviors with patients and families	**Competency Patient Care** **PGY1b** Be able to elicit a medical history that defines the presentation of illness, thereby assisting with making a diagnosis and developing a management plan Be able to completely perform an appropriate exam on patients presenting with common medical problems Synthesizes all available data (history, physical examination, and prelim lab data to define each patient's medical problem Be able to integrate past and current clinical information in order to develop a problem appropriate diagnosis Be able to prioritize problems in order to complete daily patient care duties in an accurate and timely manner Demonstrate appropriate monitoring and follow-up of patients, including laboratory data and test results Be able to perform required family medicine procedures with supervision
Medical Knowledge **PGY1a** Demonstrate a satisfactory level of basic and clinical science knowledge in order to recognize and treat common diseases Identify and use various educational resources to seek information about patients' diseases Attend conferences to continuously learn and reinforce medical knowledge and skills	**Medical Knowledge** **PGY1b** Demonstrate a satisfactory level of basic and clinical science knowledge in order to recognize and treat common diseases Demonstrate knowledge of preventive care guidelines Apply learned medical knowledge to diagnosis, treatment and prevention of disease Be an active participant in daily rounds and outpatient sessions
Practice-Based Learning **PGY1a** Access medical information using various educational resources to assist in medical decision-making Beginning to identify his/her limitations of knowledge and skills and	**Practice-Based Learning** **PGY1b** Be able to formulate clinical questions in the day-to day care of patients Be able to identify his/her limitations of knowledge and skills and seek help when needed

seek help when needed Asks for feedback	Accept feedback and develop self-improvement plans when appropriate Start to develop skills in teaching with patients, staff and colleagues Show ability to analyze written work, teaching style, patient care issue and self- evaluate current competence
Interpersonal &Communication Skills **PGY1a** Identifies need for interpreter to engage patients in clinical setting Demonstrate complete, legible, and timely documentation of medical information Be able to write an accurate and concise history and physical Uses structured template to provide accurate sign-out to team members	**Interpersonal &Communication Skills** **PGY1b** Effectively uses interpreter to engage patients in clinical setting including patient education Use effective listening, narrative and non-verbal skills to elicit and provide information Be able to accurately and concisely present to attendings and colleagues Be able to write an accurate and concise history discharge summary Be able to perform an accurate and concise sign-out to other team members Be able to communicate in oral and written form a cohesive plan in sign-out rounds
Professionalism **PGY1a** Demonstrate professional conduct in interactions patients and their families, colleagues, and other members of the health care team Demonstrate respect, compassion, integrity, and honesty Show responsibility for meeting program requirements	**Professionalism** **PGY1b** Work effectively as a member of the health care team Document and report clinical information truthfully Follow formal policies Recognize and manage obvious conflicts of interest, such as caring for family members and professional associates as patients
Systems Based Practice **PGY1a** Show responsibility for meeting requirements of medical practice of HCMC and Whittier Clinic: • timely completion of notes and discharge summaries • timely evaluations of attendings/peers/etc. • timely response to pages Appropriately manage 4 patients per clinic session	**Systems Based Practice** **PGY1b** Advocate for high quality patient care and assists patients in dealing with system complexity Be able to recognize system problems Demonstrates understanding of costs of common diagnostic and therapeutic tests Appropriately manages 6 -7 patients per clinic session

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CONTINUITY OF CARE POLICY

Purpose:
To ensure that Family Medicine residents maintain continuity of responsibility for patients in all settings.

Policy:
Continuity of Care is a core value of Family Medicine. All residents will maintain continuity of responsibility for some patients in all settings, including urgent or emergent care, long-term care, hospitalization or consultation with other providers. Continuity of responsibility will include active involvement in management and treatment decisions and interactive communications about management and treatment decisions.

Procedure:
All primary physicians will be notified when their continuity patients are admitted to the hospital. There will be regular communication between the primary physician and the inpatient team. This will be conducted primarily through staff messages and in the electronic medical record (EPIC).

In addition, for patients with prolonged hospitalization, the resident will visit the patient and write a note in the chart. The note will be labeled Primary Care Physician Inpatient Visit. Patient visits will be entered into the Family Medicine procedure database

All residents will care for 10 primary care obstetric patients. The resident will care for the patient during pre-natal care, during hospitalization for complications and delivery and during the post-partum period. Documentation of this care will be logged into the Family Medicine procedure data base.

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EVALUATIONS

A. ACGME Core Competencies:

Residents will be evaluated by faculty in these six categories:

1. Patient Care
    - a) Caring and respectful behavior
    - b) Interviewing
    - c) Informed decision making
    - d) Developing/implementing plans of care
    - e) Counseling patients and family
    - f) Using IT to support patient care
    - g) Procedures
    - h) Preventive health services
    - i) Working within a team
2. Medical Knowledge
    - a) Investigative and analytical thinking
    - b) Application of basic science
3. Practice Based Learning and Improvements
    - a) Analyze practice for improvements
    - b) Use evidence from studies
    - c) Use information about patients and community
    - d) Application of research and statistical methods
    - e) Use of information technology
    - f) Facilitate learning of others
4. Interpersonal & Communication Skill
    - a) Creation of a relationship
    - b) Listening Skills
    - c) Working within a team
5. Professionalism
    - a) Respectful
    - b) Ethically sound practice
    - c) Sensitive to culture, age, gender and disability issues
6. Systems-Based Practice
    - a) Understanding interaction of practice with larger system
    - b) Knowledge of practice and delivery systems
    - c) Practice cost effective care
    - d) Advocate for patients within the system
    - e) Knowledge of partnering with managers and providers

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RESIDENT EVALUATION POLICY AND PROCEDURE

Policy:
The Family Medicine residency is responsible for ensuring that all residents are systematically evaluated in a timely manner. The residency must demonstrate the ability to accurately assess the residents' performance and competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems based practice. The program must give timely feedback in the form of multiyear written assessments, which are easily accessible to residents. These assessments must include the use of assessment results, including evaluation by faculty, patients, peers, self and other professional staff, to allow the resident to achieve progressive improvements in competence and performance.

Procedure:
All residents are provided with written evaluations, done by supervising faculty, at the end of all rotation experiences- both inpatient and outpatient.
Residents are evaluated on the basis of 6 ACGME competencies:

Patient Care
Medical Knowledge
Practice based learning and improvement
Interpersonal and communication skills
Professionalism
Systems Based Practice

Evaluations are also completed by patients, preceptors, peers, clinic staff, the resident (self) and a faculty advisor. Copies are filed in the resident evaluation file. Examples of these evaluations are attached in the Appendix.

Global Assessment - summative and formative evaluation is a component of each rotation and the continuity experience. The attending will offer formative feedback on a regular basis during the rotation. He/she should meet with the intern or resident on the first day of rotation, mid rotation, and at the end of rotation, at which time a summative evaluation will be provided. The summative evaluation of the resident's performance is also called a global assessment. All rotations at HCMC use a nine point global assessment scale. Each assessment includes patient care, medical knowledge, practice-based learning, interpersonal communication skills, professionalism, and systems-based practice.
On Family medicine rotations, the global assessment is also a nine point scale which monitors the residents' progress through residency from PGY1 to PGY3. Residents move from the advanced beginner to a near master in competency achievement. The scale goes from 1-3 in the PGY1 year, 4-6 in the PGY2 year and 7-9 in the PGY3 year. Residents not meeting satisfactory rating in the global assessment may require remediation.

Periodic Resident Evaluations are completed periodically, and at least twice per year. This is a multi source assessment with input from faculty, nursing home providers, clinic staff, the Program Director, and the Program coordinator.
Each resident of the team is discussed individually. The discussion includes review of written rotation evaluations of the resident, peer evaluations, other written feedback, verbal testimonials regarding the resident, results of the Intraining examination, review of any concerns or disciplinary action, information from other sources, awards, recognition or other scholarly activity.
The resident's advisor then completes a Summative Evaluation based on the input received. The resident's faculty advisor then presents and discusses the summative assessment with the resident at the periodic resident-advisor meeting. The advisor also reviews a checklist of performance indicators with the resident.

Once yearly the "Annual Resident Promotion Summary" is completed and determination of promotion to the next year is made following the "Resident Promotion Policy and Process".

Other evaluations

OSCE – all interns will participate in an observed structured clinical evaluation (OSCE) or observed structured interactive examination (OSIE) in the fall OR spring of the internship year. This will assess patient care skills, interviewing skills, communication skills, and the ability for the intern to be able to care for patients with faculty immediately available and to provide direct supervision to the incoming class of new interns. Components of the OSCE will be reviewed by the faculty who supervise the examinations or your faculty advisor. Formative feedback will be provided. Major deficiencies might prompt a need for remedial activities.

Videotape Review – Residents are required to complete multiple videotapes throughout the 3 years of residency

One Moment In Time (OMIT) Evaluation Formative feedback will be provided, to residents intermittently in the clinic. These observations will also serve as a component of the global rotation evaluation.

Multisource Evaluations – Evaluations from multiple sources are also used in the assessment process. Evaluations from nurses, patients, peers and others who come into contact with residents are completed from one to four times per year. These valuable evaluations provide a 360^{0} assessment of the residents' achievement of competencies in patient care, interpersonal and communication skills, and professionalism.

Procedures – Procedure documentation will be maintained through the New Innovations system. Interns and residents are expected to meet procedural goals for their year of training. Independence in procedures, required of family medicine residents by the American Board of Family Medicine, is a component of the patient care competency. It is expected that the resident will take responsibility for appropriately documenting procedures performed. The resident must also notify the Chief Resident, Mentor, and Program Director of needed procedures in order to meet requirements in the allotted time.

In-Training Examination – All family medicine interns and residents are required to participate in the Intraining examination on a yearly basis. The examination will be held on the fourth Wednesday of October. Although not used as a criterion for promotion, information will be considered in the context of other ratings of the resident's medical knowledge.

Lecture Attendance – It is expected that all family medicine interns and residents will maintain an average attendance at conference of at least 80%. (This number takes into account vacations, and other required time away such as night float and some Medicine rotations). Attendance reports are reviewed quarterly by the advisor, program director and coordinator. Uncorrected attendance problems will become a component of the report to the Program Director. Major deficiencies might prompt a need for remedial activities. Attendance at lectures reflects competencies of medical knowledge and professionalism.

Record Completion – Reports of the resident's timeliness of completion of medical records are compiled by the medical director and program manager. Consistent tardiness of record completion could prompt required remedial action by the Program Director, including potential loss of vacation time in order to correct the deficiency. Note that documentation is an important component of the patient care, communication skills, and professionalism competencies.

Portfolio – Residents will be asked to detail a permanent record of their education through the creation of a learning portfolio. The electronic resident portfolio will be maintained through the New Innovations system and is a collection of documents which captures aspects of learning that are otherwise difficult to assess. Details of portfolio entries and how to evaluate are listed elsewhere. Practice-based learning and improvement will be assessed by this method.

QI Project – Third year residents will participate in a year-long Quality Improvement project of their selection. Residents will develop their projects as part of their teams and discuss them at their monthly meetings. Residents will be individually mentored by a staff member. Groups will learn the basics of performing change process utilizing PDSA cycles, concepts of data collection, basic statistical analysis, and working as a team will be stressed. Groups will be expected to produce a plan for a PDSA cycle by mid-year; and a performance report by the end of the year. Both practice-based learning and improvement and systems-based practice skills will be addressed.

RESIDENT EVALUATION FILE:

The following information is collected and stored in the resident evaluation file:

1. Basic application materials which were completed prior to entering the program
2. Written rotation evaluations
3. Peer, self, clinic staff evaluations
4. Patient satisfaction summaries
5. One-on-one precepting clinic evaluations
6. Written quarterly summative evaluations
7. End of year program summaries to document progress from one year to another and to document resident status at exit from the program
8. Report of American Board of Family Medicine Intraining Examination Results
9. Procedure documentation including documentation of competency in the performance of core procedures
10. Conference attendance records
11. Patient numbers data
12. Moonlighting approval forms
13. Incident reports
14. Records of scholarly activity, including conference presentations, research projects, CQI project reports
15. Videotaping Evaluations
16. Awards or commendations
17. Formal Remediation and development plans.

FACULTY ADVISORS:

All entering program residents are assigned to a core teaching faculty member at the start of residency training. Advisors are usually the resident's clinic partner at Whittier. One faculty advisor usually mentors a triad of residents from the G3, G2 and G1 training years.

Advisors are expected to meet or contact their advisees at least quarterly. These encounters are documented on the periodic summative evaluations which are available electronically.
The goals of these meetings are to work with the resident concerning rotations, planning electives, goals, thoughts, needs, etc. The meetings are usually informal; some faculty meet over a meal or during other unscheduled times. This is a time to give the advisor feedback, too. It can be a time to assess the relationship and confirm if it is working.

The advisors are here to teach, listen, and give direction. Residents can meet with their advisors ANYTIME. They may also use other faculty for advising.

Role of the advisor:

A. ACADEMIC RESPONSIBILITIES

A. Supervise Resident progress during training

1. Complete the Interim Evaluations
2. Review the **competencies/learning goals and expectations** for the required rotations and residents' learning goals for various electives.
3. Assist and review **self-assessment of strengths** and areas of needed improvement, guide elective choices and career planning.
4. Gather/collate/analyze data from various parts of the evaluation system and **provide meaningful feedback.**
5. Provide advice, support and **collaborative problem solving** when necessary and balanced feedback to resident during regular meetings or contact.
6. Encourage **self reflection** about resident's growth
7. Serve as **advocate for resident** within the department
8. Encourage **progressive leadership development** during residency training
9. Inquire about **resident's self-care and wellness**.

B. Participate in academic correction Roles and responsibilities to be defined

C. Supervise selection of electives

D Research and scholarly activities for residents

B. CLINICAL RESPONSIBILITIES

A. In basket supervision
B. Observation of residents in clinic
C. Team responsibilities

RESIDENT EVALUATION OF THE EDUCATIONAL EXPERIENCE

Residents have the opportunity to evaluate the quality of their educational experiences in a variety of ways. Residents can give informal feedback at any time to the Program Director or other curriculum liaisons. Formal feedback occurs in the following ways:

1. Curriculum Evaluation Meetings: Residents can give systematic feedback about rotations at the Curriculum meetings which occur every other month. Residents evaluate rotations to determine whether goals and objectives are being met. Feedback from these reviews are collated into a master document and become part of the annual action plan for improvement of the program.

2. Resident evaluation of rotations: At the end of each block rotation, residents complete an online evaluation of the effectiveness of the teaching, supervision, and the educational value of the rotation.

3. Resident evaluation of faculty: Annually, residents evaluate the main teaching faculty who attend on the Inpatient Service and precept in the continuity clinics. These evaluations are collected anonymously and the feedback is shared by the Program or Chief of the Department with the evaluated faculty.

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4. End of the year Resident Survey: The Graduate Medical Education Committee administers a confidential survey of all HCMC residents, including the Family Medicine residents at the end of each academic year. This information is presented to the Family Medicine program leaders and is used to implement curricular change.

5. Semi Annual Review: Residents have an opportunity twice per year in their meeting with the Program Director or Associate Program Director to give direct feedback about any concern with the residency program.

CRITERIA FOR ADVANCEMENT AND PROMOTION OF RESIDENTS

The decision to promote a resident from PGY1 to PGY 2 and from PGY2 to PGY3 and to graduation shall be determined by the Program Director with the advice of the Promotion and Evaluation Committee and faculty of the department.

The method of evaluation shall consist of direct observation of the resident, as well as by indirect observation through videotapes, rotation evaluations, correspondence between departments and written examinations (national boards, Intraining examinations, rotation examinations). Residents are expected to pass USMLE Step 3 for promotion to the PGY3 year. It is expected that residents will participate in all aspects of the curriculum, as well as the periodic evaluation of educational experiences and teachers. It is further expected that residents will complete all administrative responsibilities, including licensure and credentialing in a timely manner.

The criteria for advancement shall be based upon four parameters, all of which need to be judged as competent for each level of advancement. These parameters are:

1. Clinical Competence (Medical knowledge, Patient Care, Communication Skills)
   - Fund of medical knowledge
   - Clinical performance
   - Clinical judgment
   - Knowledge of limitations
   - Therapeutic doctor-patient relationships
2. Professional Behavior (Professionalism, Systems-Based Practice, Practice-Based Learning and Improvement)
   - Working relationships with others
   - Ethical conduct, honesty and integrity
   - Acceptance of responsibility, punctuality, reliability
   - Leadership skills
   - Compliance with administrative responsibilities
   - Responsiveness to the patient and the medical community
3. Technical Skills (Patient Care, Systems Based Practice)
   - Procedural competence and experience (includes OB)
   - Accurate documentation
   - Medical record thoroughness, completeness and timeliness
4. Impairment Prevention (Professionalism)
   - Absence of impaired function due to uncontrolled mental or emotional illness, personality disorder or substance abuse

The following steps shall be evaluated: the PGY1 to PGY2, the PGY2 to PGY3, the PGY3 to graduation. At each level, acceptable progress, as listed below, will need to be documented. Additionally, the resident must be judged competent to supervise others and to act with increasing independence. In the graduation step, the resident must be judged competent to act independently.

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Advancement specifics (PGY1-PGY2)

- Acceptable progress in areas
- Passing of all rotations
- Passing specific ambulatory clinic experiences
- Able to supervise PGY1s and students
- Able to act with limited independence

Advancement specifics (PGY2-PGY3)

- Acceptable progress in areas
- Passing of all rotations
- Passing ambulatory clinic experience
- Able to supervise/teach
- Able to act with increasing independence
- Passage of USMLE Step 3
- Completion of 24 months of training

Advancement specifics (PGY3 to Graduation)

- Competence in all areas
- Able to act independently
- Completion of 36 months of training
- Completion of 1650 patient visits, 10 primary OB deliveries, 40 other total OB deliveries, 2 home visits and 15 critically ill.
- Completion of FMC credentialed procedures
- Completion of research and scholarly project

Further details of promotion criteria are available in the promotion documents

(i) Promotion Procedure:

The resident's academic, professional and behavioral performance is periodically reviewed by the Program Director, faculty and the Program Promotion and Evaluation Committee. Areas of weakness or deficiency are communicated to the resident through their academic advisor at least 120 days before the promotion date to the next training level, the Program Promotion and Evaluation Committee will meet to consider the promotion of residents. The Committee will make one of three decisions about a resident's future training:

1. Promotion without reservation occurs when:
   - Faculty evaluations and assessment tools indicate satisfactory skills and knowledge both in the inpatient and outpatient settings
   - Faculty evaluations and assessment tools indicate satisfactory competency in both professional and behavioral areas
   - Satisfactory completion of all USMLE (or equivalent) examinations

2. Promotion with recommendations will be made when:
   - A minor deficiency of knowledge exists in one or two of the 6 competency areas which is correctable
   - Professional or behavioral deficiencies exist which are correctable

3. Non renewal of contract at the end of the contract year will occur when
   - Major academic deficiencies exist in more than one competency areas which preclude correction
   - A lack of professionalism exists which is incompatible with patient care or the presence of personal qualities which prevent successful interaction with residents, faculty and staff
   - Failure to successfully complete the terms of probation

Psychological or personal problems exist which make the independent practice of medicine unlikely
A written notice of intent not to renew a resident's agreement will be provided to the resident. If the primary reason for non renewal occurs within the 4 months prior to the end of the agreement, the residency program will provide the resident with as much written notice of intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement. A resident whose contract is not renewed may appeal this decision within 14 days according to the Institutional policy.

(ii) Graduation and Board Eligibility

Each resident must satisfactorily complete 36 months of training in order to graduate and be eligible to sit for the Board Certification Exam. Board expenses are the responsibility of the Resident and not paid by the Department.

A RESIDENT WILL NOT BE ALLOWED TO GRADUATE WITHOUT HAVING THE REQUIRED NUMBER OF PATIENT CONTINUITY VISITS, OB DELIVERIES-TOTAL AND CONTINUITY, NURSING HOME VISITS, HOME VISITS, AND ICU VISITS.
As of July 1st, 2006, the continuity visits are:

- 1650 for three years with at least 150 of these visits occurring in the first year.
- OB deliveries (40 including 10 continuity in order to graduate) and at least
- 2 documented nursing home visits as a part of 24 months of continuity nursing home care
- 2 documented home visits, and
- 15 critically ill patient / visits (different patients) must be documented.

RESIDENCY COMMITTEES AND PROGRAM EDUCATION MEETINGS

PROGRAM EVALUATION COMMITTEE

Charter

Purpose:
Every ACGME accredited program must undertake an annual review of the program and make recommendations and provide feedback to the Program Director with regards to the responsibilities outlined in the charter, GMEC policies and the ACGME requirements. The Program Evaluation Committee serves as an advisory Committee to the program director in the oversight in the educational activities of the residency program.

Functions:
The Program Evaluation Committee will participate actively in:

- planning, developing, implementing, and evaluating educational activities of the program *(Detail)*
- reviewing and making recommendations for revision of competency based curriculum goals and objectives; *(Detail)*
- addressing areas of non-compliance with ACGME standards *(Detail)*
- reviewing the program annually using evaluations of faculty, residents and others, as specified below*(Detail)*

Objectives:
The PEC must:

- document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE).
- monitor and track each of the following areas:
    - resident performance; *(Core)*
    - faculty development; *(Core)*

- graduate performance, including performance of program graduates on the certification examination; *(Core)*
- program quality*(Core)*

- oversee the confidential evaluation of the residency program by Residents and faculty in writing at least annually. *(Detail)*
- use the results of faculty and faculty members' assessments of the program together with other program evaluation results to improve the program.
- Monitor the progress on the previous year's action plan(s). *(Core)*

The PEC is responsible for the program's performance improvement as follows:

- must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2 of the ACGME Common Program requirements, as well as delineate how they will be measured and monitored. *(Core)*
- submit the action plan annually for review and approval by the teaching faculty and documented in meeting minutes. *(Detail)*

Membership:
The Program Evaluation Committee: must be composed of at least two program faculty members and should include at least one resident

At HCMC Family medicine residency, the members of the PEC include:
Permanent members:

- Residency Program Director
- Associate Program Director
- One representative of the Behavioral Medicine faculty

Revolving members:

- Three Revolving members from the Core Faculty, each of whom must have at least one year of faculty residency experience
  - Appointed by the Program Director
  - Each faculty member of the PEC will serve staggered terms of 3 years.
  - Faculty members should serve no more than 2 terms
- One chief resident

Meeting Frequency / Schedule

- The regular meetings of the Committee shall be held monthly on the first or third Mondays of the month from 7:00-8:00 am
- 70% of the membership of the committee shall constitute a quorum

Member roles and responsibilities:
Committee Chair

- Plans the agendas and chairs the meetings
- Facilitates discussions and ensures that appropriate decisions are made
- Ensures objectives and measures of success are met
- Ensures charter is reviewed annually

Committee members:

- Prepares in advance for committee meetings.

- Complete assignments and action items by the proposed deadlines.
- Actively participates in all committee deliberations
- Support achievement of committee objectives and measures of success during and after meetings
- Regularly attend scheduled meetings , If unable to attend, notify the committee support person and thoroughly review minutes and other committee documents

Committee support:

- Prepares agendas and minutes , Ensures documents are distributed in advance of meeting and distributed in a timely manner after meetings.
- Coordinates and disseminates communication documents as defined by the committee
- Ensures work of the committee is easily retrievable and appropriately archived.

Legend:
Core Requirements-Statements that define structure, resource or process elements essential to every graduate medical education program
Detail Requirements: statements that describe a specific structure, resource, or process for achieving compliance with Core requirement.
Approved 11/18/2013

CLINICAL COMPETENCE COMMITTEE

Clinical Competency Committee
Charter

Purpose:
The Clinical Competency Committee (CCC) is charged with monitoring and evaluating resident performance, and providing feedback to the Program Director pursuant to this charter, GMEC policies, and the ACGME requirements. The Clinical Competency Committee oversees the design and maintenance of an effective evaluation system that monitors the performance, remediation, promotion and graduation of trainees in the residency program. This committee must adequately assess residency performance and progression along the Milestones.

Commented [H1]: Do we need to broadly define the scope of performance?

Commented [H2]: Do CCC's have any formal reporting or other relationship to the GMEC?

The CCC offers the resident insight and perspectives of a group of faculty members. It determines how well a resident is meeting program standards, including patient care and a resident's progress along the educational trajectory. The process provides an early assessment of competency issues and helps shape resident performance, improvement and remediation plans.

The charge of the CCC:
The Clinical Competency Committee should:
1. review all resident evaluations semiannually; V.A.1.b).(1).(a)

2. prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME. V.A.1.b).(1).(b)

3. advise the program director regarding resident progress, including promotion, remediation, and dismissal. V.A.1.b).(1).(c)

Detailed Functions of the CCC (See Figure 1)
The Clinical Competency Committee:

- Serves as an Advisory Committee to the program director with regards to:
  - Advancement / Promotion
    - Semi-annual evaluations
  - Certification
  - Remediation
  - Termination of contract
  - Discipline

Commented [H3]: Required Function

- Assignment of supervision levels

- Regularly discusses & considers issues which may affect resident performance including but not limited to:
  - Substance abuse
  - Inadequate rest
  - Stress
  - Anxiety
  - Depression

Commented [H4]: Optional Function

2. Offers feedback to the program on issues related to resident education including but not limited to:
   - Feedback
   - Evaluation
   - Education
   - Contracts

Other responsibilities

1. Prepare and ensure reporting of each resident's Milestone progress semi-annually to the ACGME,
2. Reviews evaluation and progress of each resident in the program
   - Early identification of residents who fail to progress in the education program
   - Develops and oversees remediation and probation plans for residents under corrective action
   - Approves individualized education plans
   - Assesses residents' competency for promotion and graduation

3. Oversees Evaluation system of the residency
   - Assists in the development of evaluation / assessment tools used by the residency
   - Determines how developmental milestone are implemented and assessed in the residency program

   - Make written recommendations to the Program Evaluation Committee (PEC) for curriculum revision and evaluation development if curriculum gaps in resident evaluation or education are identified during data review,

4. Provides leadership for the residency in implementation of new evaluation standards (including milestones) in the New Accreditation System

Membership

The Clinical Competency Committee must be composed of at least three program faculty members (for our residency program our goal for CCC membership is one CCC member for every 6 residents)

Others eligible for appointment to the committee include faculty from other programs and non physician members of the health care team. These may include noncore faculty, nurses, ancillary staff.

Members will be selected by the program Director with recommendations from the CCC. A member must recuse themselves from CCC discussions if a near relative relationship or other potential conflict of interests exists.

A CCC member other than the program director serves as chair of the committee to avoid undue influence over the resident review process.

Roles and responsibilities of members:

Proceedings of the CCC are confidential and for the purpose of resident review.

Members are expected to provide constructive feedback for all residents/.

The CCC members will determine the process for managing internal disagreement regarding placement and progression of a resident's performance along the Milestones .

Members are expected to attend (either in person or remotely by conference call or SKYPE) a minimum of 75% of scheduled meetings during the academic year.

Committee Meetings:
The regular meetings of the committee will occur once per month usually the Tuesday following the Interdisciplinary Resident Evaluation Meeting
The purpose of the monthly meeting is to monitor resident performance, clinical skill acquisition, and progression along the Milestones continuum. The CCC monitors patterns in resident performance.

- 7-8 am (time can be adjusted to meet the needs of the members of the committee)
- 67% Percent of the voting membership of the Committee shall constitute a quorum.
- Documentation of the meetings of the CCC, committee members present and the residents reviewed during the meeting must be maintained

Commented [H5]: Is this needed?

Semiannual meetings of the CCC are held to prepare and ensure reporting of each resident's Milestone progress semi-annually to the ACGME. These meetings may be longer than the monthly meetings.
Support:
The Residency Coordinator and support staff will provide the CCC with necessary materials and executive assistance.

Measures of performance:
The CCC will make decisions using multiple sources of resident based on explicit assessment data, faculty and clinic team members observations and narratives to inform their evaluations of residents . Explicit assessment data used in measuring resident performance includes

- Direct observation tools- one to one precepting , video review , shadowing , faculty and team observation
- Rotation evaluations
- Community Health projects
- IMR and Challenger modules
- ITE results
- RMS Procedure logs and evaluations
- RMS periodic summaries
- RMS portfolios
- Multisource evaluations
- Research and scholarly activity
- Self assessment reflections
- Quality Improvement projects
- Teaching skill evaluations
- Patient satisfaction surveys (internal WHC or external like Press Ganey)
- Other (as determined by the CCC)

Reporting
The CCC will take data from these evaluations and apply them to the Milestones to mark the progress of residents. Aggregate de-identified data for all residents in the program will be reported to the ACGME as mandated. Utilization of the Milestones will involve comparisons to the residents peer group as well as national benchmarking data when available and thresholds will be set by the CCC for performance improvement interventions .
The CCC will recommend interventions for performance that suggests the need for specific areas for improvement.
Review of CCC policies:
A detailed review of CCC policies and procedures will be conducted annually to determine whether:

- Assessment methods accurate in informing the Milestones
- Assessment methods are identifying residents who are not meeting and those who are exceeding expectations
- CCC processes are efficient and effective

Other aspects related to the CCC:

- Should develop a shared mental model of what our brand is and what our residents at the end of training should accomplish
- Constantly review evaluation tools to ensure appropriate to measuring milestones
- Ensure that Faculty development is aligned to the work of the CCC:
    - Faculty have a shared mental model of what residents should be achieving at each stage of training
    - Creation of appropriate learning forums in which milestones are achieved at each level of training
    - Assist faculty in writing meaningful evaluation narratives in their assessments
    - Reach a common agreement of milestone narrative meanings
    - Apply QI principles to the evaluation process
    - Inter and intra rater reliability as it pertains to evaluations
    - Direct observation skills and use of check lists and direct observation tools
    - Giving feedback

Steps in the Six month review -

Twice yearly in the months of October and April, all Monday faculty meetings are devoted to faculty semiannual discussion of residents

Calendar for Milestone meetings - Table 1

	Phase 1 Adviser /CCC Dyad meeting	Phase 2 Super Resident evaluation	Phase 3 Advisor/advisee meeting	Phase 4 CCC review	Phase 5 Advisor/ Advisee Debrief	Milestone reporting
PGY2 PGY1 PGY3	**Sept- October**	**October**	**October- November**	**November - December**	**November - December**	**November 1- December 31**
PGY1 PGy3 PGY 2	**March- April**	**April**	**April- May**	**May -June (Promotion meeting)**	**May -June**	**May 1-June 15**

<u>Preplanning:</u> 1.

1. Peg sends semiannual review and a milestone document to resident for completion 2 weeks prior to the Biannual Resident Evaluation meeting (Super evaluation meeting) . Resident completes both and returns to Peg one week prior to the Biannual Resident Evaluation meeting.
2. Peg collects review documents – rotation evals ,RMS data etc
3. Peg sends items from 1 and 2 to the residents' advisers.

<u>Phase 1- Meeting between adviser and CCC dyad partner</u>
<u>Anticipated time</u>: (45 minutes per resident / 3 residents per adviser/1 .50 hours per session).
<u>Attendees</u>: Adviser and CCC member

1. Adviser and CCC dyad partner meets 1-2 weeks before the Resident Supper Evaluation meeting
2. They review documents provided by the Administrative staff. These include:
    a. the RMS Summative portfolio, which contains a summary of rotation comments
    b. RMS procedure log
    c. RMS scholarly activity portfolio
    d. Evaluations from Journal Club and M&M if available
    e. Others as identified
3. Adviser and CCCFM dyad partner create draft milestone tool for their cohort of residents using the Evaluation tools that inform the specific milestones

4. They identify any gaps in their review for discussion at the Resident Super evaluation meeting

Phase2- Biannual Resident Evaluation meeting
Anticipated time: (6-7 residents per session x10-15 mins per resident = 100 minutes
Attendees: Advisors, Teaching faculty (including Inpatient. ambulatory, Geriatrics and behavioral faculty) and clinic RNs

1. Meeting facilitator requests any narrative comments based on milestones on index residents
2. Advisor requests specific information based on gaps identified in the initial phase 1 meeting
3. Faculty adviser collates information from discussion on the draft milestone tool

Phase 3- Adviser and Resident meeting
Anticipated time: (45 minutes – 1 hour per resident) . 3 hours total per advisor
Attendees: Adviser and resident

1. Resident completes semiannual review and a self – evaluation prior to the meeting and brings with
2. Resident and adviser review and reconcile the official milestone tool and the resident self-evaluation. If they cannot come to an agreement , the advisor will bring discrepancies to the CCC
3. Adviser and resident will cover the following topics in their discussion:
   a. Rotation evaluations and progress on rotations
   b. Review of goals and objectives and discussion of progression
   c. Career plans
   d. Wellness
   e. reach agreement of the draft milestone tool partially completed previously

Phase 4 – CCC meeting
Anticipated time: (25-30 minutes per resident. Will meet 3-4 hours per week in November (December)
Attendees: CCC; others if needed and as determined by the CCC

1. CCC faculty member presents the draft milestone tools for each of their residents (theirs and dyad partner) to CCC with particular attention to the milestones outliers (too high , too low)
2. The assembled CCC reach agreement about final milestone assignments
3. Final milestones are entered in Web Ads document

Phase 5- advisor- advisee Debrief (optional)

1. Copies of final tool to advisers and residents for debrief.

Phase 6 – ACGME report

1. Milestones submitted to WebAds

(Approved September 3, 2014)

(i) The Clinical Competency Committee (CCC), formerly known as the evaluation and promotion committee, oversees the design and maintenance of an effective evaluation system that monitors the performance, remediation, promotion and graduation of trainees in the residency program. This committee:

1. Periodically reviews evaluation and progress reports of each resident in the program
2. Develops and oversees remediation and probation plans for residents under corrective action
3. Approves individualized education plans

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4. Assesses residents' competency for promotion and graduation
(ii) Composition of the Committee
1. Program Director
2. Assistant Chief of the Department of Family Medicine
3. Director of Behavioral Medicine
4. Two other teaching faculty of the residency program.

CURRICULUM MEETING

The curriculum committee is an oversight committee, which monitors and reviews the curriculum to ensure compliance with guidelines and to ensure that standards of teaching excellence are maintained on each rotation.

The committee makes recommendations to the Program Director on rotations and teaching experiences that need to be modified or changed. The committee is chaired by the Associate Program Director and the Behavioral Science Coordinator. The meetings are open to all residents and interested faculty. The committee meets once per month.

Once yearly, the Program Education Committee, the chef residents, representative faculty, and residents meet to review the program's goals and objectives and effectiveness with which they are achieved. Feedback and suggestions from the curriculum committee are taken into consideration during strategic planning and improving the residency curriculum.

RESIDENT RECRUITMENT MEETINGS

The Recruitment Committee directs the recruiting activities of the residency program. The goal is to recruit stellar applicants to the program.
This committee develops strategies for the recruitment policies and assists the departmental faculty and residents in coordinating the interview and match selection process. The committee is chaired by the Recruitment Director and consists of resident's representatives from each class. All residents are expected to attend the Recruitment meetings. All other faculty and residents are invited to attend. The committee meets once per month.

SELECTION AND DUTIES OF CHIEF RESIDENTS

HENNEPIN COUNTY FAMILY MEDICINE RESIDENCY PROGRAM
SELECTION AND DUTIES OF THE CHIEF RESIDENTS
Updated March 10, 2014

Chief residents are resident leaders, advocates and liaisons to the Family Medicine Program Director, faculty, hospital and medical community. The Chief Resident positions are leadership development positions that involve service in a number of areas including administration, education, leadership, and supervision activities of the residency. The Chief Residents are the administrative representatives for all the residents and serve as liaisons for all the residents' complaints. The Chiefs are the official intermediaries between residents, faculty and staff. The Chiefs assist the Program Director in evaluating residency concerns, developing policies and procedures and determining appropriate disciplinary actions in accordance with due process. The Chief Residents also, by their example foster the professional attitudes and image expected of Family Medicine residents. The Chief Residents report to the Program Director and work closely with the Residency

Coordinator, faculty and the Clinic Practice Manager to ensure the smooth operation of the Family Medicine residency.

QUALIFICATIONS:

Eligibility:

1. Two senior Family Medicine residents will hold the positions of Chief Residents.
2. The candidates must meet the following academic selection criteria:
   a. Successful completion of all rotations at the point of nomination and meet all criteria for promotion, this does include providing Step 3 results no later than March 1. Residents without step 3 results on the due date of March 1st are unable to be considered.
   b. The resident must not be under academic remediation or probation.
   c. Must have scored at or above the national average for their peer group on the ITE for the previous year.

Attributes:

1. *Leadership:* The resident nominees must have shown interest and involvement in resident issues and have demonstrated a high level of responsibility.
2. *Communication:* The resident nominees must have excellent written and verbal communication skills as well as outstanding interpersonal skills and work well with others.
3. *Interest in Teaching:* The resident nominees must have interest and abilities in promoting education within the residency as evaluated by the residents and faculty. There should be demonstrated ability to teach both in the ambulatory and inpatient areas.
4. *Team Player:* The resident nominees must be a team player and team builder, who can be characterized as a role model for junior residents. The chosen residents must work collegially with faculty , residents and clinic teams.
5. *Administrative Skills:* The resident nominees must demonstrate good organizational and administrative skills which include fulfilling all administrative program duties in a timely fashion.

DUTIES AND RESPONSIBILITIES:

The roles and responsibilities of the Chief Residents are summarized below:

Administrative:

- Work with the Residency Coordinator to develop the Back-up call process.
- Resolve resident scheduling problems and assist the Coordinator in finding coverage in cases of emergency.

Meeting Responsibilities:

- Attend assigned Department meetings:
  1. Faculty Retreats
  2. The Program Evaluation Committee
  3. Resident Council and Graduate Medical Education Committee at HCMC
- Chair the quarterly Family Medicine Resident Organization (FMRO) meeting.
- Meet at least monthly with the Program Director to discuss residency issues.

Educational:

- Serve as role models through active teaching and assisting of residents.
- Assist in the development and coordination of the Wednesday Core Conference including schedules, attendance, organization and introduction of speakers.

1. Chief residents also lead and coordinate the case based interactive seminars which currently occur every other month. This responsibility includes collaborating with faculty about the content and process integrated seminar, as well as ensuring involvement of the patient and family under discussion as appropriate.

- Monitor and encourage attendance at the core conferences of the residency.
- Present relevant lectures as directed.
- Coordinator and supervise the residents' teaching activities during orientation of the new residents.

Supervisory Responsibilities:

- Work with faculty and senior residents to ensure appropriate supervision of junior residents.
- Orient new Chief Residents April 1 – May 30th each year.
- Assist in the planning and implementation of the new resident orientation

Leadership:

- Maintain a high degree of integrity and is able to keep sensitive residency matters in confidence.
- Serve as a spokesperson and liaison for residents in discussion with staff, residency, and faculty meetings.
- Advocate for fellow residents both as a group and individually, ie, residents experiencing academic and nonacademic difficulties.
- Communicate resident concerns and resident educational issues to Residency Program Directors.
- Maintain communication with the Chief Residents of other HCMC residency programs as needed. Discuss procedural changes with the residents on a need basis. Chiefs should be available as a resource for problem solving for the residents.
- Maintain an atmosphere of cooperation among residents.
- Arrange and coordinate Resident Research Day and the residents' portion of the Graduation Banquet.

Recruitment:

- Take an active role in the recruitment process and works in conjunction with the Recruitment Coordinator and the Residency Coordinator. Coordinates residents' participation in resident selection and interviews.

PROCESS OF SELECTION:

1. *Nomination:* By February 1st of each academic year, the Residency Program Coordinator will invite nominations from interested PGY2 residents. Nominations must be given to the Coordinator by the designated date. Candidates for the two positions may be nominated by their peers or may be self nominated.
2. *Screening:* The current Chief Residents, Program Director and members of the Program Education Committee will screen the candidates for eligibility and possession of desirable attributes. The final slate of Suitable candidates will be required to submit a written questionnaire on why they want to be chief; how they would handle challenges and their goals and objectives for the coming year.
3. *Appointment:* The Program Director after consultation with the Program Education Committee will appoint the Chief Residents.

REQUIREMENTS AND PROVISIONS FOR CHIEF RESIDENTS

The Residency Program Director, residency coordinator will work with the Chief residents to ensure the development of required skills needed to function in the position.

- The Chief Residents receives a monthly stipend of $
- Paid expenses for attendance at the ACGME Chief Resident's Leadership Workshop or other leadership conference determined necessary by the residency program

- Office space with adequate computer support at Whittier Clinic
- The Chief Residents will be assigned one half day per week for chief administrative duties.
- Training and practice in leadership skills.

TERM

The tenure of the Chief Resident begins on April 1st with help from the current Chief Residents . Beginning on June 1st , they begin managing duties on their own.

If for any reason, one or both of the Chief residents are unable to fulfill their duties for the entire year, the residency program director with input from the PEC, faculty and residents, will appoint a replacement for the remainder of the term . The residency Director may remove the Chief resident(s) form their position for any poor performance or any adverse action.

PERFORMANCE REVIEW:

The Chief Residents will meet with the Program Director midway through their term of office for a performance review.

Revised: 1/19/2010
Updated 10/11/2016

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Elective Policy

Department of Family and Community Medicine

In December of the G1 and G2 year, the resident will meet with his/her advisor and plan electives for the upcoming PG year. G2 residents have 2 electives per year and the G3 residents have 3 electives per year. The selection process will concentrate on educational content not the timing of the elective. The advisors role includes reviewing these for broad content over the spectrum of Family Medicine (i.e., not all of the resident's electives should be medical subspecialties). The goal of this meeting is to update the residents IEP to use electives to better prepare the residents for their careers after residency.

Residents must submit their elective list to Peg no later than January 1st of each year. The FM Leadership Committee will review requests for balance and content. The requests may go back to the resident and advisor with comments for reconsideration. Residents are responsible for following any special instructions and meeting due dates/deadlines.

After receiving approval from the FM Leadership group, the resident is responsible for contacting the specific rotation to confirm. They will need to obtain relevant scheduling information and the name of the preceptor completing their evaluation. The elective experience must be at least 50% of the rotation. The resident must provide when their FM clinics can be scheduled and must include evenings.

Residents will communicate with Peg and Dr. Petersen on any changes or cancellations, once the final elective form has been turned in. The resident cannot change the elective without strong rationale to the FM Leadership Committee.

5 Steps for an Elective:

- Meet with your advisor and follow the above instructions
- Turn in elective requests to Peg by January 1 of each year
- FM Leadership Committee to meet and discuss/approve requests
- Elective requests returned to residents with instructions, deadlines/due dates
- Resident speaks with elective for final confirmation

8/16/2010

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ELECTIVE SUGGESTIONS

HCMC and OFF Site

Academic Medicine

Adolescent Medicine

Community Medicine

MN Department of Health

Dermatology (not available)

Diabetes with Laraine Steele

ENT

Interventional Radiology

Maternal / Child Health (for G3s only)

Off site elective (Twin Cities or
Out of state)

Ophthalmology

Oral Health (Dentistry at HCMC)

Ortho/Podiatry

International Elective
Out of Country Elective
(cannot be to country of origin)

Outpatient Procedures

Rural

Sports Medicine

Urban Undeserved

Urology

Medicine Electives

Endocrine

G.I.

Geriatric

Infectious diseases (not avail. in IM-
ok at Red Door)

Neurology

Nephrology (not available)

Pallative Care

Pulmonary (Pulm consults not avail.)

Renal

Rheumatology

Sleep Medicine (not available)

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Appendix I

For the period 2014-2015
Persons to contact

The following individuals may be referred to by title in this document:

Dr. Jerry Potts	Chief, Dept. of Family & Community Medicine
Dr. Charles Anderson	Assistant Chief
Dr. Allyson Brotherson	Residency Program Director
Dr. Kim Petersen	Associate Program Director
Dr Ayham Moty	Medical Director of Whittier Clinic
Molly Jacques	Practice Manager
Jessica Schuldt	Department Manager/Asst. to the Chief
Mindy Chatelle	FM Residency Coordinator
Peg Sullivan	Associate Residency Coordinator
Julene Haug	Conference Coordinator
Lynn Gannaway	Faculty Scheduler
Angee Zelaya	Clinic Scheduler

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Appendix II

May be found on our website InfoOnCall

ABFM Residency Guidelines
ACGME Institutional Requirements
RRC Program Requirements for Family Medicine
ACGME Milestones for Family Medicine
HCMC Residency Policy Manual
These can be found on the Department of Family Medicine Intranet Home Page under Resident Policies. You are responsible for this information.

Directories: InfoOnCall

InfoOnCall – Departments – Family Medicine
Clinic
- Schedules

Residents
- Curriculum:
  - Behavioral Medicine
  - Yearly Curriculum
  - Curriculum Manual
- Core Conference Schedule
- Duty Hours
- Resident Vacation/Leave/Time Off Due Dates
- Procedures
- Exam Master
- Elective Request Form
- RRC (ACGME website)
- Lists:
  - Advisor list
  - Beeper list
  - Email list
  - Team list
  - FMC Phone list
- Policies
- FMS Guidelines
- Presentations
- OB Page

May be found in the HCMC Institutional Manual

Malpractice Insurance information

APPENDIX III

Faculty Evaluations of Resident

A. Inpatient Resident Evaluation
B. One on One Precepting
    1 to 1 G1
    1 to 1 G2
    1 to 1 G3
C. HCMC Family Medicine Residency Multisource Resident Evaluation
D. Promotion Criteria:
    Intern Six Month Competency Evaluation
    Intern Promotion Evaluation
    Promotion Criteria for PGY2 to PGY3
    Graduation Criteria
E. Final Evaluation
F. One Moment In time Evaluation
G. Annual Clinic Evaluation

Resident Evaluation of Faculty and Program

H. Resident Evaluation of Program
I. Resident Evaluation of Faculty
J. Annual Evaluation of HCMC Training Programs
K. Exit Evaluations

Other Evaluations

L. Peer Evaluations
M. Patient Evaluations
N. Self Evaluations
O. Alumni Survey
P. Employer Survey
Q. Journal Club Evaluation form
R. M&M Evaluation
S. Resident Biannual Summary
T. Transitions of Care evaluation

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HENNEPIN COUNTY MEDICAL CENTER
FAMILY MEDICINE RESIDENCY

Whittier Clinic
2810 Nicollet Ave.
Minneapolis, MN 55408

FINAL EVALUATION

Name________________________________

This is a confidential report from the Hennepin County Medical Center –Family Medicine Residency Program on the above named individual. We submit this document in response to your request for verification of Family Medicine Residency training and reference information instead of other forms. This serves as verification of training and supplants all other documents.

I Verification of training
Name of Resident:

Dates of Attendance:	**From** (Start date)	**To** (End date)
Last level of training:	**PGY** (Last level)	

_________ **Completed Internship or two years of training only**
Since this physician only completed one or two years of training, the program can provide an assessment of this doctor's performance during that time only. We cannot verify qualifications for staff membership or clinical procedures

_________ Completed **Residency program**
During training, this resident's performance, level of competence and personal and moral conduct have been satisfactory. The resident is competent to perform all general Family Medicine procedures except as noted below

↑ See Appendix Item 1 (optional statement of any deviation from standard training sequence)

II. Disciplinary Action:
↑ During the dates of training at this institution Dr.________________________ was not subject to any disciplinary action

↑ See Appendix Item 2 (Description of disciplinary actions. This would not normally include Corrective or Academic Actions instituted for educational reasons that have been successfully remediated)

III. Professional Liability
↑ To the best of our knowledge, Dr. ___________________ was not investigated by any governmental or legal body and was not the defendant in any malpractice suit during residency training

↑ See Appendix item 3(Description of investigations and malpractice suits)

IV Ability to practice medicine
To the best of our knowledge, no conditions exist that would impair Dr. ____________________ ability to practice medicine

See appendix item 4. (Description of substance use, physical or mental conditions)

V. Residency Program Evaluation:
The following evaluation is based on the demonstrated performance of Dr. _______________ during residency and in the final period of education. It represents personal observation by faculty members, the Program Promotions and Evaluation Committee and a composite of multiple evaluations by rotation and clinical supervisors.

Competency	Final training period		Overall performance			
	Satisfactory	Unsatisfactory	Excellent	Good	Fair	Poor
Patient Care						
Clinical and Technical skills						
History taking and physical examination skills						
Differential diagnosis and problem list formulation						
Clinical judgment and decision making						
Preventive Medicine knowledge						
Medical knowledge						
Analytical approach to knowledge acquisition						
Use of supportive sciences						
Practice Based learning and improvement						
Computer literacy and IT knowledge						
Ability to assess practice and improve patient outcomes						
Teaching ability						
Interpersonal and communication skills						
Ability to work with others						
Patient education skills						
Professionalism						
Commitment to excellence						
Dependability and attendance						
Ethical conduct and character						
Sensitivity to diversity						
Systems Based Practice						
Delivery systems						
Cost effective practice						
Overall clinical competence						

VI. Procedure competency

At the conclusion of Dr. ______________________Family Medicine residency training, (s)he was capable of performing the following procedures: (Insert procedure page here)

VII. Competency statement and recommendations

A final summative evaluation was done by the Promotion and Evaluation Committee of Dr.______________________'s overall performance and during the final period of training of the residency. By agreement of the faculty and the Program Director, Dr.___________________ is competent and capable of independent practice of family medicine as of ________________20__

Recommended

_____________ Without reservation
_____________ With reservation because
____
____
____
_____________ Do not recommend because
____
____
____

____________________________ ______________
Program Director Signature Date

Allyson Brotherson MD
Residency Program Director
Family Medicine
Hennepin County Medical Center

___________________________ _________________
Resident Date

Hospital Seal

Appendices

Appendix 1
Variation of training schedule
____
____
____
____
____
____
____

Appendix 2
Disciplinary action or withdrawal from program
____________ Resident was terminated. Reason for termination

____
____
____
____

__________Resident withdrew from program. Reason for withdrawal
____
____
____
____
____

Appendix 3
Professional liability
___________ Resident was a defendant in a medical malpractice action
___________ Resident was a defendant in a criminal / felony action

Explanation____
____
____
____
____

Appendix 4
Ability to practice medicine
__________ Resident demonstrated alcohol/ drug dependence
__________ Resident demonstrated mental or physical health problems connected to performance

Explanation____
____
____
____

Journal Club Evaluation Form

Presenter: ______________________________
Evaluator: Faculty___ Resident___ Student___
Title of article
____
____

Please use the following 1 – 5 scale:
1) strongly disagree, 2) somewhat disagree, 3) neutral, 4) somewhat agree, 5) strongly agree

A Analysis of article

- The resident provided a coherent summary of the study. 1 2 3 4 5
  - Explains: Study Goal
  - Identified type of study
  - Discussed methodology
  - Results

B. Practice based learning and improvement

- The resident demonstrated an understanding of the methodology of the study. 1 2 3 4 5
  - Identifies strengths and weaknesses of the methodology and/or conduct of the trial
  - Draws own conclusions and contrasts them with author(s)
- The resident was able to assess the validity of the results. 1 2 3 4 5

Assesses and critiques the statistical analysis

- The resident was able to assess the applicability of the results to patient care. 1 2 3 4 5
  Connects findings to patient population here at FMC

C. Interpersonal and communication skills

- Delivery of presentation 1 2 3 4 5
  Is well-prepared (does not reread article)
  Introduces presentation (tells them what she/he is going to tell them) and summarizes presentation (tells them what she/he told them)
- Presentation & Communication Skills 1 2 3 4 5
  Resident presented material in clear and coherent fashion
  Confidence is apparent:
  Proper rate of speech Appropriate pitch of voice
  Professional phraseology
  Smooth delivery;
  Printed and audiovisual materials are accurate, clear and effective (complement what is verbally presented)
- Ability to answer questions 1 2 3 4 5
  Answers are logically presented
  Answers are accurate
  Resident can think on his/her feet

D. Suggestions for improvement

____
____
____
____

HENNEPIN COUNTY MEDICAL CENTER
FAMILY MEDICINE RESIDENCY

MORTALITY AND MORBIDITY EVALUATION FORM

Resident name________________________ Evaluator_____________________________

Topic____ Date__________

Please rate the degree to which the resident demonstrated the following tasks using the following scale:

1 Did not demonstrate 2 Minimal 3 Appropriate 4 Extensive

Please write a suggestion for improvement for scores of less than 2

1. Knowledge of disease entity

1 2 3 4

Suggestions for improvement:
____
____
____

2. Use of scientific evidence

To what extent did the resident obtain, appraise or assimilate evidence from scientific studies related to the patient's health problem

1 2 3 4

Suggestions for improvement:

____
____
____

3. **Analysis of own practice for improvement in patient care**

Resident describes the scope of the medical problem identified during inpatient care (if any) and demonstrates insight of how to improve clinical care or patient outcomes

1 2 3 4

Suggestions for improvement:

____
____
____
____

(Continued on next side)

4. **Facilitate learning of others**

Resident presents clinical information in a manner that facilitated education of residents and faculty

1 2 3 4

Suggestions for improvement:

____
____
____
____

5. Resident demonstrates appreciation and understanding of psychosocial and family systems that impacted patient care delivery

1 2 3 4

Suggestions for improvement:

____
____
____
____

HCMC FAMILY MEDICINE RESIDENCY PROGRAM
RESIDENT PORTFOLIO BIANNUAL SUMMARY

Resident_______________________ Date_________ PGY Year_________ #______

1. **PATIENT CARE**

a). Rotation evaluations

Specific concerns or notable comments

____
____
____
____

b). Clinic evaluations

___ One to One Evaluations ____ Focused resident evaluations
___ Clinic Team Evaluation ____Specific concerns or notable comments
Specific concerns or notable comments:

____
____

c). Procedures review (see attached detailed report)

Number of procedures in Procedure logger________________

Procedure	# required	# performed	Resident passed test for independence
Procedures to be credentialed in FMC (needed for graduation)			
*Toenail removal	3		
*Cryotherapy of skin	5		
Skin biopsies	5		
*Colposcopy	10		
*IUD placement	4		
Other required procedures not requiring credentialing (needed for graduation)			
Critically ill	15		
Home visits	2		
Primary OB deliveries	10		
Other OB deliveries	40		
Pap smear	10		
Laceration repair/suturing/ wound closure	5		
Family Medicine Inpatient Continuity (non ob)	10		
Circumcisions	3		
Orthopedic procedures (Begin July 2009)			
Joint aspiration and /or joint injection Knee	5		
Fiberglass short arm Cast	3		
Thumb spica	3		

d. Family Care Conferences

Training year	# observed	# scheduled	# independent
PGY1			
PGY2			
PGY3			

e. Patient numbers

Training year	# completed	#required
PGY1		150
PGY2		
PGY3		1000
Total		1650

2. MEDICAL KNOWLEDGE

a. Conference attendance

Date of review From_________ To______

Percentage attended ____________% Percentage required___________%

Overall attendance___________ %

b. ABFM Intraining examination

Training year	% correct	Percentile ranking at PGY level
PGY1		
PGY2		
PGY3		
Total		

c. USMLE Step 3

Exam scheduled Yes No

Exam passed Yes No

Specific concerns or notable comments about medical knowledge

____

____

____

3. PRACTICE BASED LEARNING AND IMPROVEMENT

a. Self reflection entries

Training year	Description	Number needed	ACGME competencies
PGY1	ACGME competencies		
PGY2	Praise and blame		
PGY3	Critical incidents		

-

b. Experiential portfolios completed (PGY3) Yes No

c. Self evaluations completed Yes No

d. Journal Club Participation

Dates of review From ______ to __________

% attended___________________

Resident presented a case Yes No

Evaluation form completed Yes No

e. Supervisory and leadership ability

PGY1 Completed RED curriculum Yes No

PGY2 Completed and passed Microskills teaching Yes No

Passed Supervisor's exam Yes No

PGY3

Specific concerns or notable comments

____

____

____

4. INTERPERSONAL AND COMMUNICATION SKILLS

a. ____ Rotation/team/peer evaluations c. ____ Patient satisfaction surveys

b____ Videotapes d.____ Patient complaints

Specific concerns or notable concerns

____

____

5. PROFESSIONALISM

a. Rotation/team/peer evaluations (attached)

Concerns?

____
____

6. SYSTEMS BASED PRACTICE

a. Rotation/team/peer evaluations (attached)

Concerns?

b. Morbidity and Mortality Conference Participation

Dates of review From ______ to __________

% attended___________________

Resident presented a case Yes No

Evaluation form completed Yes No

Specific concerns or notable comments

____
____
____

7. ADDITIONAL ASSESSMENTS

a. Scholarly project
b. Training schedules
c.

PGY year	Name of workshop	Passed	Plan for retake
PGY1	MSK workshop		
	Psychopharmacology		
	General diabetes training		
	Life support classes		
	ACLS		
	BLS		
	ALSO		
PGY2	GDM		
	APLS		
	Sports Medicine examination		
PGY3	ACLS		
	BLS		
	ATLS		

8. SUMMARY

a. Strengths and growth areas identified (See attached worksheet)
b. Educational goals for next six months identified(See attached worksheet)

10

9. CURRENT RESIDENCY STANDING

___ Meets requirements for graduation, has demonstrated sufficient competence for independent practice
___ Meets requirements for promotion to ______ year
___Currently in good standing
___ On academic correction_____ Level ______
___Other

Evaluator____________________ Date__________________

Resident_____________________ Date__________________

Updated 4.15.2009

Evaluation of Transitions of Care

Sign-out from: Sign-out to:

Y	N	Severity of each patient is clearly stated.
Y	N	To Do List is clearly transmitted if necessary
Y	N	Time per patient averaged < 3 minutes per patients _________ patients were signed out in _________ minutes
Y	N	Effort was made to try and minimize distractions (beepers, chatter etc.)

Comments on this process:

Evaluation form completed by ________________________________

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Family Medicine Inpatient Evaluation

Level 1 is target for 6 months
Level 2 is target for end of 1st year
Level 3 target for end of second year
level 4 target for graduation

Patient Care

Level 1	Level 2- end of PGY1	Level 3- End of PGY2	Level 4- End of PGY3	Level 5- Graduation
PC-1 Cares for acutely ill or injured patients in urgent and emergent situations and in all settings				
Gathers essential information about the patient (history, exam, diagnostic testing, psychosocial context) Generates differential diagnoses Recognizes role of clinical protocols and guidelines in acute situations	Consistently recognizes common situations that require urgent or emergent medical care Stabilizes the acutely ill patient utilizing appropriate clinical protocols and guidelines Generates appropriate differential diagnoses for any presenting complaint Develops appropriate diagnostic and therapeutic management plans for acute conditions	Consistently recognizes complex situations requiring urgent or emergent medical care Appropriately prioritizes the response to the acutely ill patient Develops appropriate diagnostic and therapeutic management plans for less common acute conditions Addresses the psychosocial implications of acute illness on patients and families Arranges appropriate transitions of care	Coordinates care of acutely ill patient with consultants and community services Demonstrates awareness of personal limitations regarding procedures, knowledge, and experience in the care of acutely ill patients	Provides and coordinates care for acutely ill patients within local and regional systems of care
PC-2 Cares for patients with chronic illnesses				
Recognizes chronic conditions Accurately documents a clinical encounter on a patient with a chronic condition, and generates a problem list Recognizes that chronic conditions have a social impact on individual patients	Establishes a relationship with the patient as his or her personal physician Collects, organizes and reviews relevant clinical information Recognizes variability and natural progression of chronic conditions and adapts care accordingly Develops a management plan that includes appropriate clinical guidelines Uses quality markers to evaluate the care of patients with chronic conditions	Consistently applies appropriate clinical guidelines to the treatment plan of the patient with chronic conditions Engages the patient in the self-management of his or her chronic condition Clarifies the goals of care for the patient across the course of the chronic condition and for his or her family and community Begins to manage the conflicting needs of patients with multiple chronic conditions or multiple co-morbidities	Leads care teams to consistently and appropriately manage patients with chronic conditions and co-morbidities Facilitates patients' and families' efforts at self-management of their chronic conditions, including use of community resources and services	Personalizes the care of complex patients with multiple chronic conditions and co-morbidities to help meet the patients' goals of care Continually uses experience with patients and evidence-based medicine in population management of chronic condition patients

	Understands the role of registries in managing patient and population health			

Medical Knowledge

Level 1	Level 2- end of PGY1	Level 3- End of PGY2	Level 4- End of PGY3	Level 5- Graduation
MK-1 Demonstrate medical knowledge of sufficient breadth and depth to practice Family Medicine				
Demonstrates the capacity to improve medical knowledge through targeted study	Uses the American Board of Family Medicine (ABFM) In-Training Assessment resident scaled score to further guide his or her education Demonstrates capacity to assess and act on personal learning needs	Meets Maintenance of Certification (MOC) requirements in preparation for certification examination Achieves an ABFM In-Training Assessment resident scaled score predictive of passing the certification examination	Successfully completes ABFM requirements for certification Appropriately uses, performs, and interprets diagnostic tests and procedures	Maintains ABFM certification Demonstrates life-long learning beyond minimum MOC and Maintenance of Licensure (MOL) requirements
MK-2 Applies critical thinking skills inpatient care				
Recognizes that an in-depth knowledge of the patient and a broad knowledge of sciences are essential to the work of family physicians Demonstrates basic decision making capabilities Demonstrates the capacity to correctly interpret basic clinical tests and images	Synthesizes information from multiple resources to make clinical decisions Begins to integrate social and behavioral sciences with biomedical knowledge in patient care Anticipates expected and unexpected outcomes of the patients' clinical condition and data	Recognizes and reconciles knowledge of patient and medicine to act in patients' best interest Recognizes the effect of an individual's condition on families and populations	Integrates and synthesizes knowledge to make decisions in complex clinical situations Uses experience with patient panels to address population health	Integrates in-depth medical and personal knowledge of patient, family and community to decide, develop, and implement treatment plans Collaborates with the participants necessary to address important health problems for both individuals and communities

Systems-Based Practice

Level 1	Level 2- end of PGY1	Level 3- End of PGY2	Level 4- End of PGY3	Level 5- Graduation
SBP-1 Provides cost-conscious medical care				
Understands that health care resources and costs impact patients and the health care system	Knows and considers costs and risks/benefits of different treatment options in common situations	Coordinates individual patient care in a way that is sensitive to resource use, efficiency, and effectiveness	Partners with patients to consistently use resources efficiently and cost effectively in even the most complex and challenging cases	Role models and promotes efficient and cost-effective use of resources in the care of patients in all settings
SBP-2 Emphasizes patient safety				
Understands that medical errors affect patient health and safety, and that their occurrence varies across settings and between providers Understands that	Recognizes medical errors when they occur, including those that do not have adverse outcomes Understands the mechanisms that	Uses current methods of analysis to identify individual and system causes of medical errors common to family medicine Develops individual	Consistently engages in self-directed and practice improvement activities that seek to identify and address medical errors and patient safety in daily practice	Role models self-directed and system improvement activities that seek to continuously anticipate, identify and prevent

effective team-based care plays a role in patient safety	cause medical errors Understands and follows protocols to promote patient safety and prevent medical errors Participates in effective and safe hand-offs and transitions of care	improvement plan and participates in system improvement plans that promote patient safety and prevent medical errors	Fosters adherence to patient care protocols amongst team members that enhance patient safety and prevent medical errors	medical errors to improve patient safety in all practice settings, including the development, use, and promotion of patient care protocols and other tools
SBP-4 Coordinates team-based care				
Understands that quality patient care requires coordination and teamwork, and participates as a respectful and effective team member	Understands the roles and responsibilities of oneself, patients, families, consultants, and interprofessional team members needed to optimize care, and accepts responsibility for coordination of care	Engages the appropriate care team to provide accountable, team-based, coordinated care centered on individual patient needs Assumes responsibility for seamless transitions of care Sustains a relationship as a personal physician to his or her own patients	Accepts responsibility for the coordination of care, and directs appropriate teams to optimize the health of patients	Role models leadership, integration, and optimization of care teams to provide quality, individualized patient care

Professionalism

Level 1	Level 2- end of PGY1	Level 3- End of PGY2	Level 4- End of PGY3	Level 5- Graduation
PROF-2 Demonstrates professional conduct and accountability				
Presents him or herself in a respectful and professional manner Attends to responsibilities and completes duties as required Maintains patient confidentiality Documents and reports clinical and administrative information truthfully	Consistently recognizes limits of knowledge and asks for assistance Has insight into his or her own behavior and likely triggers for professionalism lapses, and is able to use this information to be professional Completes all clinical and administrative tasks promptly Identifies appropriate channels to report unprofessional behavior	Recognizes professionalism lapses in self and others Reports professionalism lapses using appropriate reporting procedures	Maintains appropriate professional behavior without external guidance Exhibits self-awareness, self-management, social awareness, and relationship management Negotiates professional lapses of the medical team	Models professional conduct placing the needs of each patient above self-interest Helps implement organizational policies to sustain medicine as a profession
PROF-3 Demonstrates humanism and cultural proficiency				
Consistently demonstrates compassion, respect, and empathy Recognizes impact of culture on health and health behaviors	Displays a consistent attitude and behavior that conveys acceptance of diverse individuals and groups, including diversity in gender, age, culture, race, religion, disabilities, sexual orientation, and gender identity	Incorporates patients' beliefs, values, and cultural practices in patient care plans Identifies health inequities and social determinants of	Anticipates and develops a shared understanding of needs and desires with patients and families; works in partnership to meet those needs	Demonstrates leadership in cultural proficiency, understanding of health disparities, and social determinants of health Develops

	Elicits cultural factors from patients and families that impact health and health behaviors in the context of the biopsychosocial model Identifies own cultural framework that may impact patient interactions and decision-making	health and their impact on individual and family health		organizational policies and education to support the application of these principles in the practice of medicine

Communication

Level 1	Level 2- end of PGY1	Level 3- End of PGY2	Level 4- End of PGY3	Level 5- Graduation
C-1 Develops meaningful, therapeutic relationships with patients and families				
Recognizes that effective relationships are important to quality care	Creates a non-judgmental, safe environment to actively engage patients and families to share information and their perspectives	Effectively builds rapport with a growing panel of continuity patients and families Respects patients' autonomy in their health care decisions and clarifies patients' goals to provide care consistent with their values	Connects with patients and families in a continuous manner that fosters trust, respect, and understanding, including the ability to manage conflict	Role models effective, continuous, personal relationships that optimize the well-being of the patient and family
C-2 Communicates effectively with patients, families and the public				
Recognizes that respectful communication is important to quality care Identifies physical, cultural, psychological, and social barriers to communication Uses the medical interview to establish rapport and facilitate patient-centered information exchange	Matches modality of communication to patient needs, health literacy, and context Organizes information to be shared with patients and families Participates in end-of-life discussions and delivery of bad news	Negotiates a visit agenda with the patient, and uses active and reflective listening to guide the visit Engages patients' perspectives in shared decision making Recognizes non-verbal cues and uses non-verbal communication skills in patient encounters	Educates and counsels patients and families in disease management and health promotion skills Effectively communicates difficult information, such as end-of-life discussions, delivery of bad news, acknowledgement of errors, and during episodes of crisis Maintains a focus on patient-centeredness and integrates all aspects of patient care to meet patients' needs	Role models effective communication with patients, families, and the public Engages community partners to educate the public
C-3 Develops relationships and effectively communicates with physicians, other health professionals, and health care teams				
Understands the importance of the health care team and shows respect for the skills and contributions of others	Demonstrates consultative exchange that includes clear expectations and timely, appropriate exchange of information Presents and	Effectively uses Electronic Health Record (EHR) to exchange information among the health care team Communicates collaboratively with the health care team by listening attentively,	Sustains collaborative working relationships during complex and challenging situations, including transitions of care Effectively negotiates and manages conflict among members of the	Role models effective collaboration with other providers that emphasizes efficient patient-centered care

	documents patient data in a clear, concise, and organized manner	sharing information, and giving and receiving constructive feedback	health care team in the best interest of the patient	

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