



HCMC Family Medicine Residency Program
Policy and Procedure Manual
Academic Year 2019-2020

HCMC FAMILY MEDICINE RESIDENCY PROGRAM

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WELCOME

Welcome to the Department of Family and Community Medicine at Hennepin Healthcare/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.

Michelle Karsten, M.D
Program Director
Department of Family and Community Medicine
Hennepin County Medical Center
Hennepin Healthcare

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 provide opportunities for residents to learn in multiple settings (e.g., hospital, ambulatory settings, emergency rooms, home and long-term care facilities), and work with residents to develop the skills and procedures that are within the scope of family medicine. Residencies 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-ACGME Competencies

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**, following the milestone development scales. All of our curriculum teaching describes the knowledge, skills and attitudes that all trainees must develop in these areas. These six domains core competencies with graduation goals are described below:

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.

Residents and graduates will:

- Know and apply current best practice guidelines for the diagnosis and management of common inpatient and outpatient problems.
- 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

Patient Care

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

Residents and 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

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 and develop skills and habits of lifelong learning
- 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
- Use practice improvement techniques, evidence based medicine and information technology to improve patient care

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 all members of the health team.

Residents and graduates are expected to:

- Demonstrate empathy and respect
- 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

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and adherence to ethical principles. They will promote the best interest of patients, society and the medical profession.

Residents and graduates are expected to demonstrate:

- Compassion, integrity, and respect for others
- Conduct professional activities in an ethical and legally responsible manner
- 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
- Devote attention to the quality of personal and family life in order to sustain healthy relationships with others, including patients and other health professionals

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 and graduates are expected to:

- Work effectively in various health care delivery settings and systems relevant to their clinical specialty
- Coordinate patient care within the healthcare 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 and strategies to minimize them
- Understand health care financing and its impact on the quality and availability of patient care

COMPETENCY BASED EXPECTATIONS

Residency is a three year training period which trainees must successfully complete in order to earn Board Certification in Family Medicine. This residency program evaluates each resident's successful achievement in three areas: knowledge, attitudes and skills in the ACGME six core competencies.

Medical Knowledge:

1. Residents must successfully complete each of the 13 four week block rotations. Residents may need to remediate failed rotations before being allowed to proceed in their training program.

2. All residents are expected to take the annual 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:

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:

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:

1. Residents are expected to have an adult learner mentality, that is, a willingness to embrace knowledge in a motivated fashion, including the acquisition of new information and incorporation of this information into their knowledge base
2. Develop a habit of lifelong learning by completion of at least 80% of the AFP journal quizzes annually and uploading to RMS.
3. Completion of all CKSA questions administered by the ABFM.

Professionalism:

Residents will embrace the 10 tenets of the residency program's code of professional conduct:

1. Treat others as we would like to be treated
2. Be honest: maintain personal and professional integrity; represent the truth
3. Be accountable in our personal and professional lives, as our peers, patients, families and community depend on us
4. Respect and embrace diversity as it relates to gender, age, culture, race, religion, disabilities, and sexual orientation and identities.
5. Communicate respectfully
6. Be responsible for conflict resolution
7. Be healthy and sober/drug free and ready to learn
8. Be on time
9. Dress appropriately

10. Be altruistic; we are here to help people

11. Systems-Based Practice and Administrative:

1. Residents will perform their administrative duties in a timely fashion to include:
 - a. Complies with the requirements associated with presenting at 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 48 hours after the patient's visit; patient communication/inbox requests and other hospital paperwork in a timely manner.
 - d. Meeting regularly(at least quarterly) 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 forth by HCMC

RESIDENTS' ESSENTIAL JOB FUNCTIONS

EPAs for Family Medicine End of Residency Training

Entrustable Professional Activities (EPAs) are the next step in Competency Based Graduate Medical Education (CBGME). The core competencies, sub-competencies and milestones for family medicine are seen as too long and theoretical for practical use in evaluation and curricular design. (Reference Ten Cate JGME March2013 page 6-7).

The Entrustable Professional Activities are:

1. Provide a usual source of comprehensive, longitudinal medical care for people of all ages.
2. Care for patients and families in multiple settings.
3. Provide first-contact access to care for health issues and medical problems.
4. Provide preventive care that improves wellness, modifies risk factors for illness and injury, and detects illness in early, treatable stages.
5. Provide care that speeds recovery from illness and improves function.
6. Evaluate and manage undifferentiated symptoms and complex conditions.
7. Diagnose and manage chronic medical conditions and multiple co-morbidities.
8. Diagnose and manage mental health conditions.
9. Diagnose and manage acute illness and injury.
10. Perform common procedures in the outpatient or inpatient setting.
11. Manage prenatal, labor, delivery and post-partum care.
12. Manage end-of-life and palliative care.
13. Manage inpatient care, discharge planning, transitions of care.
14. Manage care for patients with medical emergencies.

15. Develop trusting relationships and sustained partnerships with patients, families and communities.

Materials developed by the Association of Family Medicine Residency Directors

BENEFITS

A(i) Salary and Deferred Compensation

Salary for 2018-19

G1: \$54,165

G2: \$56,503

G3: \$58,386

(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 to complete certain life support courses at HCMC during their residency.

They are as follows:

(i) BLS/ACLS: As a G1 resident: done prior to or during G1 orientation

(ii) ACLS: Optional during G3 year (at resident expense)

(iii) NRP: Required during G1 year,

(iv) ALSO: Required as a G1, and a 2nd time during residency, sponsored by the Family Medicine Residency Program

The Residency Program will assign, 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).

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 prior to registering for such a course.

Educational Stipend Funds

Educational Stipend. Class of 2021 and 2022:

The Educational Stipend will encompass:

--Step 3 reimbursement

During the G1 year all residents are required to take the USMLE Step 3 exam. The residency program will reimburse \$400.00 per resident with proof of payment for the cost of the exam. If you have taken the exam prior to starting the residency you can substitute this reimbursement for additional support for your license fees (to a total of the cost of a license \$392, at this time) or for support of your DEA number for no more than \$600 total reimbursement.

If you have to repeat the exam, there is no reimbursement for subsequent attempts.

--MN license application reimbursement

At the end of the G1 (for US medical school graduates) or G2 year (for other graduates), residents are required to apply for their Minnesota License. The residency will reimburse the resident \$200.00 of the license fee with proof of receipt of payment.

--Electronic devices (Surface Pros or equivalent). To allow for home EPIC access.

-Partial Reimbursement of the ABFM Board examination fee. G3 residents will receive reimbursement with proof of registration and a passing score. Registration and passing score must be provided to the program by June 15.

The stipend will no longer cover costs associated with attending CME courses (transportation, registration, food, or accommodations). There are many low to no cost **local**, quality CME courses available. Please discuss with your advisor or other faculty if you need help in finding CME courses. You may also choose to travel and attend courses as per the CME days off policy at your own expense.

Class of 2020:

BEFORE SPENDING ANY of the EDUCATIONAL STIPEND YOU MUST RECEIVE APPROVAL FROM JESSICA SCHULDT– PLEASE PLAN AHEAD.

Do not assume you will be reimbursed without prior approval.

A total of \$600.00 during residency is available.

- To be used during the PGY 1, 2, or 3rd year of training
- Upon approval, submit to Jessica your original receipts totaling \$600.00 within two weeks of attending a CME course (airline tickets, hotel, registration, food and car rental receipts). She will reimburse you.
- You may choose to spend this amount (up to \$600.00) 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 purchased, any remaining money would be available to purchase medical textbooks or other educational materials, totaling 50% of the remaining funds (\$300). 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 a book on your own.
- Reimbursement for CME activities, requests for books, etc. must be submitted no later than 90 days before the completion of residency, March 30 of your G3 year.

All Residents (G1, G2, and G3s) Requirements for approval of CME Time Off:

- CME need to be AAFP accredited (not necessarily AAFP sponsored). When reviewing your course, the accreditation section will show if it is AAFP accredited.
- Time off for out of town CME will be 1 day prior for travel, dates the CME is being held and 1 day after for travel.
- Residents MUST provide the residency a copy of the brochure (or similar) from the CME course when you submit the CME leave request. You are required to submit a copy of your paid registration upon approval of the CME leave request, and a copy of the CME credit certificate within 2 weeks of returning from the CME.

Failure to provide this information will result in loss of vacation time equal to the days granted for CME. This may result in extending residency if it violates the standard time away from residency policy. Residents receive five days leave with pay, per academic year, for CME.

LEAVE POLICIES including VACATION, ILLNESS, AND OTHER SHORT-TERM ABSENCES

The Hennepin Healthcare FM Residency leave policy is largely dictated by the ABFM Policy (available at <https://www.theabfm.org/cert/absence.aspx>) which states:

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. The ABFM defines one month as 21 working days or 30 calendar days.

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.

Long-Term Absence

Absence from residency education, in excess of one month within the academic year (G-1, G-2 or G-3 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.

Leaves of absence in **excess** of 3 months are considered a violation of the continuity of care requirement. Programs must be aware that the Board may require the resident to complete additional continuity of care time requirements beyond what is normally required to be eligible for certification.

Hennepin Healthcare Department of Family Medicine Residency Program Leave Policy

All residents are given 21 days of time away from work as allowed by the ABFM. There are “request off dates” that need to be followed for time off requests. These are 9 weeks prior to the start of all rotations. This allows adequate time to plan for clinic staffing and to notify rotations in order to arrange for coverage if needed. Vacation requests made after this date may be declined. No leave is approved without the submission of a written leave request.

If time off is needed on short notice, the requests will be accommodated as able. As a courtesy to patients, staff and your colleagues, please request this time off as soon as you are aware of the need, as clinics may need to be cancelled/patients rescheduled, or other coverage arranged. Sick days, which represent an emergent need for the resident or their immediate family, will be honored. Residents out sick for more than 2 days may be asked for a “return to work” note from their treating physician before reentry.

Residents are required to **call both their rotation as well as the FM coordinator when they are missing any assigned days (sick or other call outs)**. These days are reported to the ABFM and our records need to be accurate.

Any days that exceed this maximum allowed time away, as per the ABFM policy, “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” (extension of residency).

No more than 5 weekdays (one week) may be **scheduled** away from any rotation. If greater than one week is missed of any 4-week rotation, the resident **may** be required to repeat that missed portion or the entire rotation.

No sick leave may be taken directly before or after vacation, holiday, or PTO days without a doctor's note or other appropriate documentation. See the attached calendar that indicate Blackout Days. If a resident is sick or otherwise calls out, on one of these Blackout days, they need to provide appropriate documentation.

Medical, Mental Health and Dental Appointment Attendance Policy

The FM residency program recognizes that the ability to attend medical, mental health, and dental care appointments is important for resident health and well-being. A resident may be absent from his/her resident responsibilities for appointments of up to 2 hours in length with appropriate communication(see below) with the program coordinator. In order to be respectful to patients and co-workers, residents are asked to schedule appointments with as limited an impact to patient care as possible and with as much notice as possible. Specific plans may be developed on an individual basis to accommodate unique situations. All time off requests for appointments must be submitted in writing to the program coordinator. The program will work with you to attend these appointments, while maintaining educational quality and meeting residency goals.

Vacation/Time off Request Guidelines:

Maximum number of residents granted leave at any given time is 6.

G1 Residents: One week vacation required during the last week in June (G1 skip week).

Vacations are not allowed during the following times:

- **G1:** FMS Night Float and 3 of the 4 FMS Inpatient months, Inpatient Medicine, Inpatient Peds, Yellow Medicine (MICU).
 - **G2:** Yellow Medicine (MICU), FMS Inpatient rotations, Preventive Medicine, Children's Hospital and the last two weeks in June. Peds ED-no vacation Friday-Monday.
 - **G3:** FMS Inpatient, the last two weeks of June.
 - **ALL YEARS:** Vacations **during the ITE exam week (typically the last week in October) are only allowed if you have made arrangements to take the exam prior to the time off.**
-
- No more than two (2) consecutive weeks of vacation are allowed. (last week of one rotation and first week of the following rotation)
 - 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). See ABFM policy.
 - Some rotations will not allow time off on or surrounding major holidays, Thanksgiving, Christmas, New Year's Day, Memorial Day, Fourth of July, or Labor Day.
 - Some 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.

Miscellaneous leave (sick, personal, funeral, emergency)

In case of absence for illness, the resident must call the Program Coordinator, or their appointed designee as noted on the voicemail. Residents should **also** notify the appropriate coordinator or senior resident for their rotation.

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. This will 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.

ADDITIONAL NOTES ABOUT EXTENDED LEAVES:
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Continuation of Benefits and Salary

Residents are referred to the Resident and Fellow Leave Institutional policy governing extended leaves.

https://infooncall/cs/idcplg?IdcService=GET_FILE&Rendition=Web&RevisionSelectionMethod=Latest&dDocName=HCMC_P_039814&noSaveAs=1

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

PARENTAL / ADOPTION LEAVE

See **HCMC Policy for Resident and Fellow leave** for details of time away allowed and salary continuation during this time.

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/Paternity leave:

The resident requesting maternity or paternity leave is expected to inform the Program Director of their plans as early as possible. A resident is allowed six weeks of paid maternity leave under the hospital's disability and family leave (FMLA) policy. Any time away from residency must follow the ABFM's leave policy. Any leave that exceeds the 1 month allowed must be made up before promotion to the next academic year and will prolong residency. **PLEASE NOTE: G1 RESIDENTS DO NOT QUALIFY FOR FMLA. A resident** 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.

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 three 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 time away from residency 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)

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

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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 CK and 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 extracurricular 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 certification by the American Board of 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.

ACGME COMPLEMENT

The Family Medicine Residency at HCMC is approved for 33 permanent resident positions by the Family Medicine Residency Review Committee. It is the desire and expectation of the faculty and program that all first-year residents will complete their three years of training at HCMC.

RESIDENT RETENTION AND CORRECTIVE ACTION

HCMC - GME Policy: Resident/Fellow Progressive Discipline, Appeals & Dismissal

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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 "Progressive Discipline and/or Dismissal" Pathway 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.

Definition of 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, i.e., Adult Medicine, Emergency Medicine, Obstetrics, Pediatrics and Surgery, may 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. 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.
 9. Documentation. Any activities related to progressive discipline described in these procedures shall be documented in writing.

Coaching/Warnings – Level 1
Individual Learning Plan (ILP) - optional

Definition:

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. (Level 1)

Process:

1. The actions that may result in a Level 1 warning are:
 - a. Repeated failure to complete administrative duties- chart completion, failure to answer communication 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
3. The warning period shall not add time to the resident’s training
4. 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.

Coaching/Warnings – Level 1 – Individual Learning Plan (ILP) - optional (HCMC POLICY)

a. Residents or Fellows who are experiencing initial academic or non-academic challenges in progressing through their program and/or meeting program requirements may receive written coaching direction and/or written warnings as a means to help

them get back on track with their program. Examples are described in Definition sections 7 & 8

b. The Program Director (PD) will meet with the Resident or Fellow to address the issues, and the PD may choose to develop an Individual Learning Plan (ILP) with the Resident or Fellow

i. The ILP identifies the type of action, reasons, plan, timing of plan, expected outcome and evaluation/results

ii. The ILP is entered in the Resident or Fellow file permanently

c. The successful completion of the ILP will result in the Resident or Fellow remaining in good standing

d. Failure to successfully complete the ILP will result in the action described in the ILP

e. The Designated Institutional Officer (DIO) is available for participation as requested by the Resident/Fellow and/or PD.

Performance Improvement – Level 2 – ILP Required

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 by certified mail, of the Level 2 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
- 3. 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 of the Level 2 status 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/or teaching 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

Academic Probation-Level 3

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. 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 the resident about his/her probation
 - iv. The Program Director shall give written notice to the resident of the probation
3. 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)
4. The resident shall receive credit for training time; and salary and benefits remain in force during probation
5. 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
6. 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

Remediation of the Probationary Status:

The resident shall 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
 - 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 (e.g. increased length, repeat or additional rotations)
2. Technical skill deficiencies:
 - a. One-on-one supervision during patient care
 - b. Instructional sessions with faculty

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:

1. Remove the resident from probationary status with return to good academic standing.
2. b. Extend the Probationary Period with new or remaining deficiencies cited. Academic Probation shall not be extended more than once.
- 3.

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 the next training level and require further probationary training
- d. Subject to non-renewal of contract
- e. Recommended for dismissal from residency program

Probation – ILP required (HCMC Policy)

- a. A Resident or Fellow will be placed on Probation when he/she has not successfully completed the ILP identified in Levels 1 and 2 above, or if the deficiency is deemed to be too significant to be addressed in Level 1 and 2 in meeting the academic or non-academic behavioral standards: Examples are described in Definition sections 7 & 8
- b. The PD shall meet with the Resident or Fellow to address the issues, and the PD and Resident or Fellow will develop an Individual Learning Plan (ILP)
 - i. The ILP will identify the type of action, reasons, plan, timing of plan, expected outcome and evaluation/results
 - ii. The ILP will be permanently entered in the Resident or Fellow file
- c. While a Resident or Fellow is on probation, the following conditions apply: i. Salary and benefits remain in place, and the Resident or Fellow receives credit for his/her training time ii. He/she will not be allowed to moonlight, either internally or externally iii. Participation in electives is at the discretion of the PD iv. Vacation or Leaves of Absence shall be at the discretion of the PD
- d. The successful completion of the ILP will result in the Resident or Fellow remaining in good standing
- e. Failure to complete the ILP will result in the action described in the ILP, which may include, but is not limited to, lack of promotion to the next PG Y Level, or termination of the contract/dismissal.
- f. A Resident or Fellow placed on Probation is entitled to a hearing as described in Section B below.

The Designated Institutional Officer (DIO) shall be available for participation as requested by the Resident/Fellow and/or PD

Suspension/Summary Suspension- Level 4 (HCMC Policy)

- a. A Resident or Fellow shall be placed on Suspension when he/she has not successfully completed the ILP identified during probation, if the deficiency is deemed to be too severe for probation, or failure to comply with the terms of the Resident's/Fellow's contract.
- b. A Summary Suspension may be imposed upon a Resident/Fellow if they determine that the Resident/Fellow's continued participation in the program is detrimental to patient safety or the delivery of quality patient care.
 - . The PD will meet with the Resident or Fellow to address the issues, and the PD will develop a ILP with the Resident or Fellow
- d. A Resident or Fellow placed on Suspension is entitled to a hearing as described in Section B below.

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 re enter 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

Dismissal/ Termination- Level 5:**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 ability 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, 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 the 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 the 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

The request for a hearing:

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 a 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. Michelle Karsten serves as the Program Director. The Program Director:

- monitors licensure requirements
- supervises resident orientation, develops a 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 advisor, 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 Program Evaluation 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 at www.amion.com.

Department of Family Medicine Leadership:

Dr. Jerome Potts, Chief of the Department of Family Medicine

Dr. Kimberly Petersen, Associate Program Director, oversees inpatient training and residency scheduling and practice management.

Dr Ayham Moty, is Medical Director of the Whittier Clinic, and oversees evidence-based medicine teaching, and residency research and scholarly activity.

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 liaison for all the residents' concerns. 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 has two full-time Program Coordinators. They are responsible for assisting the Program Director with administering policies that govern the function of medical education. The Program Coordinators are 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

Highlighted yellow= rotation does not allow time off of all or part of the rotation

Block	G1		G2		G3	
1	Family Medicine Inpatient (Petersen, Councilman) 16 weeks	Continuity Clinic 1-2 sessions per week	Family Medicine-Inpatient (Petersen, Councilman) 8 weeks	Continuity clinic 2-3 sessions per week	Family Medicine-Inpatient (Petersen, Councilman) 8 weeks	Continuity clinic 3-5 sessions per week
2	*Time off allowed only 1 block of 4*					
3	G1's: No TIME off FMS in Block 11		MICU (Councilman) 4 weeks		Practice Readiness (Karsten) 4 weeks	
4			Pediatrics (includes Adolescent) (Svetaz) 4 weeks		ED (Petersen) 4 weeks	
5	Obstetrics (Pira) 4 weeks		Pediatric ED (Petersen) 4 weeks *No Time-off allowed Friday, Saturday, Sunday*		Ambulatory Pediatrics (Newman) 4 weeks	
6	Adult Medicine Inpatient (Councilman) 4 weeks		Family Medicine Obstetrics (Petersen) 4 weeks		Gynecology (Pira) 4 weeks	
7	MICU (Councilman) 4 weeks		Ambulatory Surgery/Derm (Moty) 4 weeks		Surgical Subspecialties (Anderson) 4 weeks	
8	Pediatrics Inpatient (Newman) 4 weeks		Preventive Medicine / Hazelden (Hasti) 4 weeks *No Time-off allowed if scheduled at Hazelden*		Medical Subspecialties (Councilman) 4 weeks	

9	Ambulatory Pediatrics (Newman) 4 weeks		Sports Medicine (Anderson) 4 weeks		Orthopedics *No time off weeks 1 & 3* (Anderson) 4 weeks	
10	Surgery (Moty) 4 weeks		Geriatrics (Ngodup) 4 weeks		Population Health (Hasti) 4 weeks	
11	ED (Petersen) 4 weeks		Children's Hospital Pediatric (Newman) 4 weeks		FM Elective (Petersen) 4 weeks Elective (Petersen) 4 weeks	
12	Radiology/ Family and Community Medicine (Haddow) 4 weeks		Elective (Petersen) 4 weeks FM Elective (Petersen) 4 weeks		Selective (Petersen) 4 weeks	
13	Psychiatry/ Neurology (Hinton) 4 weeks					
	G1		G2		G3	
			Motivational Interviewing (Hinton, Newman)			
			Geriatric Medicine (Nursing Home-Ngodup, McTavish) PGY 2, 3			
			Centering Pregnancy/Parenting (Hasti, Karsten) PGY 2, 3			
	Wednesday Core conferences (Barillas, Petersen, Chief residents)					
	Management of Health Systems (Petersen)					
	Research and Scholarly Activity (Anderson, Moty)					
	Behavioral Medicine (Hinton, Newman)					
	Wellness and Integrative Medicine (Haddow, Parker)					

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 undergo a process of continual quality improvement 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, and work on improving patient outcomes..

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.

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
- 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 night float weeks, vacation, academic leave, out of state or country electives, MICU, Children's Hospital and some FMS weeks. 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.

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
- Report CME from quiz completion on your AAFP CME site
- Upload a copy of transcript from AAFP website to RMS/New Innovations

B. In-Training Examination

The ABFM has identified a set of internal benchmarks for the In Training examination.

Expected Benchmarks:

<u>Year of Training</u>	<u>ITE Score</u>
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 ≥ 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. Upload to RMS

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).

Participate in the Structured ITE Prep study groups

As determined each year by the program leadership. Content may vary year to year.

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 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 REQUIREMENTS AND 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	PGY1,2	ICU, CMIC
Home visits	2	PGY2	Geriatrics rotation
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	Inpt.Pediatric rotations- HCMC and Children's, Pediatric ED
Newborn	40	PGY1,2,3	FMS Inpatient

Continuity patient visits			
TOTAL REQUIRED	Goal:1800	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	165	PGY1	WHC
Recommended by training year	715 (165 + 550)	PGY2	WHC, Nursing Home
Recommended by training year	1815 (715 + 1100)	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, WHC
GYN procedures			

Pap smears	5	PGY1-Orientation	WHC continuity clinic, GYN
LARC (Long Active Reversible Contraception) placement IUD or Nexplanon	5	PGY1, 2, 3	WHC continuity clinic, GYN Procedure workshop
Orthopedic procedures			
Joint injections (knees, shoulders)	5	PGY2, 3	Sports medicine Orthopedics

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 with targets 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 RMS 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 , Inpatient Medicine	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	OB, FMS Inpatient	
Electronic fetal monitoring	OB, FMS Inpatient	

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 <ul style="list-style-type: none"> • 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

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 Karsten.
- 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.**
- No resident will examine or prescribe medications for a patient without a note being made in the patient's chart.

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 the 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 online 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 as they advance in 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 healthcare 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, Purple South and Orange teams. Each team contains faculty physicians, advanced practice providers and residents from various training year. The team assumes the care of the patients in the team panel. Each resident has a panel of patients for whom he/she is the identified primary care provider (PCP).

Teams meet monthly with their team faculty, registered nurses and medical assistants, to discuss process issues, patient outcomes, and quality improvement plans to improve patient care.

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

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, following the standard work flow of the clinic. The patient is then escorted to a room. 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 within 48 hours of the clinic session.

The number of patients scheduled increases with training level. Up to 7 patients are scheduled for interns, and up to **10** 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. (Direct Supervision) Second and third-year residents will have an attending available to address any questions.

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 and in the team center 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 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 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

At Whittier Clinic, identification of a patients' Primary Care Provider (PCP) occurs through the 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 field in Epic. The PCP 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 the use of provider profiles and processes supplied by Whittier Clinic Leadership.

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 field will be updated appropriately.

If the provider, patient, or any member of the care team, feel reassignment is necessary after only one visit, then the PCP 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 the Centering facilitator for that EDD month and if any residents are in need of deliveries, respecting any patient preferences as stated.

- **PCP field = Identified Provider**

- **Centering Pregnancy – Whittier Clinic is an “OPT IN” clinic for Centering.** RN explains this and makes an appropriate assignment.
- **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, G2 and G3 residents may be assigned to evening clinics.

1. G2s and G3s on outpatient months will be scheduled into evening clinics, for a maximum of 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 “count” toward the overall goal of continuity patients. (End of residency: 1800 visits).

PRIMARY OB DELIVERIES AND WHITTIER CLINIC POLICY

The continuity resident must be notified when their continuity prenatal patient is admitted to the Labor and Delivery floor by the senior resident on the maternity care service. After notification, the resident must coordinate attendance and/or management of continuity prenatal patient with the faculty on duty.

The FMS faculty determines when the resident is needed in L&D and **will arrange with the resident coordinator for the resident to attend the delivery.**

Definitions

Continuity prenatal patient: a patient with whom the provider has an established outpatient relationship

Continuity resident: FM resident with established relationship with patient

Responsibilities:

Continuity resident will communicate with the inpatient attending and resident team.

FM attending will communicate with the program coordinator.

Program coordinator will contact the necessary clinic or rotation contacts to communicate the plan for resident attendance at the hospital.

Procedures:

While continuity patients are laboring, residents are expected to continue working in clinic or other rotation responsibility until the faculty determines that delivery is imminent and the resident is needed at the hospital. The FMS team will care for the patient in partnership with the continuity resident, and communicate progress with the continuity resident on an ongoing basis.

The FM Residency Coordinator will contact the continuity resident with approval or denial to attend the delivery.

If the resident is scheduled at **Whittier clinic**, the coordinator will also inform the Whittier preceptors and clinic charge nurse when the resident is approved to leave for HCMC. The remaining scheduled patients in clinic will be seen by other providers in clinic. Patients who have not yet arrived may be rescheduled as identified by the team nurse/session leader. Residents will return to clinic in a timely fashion after delivery to resume patient care.

Residents assigned to WHC Direct Care clinics may not always be able to leave these sessions to care for laboring patients.

Residents on other HCMC rotations are handled on a rotation based approach.

The following rotations **do not allow** for attendance at deliveries:

- Childrens
- Rural and Out of Country electives
- Hazelden week (Preventive Medicine)

The following rotations **may allow** for attendance at deliveries and will need to be arranged based on other immediate patient care needs:

- ED-adult and Peds
- MICU

The following rotations are primarily outpatient and **will most likely be able** to accommodate continuity delivery attendance:

- Peds/Adolescent
- Amb Surg/Derm
- Preventive Medicine (except Hazelden week)
- Sports Medicine
- Geriatrics
- Electives
- Practice Readiness
- Ambulatory Peds
- Gynecology
- Surgical Subspecialties
- Medical Subspecialties
- Orthopedics
- Population Health

The same process as outlined above should be followed. Residents need to have clear permission to attend to their patient on labor and delivery, before leaving their clinical responsibilities.

INPATIENT SERVICE: POLICIES AND PROCEDURES

LIMITATIONS OF RESIDENT SERVICE
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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.

FMS – Sick Call/Emergency Coverage 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 (612-873-8084). If unavailable a message with directions on who to contact will be left for the resident on the voicemail message. Follow these directions.
- During evening and weekends, the resident calling in must call the night back up call resident to alert them of the need to cover their work.
- Contact the faculty **and** senior resident on service to notify them of the change.

Residents will be noted to have been out sick for any shift missed. This applies to emergency leave as well. The residency coordinator will keep track of the shifts(s) missed.

Night Back Up Call on FMS

Night Backup covers the absence of residents on the inpatient service in the case of illness, emergencies or (on a case-by-case basis) other extenuating circumstances such as resident fatigue, concerns for patient safety or when clinical care needs exceed the residents' ability.

For weekend coverage, Night Backup may be used to help out with service if the senior resident and faculty feel that patient safety is an issue.

It is the responsibility of Senior Residents to look at the FM Inpatient schedule on AMION at the start of the block. This ensures that they are aware schedule variances due to vacations or academic leave.

Residents are scheduled for Night Backup call when on a non-call rotation, at the beginning of the academic year. If a resident is unable to take backup 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 be available 24 hours a day during the period he/she is serving as the back-up call resident. Please plan accordingly.

Residents are to arrive at the hospital within one hour of notification.

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 MITIGATION 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.

See policy manual and Info on Call:

Departments→Graduate Medical Education→GME Policies→Fatigue Mitigation Policy

https://infooncall/cs/idcplg?IdcService=GET_FILE&Rendition=Web&RevisionSelectionMethod=LATEST&dDocName=HCMC_P_039808&noSaveAs=

TRANSITIONS OF CARE

Purpose: To describe a formal process for transition of care from one team to another. This promotes health information exchange between teams about patients to improve patient safety and decrease errors

Rationale: Sign-outs are a common cause of errors in medicine, thus a standardized approach can help decrease some of these errors. Minimizing the number of transitions is also important to facilitate both continuity of care and patient safety.

Procedure:

To optimize patient safety, the number of transitions/sign outs should, when practical occur no more than **two times daily** on the Family Medicine Inpatient Service. This frequency minimizes the number of transitions of care for patient safety and balances appropriate rest for residents and promotes compliance with duty hours.

While on the inpatient service, residents are required to perform patient care transitions (sign-outs) using the standard written and verbal formats for transitions of care.

Utilizing the dot phrase: “fmsignout”

These transitions/sign-outs occur at 7 am and 7:30 pm daily. Sign-outs are supervised by faculty.

Responsibilities during Sign-outs:

The primary resident caring for the patient is responsible for reviewing and updating the information on the written sign-outs.

The senior resident is responsible for oversight of the intern’s written and verbal sign-outs

Faculty is present at sign-out sessions and will give feedback to residents as appropriate

Sign-outs will:

- begin at the designated time
- happen in quiet and controlled environment to limit distractions
- be concise without any unnecessary or editorialized information
- have clear roles and responsibilities of all participants. In general, G1s will give sign-outs with senior residents listening and clarifying as needed.
- have the sickest patients specifically identified.
- have information discussed in a consistent order using the agreed upon template
- not be delayed due to missing team members. It is the team members responsibility to arrive on time for sign outs.

Evaluation of the Sign-Out 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 feedback about performance.

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 name tags 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 lotion, 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.

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

(per the ACGME Common Program Requirements VI. The Learning and Working Environment . VI.F. Clinical Experience and Education; effective: July 1, 2019)

<https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf>

For details.

The ACGME duty hours apply to the FM Inpatient service as in all other areas where residents are trained.

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.

At-Home Call: This residency program does not have at home call

Documentation of duty hours

Policy:

Residents must accurately report their hours worked on the “blockly” (Q 4 WEEK) survey sent via email to all HCMC residents and fellows. Cafeteria stipends and parking privileges are contingent on compliance with the reporting of duty hours.

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.

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 June 30th 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.

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
- Reviewing and co-signing the daily note written on each patient on service
- Completion of resident evaluations
- Monitoring of resident's academic action plans
- Supervision of APPs

Senior Residents

- Review all admissions
- Assignment of daily activities of the PGY1 residents, APP and medical students
- See all OB triage patients
- Review of PGY1 daily assessment and plan
- Negotiation with attending for final therapeutic plan
- Daily examinations of each patient
- Supervision of PGY1. Review of all laboratory and radiology results
- Written and verbal sign-out to on-call team each day
- Communication via EPIC mail with patient's primary care physician as needed
- Promote teamwork among residents

Review sign-out report for accuracy
Supervision and education of medical student when on service

PGY1

Initial assessment of new patient admissions
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
Communicating with senior resident about patients plan of care
Mentoring medical students when co managing patients

Advanced Practice Providers

Initial assessment of new patient admissions
Daily progress note/discharge summary on each primary patient
Daily examination of each primary patient
Writes orders on primary patients
Written and verbal sign outs of patients to the on-call team
Discuss treatment plans with faculty

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.

**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)
<p>Competency Patient Care PGY1a</p> <p>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</p>	<p>Competency Patient Care PGY1b</p> <p>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</p>
Medical Knowledge	Medical Knowledge

<p>PGY1a</p> <p>Demonstrate a satisfactory level of basic and clinical science knowledge in order to recognize and treat common diseases</p> <p>Identify and use various educational resources to seek information about patients' diseases</p> <p>Attend conferences to continuously learn and reinforce medical knowledge and skills</p>	<p>PGY1b</p> <p>Demonstrate a satisfactory level of basic and clinical science knowledge in order to recognize and treat common diseases</p> <p>Demonstrate knowledge of preventive care guidelines</p> <p>Apply learned medical knowledge to diagnosis, treatment and prevention of disease</p> <p>Be an active participant in daily rounds and outpatient sessions</p>
<p>Practice-Based Learning</p> <p>PGY1a</p> <p>Access medical information using various educational resources to assist in medical decision-making</p> <p>Beginning to identify his/her limitations of knowledge and skills and seek help when needed</p> <p>Asks for feedback</p>	<p>Practice-Based Learning</p> <p>PGY1b</p> <p>Be able to formulate clinical questions in the day-to day care of patients</p> <p>Be able to identify his/her limitations of knowledge and skills and seek help when needed</p> <p>Accept feedback and develop self-improvement plans when appropriate</p> <p>Start to develop skills in teaching with patients, staff and colleagues</p> <p>Show ability to analyze written work, teaching style, patient care issue and self- evaluate current competence</p>
<p>Interpersonal &Communication Skills</p> <p>PGY1a</p> <p>Identifies need for interpreter to engage patients in clinical setting</p> <p>Demonstrate complete, legible, and timely documentation of medical information</p> <p>Be able to write an accurate and concise history and physical</p> <p>Uses structured template to provide accurate sign-out to team members</p>	<p>Interpersonal &Communication Skills</p> <p>PGY1b</p> <p>Effectively uses interpreter to engage patients in clinical setting including patient education</p> <p>Use effective listening, narrative and non-verbal skills to elicit and provide information</p> <p>Be able to accurately and concisely present to attendings and colleagues</p> <p>Be able to write an accurate and concise history discharge summary</p> <p>Be able to perform an accurate and concise sign-out to other team members</p> <p>Be able to communicate in oral and written form a cohesive plan in sign-out rounds</p>

<p>Professionalism PGY1a</p> <p>Demonstrate professional conduct in interactions patients and their families, colleagues, and other members of the health care team</p> <p>Demonstrate respect, compassion, integrity, and honesty</p> <p>Show responsibility for meeting program requirements</p>	<p>Professionalism PGY1b</p> <p>Work effectively as a member of the health care team</p> <p>Document and report clinical information truthfully</p> <p>Follow formal policies</p> <p>Recognize and manage obvious conflicts of interest, such as caring for family members and professional associates as patients</p>
<p>Systems Based Practice PGY1a</p> <p>Show responsibility for meeting requirements of medical practice of HCMC and Whittier Clinic:</p> <ul style="list-style-type: none"> ● timely completion of notes and discharge summaries ● timely evaluations of attendings/peers/etc. ● timely response to pages <p>Appropriately manage 4 patients per clinic session</p>	<p>Systems Based Practice PGY1b</p> <p>Advocate for high quality patient care and assists patients in dealing with system complexity</p> <p>Be able to recognize system problems</p> <p>Demonstrates understanding of costs of common diagnostic and therapeutic tests</p> <p>Appropriately manages 6 -7 patients per clinic session</p>

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 via EPIC messaging. There will be regular communication between the primary physician and the inpatient team as needed. 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 RMS.

EVALUATIONS

A. ACGME Core Competencies (See Educational Standards above for details):

Residents will be evaluated by faculty in these six competencies:

1. Patient Care
2. Medical Knowledge
3. Practice Based Learning and Improvement
4. Interpersonal & Communication Skill
5. Professionalism
6. Systems-Based Practice

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 In Training 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

Direct Observation/Milestone Tool: 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 360⁰ 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 In Training examination on a yearly basis. The examination will be held on the fourth week 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 In Training 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. 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, career and professional goals, and evaluation of progress in

residency. This is a time to give the advisor feedback as well, both on the program and the faculty.

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 and mentoring.

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

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
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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: Periodically, 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.
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.
4. 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
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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, In Training 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, and 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.

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 minimum-1800 goal 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, HOME VISITS, AND ICU VISITS.

- 1650 for three years
- 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
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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 during core conference.
- 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

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.

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
 - 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
- 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 milestones 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, and 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

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 -

Preplanning: 1.

1. Coordinator 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 one week prior to the Biannual Resident Evaluation meeting.
2. Collects review documents – rotation evals ,RMS data etc
3. Program Coordinator sends items from 1 and 2 to the residents' advisers.

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

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

Advisor- advisee Debrief (optional)

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

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
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.

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 members are expected to attend the Recruitment meetings. All other faculty and residents are invited to attend.

SELECTION AND DUTIES OF 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.

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.

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, guest calls and Sunday night calls
- 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
 4. Faculty Development meetings, third and fifth Monday (8-9 am) of the month.
- Chair the quarterly Family Physician Resident Organization (FPRO) 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.
Organize Consultant talks and AAFP journal presentations
- 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.
- Participate actively in the interview days.

PROCESS OF SELECTION:

1. Nomination: No later than 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
- 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, most weeks, 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) from 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 6/28/2019

Elective Policy

Electives-What are they and how do they work?

What is an elective? It is a block rotation that serves to:

- Supplement the required curriculum in an area of interest of the resident to create a well-rounded physician
- Provide clinic sessions in which to learn and improve outpatient clinical skills to build a skilled and facile physician across various settings

1. Every G1 and G2 resident should meet with their advisor and plan electives for the upcoming academic year. **G2 residents have 2 electives. G3 residents have 2 electives and 1 “Selective” (A) Rural, (B) Local/Underserved, or (C) Out of Country.** (see Selective guidelines for more details)

2. **All non-HCMC based electives need prior approval by the PD. Deadlines for non-HCMC based electives are 30 days earlier than the deadline for regular electives. This allows time for contracts and agreements to be in place before a resident gets final approval to attend an offsite elective.**

Choosing a new offsite experience for an elective can be complicated. Please come talk to the PD or APD as early as possible if planning an offsite elective. Consider speaking with us *6 months to one year prior to the planned experience.*

3. **Please note that the Rural Selective, and Eagan Dermatology are unique rotations in terms of scheduling. They provide concentrated experiences in clinic and elective (2 weeks of WHC clinic and 2 weeks of the elective) and do not allow time off (vacation, CME or other) on these rotations. Other electives may not be scheduled in this way.**

4. Elective rotations are a combination of continuity clinic time and elective experience. In general, half the time is spent in continuity clinic and half is spent in the elective experience. Having clinic and elective experience each week throughout the block allows for the resident to take one week (5 week days and 1 weekend) off and still receive credit for the rotation. In order to receive credit for a rotation, the resident must be in attendance for 75% of both the elective portion and Family Medicine portion.

5. Meet with your advisor. They can help review electives for content over the spectrum of Family Medicine. Electives are not allowed to be repeated.

6. An elective is your responsibility to arrange. A blank elective block schedule will be sent to you prior to your elective. The elective form is also available on the home page of RMS. Talk to the attending/preceptor/coordinator of the rotation/service/clinic that you would like to work with and determine when the best time to work there is. Remember to balance your elective between clinic and elective experience. **You must attend core conference unless you are on an offsite elective. You may not repeat an elective experience unless you can provide an acceptable educational rationale.**

7. Fill in the elective times on your blank schedule (i.e.: Monday a.m.; Tuesday p.m.; Thursday a.m. and p.m., Friday p.m.) Fill out each week, and include the dates. If you have vacation or

other time away, you need to put it on your schedule so that everyone (on both the elective side and clinic side) is aware. **One half day session of project time is allowed per rotation.**

8. Please give completed elective form to Drs. Karsten or Petersen prior to the due date for approval. Form needs to be turned into Lynn Lutz with an approval signature.

EXAMPLE OF ONE WEEK'S ELECTIVE SCHEDULE

Day/date	Sunday 5	Monday 6	Tuesday 7	Wednesday 8	Thursday 9	Friday 10	Saturday 11
a.m.		Elective	Project Time	Elective	Elective	WHC	
p.m.		WHC	Elective	Core Conf.	Elective	WHC	
evening		WHC					

9. Every block has a deadline. If you do not have your schedule completed (rotation identified, days filled in, signatures obtained) and returned by the deadline, you will be assigned a rotation at the discretion of the program. This may include call and weekends

10. Please keep a copy of your elective form. If you need to refer to it you will have it. Make sure you also give a copy of your schedule to the rotation coordinator (a list of coordinators at HCMC is on the home page of RMS).

11. A MN license is required for various electives. Please obtain your license as soon as possible.

12. We are all here to help you. If you have questions, please ask! Your advisor, Dr. Petersen, or Dr. Karsten can help you decide on an experience that would be a beneficial learning experience for you. Your chief or fellow residents may also be able to make suggestions. Mindy & Lynn Lutz are here to help, too.

ELECTIVE SUGGESTIONS

Ambulatory Surgery
Addiction Medicine
Adolescent Medicine
Alternative Medicine
Cardiology Consults
Community Medicine
Department of Health MN
Dermatology at HCMC
Dermatology in Eagan (Dr. Crutchfield)
Diabetes with Laraine Steele
Emergency Medicine
Endocrine
ENT
Faculty Development
Geriatrics
G.I.
Hospitalist- Medicine
Hyperbaric Medicine
Indian Health Services
Infectious Disease Consult
MICU
Migrant Health (July only)
Nephrology
Neurology
OB/GYN
Ophthalmology
Oral Health (Dentistry at HCMC)
Palliative Care
Physical Therapy
Podiatry

Psychiatric Consult Liaison
Pulmonary (Not Consults)
Quality Improvement
Renal
SIM Center
Sleep Medicine
Sports Medicine (G3)
Toxicology
Transgender Health
Urology
Women's Health- Abortion Training

Appendix I

For the period 2019-2020

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. Michelle Karsten	Residency Program Director
Dr. Kim Petersen	Associate Program Director
Dr Ayham Moty	Medical Director of Whittier Clinic
Tammy Didion	Practice Manager
Jessica Schuldt	Department Manager/Asst. to the Chief
Lynn Lutz	Residency Coordinator
Jen Seokaran	Residency Coordinator

Appendix II

National Guidelines and Resources

ABFM Residency Guidelines:

<https://www.theabfm.org/become-certified/acgme-program/training-requirements-initial-certification>

ACGME Common Program Requirements:

<https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf>

ACGME Family Medicine Program Requirements:

<https://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pfcetid/8/Family%20Medicine>

ACGME Milestones for Family Medicine

<https://www.acgme.org/Portals/0/PDFs/Milestones/FamilyMedicineMilestones.pdf?ver=2017-01-20-103353-463>

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.

Hospital Directories and Policies: InfoOnCall