Family Medicine

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WELCOME

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

MISSION STATEMENT

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.

PROGRAM BACKGROUND

LOCATIONS

Whittier Clinic and HCMC Minneapolis Campus

KEY CONTACTS

Dr. Jerry Potts	Chief, Dept. of Family & Community Medicine
Dr. Charles Anderson	Assistant Chief
Dr. Allyson Brotherson	Residency Program Director
Dr. Kim Petersen	Associate Program Director
Dr Ayham Moty	Medical Director of Whittier Clinic
Tammy Didion	Practice Manager
Jessica Schuldt	Department Manager/Asst. to the Chief
Mindy Chatelle	FM Residency Coordinator
Lynn Lutz	FM Assoc. Residency Coordinator
Vichitra (Jen) Seokaran	Medical Office Specialist Sr.
Lynn Gannaway	Faculty Scheduler
Angee Zelaya	Clinic Scheduler

LEARNING OBJECTIVES

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

Patient Care Skills

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

Our graduates will:

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

Medical Knowledge

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

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

Interpersonal and Communication Skills

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

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

Professionalism

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

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

Practice-Based Learning

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

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

Systems-Based Learning

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

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

COMPENTENCY BASED EXPECTATIONS FOR EACH RESIDENT

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

Medical Knowledge requirements:

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

Patient Care requirements:

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

Interpersonal and Communication Skills requirements:

1. Residents will improve and master interviewing techniques
2. Residents will produce a minimum of two videotaped patient encounters for review by the Behavioral Medicine faculty

Practice-Based Learning and Improvement Skills requirements:

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

Professionalism requirements:

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

Systems-Based Practice and Administrative requirements:

Residents will perform their administrative duties in a timely fashion to include:

Complies with the requirements associated with presenting a conference

Completion of all paperwork required by the department (leave/vacation and elective requests) in a timely manner

Completion of outpatient charts within 24 hours after patient's visit; charts and other hospital paperwork in a timely manner

Meeting regularly with faculty advisor

Documentation of required procedures on RMS

Answers departmental pages within 10 minutes of having received call

Follows policies and procedures as set by HCMC (i.e. beepers, leave requests, etc.)

Resident's Essential Job Functions

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

Patient Care:

Take a history and perform a physical examination

Use sterile technique and universal precautions

Perform cardiopulmonary resuscitation

Deliver a baby and repair an episiotomy

Assist at surgery

Move throughout the clinical site and hospitals and address routine and emergent patient care needs

Demonstrate timely, consistent and reliable follow-up on patient care issues, such as laboratory results, patient phone calls or other requests

Perform documentation procedures e.g., chart dictation and other paperwork, in a timely fashion

Manage multiple patient care duties at the same time and prioritize them

Medical Knowledge

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

Practice-Based Learning

Participate in and satisfactorily complete all required rotations in the curriculum.

Professionalism

Demonstrate personal integrity at all times.

Interpersonal Skills and Communications

Communicate with patients and staff – verbally and otherwise - in a manner that exhibits professional judgment and good listening skills that are appropriate for the professional setting.

Present well organized case presentations to other physicians and supervisors.

Input and retrieve computer data through a keyboard and read a computer screen.

Read charts and monitors.

Systems-Based Learning

Demonstrate organizational skills required to eventually care for ten or more outpatient cases per half day.

Take call for the practice or service which requires inpatient admissions and work stretches of up to 16 hours for G1s and 24 hours for G2 & G3s.

SUPERVISION

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.

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

1. New triage or admission (call immediately for preeclampsia or pre-term labor)
2. Notification of need for OB consult
3. Fetal tachycardia, category II or III fetal heart rate tracing
4. Patient in active labor
5. Significant adverse changes to vitals (hyper/hypotension, T>100.4, unexpected or unexplained tachycardia)
6. Pre-eclamptic changes (e.g. hyperreflexic, visual changes, increased BP, HELLP)
7. 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.*

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.

LINES OF RESPONSIBILITY FOR RESIDENTS AND ATTENDING PHYSICIANS ON THE FAMILY MEDICINE INPATIENT SERVICE

ATTENDING PHYSICIAN

Supervision of all orders, procedures and treatment plans

Daily examinations of each patient on service

Daily note written on each patient on service

Organization of teaching responsibilities

Completion of resident evaluations

Monitoring of resident's academic action plans

PGY3 (CHIEF RESIDENT)

Perform the duties of the PGY2 if they are in clinic or unavailable

Direct teaching of residents and medical students

Organize the monthly M&M Conference

Promote teamwork among residents

PGY2

Review all admissions.

Assignment of daily activities of the PGY1 residents medical students or extends

Review all OB triage patients

Review of PGY1 daily assessment and plan

Negotiation with attending for final therapeutic plan

Daily examinations of each patient.

Daily progress note on each patient on the Inpatient Service

Supervision of PGY1. Review of all laboratory and radiology results

Discussion of therapeutic plan with consulting physicians

Written and verbal sign-out to on-call team each day

Oversees communication via EPIC mail with patient's primary care physician

Carry the team pagers

PGY1

Initial assessment of new patient admissions

Initial assessment of OB triage patients

Daily progress note on each primary patient

Daily examination of each primary patient

Writes all orders on primary patients

Written and verbal sign outs of patients to the on-call team

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)
Competency Patient Care **PGY1a** Be able to elicit a medical history that defines the presentation of illness, Be able to perform an appropriate exam on patients presenting with common medical problems Be able to initiate a correct treatment plan based on assessment of common medical problems Beginning to prioritize problems in order to complete daily patient care duties Demonstrate caring and respectful behaviors with patients and families	**Competency Patient Care** **PGY1b** Be able to elicit a medical history that defines the presentation of illness, thereby assisting with making a diagnosis and developing a management plan Be able to completely perform an appropriate exam on patients presenting with common medical problems Synthesizes all available data (history, physical examination, and prelim lab data to define each patient's medical problem Be able to integrate past and current clinical information in order to develop a problem appropriate diagnosis Be able to prioritize problems in order to complete daily patient care duties in an accurate and timely manner

	Demonstrate appropriate monitoring and follow-up of patients, including laboratory data and test results Be able to perform required family medicine procedures with supervision
Medical Knowledge **PGY1a** Demonstrate a satisfactory level of basic and clinical science knowledge in order to recognize and treat common diseases Identify and use various educational resources to seek information about patients' diseases Attend conferences to continuously learn and reinforce medical knowledge and skills	**Medical Knowledge** **PGY1b** Demonstrate a satisfactory level of basic and clinical science knowledge in order to recognize and treat common diseases Demonstrate knowledge of preventive care guidelines Apply learned medical knowledge to diagnosis, treatment and prevention of disease Be an active participant in daily rounds and outpatient sessions
Practice-Based Learning **PGY1a** Access medical information using various educational resources to assist in medical decision-making Beginning to identify his/her limitations of knowledge and skills and seek help when needed Asks for feedback	**Practice-Based Learning** **PGY1b** Be able to formulate clinical questions in the day-to day care of patients Be able to identify his/her limitations of knowledge and skills and seek help when needed Accept feedback and develop self-improvement plans when appropriate Start to develop skills in teaching with patients, staff and colleagues Show ability to analyze written work, teaching style, patient care issue and self- evaluate

	current competence
Interpersonal &Communication Skills **PGY1a** Identifies need for interpreter to engage patients in clinical setting Demonstrate complete, legible, and timely documentation of medical information Be able to write an accurate and concise history and physical Uses structured template to provide accurate signout to team members	**Interpersonal &Communication Skills** **PGY1b** Effectively uses interpreter to engage patients in clinical setting including patient education Use effective listening, narrative and non-verbal skills to elicit and provide information Be able to accurately and concisely present to attendings and colleagues Be able to write an accurate and concise history discharge summary Be able to perform an accurate and concise signout to other team members Be able to communicate in oral and written form a cohesive plan in signout rounds
Professionalism **PGY1a** Demonstrate professional conduct in interactions patients and their families, colleagues, and other members of the health care team Demonstrate respect, compassion, integrity, and honesty Show responsibility for meeting program requirements	**Professionalism** **PGY1b** Work effectively as a member of the health care team Document and report clinical information truthfully Follow formal policies Recognize and manage obvious conflicts of interest, such as caring for family members and professional associates as patients
Systems Based Practice	**Systems Based Practice**

PGY1a	PGY1b
Show responsibility for meeting requirements of medical practice of HCMC and Whittier Clinic: • timely completion of notes and discharge summaries • timely evaluations of attendings/peers/etc. • timely response to pages Appropriately manage 4 patients per clinic session	Advocate for high quality patient care and assists patients in dealing with system complexity Be able to recognize system problems Demonstrates understanding of of costs of common diagnostic and therapeutic tests Appropriately manages 6 -7 patients per clinic session

ROTATIONS

AMBULATORY CLINIC

Family medicine residents spend increasing time in the ambulatory clinic during their residency training

Regular opportunities for ambulatory training occur through the continuity clinic experience and direct care at Whittier Clinic, ambulatory block rotations, and in outpatient specialty clinics at HCMC.

Philosophy

The Whittier clinic provides care for a variety of patients.

Patient Care Objectives

• To make available to the community quality health care which takes into account the individual's total need.

• To assure continuity of care by implementing and maintaining a plan of follow-up to include appropriate referrals to other healthcare providers

• To provide effective health education to patients

• To promote cooperation and communication among all members of the health team and allied community agencies to avoid duplication of effort and contradiction of goals

- To provide services in a manner and in a setting that recognizes the patient's dignity
- To provide services with a minimum of waiting time and in a manner that respects the patient
- To provide the same quality of health care to all patients, regardless of race, creed, or socioeconomic situation
- To provide a milieu for the education of medical students and residents in the provision of high quality, cost-effective care

TEAM STRUCTURE AT WHITTIER

The medical providers at Whittier clinic are part of interdisciplinary teams that include chronic care model precepts. Residents practice in the Purple North and Purple South teams. Each team is divided into 3 pods, each led by a core faculty provider and containing residents from each training year. Most pods contain one G3, G2 and G1 each. The team assumes the care of the patients in the panel. Each resident has a panel of patients for whom he/she is the identified primary care provider (PCP).

Teams meet twice monthly with their team faculty leads, registered nurse and medical assistants, interpreters, clerical staff, and social worker to discuss process issues, patient outcomes, quality improvement plans and, to brainstorm around complex patients or problems.

PATIENT PANELS

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

The resident's panel will increase over the three years in keeping with the increased time spent in the clinic. Current panel size goals are:

PGY1 62-90

PGY2 250

PGY3 420

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

Assignment of patients to residents by training year

Goal for scheduled and same day visits

At each PGY year goal is 65-75% scheduled

25-35% same day (either their own or team patients)

PROCESS FOR SEEING PATIENTS AT WHITTIER

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

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

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

First-year residents must have one of the precepting attendings see each patient during the first six months of the resident's first year. Second and third-year residents will have an attending available to address any questions. For all residents seeing Medicare patients, consultation with an attending is required before the patient is discharged from clinic.

All cases should be presented to the attending. Consistent dialogue between attending and resident regarding some learning issues on most patients is strongly encouraged. The attending reviews the electronic chart of patients seen in each clinic session.

Residents are expected to be at the office before their first patient. If a resident must be late or cancel a scheduled clinic session, the resident must notify the Program Coordinator or their designee prior to the start of clinic (8:00 am, 9:00 am for Direct Care, 1:00 pm, 5:30 pm). The Program Coordinator will notify the clinic scheduler who then notifies the appropriate clinic staff. The resident is responsible for notifying the senior resident/faculty when late/absent from a rotation.

The days when the resident is assigned to Whittier are determined by the rotation to which the resident is assigned.

PCP DESIGNATION

Whittier Clinic - Primary Care Provider (PCP) Designation Policy (dated 10-17-2011)

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

Assigning New Patients a PCP

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

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

Changing a PCP- Initial visit

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

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

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

PCP Reassignment Process

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

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

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

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

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

resident) is required to either ensure the interaction is documented in Epic or to generate a letter to the patient

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

OB PCPS

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

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

1. Patient has PCP at Whittier

The patient will continue her prenatal care if her PCP provides prenatal care and the patient desires to keep her PCP

2. Patient with no PCP at Whittier

    - Resident provider – RN reviews OB primary spreadsheet to determine which provider is in most need of deliveries and meets the patient's preference for a prenatal care provider.
    - PCP field = Identified Provider
    - Centering Pregnancy – RN explains option of Centering Pregnancy/ If selected PCP field = Centering Pregnancy
    - Women's Health Nurse Practitioner – RN explains option of WHNP. If selected PCP field= Identified Provider

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

Removal of Primary Care Provider in Epic

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

EVENING CLINIC

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

1. G2's on the G2 outpatient month will continue being scheduled into evening clinics, 4 per month.

2. Residents who are assigned to back up for FMS will not be assigned evening clinics during the two weeks they serve on back up

3. Residents on electives with evening or out of town obligations may petition to limit their evening clinic assignment based on educational priorities (e.g. adolescent elective has evening clinics at community clinics)

4. The patients seen during these evening clinics will "count" toward the overall goal of 500 patients seen during the G2 year

SATURDAY MORNING CLINIC

Saturday morning clinic is a voluntary moonlighting experience. Any G2 or G3 (and selected G1's – after the first six months) are welcome to moonlight in our clinic. The clinic hours are from 8:00 a.m. to approximately 12:00 noon.

Once you sign up for clinic you are responsible for finding a replacement if you cannot be there.

You cannot sign up for Saturday clinic if you are post call or on back up call.

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

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

PRIMARY OB DELIVERIES AND WHITTIER CLINIC POLICY

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

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

Note the following:

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

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

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

Residents assigned to WHC Direct Care clinics are not ordinarily allowed to leave these sessions to care for laboring patients. The FMS team assumes this responsibility for the patient while Direct Care clinics are in session. Residents on other HCMC rotations are expected to complete their patient and other care responsibilities to that rotation before assuming management and delivery of their laboring OB patients. Residents are not to abandon their responsibilities on HCMC rotations to care for or deliver their primary OB patients or L&D.

CLEAR COMMUNICATION IS IMPORTANT TO THIS PROCESS.

INPATIENT SERVICE

Limitations of Resident Service

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

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

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

CALL FOR FMS

FMS – Sick Call/Emergency Policy

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

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

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

Back Up Call on FMS

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

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

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

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

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

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

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

CONTINUITY OF CARE

Purpose:

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

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

Procedure:

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

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

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

TRANSITION OF CARE

Responsibilities during Signouts:

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

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

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

Handover sessions should not begin until all appropriate members are present

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

Handovers should be concise without any unnecessary information

Evaluation of the handover process:

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

TEN INDICATORS OF EFFECTIVE SIGNOUTS

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

CONFERENCES, SELF STUDY, AND RESEARCH

CME

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

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

CME funds for each resident are available as follows:

A Total of $600.00 During Residency

To be used during the PGY 1, 2 or 3rd years of training

Submit to Jessica your original receipts totaling $600.00 within two weeks of attending CME (airline tickets, hotel receipt, registration receipt and car rental receipt). She will prepare paperwork to reimburse you

You may choose to spend this amount (up to $600) on ABFM board prep materials instead. These materials must be approved in advance and purchased through the department

If, by the second half of your 3rd year, CME courses/Board Prep materials are not contemplated, any remaining money would be available to purchase medical textbooks or other educational materials totaling 50% of the remaining funds. Submit a list of the books (or other educational materials) to Jessica – they must be purchased through the department. You will not be reimbursed if you purchase books on your own

Reimbursement for CME activities, request for books, etc.., must be submitted no later than 90 days before the completion of your residency

A Total of $75.00 During Residency

To be used during the PGY 1, 2, or 3rd years of training

For registration for HCMC conferences or local conferences sponsored by other Twin Cities hospitals

Original invoice or receipt for registration fee must be submitted to Jessica for reimbursement within two weeks of attending CME

Saturday Clinic

Residents who hold J visas cannot work for CME money on Saturday mornings

Residents who need their patient numbers increased may sign up for a Saturday morning clinic, and patients seen will be counted. Residents cannot be paid for a Saturday if counting towards their patient numbers

G1 residents, beginning in January, may work a Saturday clinic after speaking with Dr. Potts

Reimbursement is:

For the first 5 Saturdays worked, $120.00 per clinic will be paid, plus $25.00 credit for each clinic worked towards additional CME/Board Prep materials

The 6th clinic onward is - $130.00 (each clinic worked) plus $50.00 credit for each clinic worked towards additional CME/Board Prep materials

Reimbursement for CME activities, request for books, etc, must be submitted no later than 90 days before the completion of your residency

THE FAMILY MEDICINE CORE CURRICULUM

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

TEAM MEETINGS:

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

JOURNAL CLUB

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

M&M.

Adult Medicine/ Pediatric M&M

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

Mortality (expected or unexpected)

Prolonged LOS

Avoidable admission

Outpatient complications

Procedure complications

Medication errors

Interesting cases

Communication errors/conflicts between consultants and primary care team

System flaws or system issues

Other- did not meet IOM guidelines: i.e. care of patient was not Safe, Timely, Effective, Efficient, Equitable, Patient focused

BOARD REVIEW – All faculty are involved in conducting board review sessions twice monthly.

WEDNESDAY CORE CONFERENCES:

All residents except those on ER shifts, nights, and Yellow Medicine, on vacation, ill or at "away" electives are required to attend the Wednesday Core Conference. Satisfactory attendance is defined as 80 %. Required rotations, illness, vacation and away rotations /conferences are included in the 20% allowance for absence. Attendance is documented for accreditation purposes. Residents may not sign for one another

- In order to qualify for CME travel allowance, 80% of required conferences must be attended
- Each resident must personally sign in at each core conference. This sign-in is the only record that is used to enter a resident's attendance into RMS
- Residents are expected to be on time. Attendance is recorded
- Conference attendance is averaged quarterly

Excused absences from Wednesday conferences

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

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

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

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. <u>Lifelong Learning :</u>

All residents will

Read twice monthly AFP journal and complete each quiz (2 per month).

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

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:**
- **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
- **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 a copy to your RMS portfolio**. Keep a copy for portfolio for bimonthly review

PGY2 and PGY1:

- **Follow the details of the remediation plan given to you and /or your advisor. Complete any assignments on time.**
- **Level 2 performance improvement**
- **Z score < - 0.7**
- **(< 25th percentile)**

ADDITIONAL MANDATORY STUDY

PGY3

- **Referral to professional for exam preparation and test taking strategies if you have not already done so.** (Please discuss with your advisor and /or Behavioral Science faculty who will help you to make the arrangements).
- **Do FP comprehensive questions**
- Every month, resident will be assigned 50 questions from FP Comprehensive by Dr Petersen. Resident must meet once per month with a faculty educational consultant (person to be determined) for review of exam questions.
- Resident must keep a log that they have completed the assignment. Log must be signed by educational consultant and reviewed with faculty advisor at quarterly evaluation meetings.

PGY2

- **Follow the details of the Level 2 remediation plan sent to you**
- **Referral to professional for exam preparation and test taking strategies.** (Please discuss with your advisor and Behavioral Science faculty who will help you to make the arrangements).

PGY1

- **Enroll in Exam Master and 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 Assignments (PGY1 and PGY2) or FP Comprehensive modules (PGY3) as defined.
- Completion of all biweekly AFP 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.**

ELECTIVES

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

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

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

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

5 Steps for an Elective:

1. Meet with your advisor and follow the above instructions
2. Turn in elective requests to Lynn Lutz by January 1 of each year
3. FM Leadership Committee to meet and discuss/approve requests
4. Elective requests returned to residents with instructions, deadlines/due dates

5. Resident speaks with elective for final confirmation

- **ELECTIVE SUGGESTIONS**

HCMC and OFF Site	**Medicine Electives**
Academic Medicine	**Endocrine**
Adolescent Medicine	**G.I**
Community Medicine	**Geriatric**
MN Department of Health	**Infectious diseases (not avail. in IM- ok at Red Door)**
Dermatology (not available)	**Neurology**
Diabetes with Laraine Steele	**Nephrology (not available)**
ENT	**Pallative Care**
Interventional Radiology	**Pulmonary (Pulm consults not avail.)**
Maternal / Child Health (for G3s only)	**Renal**
Off site elective (Twin Cities or Out of state)	**Rheumatology**
Ophthalmology	**Sleep Medicine**
Oral Health (Dentistry at HCMC)	
Ortho/Podiatry	
International Elective	
Out of Country Elective (cannot be to country of origin)	
Outpatient Procedures	
Rural	
Sports Medicine	
Urban Undeserved	
Urology	

EVALUATIONS

Competency description 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.

Competency anchors: (acquires, analyzes, applies knowledge)

MEDICAL KNOWLEDGE					
ACGME competency	Core knowledge	Developmental milestones for training year			
		PGY-l Rating 1-3 Near competency 12 months	PGY2 Rating 4-6 Proficiency 24 months	PGY3 Rating 7-9 Mastery 36 months	Assessment methods and tools
Demonstrate sufficient knowledge to treat medical conditions commonly managed by Family physicians, provide basic preventative care and understand the psychosocial	Knowledge of core content of family medicine	Understands the basic science and pathophysiology of some common medical problems both inpatient and ambulatory for management of adult, pediatric and obstetric patients	Understands the basic science and pathophysiology of all common medical problems both inpatient and ambulatory for management of adult, pediatric and obstetric patients Demonstrates	Understands the basic science and pathophysiology of uncommon and complex medical problems both inpatient and ambulatory for management of adult, pediatric and obstetric patients	USMLE Step 3 Rotation performance In-training examination One on one precepting Pre and post rotation tests

aspects of medicine		Demonstrate sufficient knowledge to diagnose and treat common medical conditions both inpatient and ambulatory	sufficient ability to diagnose and treat undifferentiated medical problems both inpatient and ambulatory	Demonstrate sufficient knowledge to diagnose and treat complex or rare medical conditions and multiple coexistent conditions	Direct observation One to one precepting
	Knowledge about preventive problems	Shows progression of knowledge sufficient to pass ABFM Board examinations as is evident by score of 390 on ITE Knows the preventative care services for patients of all ages	Showa progression of knowledge sufficient to pass ABFM Board examinations as is evident by score of 440 on ITE Demonstrates sufficient knowledge to provide preventative services	Showa progression of knowledge sufficient to pass ABFM Board examinations as is evident by score of 500 on ITE Consistently and independently applies preventative care services to all patients	
	Knowledge about	Understands how psychosocial	Applies knowledge of psychosocial behavior to assist in the management of		

	psychosocial problems	factors affect illness	medical problems		

Competency description: 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

Competency anchors: *(gathers information, synthesizes, partners with patients)*

PATIENT CARE					
ACGME competency	Core knowledge goal	Developmental milestones for training year → → →			
		PGY-l Rating 1-3 Near competency 12 months	PGY2 Rating 4-6 Proficiency 24 months	PGY3 Rating 7-9 Mastery 36 months	Assessment methods and tools
Clinical skills and reasoning	Data gathering Gathers essential knowledge and accurate information from patient (medical interviewing	Acquires accurate and relevant history from patient in efficient, prioritized manner (from patient, family , medical records)	Obtain subtle history from patient including sensitive, complicated and detailed information that assists with prioritizing the differential diagnosis and	Role model gathering subtle and reliable information from patient for junior members of the health care team	OSCE in Behavioral Medicine Video clinic evaluation Rotation performance

			diagnostic plan		
	<u>Performing a physical examination</u> Performs an appropriate comprehensive and accurate physical examination & diagnostic work up	Performs accurate physical examination that is appropriately targeted to the patient's complaints and medical condition	Accurately tracks important changes in the physical examination over tie both in the inpatient and outpatient setting	Demonstrates and teaches how to elect subtle , important and unusual physical findings that may inform about clinical decision making	Direct observation Standardized patients
	<u>Clinical reasoning</u> Synthesizes and interprets all available data to develop an appropriate management plan	Define a differential diagnosis for an undifferentiated patient with assistance Synthesizes all available data (history, physical examination, and prelim lab data) to define each patient's medical problem Triage patients presenting conditions to identify urgent or emergent medical	Modifies differential diagnosis and care plan based upon changing clinical course and data Develops a relevant, prioritized and an evidence based diagnostic and therapeutic plan for common inpatient and ambulatory conditions. Initiate management of patients with	Recognizes disease presentations that deviate from common patterns and that require complex decision making Independently and completely asses and	Chart audits Multisource evaluations

		conditions	emergent medical conditions	manage patients with life threatening conditions	
	<u>Procedures and diagnostic tests</u> Demonstrates developing ability to perform common FM procedures to include obtaining informed consent &documentation in the medical record	Understands indications for and demonstrates technical ability to perform procedures with supervision to include obtaining informed consent &documentation in the medical record. Actively seeks opportunities to learn new procedures	Demonstrates ability to perform procedures with minimal supervision knows complications and teaches junior resident Planning procedures needed for practice	Demonstrates independence and skill in performing procedures, manages complications, teaches juniors, provides appropriate post procedure care	Documented achievement of procedural skills Review of procedure log Direct observation Simulation
	Diagnostic tests Demonstrates developing ability to order, interpret use of common diagnostic tests				
Patient management	Delivery of patient centered medical care	With supervision , manage patients with common clinical disorders seen in the practice of inpatient , ambulatory family medicine	With minimal supervision manage patients with common and complex clinical disorders seen in the practice of impatient , ambulatory family medicine	Independently manage patients with a broad spectrum of clinical disorders commonly seen in the practice of inpatient , ambulatory	Chart audit Multisource feedback Clinic evaluations Direct observations

				family medicine	

Interpersonal and communication skills

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

Competency anchors: *(communicate with patients and families; communicate with team members; scholarly communication)*

INTERPERSONAL AND COMMUNICATION SKILLS					
ACGME competency	Core knowledge	Developmental milestones for training year →			
		PGY-l Rating 1-3 Near competency 12 months	PGY2 Rating 4-6 Proficiency 24 months	PGY3 Rating 7-9 Mastery 36 months	Assessment methods and tools
Communicate effectively with patients, families and the public across a broad range of socioeconomic and cultural backgrounds;	<u>Effective communication</u> Builds and sustains a positive relationship with patients and families	Provides timely and comprehensive verbal and written communication to patients and families	Effectively use verbal and non verbal skills to create rapport with patients and families	Uses communication skills to build therapeutic relationships Role model effective communication skills in challenging situations	OSCE Video review One on one precepting Rotation performance Feedback from clinic preceptors Multi rater evaluations
	<u>Intercultural sensitivity</u>	Effectively uses interpreter to	Demonstrates sensitivity to	Actively seeks to understand	Cultural competency

	Universally communicates clearly and respectfully with all patients and families regardless of differences	engage patients in clinical setting including patient education	differences in patients including but not limited to race , gender, ethnicity, sexual orientation, socioeconomic status, health literacy and religious beliefs	patient differences and views and reflects this in shared decision making with the patient and health care team	assessment 9IDI) Video review One to one precepting
Communicate effectively with physicians and other health care professionals	Oral presentations to Interprofessional team	Delivers oral presentations effectively (clear, concise, organized, hypothesis driven)	Effectively communicates care plan to all members of health care team	Engage in collaborative communication with all members of the health care team	One on one precepting Multi rater evaluations
	Transitions of care	Effectively communicates with team in a structured manner to maintain patient continuity during transitions of care	Role model and teach effective communication with next caregivers during transition of care	Oversees and teaches effective communication with next caregivers during transition of care	Direct observation Multisource evaluations
INTERPERSONAL AND COMMUNICATION SKILLS					
ACGME competency	Core knowledge	Developmental milestones for training year			
		→	→	→	
		PGY-I Rating 1-3 Near competency 12 months	PGY2 Rating 4-6 Proficiency 24 months	PGY3 Rating 7-9 Mastery 36 months	Assessment methods and tools
Work effectively as a member or leader of a health	Team and leadership skills	Occasionally acts as team player and occasionally	Demonstrates ability to lead on small , moderately	Frequently able to lead team to completion of a	Multisource evaluation of from members of

care team or other professional group;		takes the lead on smaller tasks	complex tasks; develops plans with multiple options while maintaining team harmony	system wide task while enhancing team harmony.	team
Maintains comprehensive and legible medical records	Maintain comprehensive , timely and legible medical records	Provides complete &timely written communication about patients that is accurate and compliant with hospital medical record standards	Constructs accurate, succinct, relevant and patient specific medical record summaries		Chart audits of Epic records

Professionalism

Competency description: Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Competency anchors *(professional behavior, ethical principles, cultural competence)*

PROFESSIONALISM					
ACGME competency	Core knowledge	Developmental milestones for training year → → →			
		PGY-l Rating 1-3 Near competency 12 months	PGY2 Rating 4-6 Proficiency 24 months	PGY3 Rating 7-9 Mastery 36 months	Assessment methods and tools
Accountability to self	<u>Professional behavior</u> <u>(physician ship and personal accountability)</u>	Demonstrates truthfulness in all actions . Willing to admit when wrong	Words and actions are above reproach	Words and actions are above reproach and demonstrates a willingness to challenge less	Feedback from clinic preceptors Video review Multi rater

	Commitment to excellence and professional development Commitment to service and the community	Committed to learning new skills	Committed to learning new skills and demonstrates continuing development of excellence	honorable actions in self and others Committed to improving existing skills and achieving excellence in many areas	evaluation Patient surveys Attendance at conferences Participation in lifelong learning activities defined by residency
Accountability to patients	<u>Compassion and respect</u>	Has empathy and can show compassion by ability to express concern to patients regardless of gender, age, culture, race, religion, disabilities, and sexual orientation.	Consciously uses compassion as a healing tool for all	Inculcates compassion into professional life ; understands balance between compassion and enmeshment	Multisource feedback Patient satisfaction surveys
	<u>Advocates for patients</u>	Recognizes the need to advocate for individual patients	Effectively advocates for individual patients	Effectively advocates for all patients system wide	

Accountability to patients	Recognizes and addresses health disparities	Recognizes the existence of health disparities in health care among the patient populations that they serve	Understand their role in addressing those issues that may create disparate care for their patients	Actively advocates for allocation of resources to those at risk for health inequities	
	Patient confidentiality	Recognizes need for patient confidentially	Maintains patient confidentially	Educates and holds others accountable for patient confidentiality	
Accountability to the profession and society	Ethical principles Corporate accountability	Documents and reports clinical information truthfully Follows formal policies	Accepts and acknowledges personal errors	Upholds ethical expectations of research and scholarly activity	Direct observation Multi source feedback
	Demonstrate the defining attributes of the medical professional	Recognizes the need to maintain appropriate professional relationships with peers, patients , families, staff	Maintains patient confidentially	Serve as professional role model for more junior colleagues	

Practice Based Learning and Improvement

Competency description: 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.

Competency anchors: *(Life-long learning, EBM, Quality improvement and Teaching skills)*

PRACTICE BASED LEARNING AND IMPROVEMENT					
ACGME competency	Core knowledge	Developmental milestones for training year			
		PGY-l Rating 1-3 Near competency 12 months	PGY2 Rating 4-6 Proficiency 24 months	PGY3 Rating 7-9 Mastery 36 months	Assessment methods and tools
Learning and improving from patients	Demonstrate evidence of improving knowledge base by reading about patients	Identify learning needs (clinical questions) as they arise in patient care activities	Classify and effectively articulate clinical questions	Develop a system to track, pursue and reflect on clinical question	Journal Club participation Rotation performance Participation in research project M&M contributions
Learning and improving via feedback and self assessment	Using feedback	Welcomes feedback from all members of the health care team	Actively seeks feedback from all members of the health care team and integrates with external data and self assessment with assistance	Reflects on all feedback and develops improvement plans independently	Portfolios
Learning and improving via audit of performance	Improve quality of care for patients	Appreciate the responsibility to assess and improve care for a population of patients Perform a review audit of patient panel using standardized guidelines	Reflect on audit compared with logical and national benchmarks and explore reasons for deficiencies in outcomes	Identify areas in own practice that can be changed to improve outcomes o care. Engage in quality improvement intervention	CQI participation and Performance Lean project METRIC

Learning and improving via participation in QI projects					
Learning and improving from IT at the point of care					
Teaching others		Can assist learner in assessing information	Assesses the educational needs of learners and can set clear earning expectations	Organizes and sets up teaching time . Can adjust teaching style , information and jargon to suit the level of the learner	

System Based Practice

Competency description: 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.

Competency anchors :*(health care delivery, cost –effective practice, patient safety and advocacy, system causes of error)*

SYSTEM BASED PRACTICE					
ACGME competency	Core knowledge	Developmental milestones for training year			
		PGY-l Rating 1-3 Near competency 12 months	PGY2 Rating 4-6 Proficiency 24 months	PGY3 Rating 7-9 Mastery 36 months	Assessment methods and tools
Work effectively in various health care delivery settings and systems		Understand the unique services provides by each health care delivery system in which they care for patients	Participate in the management of care coordination activities and transitions of care between different the	Participate in the management of patient centered care coordination activities between multiple delivey systems	

			hospital, nursing home and ambulatory settings		
Coordinate patient care within the health care system		Articulate the need for care coordination and case management for complex patients	Participate and contribute to care coordination conferences and case management activities for complex patients activities	Manage care coordination and case management for complex patients with the interprofessional team at the point of care	
Cost effective practice	Provides effective healthcare and considers resource allocation without compromising quality of care	Demonstrates understanding of costs of common diagnostic and therapeutic tests	Minimizes unnecessary care including tests, procedures, therapies Demonstrates the incorporation of cost awareness principles into standard clinical judgments and decision making	Demonstrates the incorporation of cost awareness principles into complex clinical scenarios	Direct observation One on one precepting
Work in interprofessional teams to enhance patient safety and improve patient care quality	Works effectively with an interprofessional (multidisciplinary) team	Recognize areas in their practice where they work with interdisciplinary teams. Appreciate the roles of all members of the interdisciplinary team	Consider and validate the contributions of all members f the team	Actively use and coordinate the activities of all team members	

Demonstrates efficiency in patient care settings especially in the ambulatory setting	Demonstrates ability to prioritize and manage time effectively	Appropriately manages 6 -7 patients per clinic session	Appropriately manages 8-9 patients per clinic session	Appropriately manages 10-12 patients per clinic session	Direct observation Multisource feedback
Identify and correct system errors					

ACGME CORE COMPETENCIES:

Residents will be evaluated by faculty in these six categories:

1. Patient Care:

a) Caring and respectful behavior

b) Interviewing

c) Informed decision making

d) Developing/implementing plans of care

e) Counseling patients and family

f) Using IT to support patient care

g) Procedures

h) Preventive health services

i) Working within a team

2. Medical Knowledge

a) Investigative and analytical thinking

b) Application of basic science

3. Practice Based Learning and Improvements

a) Analyze practice for improvements

b) Use evidence from studies

c) Use information about patients and community

d) Application of research and statistical methods

e) Use of information technology

f) Facilitate learning of others

4. Interpersonal & Communication Skill

a) Creation of a relationship

b) Listening Skills

c) Working within a team

5. Professionalism

a) Respectful

b) Ethically sound practice

c) Sensitive to culture, age, gender and disability issues

6. Systems-Based Practice

a) Understanding interaction of practice with larger system

b) Knowledge of practice and delivery systems

c) Practice cost effective care

d) Advocate for patients within the system

e) Knowledge of partnering with managers and providers

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.

<u>Procedure:</u>

All residents are provided with written evaluations, done by supervising faculty, at the end of all rotation experiences- both inpatient and outpatient.

Residents are evaluated on the basis of 6 ACGME competencies:

Patient Care

Medical Knowledge

Practice based learning and improvement

Interpersonal and communication skills

Professionalism

Systems Based Practice

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

Global Assessment - summative and formative evaluation is a component of each rotation and the continuity experience. The attending will offer formative feedback on a regular basis during the rotation. He/she should meet with the intern or resident on the first day of rotation, mid rotation, and at the end of rotation, at which time a summative evaluation will be provided. The summative evaluation of the resident's performance is also called a global assessment. All rotations at HCMC use a nine point global assessment scale. Each assessment includes patient care, medical knowledge, practice-based learning, interpersonal communication skills, professionalism, and systems-based practice.

On Family medicine rotations, the global assessment is also a nine point scale which monitors the residents' progress through residency from PGY1 to PGY3. Residents move from the advanced beginner to a near master in competency achievement. The scale goes from 1-3 in the PGY1 year, 4-6 in the PGY2 year and 7-9 in the PGY3 year. Residents not meeting satisfactory rating in the global assessment may require remediation.

Periodic Resident Evaluations are completed periodically, and at least twice per year. This is a multi source assessment with input from faculty, nursing home providers, clinic staff, the Program Director, and the Program coordinator.

Each resident of the team is discussed individually. The discussion includes review of written rotation evaluations of the resident, peer evaluations, other written feedback, verbal testimonials regarding the resident, results of the Intraining examination, review of any concerns or disciplinary action, information from other sources, awards, recognition or other scholarly activity.

The resident's advisor then completes a Summative Evaluation based on the input received. The resident's faculty advisor then presents and discusses the summative assessment with the resident at the periodic resident-advisor meeting. The advisor also reviews a checklist of performance indicators with the resident.

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

Other evaluations

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

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

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

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

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

In-Training Examination – All family medicine interns and residents are required to participate in the In-training examination on a yearly basis. Beginning in 2011, the examination will be held on the fourth Friday of October. Although not used as a criterion for promotion, information will be considered in the context of other ratings of the resident's medical knowledge.

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

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

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

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

RESIDENT EVALUATION FILE

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

1. Basic application materials which were completed prior to entering the program
2. Written rotation evaluations
3. Peer, self, clinic staff evaluations
4. Patient satisfaction summaries
5. One-on-one precepting clinic evaluations

6. Written quarterly summative evaluations
7. End of year program summaries to document progress from one year to another and to document resident status at exit from the program
8. Report of American Board of Family Medicine Intraining Examination Results
9. Procedure documentation including documentation of competency in the performance of core procedures
10. Conference attendance records
11. Patient numbers data
12. Moonlighting approval forms
13. Incident reports
14. Records of scholarly activity, including conference presentations, research projects, CQI project reports
15. Videotaping Evaluations
16. Awards or commendations
17. Formal Remediation and development plans.

FACULTY ADVISORS

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

Advisors are expected to meet or contact their advisees at least quarterly. These encounters are documented on the periodic summative evaluations which are available electronically.

The goals of these meetings are to work with the resident concerning rotations, planning electives, goals, thoughts, needs, etc. The meetings are usually informal; some faculty meet over a meal or during other unscheduled times. This is a time to give the advisor feedback, too. It can be a time to assess the relationship and confirm if it is working.

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

Role of the advisor:

A. ACADEMIC RESPONSIBILITIES

A. Supervise Resident progress during training

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

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

C. Supervise selection of electives

D Research and scholarly activities for residents

B. CLINICAL RESPONSIBILITIES

A. In basket supervision

B. Observation of residents in clinic

C. Team responsibilities

RESIDENT EVALUATION OF THE EDUCATIONAL EXPERIENCE

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

1. Curriculum Evaluation Meetings: Residents can give systematic feedback about rotations at the Curriculum meetings which occur every other month. Residents evaluate rotations to determine

whether goals and objectives are being met. Feedback from these reviews are collated into a master document and become part of the annual action plan for improvement of the program.

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

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

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

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

CRITERIA FOR ADVANCEMENT AND PROMOTION OF RESIDENTS

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

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

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

1. Clinical Competence (Medical knowledge, Patient Care, Communication Skills)

- Fund of medical knowledge
- Clinical performance
- Clinical judgment
- Knowledge of limitations

- Therapeutic doctor-patient relationships

2. Professional Behavior (Professionalism, Systems-Based Practice, Practice-Based Learning and Improvement)

- Working relationships with others
- Ethical conduct, honesty and integrity
- Acceptance of responsibility, punctuality, reliability
- Leadership skills
- Compliance with administrative responsibilities
- Responsiveness to the patient and the medical community

3. Technical Skills (Patient Care, Systems Based Practice)

- Procedural competence and experience (includes OB)
- Accurate documentation
- Medical record thoroughness, completeness and timeliness

4. Impairment Prevention (Professionalism)

- Absence of impaired function due to uncontrolled mental or emotional illness, personality disorder or substance abuse

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

<u>Advancement specifics (PGY1-PGY2)</u>

- 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

<u>Advancement specifics (PGY2-PGY3)</u>

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

Advancement specifics (PGY3 to Graduation)

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

Further details of promotion criteria are available in the promotion documents

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

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.

GRADUATION AND BOARD ELIGIBILITY

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

A RESIDENT WILL NOT BE ALLOWED TO GRADUATE WITHOUT HAVING THE REQUIRED NUMBER OF PATIENT CONTINUITY VISITS, OB DELIVERIES-TOTAL AND CONTINUITY, NURSING HOME VISITS, HOME VISITS, AND ICU VISITS.

As of July 1st, 2006, the continuity visits are:

- 1650 for three years with at least 150 of these visits occurring in the first year.

- OB deliveries (40 including 10 continuity in order to graduate) and at least

- 2 documented nursing home visits as a part of 24 months of continuity nursing home care

- 2 documented home visits, and
- 15 critically ill patient / visits (different patients) must be documented.

ALL procedures must be documented on New Innovations Residency Management Suite (RMS) to be considered toward residency completion requirements.

The procedure database will be the sole source of information regarding procedures documented during residency training. 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 quarterly). For any questions regarding this policy, please see the Residency Program Director. For technical questions regarding the documentation, please contact the Residency Coordinator/Associate Coordinator or the Dept. Chief.

<u>Curriculum</u>

1. Didactics:
    a. Residents will participate in a procedure didactic during orientation and during the Wednesday Core conference series.
2. RRC general procedures (required for certification). General procedures that the RRC in Family Medicine have indicated are mandatory for successful Board eligibility.

Procedures needed for ABFM certification

Procedure	**Credentialing target**	**Recommended time for certification**
Critically ill	15	PGY2
Home visits	2	PGY2
Primary OB	10	PGY3
Other deliveries	40	PGY3

Continuity patient visits	1650	
	150	PGY1
	500	PGY2
	1000	PGY3

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 the performance of these before graduation. 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**
Anoscopy		
Cryocautery of skin lesions	5	PGY1, 2, 3
Endometrial biopsy		
Eye fluorescein exams		PGY3
Incision and drainage of abscess		
Immobilization and stabilization of severe sprains		PGY1, 2, 3

Immobilization and stabilization of non – displaced fractures		PGY1, 2, 3
Injection and aspiration of points		PGY2, 3
Injection and aspiration of tendons, ligaments and muscles		PGY2, 3
Pap smears	10	PGY1- Orientation
Simple laceration repair with sutures		PGY1 ,2
Skin biopsies	5	PGY1, 2, 3
Splints		PGY2, 3
Toenail removal	5	PGY1, 2, 3
IUD placement	7	PGY1, 2, 3
Colposcopy	10	PGY3
Family Care conferences	3	PGY1, 2, 3
Continuity of Care visits	8	PGY1, 2, 3

b) Procedures with no test of independence

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

Procedure	**Credentialing target**

Family Medicine Inpatient Continuity (non ob)	10
Circumcisions	3

The following are the procedures and interpretive skills which residents are required to learn on each rotation.

Rotation Experience	**Procedure**
Adult Medicine	ABG interpretation, management Bi pap machine Chest X ray interpretation EKG interpretation Fluid and electrolyte management Central Line insertion Spirometry
Pediatric	Cerumen removal Developmental screen interpretation Laceration repair Newborn resuscitation Peak flow measurement Pediatric X ray interpretation
Obstetrics	Vaginal delivery /episiotomy repair Laceration 1st and 2nd degree 3rd degree Amniotomy Insertion of intrauterine pressure catheter with or without amnioinfusion Fetal scalp electrode placement Labor Induction/

	Augmentation Cervical ripening with prostaglandins Management of VBAC Circumcisions Interpretation of fetal monitor
Gynecology	Colposcopy Cervical biopsy ECC LEEP IUD insertion Pelvic and breast examination PAP smears
Surgery	Aseptic technique Bladder catheterization local/regional anesthesia Minor skin procedures Toenail Parenteral nutrition Surgical wound closure Wound debridement Knot tying
Emergency Medicine	Anoscopy NG tube insertion Burn management Nasal packing Removal of foreign bodies Laceration repair
Orthopedics	Cast and application Closed reduction of fracture Management of sprains Extremity X rays
Sports Medicine	Application of braces Joint aspiration Performance of musculoskeletal exam Rehabilitation of sports injuries

c) 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.

d) Advanced Procedures

Residents may record advanced procedures in which they have received additional training during elective or rotation time. These will include procedures like colposcopy and LEEP and others to be determined by the Department.

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

1. Knowledge of the indications and contraindications for the procedure
2. Knowledge of potential risks of the procedure and the ability to clearly explain these risks to the patient
3. Technical proficiency to complete the procedure
4. Ability to anticipate and handle potential complications
5. Appropriate documentation of the procedure

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 an independence rating by faculty or senior resident (for OB procedures) no further test of independence is required

Supervision of Procedures:

All procedures must be supervised, either by a senior resident or a faculty physician

INTERPRETIVE SKILLS

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

Skill	Setting	Recommended time for certification
EKG interpretation	Orientation, core conference, Cardiology	PGY1
Urinalysis	Continuity clinic	PGY1
X-ray interpretation	Radiology, sports medicine, medicine rotations	PGY2
Spirometry	Continuity clinic	PGY2
Wet Mount and Fern test	OB, FMS Inpatient	PGY1

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.

SELECTION AND DUTIES OF CHIEF RESIDENTS

The chief resident is a resident leader, advocate and liaison 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.

TERM

The tenure of the Chief Resident extends from May 1st to April 30th of each academic year.

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 January 1. Residents without step 3 results on the due date of January 1st are unable to be considered.
    b. The resident must not be under academic remediation or probation.
    c. Must have achieved a composite score of not less than the 35th percentile on the ABFM In-Training Examination.

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 good written and verbal communication skills. They must also be comfortable in electronic communication media.
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.
5. *Administrative Skills:* The resident nominees must demonstrate organizational and administrative capabilities, including familiarity with computer software tools such as word processors, spreadsheets and presentation media.

DUTIES AND RESPONSIBILITIES:

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

Administrative:

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

Meeting Responsibilities:

- Serve on the Curriculum, Recruiting and Conference committees of the residency.
- Attend the Family Medicine Department Meeting and represent residents at the following committee meetings:
    1. Resident Council and Graduate Medical Education Committee at HCMC
    2. Family Medicine Leadership meeting
- Chair the quarterly Family Medicine Resident Organization (FMRO) meeting.
- Keep and distribute minutes of the FMRO meetings.
- 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.
- Monitor and encourage attendance at the core conferences of the residency.
- Attend one national meeting annually.
- Assist in the teaching and supervision of medical students.
- Assist in the organizing of the monthly journal club.
- 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.

Leadership:

- Provide leadership to the residency body.
- 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.
- Participate in making clinic policies and serves as a spokesperson for the residents in initiating changes in the Family Medical Center and the residency program in general.
- Maintain an atmosphere of cooperation among residents.
- Arrange and coordinate Resident Research Day and the residents' portion of the Graduation Banquet.

Recruitment:

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

PROCESS OF SELECTION:

1. *Nomination:* In January of each academic year, the Residency Program Coordinator will invite nominations from interested 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. Suitable candidates may be required to appear before the Program Education Committee to present 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.

TIME DESIGNATION FOR DUTIES:

The Chief Residents will be assigned one half day per week for chief administrative duties.

BENEFITS:

- The Chief Residents receive a monthly stipend.
- Paid expenses for attendance at a Chief Resident's Leadership Workshop or other leadership conference paid for by the residency program.
- Training and practice in leadership skills.

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

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.