Resident Physician Manual

2018-2019

GRADUATE MEDICAL EDUCATION

Gwinnett Medical Center

Family Medicine

Family Medicine Residency Program

The information contained in this Manual is an adjunct and does not replace or exempt compliance with the guidelines and policies set forth by your employer in the Resident Physician Manual for Gwinnett Medical Center. Please use both manuals when referencing a topic. The Resident Physician Manual is available on the hospital intranet/sharepoint site.

The purpose of this policy manual is to provide you with the guidelines and expectations of the Family Medicine Residency program. You are responsible for the information contained herein. The manual is also subject to change as needed and as the program grows. Residents are responsible for reading and understanding the contents of this manual, as well as any revisions that are made. Please do not hesitate to ask the faculty or residency administrative staff about this manual.

I hereby acknowledge I have received and accepted and agree to be held to the standards of the procedures and policies herein contained. Furthermore, I understand that email is the method of communication for policy changes, and I agree that email notification will serve as official notice for updates to this manual.

Signature:_____ PGY 1 2 3

Date: _____

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Revised 5/7/2018

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INTRODUCTION

Welcome to your residency program. Family Medicine is a challenging and rewarding specialty that centers on the patient as a whole person within the social context of a family and community. The principles of Family Medicine mandate health care that is comprehensive, continuous, and oriented toward the individual, their social support system, and community. Within this residency, you will be exposed to all aspects of Family Medicine, with the goal being to provide you with the knowledge and skills to practice and deliver excellent health care. This residency also recognizes that personal maturity and self-awareness are extremely important. Upon graduation, you will be a physician who is competent in comprehensive care of the full spectrum of ages and conditions that family physicians should excel at caring for, and have developed the skills required to be professionally and personally successful.

THE FAMILY MEDICINE RESIDENCY POLICY MANUAL

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HISTORY

The Gwinnett Health System (GHS) is a well-established not-for-profit healthcare network, which supports acute care hospitals in Lawrenceville and Duluth, Georgia (553-beds), The Glancy Rehabilitation Center, the Gwinnett Extended Care Center, and its affiliated practices and specialty centers. Gwinnett Medical Center (GMC) has been at the forefront of medicine, recognized by Healthgrades™ as one of America's 100 Best™ Hospitals, with cutting-edge technology in cardiovascular, orthopedic and neuroscience specialty care, as well as a level II Trauma Center. It is governed by the Gwinnett Hospital System and its Board of Trustees. GMC will function as the sponsoring institution for the Graduate Medical Education Department and its residency programs. The Board, the CEO and the Director of Graduate Medical Education work in partnership to support and grow our Graduate Medical Education programs. Our goal in Graduate Medical Education is to recruit, train and place primary care providers in suburban and rural Georgia. We believe our program will greatly benefit our region and enhance the health of our communities, and are working with our partner health education institutions, Philadelphia College of Osteopathic Medicine's Suwanee, Georgia Campus, and the Georgia Regents University's Athens Campus.

As our flagship hospital, Gwinnett Medical Center–Lawrenceville is more than just a full-service hospital featuring the latest medical technology and treatments. The main hospital campus contains acute care beds and intensive care units, a dialysis unit, a center for sleep disorders, outpatient laboratories and treatment centers as well as outpatient procedure units and day surgery. The Strickland Heart Center is a state of the art full service cardiac treatment center. The Emergency Department is a level two trauma center with full medical and surgical support as well as pediatric emergency services. The campus also houses a cancer treatment center, the Woman's Pavilion with both Obstetrical and Gynecological inpatient and outpatient facilities as well as a new born nursery facility and a Neonatal intensive Care. Supporting buildings contain the Extended Care Center, a skilled nursing and rehabilitation unit as well as several support buildings housing sports rehabilitation, orthopedic offices, outpatient imaging, a pain treatment center, and at the Strickland Family Medicine Center in which resident physicians and their preceptors will see a fixed, continuity panel of patients.

In 2010, the GHS Board, as part of its strategic planning process set on a course to respond to the projected primary care physician shortage in the state of Georgia. It partnered with the Board of Regents, The Georgia Physicians' Task Force, the Philadelphia College of Osteopathic Medicine (PCOM) and MCG-Athens to recruit for and start two new residency programs in the GMC system in Internal Medicine and Family Medicine. Both programs are to be dually accredited by both the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA). GHS believes that the region it serves in North Eastern Georgia and its hospital system is poised to provide excellent training to resident physicians and that those residents upon graduation will stay and practice in the region as is commonly seen in most community residency programs.

Gwinnett Medical Center Family Medicine Residency

VISION: To improve the health of all the lives we touch.

MISSION: Train Family Medicine physicians to provide high quality, cost effective care, to the greatest number of people possible in the region.

VALUES: Our Residency's core values mirror our sponsoring institution:

- Customer is first and foremost
- Respect for the individual
- Pursuit of excellence
- Promotion of positive change
- Service to the community

PROGRAM GOALS AND OJECTIVES

The Gwinnett Medical Center Family Medicine Residency Program has the goal of producing Family Physicians who are independently capable of providing high quality care to their patients and their families in an efficient and multi-disciplinary way. We believe that while training in our region our resident physicians will learn to provide care in many settings: hospital, out-patient, emergency departments, at home and in long term care facilities to name a few. Further, we hope to retain many of these learners after they complete their training in our region to continue to provide quality, patient centered primary care improving the over-all health of our area.

Our curriculum is core competency based. Our resident physicians will be trained using this system with milestones escribing and marking their progress and achievements. An overview of this milestone system based on the Core Competencies is as follows:

1. **Patient Care**
    a. Able to deliver acute care in all settings in urgent and emergent situations
    b. Able to care for patients with chronic illnesses
    c. Is able to work with the patient and their family to improve overall health through education and prevention
    d. Delivers patient centered, ongoing care to address ongoing signs and symptoms that may appear or persist over time
    e. Is able to recommend, explain, and perform specialty appropriate primary care procedures to meet the health care needs of their patients
    f. Provide a personal medical home for patients of all ages and genders.
2. **Medical Knowledge**
    a. Demonstrates adequate medical knowledge with sufficient breadth and depth for family medicine practice
    b. Is able to apply critical thinking and analysis skills in the delivery to care to their patients
    c. Pass the Family Medicine Board Certification Exam
    d. Develop lifelong learning skills that will enable them to maintain certification
3. **Professionalism**
    a. Progresses during training to develop a level of professionalism commensurate with their training and practice
    b. Demonstrates Professional conduct and accountability with patients, families and peers.
    c. Demonstrates humanism and cultural understanding
    d. Maintains emotional, physical, and mental health and is able to continually demonstrate professional and personal growth.

4. **Practice Based learning and Improvement**
    a. Understands and delivers efficient and cost conscious medical care
    b. Able to emphasize patient safety
    c. Understands and is able to advocate for individual and community health
    d. Is able to coordinate multi-disciplinary, team based care
5. **Systems Based Practice**
    a. Is able to search for and incorporate evidence based studies and information into their practice and care for patients
    b. Demonstrates self-directed learning techniques
    c. Demonstrates the ability to improve the processes and systems in which they provide care.
6. **Interpersonal Communication Skills**
    a. Is able to develop a meaningful professional and therapeutic relationship with patients and their families.
    b. Effectively communicates with patients, families, and the general public
    c. Effectively communicates with peers, other health care professionals, and their health care teams.
    d. Is comfortable with the use of technology in communication and the delivery of health care.

7. **Osteopathic Manipulative Medicine (For DO Residents)**
    a. Demonstrate the ability to perform osteopathic structural examinations and osteopathic manipulative treatments including reassessment as interwoven through all six competencies.

FACULTY

PROGRAM DIRECTOR- Kevin E. Johnson, M.D. , FAAFP, joined faculty in August of 2013 as Program Director. Dr. Johnson is Board Certified in Family Medicine and holds a Certificate of Added Qualification in Hospice and Palliative Medicine. A graduate of the University of Oklahoma Health Sciences Center, he completed his residency in Family Medicine at New Hanover Regional Medical Center in Wilmington, North Carolina and a fellowship in Faculty Development in Family Medicine at the University of North Carolina at Chapel Hill. Through his diverse clinical experiences in a FQHC in Asheboro, NC, rural solo private practice in Clinton, Oklahoma, as a civilian hospitalist for the Army at Ft. Bragg in Fayetteville, NC, and as an assistant professor in academic Family Medicine for the University of North Carolina affiliated program in Wilmington, NC, where he served as assistant program director, he maintains a broad clinical teaching skillset. He also has expertise in health informatics and practice management issues, and has published and presented on a wide variety of clinical and medical education topics.

DIRECTOR OF OSTEOPATHIC EDUCATION- William Bostock, DO, FAAFP joined faculty May 2014, as Osteopathic Residency Program Director. Dr. Bostock is a native of Georgia and has practiced Family Medicine in Lawrenceville, Georgia since 1986. Dr. Bostock graduated physician's assistant school from the Medical College of Georgia and graduated medical school from the Kansas City University of Medicine and Biosciences. He completed his Family Medicine Residency at the Medical College of Georgia. A member of Phi Sigma Alpha, National Honor Fraternity of Scholastic Excellence. Dr. Bostock was a Promina Health System Board Member and served as Chairman of the Board of the Gwinnett Hospital System PHO. Dr. Bostock is Board Certified in Family Medicine by the American Academy of Family Practice and in 1993, he became a Fellow of the American Academy of Family Practice. Dr. Bostock is a member of many state and national medical societies, including the American College of Osteopathic Physicians, American Osteopathic Association, American Academy of Family Physicians, and American Medical Association.

ASSISTANT PROGRAM DIRECTOR-Amimi Osayande MD, FAAFP Dr Osayande is a graduate of the University of Benin in Benin City, Nigeria. Dr Osayande joined the program in June of 2016 as assistant residency program director. She completed her post graduate residency at Brody School of Medicine in East Carolina University, Greenville, North Carolina in 2008. She spent one year in private practice before joining an academic family medicine practice in 2010 where she spent six years; four as a core faculty with the last two as Associate program director before transferring to GMC. Her interests include residency education, medical and creative writing, critical appraisal of evidence based medicine literature, pediatric/adult obesity and Women's health. She has published articles for the American Family Physician, Journal of Family Practice, and has numerous chapters in medical books. She also serves as a peer reviewer for various journals and online
medical resources.

SFMC CLINICAL SERVICES DIRECTOR- Mirtha Aguilar Alvarado, MD joined the program in November 2015 and currently serves as director of Quality Improvement for family medicine. She was born and raised in La Paz- Bolivia and earned her M.D. degree from the

Universidad Mayor de San Andres in La Paz- Bolivia in 1996. She practiced medicine in rural and underserved communities in her native country and was Director of Health Project's for rural communities and worked managing Reproductive Health Programs at CSRA (nonprofit organization). Dr. Aguilar completed her training in Public Health, obtaining a Master degree from the Nur University in La Paz, Bolivia. She moved to USA and completed residency training at Saints Mary and Elizabeth Medical Center, in Chicago, where she was selected Chief Resident. She received her Board Certification as Family Physician by the American Family Medicine physician in 2014 and completed a Fellowship in Women's Health at McNeal Hospital in Berwyn, Illinois in 2015. She joined Gwinnett Medical Center Family Residency Program in 2015 to pursue her interest in teaching. Other professional interests include outpatient gynecologic procedures, women's health, and healthcare for underserved communities, patient education. She is fluent in Spanish and when not working enjoys hiking, listening to music and dancing.

DIRECTOR OF SPORTS MEDICINE- Purnima Bansal, MBBS, - Joined faculty in 2018. She received her medical degree from Kasturba Medical College, Mangalore, India completed her family medicine residency at Case Western Metrohealth in Cleveland Ohio, and completed her fellowship in Primary Care Sports Medicine at Boston Children's Hospital and Harvard Medical School in Boston MA. She served on faculty at Tufts University , and at Bluegrass MD Jennie Stewart medical Center in Hopkinsville, KY prior to joining the faculty at GMC. She is currently working to develop a Primary Care Sports Medicine Fellowship for the system.

DIRECTOR OF BEHAVIORAL HEALTH- Carol Minor, LCSW, Serves as director of Behavioral Medicine Education for the GMC Family Medicine Residency. She has a master's degree in social work from the university of Georgia, and has been in private practice since 1992 in individuals and couples counseling. She has managed and directed the Employee Assistance Program for GMC since 2000.

DIRECOR OF PHARMACOLOGY- Candis M McGraw-Senat, PharmD, BCACP Dr. McGraw received her Doctor of Pharmacy degree at Temple University School of Pharmacy in Philadelphia, Pennsylvania. She currently is an Assistant Professor of Pharmacy Practice at the Philadelphia College of Osteopathic Medicine, School of Pharmacy and a clinical pharmacist at Strickland Family Medicine Center. Prior to joining PCOM School of Pharmacy, she has served as an Adjunct Professor at Temple University School of Pharmacy, Philadelphia University Physician Assistant Program, and University of the Sciences Philadelphia College of Pharmacy. Dr. McGraw has also earned a teaching certificate through University of the Sciences Philadelphia College of Pharmacy.
Dr. McGraw's practice and research interests include diabetes, hypertension, and high risk patient populations. Dr. McGraw is very passionate for academia and ambulatory care and she looks forward to obtaining her certification as a diabetes educator. Outside of teaching at PCOM, Dr. McGraw engages in medical mission trips, most recently to San Juan, Dominican Republic with the organization Solid Rock International.

Barbara Joy Jones, DO – Joined faculty in 2017 after completing her residency at GMC. She completed her DO at the Georgia Campus of PCOM and completed a 1 year O.M.M. fellowship

prior to starting residency at GMC. She serves as OMM faculty at Strickland Family Medicine Center, and maintains a private practice in Lilburn as well.

Katharine Murphree, MD Joined the Faculty in 2018 after completing residency at GMC, and completed her MD at University of Alabama at Birmingham. She is taking on the role of Point of Care Ultrasound education and will have her clinical practice focus mainly in Duluth Family & Sports Medicine. She will also serve as attending on the Family Medicine Inpatient Service.

Daniel Frilingos, MD, serves as inpatient teaching faculty for the Family Medicine Residency program. He received his medical degree from the Medical College of Georgia, and completed his internal medicine residency at Atlanta Medical Center, where he was selected chief resident and subsequently served as faculty attending in the Internal Medicine program at AMC prior to joining faculty at GMC.

DESIGNATED INSTITUTIONAL OFFICIAL- Mark Darrow, M.D., FACP, joined the GHS system in October of 2012 as Director of Graduate Medical Education. Dr. Darrow is a Fellow of the American College of Physicians and a Diplomate in Geriatric Medicine with the American Board of Internal Medicine He is a graduate of the SUNY Stony Brook Health Sciences University and completed his residency in Internal Medicine at The Mary Imogene Bassett Hospital in Cooperstown NY. He has also completed a fellowship in Faculty Development in Family Medicine at the University of North Carolina at Chapel Hill. He has practiced as a solo private practitioner, an academic professor, clinician, and educator. Additionally he has broad administrative, leadership, practice management, and program development experience. He has published and presented on a wide variety of clinical and medical education topics at regional, national and international institutions and meetings.

Strickland Family Medicine Center	**PHONE**
FRONT OFFICE	
Main Line- Lawrenceville	(678) 312-0400
Front Desk	(678) 312-0401
Back Line -Nurses	(678) 312-0410
Fax Line	(678) 312-0423
SFMC Clinical Manager/Susan Joy Allen	(678) 312-0491
Residency Coordinator/Trena	(678) 312-0425
Front Desk Coordinator/Christian	(678) 312-0426
Lab Supervisor	(678) 312-0471
Lab	(678) 312-0404
Population Health /Ginni Holland	(678) 312-0403
CLINICIAN STATION	
1	(678) 312-0413
2	(678) 312-0411
3	(678) 312-0412
4	(678) 312-0414
RESIDENT WORKROOM	
Station #3	(678) 312-0408
Station #4	(678) 312-0469
Station #6	(678) 312-0468
Station #7	(678) 312-0418
Station #8	(678) 312-0417
Station #10	(678) 312-0467
Station #11	(678) 312-0407
PRECEPTING ROOM	(678) 312-0406
SFMC BACK OFFICES	
Library	(678) 312-0409
Break Room	(678) 312-0416
Conference Room	***(678) 312-0419***
SFMC PROVIDERS	

Mirtha Aguilar, MD	(678) 312-0421
William Bostock, DO	(678) 312-0420
Kevin Johnson, MD	(678) 312-4071
Amimi Osayande, MD	(678) 312-0422
Margaret Apara, NP	(678) 312-0492
Duluth Family & Sports Medicine	**PHONE**
FRONT OFFICE	
Main Line-Duluth	(678) 312-7800
Associate Health & Wellness	(678) 312-7815
Front Desk -Dawn	(678) 312-7801
Office Coordinator-Yajaira	(678) 312-7814
Fax Line	(678) 312-7818
Lab	(678) 312-7807
CLINICIAN STATION	
Felethia/Milca	(678) 312-7810
Deborah	(678) 312-7812
DFSM PROVIDERS	
Purnima Bansal, MD	(678) 312-7803
Margaret Apara, NP	

RESIDENT RESPONSIBILITIES

Beyond the expectations of the program and adherence to the goals and objectives, the resident is responsible for the following:

1. Pursuing in a self-directed manner his/her own advancement of medical knowledge.

2. Participating actively in the programs and functions of the residency program.

3. Adhering to the policies of the Family Medicine Residency Program, Family Medicine Center, Gwinnett Medical Center, and any other rotation sites.

4. Timeliness and punctuality at conferences, clinic days and other meetings.

5. Respect for confidentiality.

6. Attention to patient care responsibilities such as lab follow up, careful and accurate patient care documentation, completion of forms, and responsiveness to nursing/staff/patient concerns/calls.

7. Timely completion and adherence to appropriate administrative responsibilities such as leave requests, call changes, unscheduled absences, completion of forms, etc.

8. Active participation in medical education of students, residents and any learners assigned to our program.

9. Prompt provision of evaluations for students, faculty, rotations and other evaluative requests.

10. Positive participation in resident /faculty recruiting.

11. Fulfill call schedule responsibilities to the Family Medicine Center and all other rotations.

12. Speak, behave, and dress in a manner appropriate for a medical professional.

13. Prompt notification of attending/faculty/supervisors of patient medical/legal status changes.

14. Receive evaluation and feedback in a professional manner.

15. Attention to patient safety.

ACGME and AOA GENERAL COMPETENCIES

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

- communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- gather essential and accurate information about their patients
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- develop and carry out patient management plans
- counsel and educate patients and their families
- use information technology to support patient care decisions and patient education
- perform competently all medical and invasive procedures considered essential for the area of practice
- provide health care services aimed at preventing health problems or maintaining health
- work with health professionals, including those from other disciplines, to provide patient-focused care

Medical Knowledge: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline

Practice Based Learning and Improvement: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- obtain and use information about their own population of patients and the larger population from which their patients are drawn
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- use information technology to manage information, access on-line medical information; and support their own education
- facilitate the learning of students and other health care professionals

Interpersonal and Communication Skills: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Residents are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients

- use effective listening skills and elicit and provide information using appropriate nonverbal, verbal, and writing skills
- work effectively with others as a member or leader of a health care team or other professional group

Professionalism: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

System Based Practice: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

Osteopathic Philosophy and Osteopathic Manipulative Medicine: (for DO residents)

- demonstrate understanding and application of osteopathic manipulative treatment (OMT) by appropriate application of multiple methods of treatment, including but not limited to, High Velocity/Low Amplitude (HVLA), strain/counter strain, and muscle energy techniques.
- demonstrate, as documented in the medical record, integration of osteopathic concepts and OMT in all sites of patient care including the continuity of care training site, the hospital, and long term care facility. It is understood that integration implies the use of OMT in such conditions as, (but not limited to) respiratory, cardiac, and gastrointestinal disorders, as well as musculoskeletal disorders.
- understand the philosophy behind osteopathic concepts and demonstrates this through integration into all clinical and patient care activities.
- describe the role of the musculoskeletal system in disease, including somato/visceral reflexes, alterations in body framework, and trauma.
- understand the indications and contraindications to osteopathic manipulative treatment.

BENEFITS

- Please also refer to the Resident Physician Manual and GMC handbook for details.

LIFE SUPPORT COURSES

- BLS (Basic Life Support),
- ACLS (Advanced Cardiac Life Support)
- PALS (Pediatric Advanced Life Support)
- NRP (Neonatal Resuscitation) Course

All residents will be required to certify during their R1 and R3 year. Times for this re-certification will be arranged by the department for R1 and thru net learning for R3.

CALL ROOMS

Private call rooms are available, with private showers but not always on a per room basis, each room will also be equipped with telephone and computer to facilitate patient care.

PARKING

Designated free parking is provided by GMC at specific locations on campus. Residents are requested to refrain from parking in other than designated areas on campus. Tickets will be issued and repeat violators will be subject to disciplinary action.

MEALS

Resident physicians will be provided, without charge, meals while on call in the hospital. Badges are authorized a set amount on a monthly basis and meals will be deducted from that amount. There are private physician dining areas on GMC-L that offer a full selection of meal choices for lunch, and at GMC-D physicians are given a meal for lunch for free (show MD/DO badge at register) Snacks and other refreshments are also available in the physician's private dining room or the Medical Staff Lounge at no cost. After hours when the cafeteria is closed prepackaged food is available in the Medical Staff Lounge on both campuses at no cost.

LAB COATS AND SCRUBS

Each resident is issued two lab coats at the beginning of their training and may receive two additional coats per year. Laundering of these lab coats is done at no cost to the resident through laundry service supplied at the SFMC. Medical center owned scrubs can be obtained at various locations throughout the hospital and are not to be worn outside or removed from medical center property.

CELL PHONE ALLOWANCE

Each resident receives a call phone allowance of $100 per month to defray the cost of maintaining a smart phone capable of using the TigerText application. This will be the primary form of communication for patient care on most rotations, and expectation to respond to all texts in a timely manner.

CME STIPENDS

Each resident is allocated a professional development fund of $500 per intern and $1000 per year for PGY2/3 Acceptable uses of these funds include travel and tuition for CME conferences,

medical textbooks, journal subscriptions, subscriptions for web-based educational material and medical software. This money must be used within the academic year it is given.

DRESS CODE
Resident Physicians must dress appropriately and hospital-issued picture identification badges must be worn above the waist for identification at all times. Uniform attire is not required. The resident must be immediately identifiable as a physician and appearance or manner of dress must not diminish professional effectiveness. (See Human Resources Policy 300-505 for further guidance).

Scrub suits are permitted when on call at night but are discouraged outside appropriate areas during regular working hours. Scrub suits, caps and masks should not be worn while making rounds or in patient areas. Residents are required to change from scrub suits before they leave the Medical Center premises.

Jeans of any color are not permitted at any time in the medical center.

OSHA prohibits the wearing of open toed shoes in the healthcare setting.

Scrubs are not appropriate attire for clinic work at SFMC, with the exception of procedure clinical sessions, unless pending imminent delivery the resident is planning to attend or procedures are being performed requiring their use. Scrubs are not to be taken home or used outside of the scrub required locations with in the hospital, and should not be used in the ED or inpatient service with the exception of night float.

FIREARMS
Firearms of any type or purpose are strictly forbidden on any hospital property.

TOBACCO USE
Tobacco use is strictly forbidden on any hospital property. This includes Gwinnett Medical Center as well as the Strickland Family Medicine Center.

LICENSING
During post graduate training, residents are covered by a training license offered by the Georgia Composite Medical Board (GCMB), which is kept on file through the office of Graduate Medical Education. All residents must have a resident training license or a full license prior to the effective date of employment. The fees for this license will be paid by Gwinnett Medical Center. If a license is not issued by the effective date of the Agreement of Appointment, the resident will not be an employee of the Medical Center and will not be paid. Associated benefits, i.e., health and dental insurance, will not be provided.

Residents may apply for full Georgia state licensure as soon as they are considered eligible. Graduates of medical schools in the US or Canada are required to complete one year of training accredited by the ACGME, AOA, COA, RCPSC, or CFPC. International Medical School graduates and Fifth Pathway applicants who graduate from medical school on or before July 1,

1985 must complete one (1) year of post-graduate/residency training in the US in a program approved by the ACGME, AMA or the RCPSC.

The GCMB uses the list titled *Medical Schools Recognized by the Medical Board of California* as its official reference for approval of medical schools located outside the United States and Canada. Graduates of the schools contained in this list are required to complete one (1) year of post graduate training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME). Graduates attending schools not listed in the Medical Schools Recognized by the Medical Board of California must complete three (3) years of post-graduate training in a program accredited by the
ACGME. The list can be viewed online at: http://www.mbc.ca.gov/applicant/schools.html. The fees associated with obtaining a full license are the responsibility of the resident. Please notify residency program staff if you apply for and receive a full Georgia state medical license.

EXAMINATION POLICIES

The In-training Exams

The ABFM In-Training exam is given each October. All residents are required to take this exam regardless of degree (MD/DO). This exam provides a reasonable assessment of how well a resident may perform on the ABFM certification exam. It may also provide some insight into level of medical knowledge in specific content areas.

For Osteopathic residents, the ACOFP In training exam is given in October of each year as well. All Family Medicine Osteopathic residents must take this exam

If a resident receives a composite score placing them at risk for failure of the ABFM certification exam, the following will be required;

- Resident will be placed on a monitored educational plan
- Resident will meet at least one time with a faculty member designated to assist with test taking. Additional meetings will be scheduled as deemed necessary by the faculty advisor and residency Program Director.
- Resident will work with the faculty to develop an Education Plan. This plan may include:
    - evaluation of exam-taking skills
    - assigned reading to improve medical knowledge in specific content areas
    - practice tests
    - other specific learning experiences as deemed necessary
    - professional evaluation for learning disabilities may be offered

Failure to complete these tasks as required will cause the resident to be placed on probation. Residents enrolled in the Osteopathic Recognition track will also be required to take the CORRE examination when available in 2018.

USMLE/COMPLEX-USA-USA Step 3

As per the GMC Resident Physician Manual, Family Medicine and Internal Medicine residents must pass the USMLE/COMPLEX-USA/COMLEX Step 3 exam by the first of March of their second year. Residents failing to pass the exam by the above deadlines will not have their training agreement renewed.

GMC will pay exam fee for successful passage of Step3 examination if completed during employment. No reimbursement can be given for individuals who have already completed step 3 prior to employment.

BOARD CERTIFICATION

The American Board of Family Medicine exam is offered April and November each year. All 36 months of training must be completed by June 30 of the year of graduation to sit for ABFM Certification Exam in April of the same year. Residents who are expected to complete training between July 1 and October 31 may be declared eligible to apply for the April examination based on a recommendation from their residency program director. Residents who graduate later than October 31 or who are unable to obtain an active license in time for the April Boards are eligible to take the Boards in November. Certification will be awarded when all of the criteria are met:

1. Successful performance on the ABFM MC-FP Examination
2. Program Director verifies the resident has met all of the ACGME program requirements
3. Candidate obtains a valid, full, and unrestricted license to practice in the US or Canada

The American College of Osteopathic Family Physicians offers the Board Examination two times per year. The OMT practical exams are given during the National Conference in the spring and fall. The cognitive assessment is given at local online testing centers throughout the country. This portion is offered about 4 weeks after the practical exam. Osteopathic physicians, who will complete their residency requirements by July 31, may take the exam in the spring prior to their residency completion. Those completing requirements after July 31 can take the exam in the fall.

GMC will pay for certification examinations fees for certification examinations taken and scores received before the completion of residency training. No reimbursement will be provided for non-passing scores or for exams scheduled or taken after completion of 36 months of training. Additionally GMC will provide additional funding to pay travel expenses for O.R. residents to take hands on practicum at the required location. Preliminary passage notifications can be used to apply for reimbursement.

GRADUATION

GMC hosts a graduation for all the GMC residencies in June of each year. In addition, the Family Medicine residency hosts a department celebration for graduates in June. Graduating residents are expected to be in town and attend both events. While graduation often occurs before the final day of work, residents are expected to work until the last day of their contract. ACGME regulations do not allow residents to complete training on PTO/Leave.

RESIDENCY POLICIES AND PROCEDURES

LEAVE POLICIES (See Form A)

Time away from the residency is classified into the following types of leave:

1. Vacation
2. Sick Leave
3. CME Leave
4. Administrative Leave
5. Extended Leave/Parental Leave
6. Bereavement Leave

General Considerations

- The American Board of Family Medicine sets the regulations that govern leave during residency training.
- Residents are allowed a maximum of **27 working days** per year to use for leave purposes; *any combination of leave that exceeds 27 days per year will result in extension of residency for that amount of time. (See Extension of Residency Policy).*
- Residents may not miss more than **5 working days** from any rotation that allows leave unless given permission from the rotation director and residency director. Residents who are granted permission to miss more than 5 days may be required to make up the extra days missed. This includes anything that takes you away from the rotation, including CME, board exams, ACLS. Even though these days do not count towards the 21 days away from the residency they are time away from a given rotation.
- A leave form must be completed for all types of leave. This includes a designation of a covering physician for any leave longer than 2 days. The covering physician is responsible for answering patient care questions, prescription refills, and urgent patient issues. Other coverage, such as call or inpatient coverage, needs to be clarified on the leave request.
- Leave may not overlap the end of the academic year.
- Vacation periods may not accumulate from one year to another.
- Annual vacations must be taken in the year of the service for which the vacation is granted.
- Leave may not overlap the academic year. No two vacation periods may be concurrent (e.g., last month of the G-2 year and first month of the G-3 year in sequence)
- A resident does not have the option of reducing the total time required for residency (36 calendar months) by relinquishing vacation time.
- Time away from the residency program for educational purposes, such as workshops or continuing medical education activities, are not counted in the general limitation on absences but should not exceed 5 days annually. Certain program requirements involve time away from the residency but do not count towards the 21 days/year. Requests for

this leave must be made 90 days prior to the **first day** of the month in which the leave is requested. These include:

1. BLS/ACLS/PALS/NRP certification
2. USMLE/COMLEX-USA Step 3 - day of test only.
3. ABFM and ABOFP board examinations
4. Approved CME Conferences

Residents have ongoing clinical responsibilities throughout their training. It is therefore essential that vacation and leave be scheduled well enough in advance that both service and patient obligations are covered. These clinical obligations primarily include

1. **Call** - This is rotation dependent; therefore, requests for vacation and leave need to be in compliance with the guidelines for the individual rotations. A request for vacation and leave needs to include the approval of the specific rotation and the Family Medicine Residency Director. Call responsibilities for Family Medicine are determined and scheduled by the chief resident. If leave is requested less than 60 days prior to the first day of the month in which the leave occurs, the resident is responsible for arranging call coverage.

2. **SFMC/DF&SM Clinic** – It is the responsibility of each resident to be available to care for his or her own patients on a continuity basis. This imperative requires that time away from the residency should include sufficient notice to minimize rescheduling of patients and appropriate coverage for patient needs while the resident is away. If leave is requested less than 60 days prior to the first day of the month in which the leave occurs, the resident is responsible for rearranging clinic patients.

VACATION

- Each first year resident will receive twenty-two (22) working days of paid leave/PTO (twelve (12) sick and ten (10) vacation) at the beginning of the year.
- All other Resident Physicians will receive twenty-seven (27) days of paid leave (twelve (12) sick and fifteen (15) vacation). Unused sick leave may be carried over to subsequent years, but there is no cash value for unused sick or vacation time.
- Vacation time may not be carried over to subsequent years.
- Any days off over the number of days available will be without pay.
- As vacation is a planned absence. Requests for this leave must be made 90 days prior to the **first day** of the month in which vacation is requested.
- Requests will be handled on a first-come first-served basis with the requirement that adequate personnel be available to provide coverage. **A request for leave is not a guarantee for leave.**
- Please submit leave as far in advance as possible and **do not** make plans until leave is granted.
- It is highly recommended that leave be spaced throughout the year to maintain balance and provide adequate stress relief.
- Vacation is not permitted during any 1 or 2 week rotation
- Leave may not overlap end of the academic year.

- R-3's taking vacation during the final month of residency are required to complete all responsibilities necessary for graduation prior to leaving, and must be present for graduation ceremonies.
- Residents may take vacation only during designated months. Shorter periods of CME/administrative leave may occasionally be granted, though such leave must be cleared with the rotation supervisor and the Program Director in advance.

SICK LEAVE

- Residents are entitled to be paid for up to 12 sick days per year, though use of all sick days may result in an extension of residency. Additional sick days will be unpaid but may be still covered under the GMC FMLA policy. Sick leave is looked at as protection against serious/lengthy illnesses. Sick leave must be taken in accordance with the FMLA.
- It is important to remember that <u>any combination of leave that exceeds 27 days per year will result in extension of residency for that amount of time.</u>
- <u>Sick days may be carried over to the next academic year</u>
- Leave request forms must be submitted for all planned sick leave (scheduled procedures, doctor's appointments) and should be completed as early as possible. In the case of an unexpected illness, an Email notification must be sent to the Residency Coordinator to serve as documentation of the day away. (See additional sick time notification policy)
- All efforts should be made to schedule appointments on days off/post call days. Time away during working days will count towards sick time.

CME LEAVE

- Residents are granted up to **5 working days** per year for CME for professional meetings
- CME leave is included in the 27 days/year limit
- A copy of the meeting/conference schedule should be submitted with the request form
- Leave requests <u>must</u> be made <u>90 days prior to the **first day** of the month</u> in which the meeting or event occurs.
- The same expectations regarding call/clinical responsibilities for vacation apply to CME leave.
- If advanced notice cannot be given, it is the responsibility of the resident to negotiate adequate coverage for all patient-care responsibilities. This will include release from responsibilities on other services, Family Medicine call responsibilities, and clinic coverage.
- Leave will be permitted inside of the 90 day limit at the discretion of the Residency Program Director ONLY if
    - There is adequate coverage in the clinic for patient care activities
    - The leave does not result in rescheduling of a significant volume of patients.
    - The resident documents arrangements for call coverage

ADMINISTRATIVE LEAVE

- <u>Administrative Leave</u>

- Administrative leave may be granted at the discretion of the Residency Directors.
- The length of administrative leave must not exceed the 27 days/year limit to avoid extension of residency

- Interviews
  - Residents in their final year may take administrative leave for interviews.
  - Residents are expected to submit a leave request as soon as an interview date is confirmed. Though leave for interviews is often granted on short notice, it remains the resident's responsibility to ensure that all patient care and service obligations are covered in their absence, including rescheduling clinic patients and finding coverage for call.
  - The number of interview days must not exceed the 27 days/year limit to avoid extension of residency

- Requirements
  - Leave requests must be made 90 days prior to the **first day** of the month in which the meeting or event occurs.
  - The same expectations regarding call and clinical responsibilities for vacation will also apply to administrative leave
  - If advanced notice cannot be given, it is the responsibility of the resident to negotiate adequate coverage for all patient-care responsibilities. This will include release from responsibilities on other services, call responsibilities, and clinic coverage
  - Leave will be permitted inside of the 90 day limit at the discretion of the Program Director ONLY if
    - There is adequate coverage in the clinic for patient care activities
    - The leave does not result in rescheduling of a significant volume of patients.
    - The resident documents arrangements for call coverage

EXTENDED LEAVE/PARENTAL LEAVE

- See House Staff Manual, Special Requirements and ABFM Requirements for Certification for details. Unused vacation time may be used for extended leave.

*******Any leave beyond the 27 working days/year allowed will result in extension of residency and requires approval of the Program Director and the ABFM.*******

- Maternity leave may involve a combination of vacation, sick leave or elective time. The program director needs to be notified as early as possible of the request for maternity leave. The resident is expected to work with colleagues to arrange rotation changes, call schedules and leave time to minimize excessive burden. Maternity leave may be paid if enough vacation and paid personal leave is accrued. The details of a parental leave plan should be worked out with the input of the residency director and completed as far in advance of delivery as possible.

- Leaves of absence in **excess** of three months (including vacation and sick time) are considered a violation of the continuity of care requirement. Programs must be aware that the Board may require the resident to complete additional continuity of care time requirements beyond what is normally required to be eligible for certification.
- Paternal leave may involve a combination of vacation and sick leave.
    - Additional leave beyond the 21 days/year limit will result in extension of residency.
- Leave of Absence
    - Residents may elect to take a leave of absence for personal or academic reasons.
    - Portions of this leave may be paid if sufficient paid leave has accrued.
    - Extended leaves of absence greater than 3 months from the residency may jeopardize a resident's eligibility for board certification.

- Impairment
    - Residents identified as being impaired will be offered the option of taking a leave of absence from the program and seeking appropriate rehabilitation help. Residents who refuse the leave of absence will be suspended from the program, subject to appeal. Reinstatement procedures and follow up are in accordance with the policies and procedures of the Health and Effectiveness Program of the Georgia Medical Society. Please refer to the GMC Resident Physician manual for more details.

REMEDIATION

If a resident fails to satisfy the requirements for passage of a rotation, resident will meet with Program Director at the earliest convenience to discuss causes for failure and develop an immediate plan for remediation. ACGME regulations state that no more than 50% of elective time may be used for remediation. If a resident exceeds the months required for remediation allowed by use of electives extension of residency will be planned (see below)

BEREAVEMENT LEAVE

Per GMC policy three (3) days absence with pay will be granted for a death in the <u>immediate family</u> (parent, spouse, children or sibling). These days do count towards the 27 day absence maximum for ABFM.

JURY DUTY

If a resident if summoned for jury duty, please contact residency program staff immediately so appropriate arrangements can be made.

EXTENSION OF RESIDENCY

<u>Residents who miss more than 21 working days per year for any reason may be required to extend their residency training as follows:</u>

1. 1-10 additional days, an additional 2 weeks of residency will be required.
2. 11-20 additional days, an additional month of residency will be required.
3. Days in excess of 20 working days (1 month) will require additional months of residency prorated as above.

SICK TIME NOTIFICATION

In the event of absence due to illness, it is the resident's responsibility to notify the clinic or rotation as soon as possible. It is the expectation that the resident will speak directly to the responsible party to convey their illness and expected time away. Sick leave applies to the time away from the program which cannot exceed 27 working days without extension of the residency.

On rotation:

The resident is expected to call their senior resident and preceptor directly. **Leaving a voicemail is not acceptable**. In addition, they need to notify residency program staff (coordinator) of their absence. This may be left as a message.

In clinic:

The resident is expected to call the SFMC nurse's line 678-312-0401 for acute illness or other urgency that makes clinic attendance impossible. In addition, you must notify the residency program (coordinator) staff of the absence. This may be left as a voicemail message.

In addition to notifying your department, all staff must call the GMC sick line at 678-312-2567 if you have any of the following:

- Sore throat with fever
- Conjunctivitis with discharge, pink eye
- Cough with fever
- Diarrheal diseases
- Enterovirus infections
- Fever
- Possible shingles
- Undiagnosed rash with fever
- Possible chickenpox
- Localized skin or wound infections
- Other department specific (i.e. fever blisters in high risk areas)

In your call or email, please provide the following information:

- Your last name
- Area and shift scheduled to work
- General symptoms

Call:

If call coverage is involved, the resident is responsible to find coverage. Call is never to be left uncovered. The resident may contact the faculty for assistance but is ultimately responsible for finding coverage.

ELECTIVE POLICY

Electives must be identified and the Elective Request form completed at least 90 days in advance of the start of the elective. The resident must prepare and present this form to their faculty advisor and the Program Director with the learning goals and objectives the resident desires. An appropriately credentialed attending/supervisor must be identified and agree to be responsible for supervision and evaluation of the resident. An evaluation by this supervisor will be required or no credit will be given.

If a resident has not identified an elective experience and completed the required paperwork at least 60 days in advance, he/she will be placed in the FMC and have additional call responsibilities assigned by the chief resident.

AWAY ELECTIVE POLICY

An away elective must have a request form completed, and the elective approved by the GMEC at least 90 days in advance of the elective. Away electives will be considered only if clear educational benefit can be obtained and that opportunity is not available within the region. Away electives are only available to second and third year residents and only with the approval of their faculty advisor and the Program Director. Away electives may only be one month in length and three months must exist between away electives. No more than 2 away rotations may be taken during the 36 months of residency.

The resident must prepare and present their faculty advisor and the Program Director with the learning goals and objectives the resident desires. Final approval is from the Program Director and the GMEC. Clear educational objectives must be outlined and written by the resident. An appropriately credentialed attending/supervisor must be identified and agree to be responsible for supervision and evaluation of the resident. An evaluation by this will be required or no credit will be given. The resident must identify a resident who will be available to provide patient care coverage in their absence. Residency funds are not available to reimburse any aspect of an away elective. If approved a leave request form must be completed. If a resident has not identified an elective experience and completed the required paperwork at least 90 days in advance, he/she will be placed on an assigned elective by residency staff and have additional call responsibilities assigned by the chief resident.

FORM A FACULTY and RESIDENT LEAVE REQUEST

Name: _____

Rotation Involved: _____

Reason for Leave: _____

☐ VACATION

☐ SICK

☐ CME: Specify

☐ ADMINISTRATIVE: Specify

☐ OTHER (please specify)

Dates of Absence: _____ thru _____

Date returning to work: _____ **Total days of leave** _____

Covering Physician: _____

Signature: _____ Date_____

APPROVALS

Covering Physician: _____ Date_____

Program Director: _____ Date_____

Residency Coordinator _____ Date _____

Patient Scheduling _____ Date _____

Chief Resident _____ Date _____

COMMENTS:

All requirements met, all schedules clear. Final approval: _____

Return a copy to the person requesting leave.

Form B **ELECTIVE REQUEST**

Community-based elective requests must be made 90 days prior to the start of the rotation.
Away electives must have 90 days advance notice and must be approved by the GME committee.

Electives may only be one month in rotation and three months must exist between away electives. Clear educational objectives must be outlined by the resident. An appropriately credentialed attending/supervisor must be identified and agree to be responsible for supervision and evaluation of the resident. Documentation will be required.

Resident Name: _____ Date of Request: _____

Proposed Elective: _____ Dates for Elective: _____

Location / Address:_____

_____

_____

Phone: _____

Attending(s) for Elective: _____
A CV of the attending with supporting appropriate credentials may be requested.

Please provide clear, specific educational goals and objectives for this rotation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Advisor approval: _____ Date: _____

Program Director approval: _____ Date: _____

FAMILY MEDICINE CONFERENCE SERIES ATTENDANCE

First year residents are expected to attend the conferences provided for each service and rotation. Conference attendance will be monitored. First year residents will also be required to attend Conferences at the GME education center each Wednesday from 12:00 to 5:00. Additionally Thursday Grand Rounds from 12:00-1:00 are also required.

Second and third year residents are required to attend the weekly Conference Series. Excused absences include scheduled leave time, illness, and inpatient care emergency/admission/delivery. Residents who are post call must not violate the duty hours policy and will be excused from conference.

As part of our professionalism competency, the following will apply for afternoon conferences:

1. Faculty conference facilitator will take attendance for each conference segment.

2. Attendance is mandatory at all sessions of the Wednesday Conference unless you are on service, caring for a patient, post call or on approved time away. Approved time away needs to have a request properly signed and on file. The 60 day rule will be waived for a "conference only" absence.

3. If you have an appointment scheduled during conference time, you will need to take ½ day vacation to miss <u>any</u> segment of the conference.

4. Being on time for conference is expected. If you are more than 10 minutes late for any conference session, you will be marked tardy on the attendance sheet. The first unexcused tardy event will result in a warning letter. The second unexcused tardy offense will result in Saturday School.

5. Appropriate travel time will be allowed to get to offsite teaching locations such as Sim lab, casting lab, etc.

Interns are also required to attend residency support meetings as arranged by the Behavioral Medicine faculty unless they are on leave or have a patient care emergency. These support meetings typically occur at the hospital.

RESIDENT SUPERVISION POLICY (See also GME Policy #9380-11)

As a resident it is expected that you will have increasing amounts of autonomy over your three years. However, as trainees, you need to have access to expert opinion when needed. There are four levels of supervision which can be employed.

Level 1. *Direct supervision* –supervising physician is physically present with the resident and patient.

Level 2a. *Indirect supervision with direct supervision immediately available – the supervising physician* ***is physically within the hospital*** or other site of patient care, and is immediately available to provide direct supervision.

Level 2b. *Indirect supervision with direct supervision available – the supervising physician is* ***not physically present within the hospital*** or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Level 3. *Oversight – The supervising physician is available to provide review of procedures/encounters* with feedback provided after care is delivered.

Supervising physicians may include faculty or senior residents who have been evaluated and deemed appropriate to supervise junior residents.

All R1 residents will have Level 1 supervision until they have been evaluated in the clinic and the hospital and deemed appropriate for Level 2a supervision. All R1s will have either Level 1 or Level 2a supervision during their R1 year.

All R2 and R3 residents will be provided the following levels of supervision:

During clinic experience there will be at least one physician faculty available on site per 4 residents to assist with assessment and treatment of patients seen in clinic. This supervising physician faculty member will provide Levels 1 and 2a in accordance to the precepting policy (listed below).

In the hospital setting, the supervising faculty physician will provide Level 1 supervision during morning rounds and Levels 2a and 2b supervision during the day and Level 2b at night. This attending physician will be available to come in for direct supervision of patient management or excessive patient load at any time. It is expected that the attending will come in to directly supervise patient care and assist with management any time a resident requests assistance, or if the attending feels that his/her presence is necessary for patient safety.

It is expected that second year residents will call the attending for all admissions/evaluations at time of admission. Third year residents may "batch" their phone calls about admissions if both the resident and attending concur that the resident has met this level of competence. It is

expected that all residents will notify the attending physician immediately for the following situations:

1. Admissions to the intensive care unit or intermediate unit
2. Pediatric admissions
3. Admissions of patients expected to die very soon, such as hospice or palliative care patients
4. Obstetric evaluations – both admissions and triage patients
5. ED evaluations where the patient will be discharged home
6. Immediate consultation with other specialists needed
7. Any time there is a question about patient management

In labor and delivery, an attending family physician will provide Level 2a supervision for actively laboring patients, and Level 1 supervision at delivery. Residents are expected to review all patients in triage with the attending physician prior to discharge.

Required Resident Supervision for "High Risk" Procedures in the Clinical Sites

1. Emergency Room:

Attending physicians or credentialed senior residents must directly supervise the critical portions of all invasive procedures.

2. All Medical ICU areas and Inpatient Medical areas:

Procedures: Arterial Catheter Insertion, Thoracentesis, Central Venous Catheter Placement, Lumbar Puncture and Paracentesis – All residents must be directly supervised by a credentialed senior resident or attending physician.

3. Newborn Nursery:

All procedures must be directly supervised by a credentialed senior resident attending physician

4. Labor and Delivery

Procedure: Vaginal Delivery, Vacuum Delivery, Forceps Delivery, Episiotomy, Repair of Lacerations, Manual Exploration of Uterus, D&C, D&E – all residents must be directly supervised by a credentialed senior resident or attending physician.

Procedure: Amniotomy, Placement of Internal Monitoring Devices – PGY 1 residents must be directly supervised by a credentialed senior resident or attending physician. PGY 2 and PGY 3 residents may perform these procedures with Level 2a supervision if credentialed.

Procedure – Limited Obstetrical Ultrasound – All residents must be directly supervised by a credentialed senior resident or attending physician.

FACULTY SUPERVISION

The Family Medicine attending physicians are directly responsible to the Program Director of the Gwinnett Medical Center Residency in Family Medicine Program. This program has direct oversight by the Department of GME by Dr. Mark Darrow, DIO/IEO. and all Family Medicine faculty attendings have hospital privileges as directed by Gwinnett Medical Center Medical Staff office. All Family Medicine attendings and faculty are board certified by the American Board of Family Medicine or American Board of Osteopathic Family Physicians.

PRECEPTING OF PATIENT CARE AND DOCUMENTATION POLICY

1. A faculty family physician will be present on site at all times that residents are seeing patients at to provide Levels 1 and 2a supervision.
2. All office visit notes completed by residents must be routed to the preceptor for review for Level 3 supervision. Feedback from the preceptor on these notes is an important part of both resident supervision and resident education.
3. All EKGs and NSTs must be precepted at the time they are read/interpreted.
4. All procedures must be precepted at the time they are performed. If the resident is credentialed for a procedure, he or she may perform the procedure with Level 2b supervision at the discretion of the preceptor. Residents should notify the preceptor anytime they intend to perform a procedure. All PGY-1 residents must have direct supervision for all procedures.
5. All PGY-1 residents will present all patients to the preceptor at the time of the patient's visit. During the first 6 months of training, the preceptor will directly supervise all of these patients and write an acceptable "SOAP" note. After 6 months of training, the preceptor will continue to provide direct supervision for all complicated or acutely ill patients, as well as those patients required to be seen by Medicare/Tricare. For other patients, the preceptor and resident may decide if the preceptor should see the patient. However, all patients still must be discussed with the preceptor and a precepting note completed by the preceptor at the time of their visit
6. After completing 12 months of training, and being promoted to the second year, residents may see patients without verbally precepting. Exceptions include;
    a. Medicare or Tricare patients, OB patients, patients requiring admission to the hospital or acute referral to another specialist. All of these patients must be discussed with the preceptor at the time of the patient's visit. For billing purposes, all Medicare or Tricare patients with the exception of CPT codes 99211-3 and 99201-3 must be directly supervised (seen in person) by the preceptor and an appropriate note must be placed in the EMR. These patient charts will be flagged. The office staff will stamp them as "precepting required"
7. Second and third year residents are learners, and the expectation is that they will continue to precept patients throughout their training for educational purposes, not just to meet billing requirements.

By law, attending physicians must review and evaluate the care of Medicare patients provided by residents at time of visit. Faculty will see all Medicare/Medicaid patients at time of the visit.

- Residents must bring Medicare patients to the preceptor's attention.
- All Medicare patients seen by a first year resident in the first six months of training must be seen by the precepting attending regardless of level of care.
- Precepting attendings must be present for the key portion of a Medicare/Tricare patients' examination with the exception of 99211-3 and 99201-3 for all levels of residents. For all levels of billing the precepting attending must document involvement in the history and physical, assessment, therapeutic plans and any other key components of care.
- Precepting attendings must be present for the key portion of any procedure performed on Medicare patients regardless of level of training of the resident.

Resident Supervision and Accountability Policy

9380-11

Original Date	Review Dates	Revision Dates
03/2013	03/2014; 03/2015; 03/2016	04/2017

POLICY

This policy outlines the mechanisms by which the resident is supervised by the medical staff of Gwinnett Medical Center (GMC) to ensure patient safety and quality patient care. While the attending physician is ultimately responsible for the care of patients, everyone, including physician learners are accountable for a structured chain of responsibility as it relates to the supervision of patient care and education. This policy sets forth the standard at Gwinnett Medical Center that residents are supervised at all times, and applies to all areas of the medical center where residents provide patient care. Monthly attending/resident schedules are also listed on the hospital intranet.

DEFINITIONS

Direct Supervision: The supervising physician is physically present with the resident and patient.

Indirect Supervision: There are two types of indirect supervision:

-Supervision is immediately available (within 30 minutes) as the supervising physician is physically within the hospital or other site of patient care.

-Supervision is available by means of telephonic and/electronic modalities (within 30 minutes). In this case the supervising physician is not physically present within the hospital or other site of patient care.

Oversight: The supervising physician is available to provide review of procedures and encounters with feedback provided after care is delivered (e.g., post-hoc review of resident delivered care with open dialogue regarding the appropriateness of that care).

General Responsibilities of a Resident:

- Must have a Georgia state training license.
- May issue prescriptions (including narcotics).
- May write orders within the scope of their professional activities within the Medical Center's educational programs.
- May do history and physicals (H&P's) to develop assessment and treatment plans.
- May assist in surgery.
- May assist in the Emergency Department with procedures as appropriate with training and as approved by the Program Director.
- May perform initial and ongoing assessment of patient's

medical, physical, and psychosocial status. May perform daily rounds, record progress notes, operative notes, and discharge summaries.

- Participate with and accept supervision on quality issues and feedback to assure the constant provision of safe and effective patient care.

- Must successfully pass Part Three of the United States Medical Licensing Examination (USMLE) and/or the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) prior to promotion to Post Graduate Year-3(PGY-3) and/or Office of Graduate Medical Education-Year 3 (OGME-3).

PROCEDURE/GUIDELINE

It is recognized that in an academic environment such as medical education, two competing forces must be recognized and accommodated: that the residents need supervision and their need for increased autonomy. To achieve this balance requires a great deal of effort. Residents are here for the primary purpose of receiving education and training in their respective specialties. It is the responsibility of staff physicians with appropriate clinical privileges involved in the residency training programs to ensure that:

A. The educational quality of these programs is maintained at a high level, and the patient care delivered by residents pursuant to their education and training is appropriate in content and of consistently high quality.

B. The supervision of the resident is the responsibility of the faculty members of the medical staff and of those staff physicians who hold part-time appointments, affiliations, or preceptorships with Gwinnett Medical Center's Office of Graduate Medical Education (GME).

C. Each of the residency programs has detailed guidelines for resident supervision and evaluation as the resident's progress through their educational training program. These guidelines are compiled in the specific departmental manuals as required by the respective Accreditation Council for Graduate Medical Education (ACGME). If any question arises regarding a resident's capabilities to provide patient care, the level of that care, or the ability to perform a specific procedure, information can be found on GMC's Intranet (www.gwinnettmedicalcenter.org). Additionally, the responsible teaching attending, the Program Director, the Program Coordinator, or the GME office can be contacted.

1. Residents are expected to interact with patients under the direction of admitting/attending physicians or residency program faculty who delegate to residents a defined portion of that medical care responsibility. Medical care begins with admission of the patient, continues through the daily progress of the

hospitalization, and concludes with discharge of that patient from the hospital with completion of the permanent medical record on that patient.

2. Specific resident capabilities are determined by and documented by the respective programs as recorded electronically on the hospital's clinical privilege page.
3. Levels of Supervision: To ensure oversight of resident supervision and graded authority and responsibility, the programs must use the classifications of supervision as outlined above in the "Definitions" section of this policy, i.e. Direct Supervision, and Indirect Supervision. PGY-1 residents should be supervised either directly or indirectly, with direct supervision immediately available.
4. Residents themselves may function as supervisors. ACGME guidelines require that the Program and Institution recognize and support as part of their training residents as teachers and supervisors. In most cases senior residents serve in a supervisory role of junior residents in recognition of the progress toward independence, based on the needs of each patient and the skills of each individual resident. This process may also refer to any level of resident interacting with Health Professional students of various specialties and level of training.
5. Supervision of residents extends to private attendings with clinical privileges in Gwinnett Medical Center. In these cases, the private attending will coordinate with the faculty physician in supervising the resident. However, those private attendings who do not want to participate in the teaching programs may have their patients admitted to their service without teaching responsibilities and without residents involved in their care. Patients may also request that residents not be involved in their care.
6. Every physician who provides or supervises the provision of services to a patient is responsible for the correct documentation of the services rendered. For claims submitted on behalf of teaching physicians, only services actually provided may be billed.
7. Supervision of residents will be documented in the medical record by teaching physicians. The attending departmental faculty member reviews the medical record and co-signs the face sheet, procedure notes, admitting history and physicals, and discharge summary.
8. Faculty supervision assignments must be of sufficient duration as to assure adequate assessment of resident knowledge, skill, and professionalism and to delegate to that resident the appropriate level of autonomy.

a. The program will set guidelines and rules outlining the circumstances in which a resident must communicate with the faculty member when delivering patient care
b. Each resident must know their scope of practice, the circumstances and situations they are permitted to act and treat.

i. PGY1 residents must be supervised directly or indirectly with supervision immediately available
ii. More senior residents, based on scope of practice, milestones and competency may have similar supervision and at times the indirect supervision may not need to be physically, immediately available.

Resident Clinical Experience and Education Policy

9380-09

Original Date	Review Dates	Revision Dates
02/2013	03/2014; 02/2016;02/2017	01/2015, 04/2017

POLICY:

To assure Institutional and Programmatic compliance with the Common Program requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME), the Graduate Medical Education Committee (GMEC) establishes this policy governing the educational and clinical opportunities at our institution. This includes the resident work/duty hours as well as assurance there are opportunities for rest and personal activities.

DEFINITIONS:

Clinical and Educational Work Hours: Refer to the maximum number of hours worked per week. Included in this definition are hours spent in patient care activities both in-patient and out-patient, on campus or off, or time in didactic sessions as required by the Program or Department and moonlighting activities of all types if applicable.

Reporting: Is the responsibility of the individual resident and the respective Department through use of electronic or manual data entry as available and per GMEC and Human Resources requirements. Reporting shall take place every day.

Oversight: The responsibility of the individual academic department, the Graduate Medical Education office, its officers and staff, as well as the Graduate Medical Education Committee.

At-Home Call: Pager call may not be scheduled on a resident's day off and is to be counted as part of the 80 hour work week.

Exceptions: This term refers to limited situations where the maximum may be extended up to 10% or 88 hours per week based on sound educational rationale and justification.

Mandatory Time off: Refers to a scheduled minimum of at least one day free of duty every week.

Maximum Duty Period Length: Length of time a given resident is allowed to continuously work.

PROCEDURE/GUIDELINE:

A. Clinical and educational work hours for all residents must be limited to no more than 80 hours per week averaged over a 4 week time period.

B. Mandatory Free time from clinical and educational work hours: The Program rotational schedules will be designed with a reasonable amount of rest and personal well-being time away from work.

C. Minimum Time off between clinical/educational hours
    1. Residents must have at least 8 hours off between duty periods
    2. Residents must have one-day-in-seven off between duty periods
    3. In a circumstance where a resident chooses to stay longer for patient care or returns to the hospital with less than eight hours of free time, it still must occur within the 80 hours work week guideline and comply with the one-day-in-seven requirement. These occurrences will be approved by the Program Director and must be reported to GMEC as they occur.
    4. Residents will have at least 14 hours of free time after 24 hours of in-house call duty.
    5. Residents must receive a minimum of one-day-in-seven free from clinical and educational work when averaged over four weeks. At home call CANNOT be assigned on these days.

D. Maximum Clinical and Educational Period Length:
    1. Clinical and educational work periods must be less than 24 hours continuous for all residents.
    2. No resident is to be assigned additional clinical duties after 24 straight hours of continuous duty.
    3. Up to 4 hours of additional time for activities related to patient safety, the provision of transitions of care and /or resident education are allowable.

E. Clinical and Educational Work Hour Exceptions: In the rare situation when, after handing off all patient care and work responsibilities a resident decides, on their own, they may return to the clinical site for the following:
    1. Provide are for a very ill patient
    2. For the attention or emotional needs of a family member or the patient.
    3. Attend unique educational events.
    4. These additional exceptions are to be reported to the GMEC at its next meeting, along with the reason and are counted as part of the residents eighty hour work week.
    5. A given Program's Educational Review Committee (PEC) may grant rotation specific exceptions for up to 88 clinical and educational work hours based on educational rationale.
        a. The request must be prepared by the Program Director (PD) who is to assure that it follows the work hour and work hour exception policy rules
        b. The PD must then submit it to the GMEC and DIO and obtain their approval prior to submitting it to the specific PEC for final approval.

F. **Night Float:** Residents performing the In-House duties of Night Float must occur within the 80 hour work week and one-day-in-seven off context.

G. **At Home Call:** At home call shall not be subject to every third night limitation but must comply with the 80 hour work week, and the one in seven duty free day requirement. It must not be so frequent or rigorous to preclude rest time and reasonable personal time for the resident. Should the resident have to return to the hospital while on At Home Call to provide direct patient care, the hours rendered must be included in the 80 hour maximum weekly limit.

H. Monitoring of duty hours
    1. All residents will be required to take an active role in monitoring and recoding their work hours on a daily basis. Use of available resources for such duty logs shall be part of the education and orientation of residents to a program and methods for the entry of this information will be made readily available in the forms that are easy to access as available in the institution.
    2. Programs will be responsible for the monitoring and oversight of duty hours and be able to respond as soon as possible to any lapses in reporting or breaches in the duty hour requirements. The Program Coordinator and Director will work to remedy any individual or programmatic issues that may cause a breach in this policy.
    3. GMEC and the Graduate Medical Education office will also monitor duty hour compliance and require reporting of any policy breaches during every committee meeting.
    4. Exceptions that occur are to be approved, recorded as to reason by the respective department, and are to be reported as a duty hour exception at the next GMEC meeting.

Resident Physician Fatigue Mitigation and Well-Being Policy

9380-08

Original Date	Review Dates	Revision Dates
02/2013	03/2014; 03/2015; 02/2016;02/2017	04/2017

POLICY:

This policy outlines the processes in place that the Department of Graduate Medical Education (DGME) and its Programs will employ to protect residents from the effects of sleep deprivation, fatigue, burnout, or depression. Duty hours will be restricted as outlined by the Duty Hours Policy. Further, this policy acknowledges that self -care is also an important part of training and professionalism. The over sight of resident well-being is the responsibility of the institution, the supervising educators, and the resident physicians. This policy seeks to outline that process and the definitions as set forth by the Accreditation Council for Graduate Medical Education's (ACGME's) Common Program Requirements.

DEFINITIONS:

Fatigue: is to be defined as a condition where an individual is deemed potentially mentally or physically unable to perform safely, patient care duties. Signs may include but are not limited to; falling asleep in a patient care area in the hospital, unusual orders, unanswered calls, or denials by residents of verbal orders, late arrival, habitual sleepiness, or need for naps during duty hours.

Well-Being: The psychological, emotional, and physical state of an individual that are critical to the development of a competent and caring physician that works to eliminate or greatly minimize the occurrence of burnout and/or depression

Strategic Napping: is a technique to assist in maintaining alertness. It usually is defined as a brief nap or rest period when possible to help an individual stay rested while on duty.

Mandatory Napping: Defines a situation where an individual who has shown signs of sleep deprivation and fatigue is dismissed from patient care duties at the first appropriate opportunity and instructed to take a nap in the hospital on-call room without his or her beeper. This may occur while on duty or at the end of a duty period before the individual is allowed to leave the hospital and return home.

PROCEDURE/GUIDELINES:

FATIGUE:

A. Education sessions will be provided at orientation of every resident and new faculty members to recognize fatigue and signs of sleep deprivation in themselves and their colleagues. Each individual will also be made familiar with Departmental and programmatic resources and procedures when fatigue is identified.

B. When feasible and possible all residents and faculty are encouraged to consider strategic napping to stay refreshed and avoid excessive fatigue. Discretion is to be used as to location and timing of this rest period.

C. A resident found to be asleep in any patient care area of the hospital besides the on-call room will be evaluated for sleep-deprivation and excessive fatigue.
D. Residents writing or giving unusual orders, or having a significant number of unanswered calls, will be evaluated for possible sleep deprivation and excessive fatigue.
E. Residents who arrive late for their shift because of waking up late will be observed closely that shift for other signs of sleep deprivation and fatigue.
F. Residents who suffer repeated episodes of sleep deprivation, demonstrate consistent signs of fatigue, and require repeated need for naps during duty hours will be subject the procedures below.
G. Residents who report falling asleep while driving or who fall asleep in the emergency room or the operating room will be suspected of needing fatigue management intervention.
H. **Assessment:** In general, every member of the patient care team is ultimately responsible to assess and report observed signs of fatigue and sleep deprivation in ANY member of the team. While the patient care team is typically comprised of junior and senior level residents, an attending or supervising physician, nursing personnel, and any other individuals who may be in a position to have observed issues of alertness or fatigue are encouraged to report their suspicions to a supervisor. The Department of Graduate Medical Education understands in addition that each of these members may have different levels of tolerance and perspectives of this concept but encourages reporting in any suspected condition as patient safety is first and foremost concern in this setting.
    1. Nursing staff who observe signs of sleep deprivation and fatigue in a resident will inform supervisors, resident and attending staff of this observation.
    2. Residents arriving to assume care in the morning or on weekends will specifically note whether the resident completing a night shift or weekend shift appears to have sleep deprivation or fatigue. Likewise, members of the outgoing team have the responsibility to assess the alertness levels of the individuals assuming care to assure they had the opportunity to sleep in the time period before sign in.
    3. The supervising attending physician will ultimately be responsible for monitoring any mandatory napping that is assigned and assuring that patient care continues uninterrupted by activating the appropriate back up system or protocol.

I. **Mandatory napping:** Residents who show signs of sleep deprivation and fatigue while at work will be dismissed from patient care duties at the first appropriate opportunity and instructed to take a mandatory nap in the hospital on-call room without his or her beeper. The resident will be allowed to complete his or her shift if he or she awakens before the completion of that shift. If the resident continues to sleep past the end of the shift, he or she will be allowed to complete the nap and drive home after a period to allow sleep inertia to pass (up to 20 minutes). The Department and Programs will have coverage protocols in place either by providing

additional personnel or shifting patient care duties of the resident in question to another provider so that patient care will be maintained.

J. Further assessments: Residents who suffer repeated episodes of sleep deprivation, demonstrate consistent signs of fatigue, and require repeated naps during duty hours will be referred to the Program Director. Interventions may include the following: a review of reported duty hours by the resident; an assessment by the Residency Coordinator to assure that self-reporting of duty hours are accurate. If the Program Director determines that there may be a chronic alertness condition, the resident will be referred to Occupational Health for an assessment.

K. **Reporting:** In general the issue of fatigue mitigation is to be considered a Program responsibility however in the situation where a given rotation appears to be producing excessive fatigue or the Program identifies a systems process or issue that appears to be consistently creating alertness issues then the Program Director, Program Coordinator, or the resident member of the Graduate Medical Education Committee will be asked to produce a summary report for committee discussion, inquiry, and or action.

WELL-BEING:

A. Education sessions will be provided at orientation for every resident and new faculty members to acknowledge the importance of this concept and teaching awareness of the importance of protected time, the provision of administrative support and the promotion of flexibility and professionalism as it extends to minimizing burnout and depression.

B. Program Coordinators, Program Directors and resident physicians alike will be made aware of how schedules, work load and intensity impact well-being.

C. The GMEC on a monthly basis will, as part of its permeant standing agenda poll resident and faculty members of the committee for signs of fatigue and issues of well-being to assure they have been or continue to be addressed as they occur.

D. During orientation and at the beginning of every year the availability through Human Resources of mental health, medical health and dental health as well as stress relief is reviewed. These appointments can occur during regular work hours and are counted as such. A psychologist is available at no charge should these services be needed.

E. Residents and faculty are taught the self-screening tools and warning signs of burnout, depression or substance abuse and how to anonymously report them to either Human Resources or the Program Director depending on the situation and concern.

L. **Assessment:** In general, every member of the patient care team is ultimately responsible to assess and report observed signs of burnout in ANY member of the team. While the patient care team is typically comprised of junior and senior level residents, an attending or supervising physician, nursing personnel, and any other individuals who may be in a position to have observed issues of alertness or fatigue are encouraged to report their suspicions to a supervisor. It is understood that each of these team members may have different levels of tolerance and perspectives of this concept but encourages reporting in any suspected condition as patient safety is first and foremost concern in this setting.

1. Nursing staff who observe signs of burnout, indifference, or depression in a resident will inform supervisors, resident and attending staff of this observation.
2. Likewise, members of the patient care team have the responsibility to assess the well-being of all individuals providing patient care to assure they had the opportunity to sleep in the time period before sign in.
3. The supervising attending physician will ultimately be responsible for assuring that any and all of these concerns and observations get followed up and that the appropriate notification of the program and action plans are initiated

Assurance of coverage: In the event that a resident physician is unable to fulfill their work or rotational duties due to fatigue, illness or family issues, the respective Program Director is responsible for assuring that patient care duties are covered and that there is no fear of negative consequences for the resident in need.

KEYWORDS
Sleeplessness
Insomnia

Resident Work Environment Policy

9380-10

Original Date	Review Dates	Revision Dates
03/2013	03/2014; 03/2015; 02/2016; 4/2017	

POLICY:

This policy sets forth definitions, protocols and guidelines that affirm Gwinnett Medical Center's (GMC) commitment to a nurturing educational and work environment free of fear of intimidation or invalidation in which residents are supported with adequate infrastructure, and are able to raise concerns in a constructive and effective manner. GMC and its affiliates understand that a resident physician's work environment is a unique setting in which education is coupled with patient care and both are an essential part of physician training. Issues of communication between resident physicians and Graduate Medical Education (GME) administration and hospital administration, service obligations, lifestyle issues, and the function of ancillary support services in the hospital and community are very important.

DEFINITIONS:

Resident forums: Meetings supported by the GME office in which residents are able to meet and discuss relevant programmatic issues of all types without fear of intimidation and in an anonymous way.

Patient Support Services: Services that include IV placement, phlebotomy, and transporter services.

Laboratory/Pathology/Radiology Services: Define the listed services available at the institution to support in a timely manner quality patient care.

Medical Records Services: A system that documents and records a patient's illnesses and care. One that is able to support that quality care, a resident's education, quality assurance activities, and provide a potential resource of data for scholarly activity.

PROCEDURE/GUIDELINE:

A. Resident Forums:

1. Will occur no less frequently than quarterly and will include all residents.
2. The meetings will have an agenda constructed completely by the resident staff.
3. The residents will determine the Leadership structure for the scheduling and conduction of the meetings.
4. A GME liaison will attend each meeting as a resource only and will also serve to record minutes and as a conduit of information and requests from the group,

when needed, to GME and Academic Program administration. Program Directors, Program Coordinators, the Director of GME, faculty and or members of GMC's administration may only attend if requested by the residents by simple majority or consensus.

5. Anonymity of the group, individuals and opinions expressed will be maintained at all times by attendees of the meetings. NO efforts are to be made to single out individuals or differences of opinion by attendees or those in the GME office, programs, faculty or administration.
6. Requests, issues, ideas, and proposals will be brought to the attention of the Director of GME by the GME liaison only for further decision and or action.

B. Hospital Support Services:

1. GMC will strive to provide the following services on its clinical campuses to minimize resident physician work that may be considered extraneous to their educational goals and objectives.
2. Hospital Support services include: Patient Support Services, Laboratory/Pathology/Radiology Services, and Medical Records Services.
3. There will be active surveillance by the GME office and the medical staff to ensure that the learning experience for the resident physicians is not compromised by excessive reliance of residents to fulfill medical staff and non-physician service needs and obligations of the institution.

Moonlighting Policy
9380-07

Original Date	Review Dates	Revision Dates
01/2013	03/2014, 03/2015, 02/2016; 02/2017;	04/2017

POLICY

This policy outlines the institutional rules, processes and procedures governing voluntary medically-related work performed by a resident in training outside of the requirements of his/her training programs. It includes work performed both internally and externally relative to the institution.

DEFINITIONS
External Moonlighting: Voluntary, compensated, medically-related work performed outside of Gwinnett Medical Center (GMC) or any of its related participating sites.

Internal Moonlighting: Voluntary, compensated, medically-related work (not related to training requirements) performed inside of GMC or any of its related participating sites.

PROCEDURE/GUIDELINE

D. Restrictions:

9. Moonlighting must not interfere with achievement of goals and objectives as require by the resident's training program. It must not interfere with resident fitness and well-being or compromise patient safety or quality of care.
10. All time spent moonlighting by the resident both internally and externally MUST be counted towards the 80 hour maximum weekly hour work limit. Any department granting permission to a resident for moonlighting is responsible for tracking and recording hours worked.
11. Post Graduate Year-1 (PGY-1) Residents are not permitted to moonlight.
12. Malpractice insurance coverage provided during training will NOT be provided to a resident undertaking external moonlighting activities and the resident is responsible for securing such coverage with the entity to which he or she is providing such service.

E. Procedure:

1. A resident MUST seek and receive written permission from the Program Director (PD) before securing a moonlighting position of any type.
2. The Program Director reserves the right to approve or deny such activity based on departmental coverage needs, the nature and activity of the actual moonlighting opportunity, and the resident's performance and evaluations to date. The Program Director may choose to bring an individual situation to the Graduate Medical Education Committee (GMEC) for approval and/or further discussion.

A copy of this written permission will be submitted to the Director of Graduate Medical Education (DGME).

FORM C **MOONLIGHTING REQUEST FORM**

Resident Name: _____

Level: PGY1 PGY2 PGY3

I am in good standing in all aspects of the training program:		Yes	No	
I have an unrestricted Georgia medical license:	Yes	No	N/A	
Malpractice coverage been obtained for this activity:		Yes	No	N/A
Evidence of permanent license and malpractice coverage is included:		Yes	No	N/A

Location of Moonlighting Activity:

Address: _____

_____

Phone: _____

Contact Person: _____

Proposed date(s) of Moonlighting: _____

Duration of Moonlighting Activity: _____

Estimated number of hours per month:_____

Type of Moonlighting Activity (please briefly describe responsibilities, e.g. ER, outpatient care, etc)

I understand that moonlighting is in addition to the regular duties of my residency. I believe that this moonlighting activity will not interfere with my ongoing patient care and educational responsibilities. I attest that I have met all of the requirements outlined in the Family Medicine policy on moonlighting.

Resident Signature: _____ Date: _____

Approved/Not Approved _____ Date: _____

Program Director

The original is to be kept in the Resident file and a copy returned to the resident.

MEDICAL RECORDS POLICY

It is expected that all residents will keep their medical records up to date. This includes their ambulatory EMR, hospital records, as well as any paperwork that needs to be completed for patient care.

The standard of care for Family Medicine Center for medical records is as follows:

* Office visits must be completed within 24 hours of patient being seen. This includes notes completed and superbills turned in to the coder within this time frame.
* Phone notes and prescription refills must be addressed within 48 hours
* Paperwork should be addressed within 3 business days of arrival in box

Policy Violations:

1. The assigned coder will monitor outstanding charts bi-weekly and will notify all providers of incomplete charts. The providers with incomplete notes more than 24 hours old will have 24 hours after this email is sent to complete all outstanding charts. After those 24 hours, any outstanding charts will be forwarded to the program director and program administrator
2. The program administrator will then give the resident a written warning that details when the outstanding documents need to be completed. This time frame is typically 2 days, unless there are extenuating circumstances in which case the Advisor and/or program director will use his or her judgment to define an appropriate time period.
3. Failure to complete the records within the specified time will result in additional warnings until they are completed. 2 or more warnings in 1 quarter will result in the resident participating in the Good Citizenship Curriculum (described later) and being placed on observation per the due process policy.
4. All residents must completely clear their EMR desktop of all outstanding documents before leaving for vacation, CME, or professional leave of 5 days or longer. Failure to clear EMR documents prior to vacation or professional leave will result in a warning.
5. Residents who receive 3 or more warnings in an academic year will be placed on probation and be placed on leave immediately until the documents in question are complete. This leave may come from personal leave or vacation. 3 or more warnings within the same academic year will result in continued probation or suspension which could include unpaid leave, an extension of residency or termination of employment at the program director's discretion. Residents with 3 or more medical records warnings in an academic year will have "difficulty with timely medical record completion" placed in their end of residency letter.
6. As part of any observation or remediation plan, the residency program will assist the resident in investigating the challenges associated with completing records in a timely manner (e.g. typing skills, computer literacy, etc.) and provide assistance in improving those skills

CONTINUITY CLINIC NUMBERS POLICY

Residents are required by the Residency Review Committee for Family Medicine to see a minimum number of their own continuity patients per year. These numbers are as follows:

1. R1s – 180 visits
2. R2 and R3 – 1800 visits over the course of the 2 years
3.

To ensure that the appropriate numbers are met the following benchmarks must be kept as goals;

1. R1s must see a minimum of 40 patients per quarter in the first half of the year and 50 patients per quarter in the second half of the year.
2. R2s must see a minimum of 110 patients per quarter with 250 being seen by the middle of their R2 year.
3. R3s must see a minimum of 225 patients per quarter with 500 being seen by the middle of their R3 year.
4. All residents must complete a minimum of 3 home visits on continuity patients during the course of their residency training.
5. All residents must see a minimum of 2 assigned Long Term Care Facility residents on at least a bi-monthly frequency the last 2 years of the program.

These numbers will be evaluated on a quarterly basis and by the Clinical Competency Committee (CCC) Failure to make the mid-year mark may result in the resident being placed on observation with additional clinic sessions added to meet the desired goal. The residency will work with residents having difficulty with efficient patient care to investigate and remedy the issues involved in inefficiency. Failure to meet the appropriate year end goals may result in delay of promotion or graduation at the discretion of the program director.

OTHER RESIDENT ADMINISTRATIVE DUTIES

There are other administrative duties that residents may be asked to perform. This includes resident representation on all hospital committees, recruitment fairs for the residency and representation at state and national meetings. In most cases residents will be offered a choice for participating and schedule accommodations made.

APPROPRIATE USE OF THE INTERNET AND SOCIAL NETWORKING SITES

Consult the Resident Physician Manual and related GMC institutional and Medical Staff policies on the subject.

RESIDENT IMPAIRMENT PREVENTION POLICY

Because residency represents a time of intense learning and intellectual demands, residents also may experience stress and impairment in their cognitive functioning. The responsibility of the residency is to promote adaptive coping through integrated preventive measures, as well as to identify a structured mechanism for remediation and intervention for cognitive, structural, affective and interpersonal difficulties.

The Family Medicine Guidelines for Prevention of Impaired Residents includes

1. Selection/early identification
2. Remediation
3. Evaluation.

Each section addresses cognitive, structural, affective and interpersonal concerns.

SELECTION/EARLY IDENTIFICATION

Cognitive

1. Meeting with faculty member for initial interview to review individual learning history
2. Identification of incoming residents with past history of academic difficulty
    - ranking in lower third of class
    - ranking in lower third of national exams or failure of national exams
    - failure of one rotation in clinical sciences
    - failure of two or more rotations in basic sciences
3. Low scores on monthly rotation evaluations
4. Identification of specific content deficits on rotation evaluations
5. Scores in lower third on training exams
6. Deficits identified on standardized evaluation during orientation period

Structural

1. Recognition of time management difficulties
2. Awareness of organizational difficulties
3. Difficulties in problem solving

Affective

1. History of emotional adjustment problems before or during medical school
2. History of psychiatric illnesses including depression, anxiety, OCD and bipolar disorder
3. History of substance abuse/dependency
4. Concerns identified on standardized personality evaluations conducted during internship training

Interpersonal

1. "At risk" factors entering internship: Long distance from home, recent marital-family changes, cultural differences, low rank or outside-match individuals
2. Early preceptor evaluations, advisor meetings, support groups currently in operation to assess coping skills.
3. Faculty, clinical nurse and clinical pharmacy staff evaluations of interpersonal skills and doctor-patient encounters

4. Use of rotation evaluations for feedback regarding residents' interpersonal skills
5. Concerns identified on standardized personality evaluations conducted during orientation or during internship training

REMEDIATION

For cognitive, structural, affective and interpersonal concerns, the resident, advisor and residency Program Director serve as the cornerstones of any effective remediation. Other resources may include behavioral faculty, other faculty, and extra-department faculty. Once a concern has been identified, residents may be placed on observation, remediation, or probation as determined by residency Program Director and advisor. (See Due Process). The advisor will review and report the resident's progress on a regular basis until the goals of remediation have been met. With psychological problems, all attempts at confidentiality will be pursued, including provide outside resources, if appropriate. The resident is responsible to take the corrective action while the program is responsible to help identify resources and offer suggestions.

EVALUATION

The contract initiated by the resident Residency Program Director and advisor should serve as the basis of evaluation. All attempts should be made to have the goals of remediation measurable, observable, or assessed by reliable and valid measures. They will be performance based. Formal tests, oral exams, serial patient encounters, or standardized patients may be used to evaluate the intervention program.

OTHER DEPARTMENTAL RESPONSIBILITIES

1. Faculty will meet before the beginning of internship to review all resident files. Specific "at risk" persons may be identified.
2. Faculty meetings will be used for more frequent review of cognitive and psychological progress in training.
3. A specific procedure/method for reviewing resident files is used at all Resident Evaluation meetings to ensure thorough review of progress. This includes rotation and departmental information.
4. As needed, a broader base of resident evaluations will be utilized by having formal assessment completed by nursing, behavioral medicine and pharmacy staff and other hospital personnel as deemed appropriate.

CONTINUITY OF PATIENT CARE POLICY

One of the cornerstones of Family Medicine is continuity of patient care. Much of residency education comes from following a patient through health and disease and understanding how that patient navigates through our health care system. It is expected during residency training that each resident will have multiple opportunities to follow their patients in different areas.

Obstetrical patients are a unique opportunity to follow a patient closely during a very exciting time in her life. To maximize the learning potential with maternity care, residents are expected to follow their maternity patients from prenatal care through delivery. In hospital post-delivery care and outpatient postpartum follow up is also expected. In the event that a resident is going to be gone, he/she is expected to sign out their maternity patients that are due in the near future to the on call physician.

Residents will follow their own continuity patients at the Strickland Family Medicine Center. This includes preventative and chronic disease care as well as acute care as much as possible. This includes actual visits as well as paperwork, forms, prescription refills, and referrals requested by their continuity patients. Even when on other rotations residents are expected to check their mailboxes and NextGen message list at least twice a week. When a resident provides acute care to the patient of another physician, it is expected that he/she will send an "FYI" to the primary physician.

Residents are expected to follow patients in continuity in as many settings as possible. This includes procedures if preformed on hospitalized patients, patients transferred to skilled nursing at GECC, in the ED or hospital if admitted from the clinic. Following patients through hospitalization provides important education on the course of illness and follow up. It is expected that when a patient is admitted to the hospital, the admitting resident will notify the primary physician of admission. Once the primary physician receives the message, he/she will call the inpatient service resident for information. The primary physician is expected to see the patient in house or speak to them or family members via telephone within 24 hours of notification of admission. During the patient's hospital stay, the primary resident is expected to have, at minimum, daily phone contact with the inpatient service resident, with periodic visits planned if patient's status worsens or other personal contact is deemed necessary, such as family conferences. On day of discharge it is expected that the primary resident will assist with coordination of discharge and will facilitate hospital follow within his/her schedule.

Resident Physician Scope of Practice

Policy 9380-21

Original Date	Review Dates	Revision Dates
10/15/2017	12/19/2017	

POLICY

It is the policy of the Gwinnett Hospital System Graduate Medical Education to establish guidelines and policies that supplement the delineation of privileges regarding the clinical practice of resident physicians. Unless otherwise limited by GMC GME policies and procedures, residents will comply with all current hosotial and medical staff policies applicatble to physician practice.

DEFINITIONS

Direct Supervision: The attending physician is physically present with the resident and patient.

Indirect Supervision: There are two types of indirect supervision:

-Supervision is immediately available (within 30 minutes) as the attending physician is physically within the hospital or other site of patient care.

-Supervision is available by means of telephonic and/electronic modalities (within 30 minutes). In this case the attending physician is not physically present within the hospital or other site of patient care.

Oversight: The attending physician is available to provide review of procedures and encounters with feedback provided after care is delivered (e.g., post-hoc review of resident delivered care with open dialogue regarding the appropriateness of that care).

Post Graduate Year (PGY)-1,2,3: Refers to the year of training of a given resident physician irrespective of the particular program or specialty they are in training for.

PROCEDURE/GUIDELINE

F. The supervision of the resident is the responsibility of the faculty members of the medical staff and of those staff physicians who hold part-time appointments, affiliations, or preceptorships with Gwinnett Medical Center's Office of Graduate Medical Education (GME).

G. GHS staff have the right to discuss any order with the attending physician, prior to implementing the order, and the resident physician shall facilitate the necessary contact with the physician as described in Paragraph F.3 of this policy.

H. All resident physicians must be under the direction of a supervising attending physician pursuant to their delineation of privileges, as determined by the resident physician's individual residency program. Any questions regarding delineation of privileges should be directed to the attending physician and/or director of the residency program.

I. For information on the privileges for resident physicians, reference the Gwinenttwork website, Clinical Resources, Medical Staff Information, Privileges and search by specialty (Directory of Physicians) or contact the Medical Staff Office.

J. Admission histories and physicals and daily progress notes recorded by resident physicians will be countersigned with a supervisory attestation by the attending physician prior to discharge. Discharge summaries recorded by resident physicians will be authenticated by the physician within 30 days of patient discharge.

K. Orders

L. Resident physicians may write orders pursuant to their delineation of physician privileges in their specialty and this policy.

2. Resident physican orders do not require authentication or countersignature by the attending physician in the inpatient or outpatient setting

a. Exception:

1) All orders to ADMIT TO INPATIENT OR OBSERVATION status (i.e. the order to admit as an inpatient or observation in the inpatient setting) that are written by resident physicians MUST be countersigned by the attending physician prior to discharge.

2) Home health orders and orders for durable medical equipment must be signed or countersigned by the attending physician

3) Any associate of the hospital who is qualified and allowed to accept orders from physicians credentialed by the medical staff office may also accept orders from resident physicians.

3. The associate may request to escalate up the chain of command to speak directly to the attending physician prior to accepting an order from a resident physician if there is a concern about the appropriateness of the order or the status of the patient. The resident physician in such cases will contact the attending physician and the attending physician shall respond in a timely manner consistent with the clinical situation.

M. Scope of Practice PGY-1 on inpatient services

N. Provides direct care to patients to whom they are assigned

O. Does the day to day management (examining patients, ordering labs and tests, communicating to families and consulting physicians)

P. First physician of contact for all issues regarding direct patient care

Q. Performs initial evaluation of all patients admitted to their attending physician of record

R. Is directly supervised by a senior level resident (PGY 2 or higher)

S. Scope of Practice PGY-2 and above on inpatient services

T. Provides direct supervision to PGY 1 residents providing care to patients
U. Creates initial care plans for patients with PGY 1 resident
V. Reviews all care plans, orders
W. Directly supervises medical students participating in care of patients to whom they are assigned
X. Manages admissions to the team
Y. First contact to whom questions or concerns about PGY 1 are escalated or if unable to reach PGY 1
Z. Is indirectly supervised by the attending physician

PGY-1 (intern)

- The Intern will be responsible for all daily care of the patient.
- She/He will see all patients within a timely manner and will write comprehensive histories and physical exams on each admitted patient.
- The Intern **will write all orders** and will follow-up on all patient studies and consults. Interns will review all laboratory results and medication regimens daily, making necessary adjustments.
- The Intern will discuss all admissions with the PGY 2 or above ("resident")
- Interns will present their patients to the Attending Physician and will assist students in preparing presentations.
- Interns will make lists of all patients under their care each night to checkout to colleagues in I-PASS format. The on-call Interns will write notes on all patients seen on cross-cover and will expect the same from colleagues.
- Interns will write daily progress notes and discharge notes.
- Interns are expected to attend all Grand Rounds, Patient Safety Conferences and Intern Morning Reports.
- Interns will perform all procedures on the wards and Residents are expected to assist and supervise as needed. All procedures are to be documented in the patient's chart. Informed Consent must be obtained prior to all non-emergent procedures.
- Interns will report all problems directly to the Resident.
- Interns are responsible for appropriate off service notes on all their patients prior to switching services.

- Interns should only accept patients when contacted by the Resident for that service. The Resident should be notified of all ICU transfers.

- Check out time is 6 PM. The primary house staff team is responsible until 6 PM.

- On ambulatory rotations and in continuity clinic, interns present all patients directly to the attending physician. The intern is expected to begin developing the care plan. The attending physician will directly see all patients until determined that the intern may proceed to indirect supervision, but no sooner than after 6 months of internship.

PGY-2 & PGY-3 (resident)

- Initial care plans for all patients admitted to the teaching services will be made by the Resident and Intern.

- Patients admitted to the team will be seen and examined by the Resident, and a Resident Admit Note (RAN) will be completed for each patient.

- The Resident will review daily care plans for the patients with the Intern and will lead daily work rounds with the Interns and students.

    - The Resident will assign patients to students and Interns on admission days.

- The Resident will directly supervise the work of interns and students including all procedures.

- The Resident will discuss all patient care plans with the Attending Physician on a daily basis during rounds.

- The Resident will identify any educational needs of the team and convey these to the Attending Physician.

- The Resident will immediately notify the Attending Physician of all problems, need for invasive procedures, questions on patient care, change in the level of patient care (i.e. transfer to the ICU), deaths, and risk-management issues. The Resident will make certain that the Attending Physician or another approved supervisor is present for any procedures for which the Resident has not been deemed competent to perform without direct supervision. All procedures should be recorded in the New Innovations system.

- Residents are expected to provide 1-2 teaching sessions with the students and interns each week and should pull pertinent articles for the team.

- The resident will attend all Grand Rounds, Senior Morning Report, Patient Safety Conferences and Academic Half Days. If there is a patient care issue on the floor, residents

are expected to provide support to the intern in order to have the intern return to conference as quickly as possible.

- Residents should assist Interns to allow rapid completion of discharge dictations (write progress notes, orders, call consults, etc.).

- On ambulatory rotations and in continuity clinic, PGY 2 and 3 residents present all patients directly to the attending physician. The resident is expected to develop the care plan. The attending physician will directly see patients as needed.

Transitions in Care

9380-12

Original Date	Review Dates	Revision Dates
3/2013	03/2014, 04/2015; 03/2016	04/2017

POLICY

The Department of Graduate Medical Education (GME) and its programs have established these guidelines to ensure that effective, structured hand-off processes are in place to maintain continuity of care and safety as a patient transfers between different locations, or different levels of care within the same location. In addition, these safety guidelines will assure the safe transition of physician providers from shift-to-shift and service-to-service.

DEFINITIONS

Transitions in Care: Transitions in care are structured after a comprehensive plan based on the presence of health care practitioners who are well-trained in continued care and have current information about the patient's goals, preferences, and clinical status. This includes knowledge of logistical arrangements, and scheduling and coordination among the health professionals involved in the transition.

Hand-off. A hand-off is the transfer of information, along with authority and responsibility, during transitions in care across the continuum for the purpose of ensuring the continuity and safety of the patient's care.

Continuity of Care: This implies that prior health information is utilized and an ongoing professional relationship exists between patients and providers in order to avoid medical errors and transfer vital information from person-to-person as needed when care is transferred or transitioned.

PROCEDURE/GUIDELINE

AA. Resident physicians receive training to promote communication and collaboration in patient care during hand-offs and transitions in care. Residents are provided with satisfactory data in order to perform continued care duties. A quality improvement plan is developed and defined for use by the resident in patient care. The GMC Director of Coordinated Care and staff will contribute to the resident education process. Such educational opportunities may include:

1. Formal didactics through core curriculum lectures and Grand Rounds;
2. Group or one-on-one interactions specific to a patient or the resident physician's needs.

BB. Types of transitions in care that will be included in the education and evaluation of the resident physician include the following:

1. Transitions in care for the patient:
    a. Transfer from unit to unit, floor to floor;
    b. Change in level of care;
    c. Transfer to a different health care facility or agency;

d. Discharge to home.
2. Transitions in care from provider to provider:
   a. Shift change;
   b. Patient transfers to another provider;
   c. Rotations “off-service”.

CC. Programs will design clinical assignments to optimize transitions of care to include:
1. Safe, frequent and structured transitions
2. Monitor and facilitate the process assuring both continuity of care and patient safety
3. Residents will be trained and evaluated for their competence and effectiveness in the hand off process.
4. The institution and the Program will maintain clinical schedules at all rotational sites to assure adequate patient coverage by both residents and attending physicians.
5. In the event a resident is unable to perform clinical duties and deliver patient care the program must have in place a backup system to assure quality patient care continues.

DD. Methods of communication of transitional information are:
1. To include formal written, verbal, and/or electronic (I-Pass) modalities as available and appropriate.
2. To be timely and in sufficient detail to ensure continued safe and effective patient care regardless of the situation or circumstances.

D. Where appropriate, hand-off communication will address:
1. The patients who are covered and their location (for “off-service” or shift rotations).
2. Current condition/status of the patient and relevant ongoing interventions,
3. Any anticipated changes or likely problems to occur during the coverage period,
4. Any pending diagnostic studies that should be checked or followed up during the coverage period,
5. Consultants involved, and the scope of their activity and involvement in the case, and
6. Discharge planning considerations, especially if the patient is to be discharged during the period of coverage.

E. The GME Department and the Programs will develop an evaluation process to ensure that the resident physician is able to demonstrate competence in communicating with team members in the hand-off and transition process. Evaluations will include appropriate use of the care transition guidelines, and a quality improvement plan to assure continuous effectiveness of transitions in care.

KEYWORDS
Hand-off communication

Resident Recruitment Policy

9380-05

Original Date	Review Dates	Revision Dates
02/2013	03/2014; 02/2015; 02/2016; 12/2017	12/2016

POLICY:
This policy sets forth Gwinnett Medical Center (GMC) procedures outlining the institutional commitment to the recruitment and appointment of Resident Physicians. The Director of Graduate Medical Education (DGME) and the Graduate Medical Education Committee (GMEC) are responsible for policy and procedure oversight and modification. This policy and its procedures are considered to be supplements to GMC's Human Relations Department hiring requirements and practices and are not meant to replace or supersede those practices. The Accreditation Committee on Graduate Medical Education's (ACGME) and the American Osteopathic Association's (AOA) Institutional and Common Program regulations were used to produce the procedures in this policy.

DEFINITIONS:
Resident Eligibility: Defines the qualifications necessary to be eligible for appointment to GMC's residency programs.

Resident Selection: Is a description of the criteria, guidelines, applicable employment laws and process used by GMC to choose and offer employment to a perspective resident physician.

Post Graduate Year (PGY)-1,2,3: Refers to the year of training of a given resident physician irrespective of the particular program or specialty they are in training for.

PROCEDURE/GUIDELINE

EE. The DGME and the Graduate Medical Education (GME) Department working in concert with GMC's Human Resources Department have ultimate responsibility in creating the job descriptions for resident physicians as well as the recruitment and hiring process through the Electronic Residency Application Service (ERAS) and the National Resident Matching Program (NRMP) selection processes.

FF. The GME Department will oversee the entire process as each academic department begins the Match process to assure compliance with all local hospital, state, federal hiring statues and the regulations set forth by the ACGME, AOA, and the National Resident Match organization.

GG. The GME Department will assure each academic department enrolls and verifies available and eligible residency positions in accordance with the rules and regulations set forth with the various agencies above and also observe the published deadline and blackout dates as published and required.

HH. **Resident Eligibility:**

1. Graduates of Medical Schools in the US and Canada accredited by the Liaison Committee on Medical Education (LCME) or of Osteopathic Medical Schools in the US by the AOA.
2. Graduates of Medical Schools outside of the US and Canada who meet one of the following qualifications:
   a. Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment
   b. Have full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.
3. Graduates of Medical Schools outside of the US who have completed a "Fifth Pathway" program by an LCME-accredited medical schools
4. MD applicants, or any other applicants who are physicians but not DOs, who are interested in participating in the Osteopathic curriculum will be required to demonstrate some level of preparation for entry into an osteopathic-focused position in one of our Osteopathic Recognized programs. Such preparation may be demonstrated by:
   - Structured basic Osteopathic Principles and Practice training prior to beginning residency
   - Prior completion of elective Osteopathic Principles and Practice rotations
   - Prior completion of Osteopathic Principles and Practice courses at an osteopathic medical school
   - Other experiences and training to enable the matriculated resident to demonstrate entry-level competency for participation in the program
5. GMC does not accept visa applicants of any type and these individuals are therefore not eligible to apply to GMC residency programs.

II. **Resident Selection:**

1. GMC, the DGME and the GMEC ensure that its ACGME/AOA accredited programs select from eligible applicants on the basis of residency program related criteria such as: candidate preparedness, ability, aptitude, academic achievement and credentials, communication skills, and personal qualities such as motivation and integrity. These criteria are further defined in the policies and procedures GMC has agreed to uphold as participants in the National Residency Match Program (NRMP).
2. GMC's GME programs do not discriminate relative to gender, sexual preference, race, age, religion, color, nationality, disability, or any other category prohibited by law and in concert with GMC's Human Resources policies.

3. The selection of qualified applicants to GMC's residency program will occur solely through the National Resident Matching Program or NRMP. The NRMP and its rules and regulations will be honored for the ACGME accredited programs inclusive of those with Osteopathic (AOA) recognition.

JJ. Conflict of Interest:

1. Employed individuals of the Gwinnett Health System (GHS) will not enter into business undertakings that involve a conflict between their corporate duties and their personal interest. Covered individuals will not enter into any transaction or activity where their interest is advanced at the expense of the Gwinnett Health System. Each Administrative Officer shall notify all covered individuals reporting to him/her of the GHS Conflict of Interest Policy #300-510.
2. The GHS Conflict of Interest Policy includes guidelines for the following topics :
    A. Conflict of Interest transactions
    B. Conflict of Interest Activities
    C. Administrative Requirements for Potential Conflicts of Interest
    D. The Process for Approval Authority

KK. Inducements

1. No cash, bonus or other financial inducements for interviewing, ranking or signing are permitted.
2. Promotional items or "premiums" of insignificant value are permitted (e.g. Pens, tags, T-shirts, cups, etc.) under the regulations at § 411.357(k) set forth as an exception to the physician self-referral prohibition for certain non-monetary compensation. These benefits are not considered inducements and may be provided as applicable under the regulations and will not exceed the annual amount set forth by the Centers for Medicare and Medicaid Services (CMS).

KEYWORDS

None

GME Professionalism Policy

9380-20

Original Date	Review Dates	Revision Dates
5/2017		

POLICY

This policy sets forth the general guidelines outlined in the Accreditation Council for Graduate Medical Education's (ACGME) Common Program Requirements that assure Gwinnett Medical Center (GMC) and its Residency Programs will educate and evaluate its resident physicians and Faculty members on their respective professional responsibilities.

DEFINITIONS

Resident Physician: Physicians in a specialty-specific training program

Faculty Physician: Teaching physicians who participate in the resident rotations and are therefore responsible for resident's performance as outlined in the curriculum and as defined by the clinical competencies and milestones for the given specialty.

Professionalism: The broad spectrum of responsibilities of physicians including their obligation to be appropriately rested and fit to provide the services and care required by their patients.

PROCEDURES/GUIDELINES

LL. Professionalism Learning Objectives:

1. The individual program must assure these objectives are accomplished through the blend of supervised patient care responsibilities, clinical and didactic teaching and educational events and ensure manageable patient care duties. Some examples at GMC include:
    a. In a patient and outpatient care delivery
    b. Multi-disciplinary Grand rounds, Departmental grand rounds
    c. Departmental/Specialty specific didactic sessions
    d. Institutional and employment required CBLs or didactic sessions
    e. Regional or local required sessions available
2. The Programs will assure that manageable patient care loads and responsibilities are achieved by Program oversight, faculty and senior resident evaluation of individual resident workloads on a daily basis. Additionally,

using the same process of surveillance, will assure the resident physicians are not obligated to fulfill non-physicians duties to an excess.

MM. Institutional Responsibilities

1. Provide a civil environment free from learner and physician mistreatment, abuse, or coercion.
2. Assure at both the program level and the institutional level that education regarding unprofessional behavior and the process for reporting, investigating and addressing these issues is in place, confidential, and effective
    a. Required presentations by the DIO and the CMO at orientation address the institutional and programmatic educational effort
    b. Program and monthly rotation evaluations contain opportunities for reporting concerns
    c. The Resident Training manual and several other GME policies outline the process for approaching the Program Director, faculty or GME leadership with these concerns when appropriate.
    d. The GMEC and the DIO are ultimately responsible for assuring responsiveness, education, disciplinary, and policy changes needed within a given program
    e. The CMO and the Medical Staff policies on Professionalism at the institutional level are also in place to assure proper Medical Staff office support and response.

NN. Program Responsibilities:

1. The Program Director must ensure, in partnership with the sponsoring institution, that a culture of professionalism exists that supports patient safety and personal responsibility in the learning environment.
2. The Program will assure that residents and faculty demonstrate understanding of their role in patient safety and the delivery of family centered care to include:
        a. The responsibility of monitoring for and the reporting of unsafe conditions and adverse events.
        b. Assure continued fitness for work including personal time management, recognition of impairment from illness, fatigue or substance abuse in themselves, their peers and other members of the health care team.
        c. Commitment to life-long learning
        d. Awareness of and the Monitoring of patient care quality indicators and the accurate reporting of clinical and educational work hours, patient outcomes and clinical experience. Responsiveness to patient needs must supersede self-interests of the provider inclusive of circumstances that may require

transitioning a patient's care to another provider when needed and appropriate.

e. Willingness to participate in the institutional safety review committees, ad-hoc committees on the subject, and as resource members of Root-Cause-Analysis committees when needed and relevant.

OO. Program and Institutional Resources:

1. The responsibilities outlined above will be accomplished through
    a. Educational sessions on patient safety given at orientation and ongoing
    b. Encouraged participation in daily patient safety rounds by senior residents either voluntary or assigned by the program. The DIO will regularly attend these meetings
    c. Education ongoing in the use of the institutions adverse event reporting system (Verge). This is to include events reported by the teaching service or those reported about the teaching service or the patients under their care.
    d. Incidents and adverse events that are reported may lead to corrective actions, new educational sessions, Root cause analyses or a number of other Programmatic, institutional or Departmental changes. The Resident physicians and faculty involved in the events are required to participate in these meetings but may be asked to contribute or serve on a committee created to address the event
    e. GMEC meetings will include on the permanent monthly agenda, an inquiry for any observations or outcomes germane to the institution or its programs in general to assure attention is paid to needed changes in policy or educational opportunities that may arise on the subject.

PP. Resident Physician and Faculty Responsibilities

1. Physicians must demonstrate responsiveness to patient needs. These may:
    a. Supersede the provider's self-interest
    b. Require forgoing or modifying an intervention or treatment that is recommended by the provider
    c. Under some circumstances, be best served by transitioning the care of the patient to another qualified and/or capable provider.

KEYWORDS

Professionalism

MEDICAL STUDENTS / LEARNERS ON ROTATION IN FAMILY MEDICINE

A number of student learners rotate through Family Medicine Center clinic on an annual basis: 3rd year medical students; 4th-year students from medical and osteopathic schools across the country. With students, the resident has the opportunity to function as a teacher, mentor, and role model.

The following are the expectations for resident teaching of learners:

1. **Due to the need for first-year residents to become acquainted with their own patients and learn the clinic system themselves, in general students will not be assigned to work with first-year residents.**

2. Remember that as students are being graded for their performance, they are also evaluating programs to select for their training. Residents who are interested (and interesting) teachers increase the value of the training program and help to recruit other quality residents.

3. In teaching, it is important to remember the level of training of your students. Consider where the learner is in their year, what rotations they have already completed, etc.

4. Residents should review their schedule and select patients that are educational for the students to see. Each case should have a couple of teaching points.

5. The student will see the patient and then precept them with the resident. The resident will then go to see the patient with the student; the resident is required to lay eyes and hands on every patient.

6. The resident is expected to edit the student's note and to co-sign notes – full history, physical, and assessment/plan must be documented – an "I saw the patient with…" note is NOT acceptable!

7. Give the student immediate feedback on their performance. Pick out positives in the student performance as well as areas that need development.

8. Part of the professionalism component of residency also involves completing evaluation forms of students with whom you have worked in a timely manner. Evaluations are done midway through and at the end of the rotation. The resident comments on the student's strengths and weaknesses and recommendations for improvement are especially important. Evaluate the student by their stage of training.

There will be an award given annually to the Family Medicine resident who provides the most education to learners rotating through Strickland Family Medicine. Each learner rotating through our clinic will be asked to nominate one resident as the recipient of this award for excellence in teaching. Residents at all levels of training are eligible to receive this award.

The following are student requirements with which residents should be familiar:

1. **Appearance:** Medical students are expected to present a clean, neat appearance in the clinic and on rounds in the hospital. If hair is long, students should be able to pull it back if they are doing any procedures. (Or tuck it under a surgical scrub cap!) Clothing (including short white student coats) should be clean and neat. Scrubs are not to be worn for routine clinic work.
2. **Timeliness:** Students are expected to be prompt and eager to work each day. Persistent tardiness or unexcited absences may result in a grade of Incomplete and/or loss of Professionalism points.
3. **Schedules**: There will be weekly didactic sessions. Students will have no clinical duties on days when these sessions occur. If there is any question regarding schedules, they can be clarified by the residency administrative assistant or the Pre Doctoral Director.
4. **Hospital Policy involving student work:** Please review the policy in the Inpatient Manual. Students will not be expected to perform independently except as stated. All student work must be precepted. Notes must be completed by the overseeing resident or faculty member. A complete note, that must stand independently, must be submitted by the supervising resident.
5. **Student Goals:** Students are here to learn. Students should gain an appreciation of the depth and scope of Family Practice - for the diverse types of medical problems seen by family physicians on a daily basis. During this rotation, the student should become comfortable evaluating and managing common problems seen in a Family Medicine setting.
6. **Specific clinical goals**:
   - Data gathering skills: Students should be able to take a thorough history and do a complete physical on both adult and pediatric patients. Work should be complete but not include unimportant information.
   - Organization: This includes both written and oral communication. Both student notes and presentations should flow logically and be easy to follow. Students should follow the SOAP format. Students should have a differential diagnosis and a plan when they present, even if it ultimately differs from the plan agreed upon by the physician and the patient.
   - Interest in learning
   - Technical skills (when applicable)
   - Interpersonal skills: Students should be able to interact well with patients, nursing staff, residents, administrative personnel and faculty.
   - Health Promotion: The student should understand the importance of inclusion of health promotion issues into every patient visit.

EVALUATION AND PROMOTION

FACULTY ADVISOR

At the beginning of residency, each resident will be assigned a physician faculty advisor. This person will remain their advisor for the entire three years of the residency and will be the contact person with regard to a variety of issues, such as feedback from faculty reviews, review of in training exam scores, professional growth and development, choosing electives, reviewing CME requests, career pathways, professional opportunities and other issues as needed.

EVALUATIONS

Assuring competency in the field of Medicine is a difficult achievement and is the ultimate goal of residency training. There is no single assessment which can assure a physician can safely practice in an unsupervised environment. The program will utilize a diverse array of assessments, including: written examinations, oral examinations, 360° peer and self-evaluations, rotation and preceptor evaluations, staff and patient evaluations and surveys, observed clinical skills examinations, video reviews of actual patient encounters, and direct observation by faculty and supervisory physicians to evaluate competency and assure safety. Every attempt to maintain confidentiality will be taken by the program, and all electronic evaluations will be blinded to not only the individual but also the residency staff and faculty.
The Clinical Competency Committee (CCC) –see CCC policy will meet on a regular basis to review progress towards achievement of the required milestones and make recommendations to the program director for advancement of the residents in supervision and promotion, and will also make recommendations on remediation and retention.

360° DEGREE RESIDENT EVALUATIONS

Resident performance is evaluated in a 360 degree format. This means evaluations are performed by supervisors (faculty and preceptors), peers (other residents), staff, patients and the resident themselves. All are important for both formative and summative resident evaluation. All evaluations are completed through New Innovations, an electronic software system used by the GMC residency programs.

1. Supervisors' evaluations
    a. Residents will be evaluated on each rotation by their supervising attending and, if applicable, supervising resident.
    b. In addition, faculty will complete periodic evaluations of resident performance in clinic and on call
    c. Residents will have the opportunity to review their rotation evaluations online at NewInnovations and have the opportunity to respond to supervisor evaluations if they feel they are unfair or incorrect.
    d. Residents are encouraged to actively seek feedback on their performance during their rotation so they will be aware of their written evaluation.
2. Peer evaluations – residents will be required to complete competency based evaluations of their peers yearly. Evaluations are strictly confidential and only summary data is given to the resident.

3. Staff evaluations – the staff of Family Medicine Center will complete evaluations of each resident on a yearly basis. Evaluations are strictly confidential and only summary data is given to the resident.
4. Patient evaluations – patients will complete evaluations of each resident twice yearly. Evaluations are strictly confidential and only summary data is given to the resident.
5. Self-evaluations – residents will complete self-evaluations prior to each quarterly evaluation and meeting with their advisors.

RESIDENT PERFORMED EVALUATIONS

Evaluation of the residency by the residents is an essential method for improvement. Residents complete evaluations in New Innovations in the following areas:

1. Evaluation of faculty – residents evaluates all Family Medicine faculty on an annual basis. In addition, residents evaluate all faculty and preceptors at the time of a rotation where they worked with that faculty/preceptor. Evaluations are strictly confidential and only summary data is given to the faculty/preceptor. The evaluations are seen only by the Residency Administrator.
2. Evaluation of rotation – residents evaluates all rotations at the time of the rotation. Evaluations are strictly confidential and only summary data is given to the rotation director.
3. Evaluation of program annually – residents evaluate the program as a whole annually. Evaluations are strictly confidential and only summary data is given to the faculty.
4. 360 evaluations of peers – residents evaluate their family medicine resident peers on annually. Evaluations are strictly confidential and only summary data is given to the resident.

CLINICAL COMPETENCY COMMITTEE (CCC)
(See also GME Policy #9380-16)

The Clinical Competency Committee is comprised of the Family Medicine faculty, Residency Coordinator and Chief resident (when available or another senior level resident. at least twice per year, the Resident Evaluation Committee will review all aspects of residency performance, including rotation evaluations, clinical skills, professional development, involvement in the residency, in-training examination scores and other developmental and performance related areas in the residency.

1. The resident advisor will review the following prior to this meeting:
    1. All available 360 degree evaluations
    2. Resident portfolio
    3. Resident visit numbers
    4. In-training exam scores
    5. USMLE/COMLEX-USA scores
    6. Resident procedure log
    7. Resident diagnoses log
    8. Medical record completion
    9. Conference attendance
    10. Career goals and plans
    11. Pertinent personal issues
    12. Feedback on the residency
2. The advisor will present her/his findings to the Resident Evaluation Committee and facilitate any discussion
3. The resident's progress on curricular and programmatic milestones will be assessed and reported
4. The resident will complete a self-evaluation and a draft education plan
5. The advisor and resident will meet to discuss the findings of the Resident Evaluation Committee and review the resident's self-evaluation and education plan
6. Together the advisor and resident will formulate a competency based education plan for the next several months.

PASSING A ROTATION

Residents are required to successfully pass 39 blocks of rotations to graduate from the program. The following is required to successfully pass a rotation.

1. Attendance
2. A "meeting expectations" score or better on their evaluation by supervising physician.
3. Completion of any required learning tasks for that rotation
4. Completion of rotation and supervisor evaluation.

A score of "meeting expectations" in all competencies means that the resident has met the expectations for the rotation and is functioning at an acceptable level for their program year. If the resident scores less than "meeting expectations" in 1 competency, an alternative remediation will be required as determined by the resident, Advisor and Residency Director. If the resident scores less than "meeting expectations" in 2 or more competencies, the rotation will have to be repeated. A resident may use up to 1 month of elective time to remediate a rotation. More than one failure of a rotation will require extension of the residency until all rotations are completed in a satisfactory manner.

PROMOTION AND GRADUATION CRITERIA

Duration of Appointment and Conditions for Reappointment

The duration of the residency training program in Family Medicine is 36 months. Reappointments are made annually based upon recommendations of the residency director and consensus of the Family Medicine Residency Program faculty. All competencies of the program must be met in an overall satisfactory manner and must be concluded prior to recommendation for reappointment. Advancement is contingent upon but not automatically granted for a satisfactory overall evaluation.

Promotion of Residents

The Resident Evaluation Committee conducts a comprehensive evaluation of each resident three times per year. Promotion is contingent upon a satisfactory overall evaluation. Recommendations regarding promotions, remediation, or dismissal are forwarded to the program director for final approval. Remediation and dismissal actions are subject to review under "due process."

For advancement to occur the resident will be evaluated and considered for advancement at three levels: PGY 1 to PGY 2, PGY 2 to PGY 3, and PGY 3 to graduation. Specifics for advancement include:

Advancement Schematic

PGY 1 to PGY 2	PGY 2 to PGY 3	PGY 3 to GRADUATION
• Acceptable progress in all competencies • Able to supervise PGY 1 and students • Able to act with limited independence including phone triage and assessment • Utilizes supervision appropriately • Successful completion of 13 blocks of residency rotation indicated by at least one completed passing evaluation for each rotation • 150 continuity patient visits • Completion of 1 continuity home visit • No more than 22 working days absent • Portfolio and education tasks completed for PGY 1 activities	• Acceptable progress in all competencies • Able to supervise and teach all levels • Utilizes supervision appropriately • Successful completion of 13 blocks of residency rotation indicated by at least one completed passing evaluation for each rotation • Passage of USMLE/COMLEX-USA Step 3 • Be on track to complete 1500 continuity patient visits by end of PGY 3 year • Completion of 1 continuity home visit • No more than 22 working days absent • Portfolio and educational tasks completed for PGY 2 activities	• Competence in all parameters • Able to act independently and supervise/teach all levels • Acknowledges limitations • Successful completion of all 39 blocks of residency rotation indicated by at least one completed passing evaluation for each rotation • Have completed 1500 continuity visits in PGY 2 and PGY 3 year • Completion of 1 continuity home visit • Completed at least 40 deliveries of which 10 are continuity deliveries • No more than 22 working days absent • Portfolio and educational tasks completed for PGY 3 activities

Failure to advance will require documentation and will be individually considered for possible remediation. Remediation plans will be determined by the Program Director and faculty. Successful completion will be necessary for reconsideration of advancement.

PROCEDURES FOR DISCIPLINE (See also GME Resident's Manual Policy #9380-00)

Concerns or complaints regarding residents of any nature will be referred to the residency director for review. Disciplinary action for concerns will be appropriate to the nature of the complaint following evaluation of the problem. Any disciplinary action which results will be specifically outlined and carefully monitored. Actions may consist of verbal counseling, written warning (including observation, remediation and probation), suspension or termination of contract. All disciplinary actions are subject to review through "due process." In addition, at the discretion of the Program faculty, residents demonstrating deficiencies regarding moral or ethical conduct may be denied promotion until additional training or supervision during the probation period is satisfactorily completed. Please see the Resident Physician Manual for a further description of the Disciplinary and Grievance Procedure.

DUE PROCESS

1. **Initial Problem Identified – Verbal Counseling**
    a. All faculty are encouraged to provide direct feedback to residents on a daily basis regarding routine concerns.
    b. When problems are more serious, or of a repetitive nature, the resident's advisor should be notified without delay. This will initiate the first step of the evaluation process, involving information gathering and verbal counseling. The resident will be informed that this process has been initiated and verbal counseling will occur.
    c. As soon as possible, the advisor will inform pertinent faculty, including the program director and chief resident that this process has been initiated.
    d. Observation, remediation, probation, or suspension may be immediately initiated during this stage if a problem is identified that is deemed sufficiently serious.
2. **Observation**
    a. Specific assignments or guidelines will be prescribed by the advisor with faculty input. The chief resident will be part of these discussions in order to provide input and information that may have bearing on the resident's case.
    b. The period of this observation should be from 1-3 months
    c. Feedback will be provided at least monthly
    d. Problems not resolved by the end of the observation cycle may require further remediation, probation or suspension.
    e. Remediation, probation or suspension may be immediately initiated during this stage if a problem is identified that is deemed sufficiently serious.
    f. Successful completion of observation requirements will result in reinstatement of the resident in good standing. If the problem recurs following completion of the observation period, the advisor and program director will determine an appropriate level of intervention.
    g. If certain items of the observation requirements have been satisfied, but others remain problematic, the faculty has the option of extending the observation period to allow for successful completion of the remaining requirements.
    h. Details of the observation cycle will not become part of the resident's permanent record, and will not be released to credentialing agencies or third parties.
3. **Remediation**

a. Resident issues that lead to remediation are by definition those academic and professional issues that have failed observation or that require the resident to repeat a specific experience. Examples:
    i. Failure of a rotation
    ii. Failure of USMLE/COMLEX-USA Step 3 or poor performance on the In-training Exam
    iii. Deficiencies in any of the six core competency areas that do not resolve with observation.
b. The resident will be notified as soon as possible of remediation status, even if formal documentation of the problem is pending.
c. The chief resident will be included in subsequent discussion about the resident's case.
d. The resident's advisor and Program Director will formulate a remediation plan with input from the resident.
e. The remediation plan will contain the following:
    i. Reason for remediation
    ii. Duration of remediation and/or specific expectations necessary to complete the remediation cycle
    iii. Assistance that will be made available to the resident to meet those requirements
    iv. The mechanism for measuring improvement (clearly defined standards)
    v. Consequences of failure to meet remediation requirements
f. The resident will receive at least monthly feedback on his/her performance. Additional corrective steps may be instituted to help the resident successfully resolve the problem.
g. The advisor and Program Director will assess the results of the resident's performance during the remediation period and inform the resident of his/her findings.
h. Residents on remediation cannot seek or hold residency office, such as chief resident and may be relieved of other ancillary duties such as applicant interviews or committee membership.
i. Records of remediation actions are kept in the resident's file but will not become a part of the end of residency summary if completed in a satisfactory manner.

4. Probation

a. Failed remediation or infractions deemed sufficiently serious will warrant a probation cycle. Examples may include, but are not limited to;
    i. Unprofessional behavior
    ii. Significant breaches of standard of care
    iii. Deficiencies in any of the six core competency areas that have failed remediation or are sufficiently serious.
b. The resident will be notified as soon as possible of probationary status, even if formal documentation of the problem is pending.
c. The chief resident will be included in subsequent discussion about the resident's case.

d. The resident's advisor and Program Director will formulate a probation plan with input from the resident. Depending on the circumstances, this plan may include;
    i. Academic, professional or mental health counseling
    ii. Remediation of activities
    iii. Restricted patient care responsibilities
    iv. Required time away from the standard residency activities to complete required elements of the plan
e. The probation plan will contain the following:
    i. Reason(s) for probation
    ii. Duration of probation and specific expectations necessary to complete the probation cycle
    iii. Assistance that will be made available to the resident to meet those requirements
    iv. The mechanism for measuring improvement (clearly defined standards)
    v. Consequences of failure to meet probation requirements
f. The resident will receive regular feedback on his/her performance. Additional corrective steps may be instituted to help the resident successfully resolve the problem.
g. Successful completion of probationary requirements will result in reinstatement of the resident in good standing.
h. Recurrence of behaviors or practice errors that initiated probation will result in immediate resumption of probation or non-renewal of the resident's letter of agreement.
i. Residents on probation cannot seek or hold residency office, such as chief resident and may be relieved of other ancillary duties such as applicant interviews or committee membership.
j. Records of probation actions are kept in the resident's file in the residency office and become a part of the end of residency summary. **This information may be released to credentialing agencies or third parties**.

5. Suspension

a. In the event of resident behavior that is deemed dangerous to patient care or the well being of co-workers, or failure to successfully complete requirements of probation, the Program Director may suspend the resident's clinical and/or educational duties. Reasons for immediate suspension may include, but are not limited to;
    i. Substance abuse
    ii. Inappropriate sexual overtures to patients or colleagues
    iii. Anger management issues
    iv. Active psychiatric or medical issues that interfere with patient care.
b. If a resident is suspended, the Residency Director and advisor will complete formal documentation of the issue resulting in suspension within 7 days. The resident may appeal under GME policy.
c. The documentation will clearly delineate the nature of the problem and criteria for re-instatement of the resident as described above for remediation and probation.

6. Non-renewal of contract

a. In the event that a resident is not able to meet the minimum criteria for promotion, or has failed to meet the requirements of remediation, probation or suspension, the Program Director, in consultation with Residency Faculty and the office of GME, may decide to not renew the resident's contract. The reasons for non-renewal will be formally documented and presented to the resident.
b. The resident has the right to appeal non-renewal of their contract under GME policy.

If probation is successfully completed, this will be noted in the end of residency letter.

RESIDENT GRIEVANCES (See also GME Resident's Manual Policy #9380-00)
All residents have access to mechanisms that assure that resident grievances are given appropriate attention. This is not to be confused with the policy described as the resident's right to "due process." Due process procedures are followed when a resident requests formal review of an action against him/her. If however, residents have a complaint about working conditions, poor treatment by attending physicians, sexual harassment or the like and the resident attempts to resolve the complaint through normal channels has failed, this policy applies. Accordingly when a resident has a complaint or grievance it should be discussed with the resident's advisor or the residency director. If the resident feels that the complaint or grievance has not been satisfactorily addressed through this mechanism, it should be referred to the program director. Residents have the right to complete a written statement if they disagree with an evaluation. See the House Staff Manual for further procedures regarding grievances.

THE GOOD CITIZEN CURRICULUM (GCC)

Part of the education of residency is learning to complete required tasks and paperwork. While these may not seem to directly impact the resident's individual education, failure to complete these tasks significantly hamper the ability of the residency to function smoothly.

For residents who do not complete a given administrative task in a timely manner, a verbal warning will be issued. If the same task is not completed in a timely manner a second time in a quarter, the resident will have the opportunity to participate in the Good Citizenship Curriculum aka "Saturday School". This involves meeting with the inpatient team at 6:30AM on Saturday morning and rounding on patients assigned by the inpatient resident. Once rounding is complete, the resident is released to complete the delinquent administrative task if needed and is expected to inform the on call attending once the task is complete. The resident will be notified by Tuesday of his/her requirement to participate in the GCC the immediately following Saturday. Exceptions will only be made for pre-approved leave and duty hours violations. Time spent in "Saturday School" will be counted in the weekly duty hours tally and the 80 hour work week will be taken into consideration when the need for this time arises so as not to create a duty hour violation.

Administrative tasks subject to Saturday School may include (but are not limited to):

1. Hospital records, discharge summaries, putting discharge information into EMR
2. Evaluations – rotation, faculty, peer
3. Rotation and conference attendance
4. Logging duty hours
5. Vacation requests returned in a timely manner
6. Elective requests returned in a timely manner
7. Completing conference presentations on schedule
8. Completing clinic charts and paperwork
9. Failure to attend to Nursing Home call needs in a timely fashion
10. Failure to complete AND return to the DOME the required number of OMT/structural examinations every month as follows:
    - 1st year residents must document 5 inpatient and 2 outpatient OMT/Structural exams/month
    - Upper level residents must document 2 inpatient and 5 outpatient OMT/Structural exams/month

DOCUMENTATION OF EXPERIENCE

Every Family Medicine residency program is required by the "Special Requirements for Family Medicine Residencies" to have a system for documenting resident educational experiences. The summary of documented experiences is often requested by hospitals applied to for privileges after residency. **Begin documenting on Day One of the residency and do not fall behind.** The following areas require documentation:

1. Procedures
2. Diagnoses
3. Portfolio
4. Completion of learning activities

Procedure Performance Requirements and Documentation

All procedures are logged into New Innovations. Procedures fall into 1 of 3 categories:

1. Core – these are procedures that the resident must obtain competence before graduation. A minimum number of procedures are required and faculty must sign off.
2. Experience – these are procedures that the resident must experience but not necessarily demonstrate competence. A minimum number of these procedures is required and a higher number is required to demonstrate competence. Faculty must sign off on a certain number for competence.
3. Optional – these are procedures that the resident may or may not experience during residency. There are no minimum numbers required but there is a number required if the resident would like to demonstrate competence. Faculty must sign off on a certain number for competence.

All of these procedures are listed in New Innovations and categorized as Core, Experience or Optional. Procedure logs will be reviewed at the Resident Evaluation Committee.

DIAGNOSES DOCUMENTATION

Diagnoses can also be logged into New Innovations. These are used to track the types of patients seen during residency.

PORTFOLIOS

Each resident is given a portfolio to complete during residency. The portfolio is a yearly series of reflections on individual growth in each of the 6 core competencies. Further instruction will be given during orientation.

LEARNING ACTIVITIES

Each rotation has a series of learning activities associated with it. This can include readings, online tests, projects, presentations or cases. These activities are tracked through New Innovations. In addition, there are learning activities that are independent of rotations, such as FPIN completion, Problem Based Learning Research projects, and conference presentations. Each resident is responsible for tracking his/her progress.

Chief Resident Role Description

Chief Resident Duties will be divided among two chief residents

A. Desired Characteristics of Chief Residents

1. Believes in, and is enthusiastic about, the program Mission and Vision
2. Is recognized by both peers and faculty as a leader
3. Possesses the ability to relate effectively with peers and faculty
    a. Is adept at diplomacy and negotiation
    b. Has highly developed written and verbal communication skills.
4. Displays competence as a Family Medicine Resident (as defined by the ACGME Competencies and Milestones – Interpersonal and Communication Skills, Patient Care, Medical Knowledge, Professionalism, Systems-Based Practice, Practice-Based Learning)
5. Is of upstanding character and integrity
6. Is willing to serve as an ambassador for the program and a resident-faculty liaison
7. Is in their last year of training during their tenure as chief
8. Is attentive to details and completes tasks by deadline
9. Is in good academic standing. Any change in academic or administrative standing with the program will result in forfeiture of chief position.

B. Duties of Chief Residents

Administrative Chief Residents will:

1. Select a faculty "Chief Coach" who will facilitate their development as a leader, and meet with this coach monthly
2. Meet at least monthly with the Medical Director regarding practice issues, and as needed with the Program Director.
3. Proactively seize opportunities to develop and refine leadership, management, and educational/teaching skills.
4. Participate in new chief orientation as both incoming and outgoing chiefs.
5. Schedule and facilitate a bi-monthly resident meeting
6. Help to coordinate and be involved with new resident orientation
7. Keep all inpatient and outpatient medical records up-to-date as per departmental policy
8. Participate in Chief Resident Development activities and meetings as they are offered
9. Prepare the Family Medicine resident call schedule each month and insure an equitable distribution of call and back-up call
10. Function as a liaison between faculty and residents and bring residency administrative issues and potential solutions to the attention of the faculty through attendance at and participation in designated monthly meetings
11. Attend all Practice Leadership meetings and all Practice Innovation meetings, taking an active role in presentations and discussions.

11. Solicit from residents all administrative issues regarding policies, clinics, rotations, etc and work with the Program Director and Medical Director to help address these
12. In the case of unplanned absences of residents from Clinic or IPS, be responsible for either appointing another resident to cover or cover the absent resident themselves if needed
13. Bring resident morale and behavior issues to the attention of the appropriate individuals
14. Coordinate the selection of the graduation awards for "Family Medicine Inpatient and Outpatient Attending of the Year," "Outstanding First Year Family Medicine Resident," and "Family Medicine Resident Community Service" as well as any other awards deemed appropriate.
15. Serve as a member of and resident representative to the Program Evaluation Committee
16. Serve as the resident elected representative to the Graduate Medical Education Committee
17. Meet at Quarterly with nursing leadership at GMC D to discuss resident and nursing relations.
18. Distribute information to residents in a timely manner. Information may include AAFP or NCAFP meetings, announcements, grant applications, moonlighting/job opportunities, etc.
19. Participate in recruiting, including scheduling of residents for dinners, lunches, interviews.

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<u>Educational</u> Chief Residents will:

1. Preside over weekly conferences, introducing speakers and assuring that sessions stay on time
2. Model collaborative, interactive, evidence-based adult learning
3. Assist the Associate Program Director in reviewing the conference feedback forms and writing thank you letters to outside speakers
4. Participate in new chief orientation as both an incoming and outgoing chief.
5. Help to coordinate and be involved with new resident orientation
6. Meet with Curriculum Committee approximately 4 times/year to work on curriculum improvement
7. Be integrally involved in board review development and implementation
8. Function as a liaison between faculty and residents and bring residency education and curricular issues and potential solutions to the attention of the faculty through attendance at and participation in curriculum-related faculty meetings
9. Assist the Administrative Chiefs in scheduling and facilitating a bi-monthly resident meeting
10. Assist behavioral medicine faculty in developing educational retreat program for spring retreat.

11. Participate as requested in content/changes and annual updates of the resident policy manual.
12. Meet with Associate Program Director monthly to facilitate their development as a leader, and progress toward chief goals
13. Participate in Chief Resident Development activities and meetings
14. Proactively seize opportunities to develop and refine leadership, management, and educational/teaching skills.
15. Help to insure completion of conference and rotation feedback forms
16. Implement other programs/processes as agreed upon by the Education Chief, Associate Program Director, and the Program Director
17. Serve as a member of and resident representative to the Program Evaluation Committee

C. Benefits for Chief Residents

1. Each Chief Resident will attend the American Academy of Family Practice (AAFP) Chief Resident Leadership Development Workshop the Spring of their second year or the Fall of their third year. This time will not count against their CME time, and they will each receive a maximum of $2,000 to cover these CME expenses.
2. Chief Residents will have one half-day per block set aside for administrative duties during their regular office sessions during the first half of their third year. It is expected that they will use this time for their chief resident responsibilities, and if it is not needed, they will attend to rotation or clinical responsibilities. During the second half of their third year, they will receive gradually reduced administrative time to correspond with decreased Chief duties. Administrative time is subject to reduction based on the ability to meet program requirements for number of patients seen in the office setting.
3. A stipend of $500 per year paid monthly.

D. **APPLICATION:**

Interested residents will submit via email by the deadline to the program director:

1. Letter of interest indicating which position they desire
2. Complete updated curriculum vitae.

The application will be considered by the faculty and only those residents in good standing and with approval of the faculty will be submitted to the residents for vote. This election occurs in spring or as otherwise scheduled by the program for the upcoming academic year.

Disaster Policy (See also GME Policy #9380-04)

Disasters, such as weather extremes, epidemics, terrorism, or other physical or natural disasters can have a significant impact on residency education. The ACGME defines 2 types of such disaster:

1. An ACGME defined disaster is "An event or set of events causing significant alteration to the residency experience at one or more residency programs". This involves a disaster so significant that residents need to be transferred to other locations to finish their training.
2. A Local Extreme Emergent Situation is "A local event (such as a hospital-declared disaster for an epidemic) that affects resident education or the work environment but does not rise to the level of an ACGME-declared disaster." This involves a disaster that may temporarily disrupt residency training but not to the extent that transfer is needed.

In an ACGME defined disaster, the program director will work directly with the DIO/IEO to facilitate transfer of residents.

In the event of a local extreme emergent situation, as per "**Responsibilities of ACGME-accredited Institutions in Local Extreme Emergent Situations"** the following basic principles apply*:

1. Residents are, first and foremost, physicians, whether they are acting under normal circumstances or in extreme emergent situations. Residents must be expected to perform according to society's expectations of physicians as professionals and leaders in health care delivery, taking into account their degree of competence, their specialty training, and the context of the specific situation. Many residents at an advanced level of training may even be fully licensed in their state, and, therefore, they may be able to provide patient care independent of supervision.

2. Residents are students. Residents should not be first-line responders without appropriate supervision given the clinical situation at hand and their level of training and competence. If a resident is working under a training certificate from a state licensing board, they must work under supervision. Resident performance in extreme emergent situations should not exceed expectations for their scope of competence as judged by program directors and other supervisors. Residents should not be expected to perform beyond the limits of self-confidence in their own abilities. In addition, a resident must not be expected to perform in any situations outside of the scope of their individual license. Expectations for performance under extreme circumstances must be qualified by the scope of licensure, which varies by state.

Decisions regarding a resident's involvement in local extreme emergent situations must take into account the following aspects of his/her multiple roles as a student, a physician, and an institutional employee:

the nature of the health care and clinical work that a resident will be expected to deliver;
resident's level of post-graduate education specifically regarding specialty preparedness;

resident safety, considering their level of post-graduate training, associated professional judgment capacity, and the nature of the disaster at hand;
board certification eligibility during or after a prolonged extreme emergent situation;
reasonable expectations for duration of engagement in the extreme emergent situation; and,
self-limitations according to the resident's maturity to act under significant stress or even duress.

* From the ACGME/AOA websites.

Epidemic Infectious Disease Policy

Working in the health care field is a double risk for faculty and residents. They are both at higher risk for contracting contagious infectious diseases, and they will need to work harder to see more patients who may have contracted the infectious disease. This becomes even more challenging if multiple providers become sick with contagious infectious diseases, particularly influenza. In the event that more than 1 provider is out sick with a contagious infectious disease the following policy will be followed:

1. All providers who present to work with a fever greater than 100.4 and cough will be asked to go home. They may not return to work until they have been afebrile for 24 hours without the aid of antipyretics. The usual sick policy applies for the ill faculty or resident, including notifying the clinic, rotation, senior resident, residency coordinator, etc.
2. Essential services, in order of importance are the inpatient service, including call, and the clinic.
3. If multiple providers become ill and any of the above essential services are affected "code flu" will be text paged. All residents and faculty will be expected to meet at Family Medicine Center to assign coverage for clinic and the inpatient service. This may include removing residents from non-essential rotations. All rotation days missed will be tracked by the Residency Coordinator and extra shifts worked will be noted.

In the event that a critical number of faculty and residents are ill, the decision may be made to modify or close the clinic until an appropriate number of providers are able to care for patients.

KEY ACADEMIC AGENCIES

American Board of Family Medicine (ABFM) https://www.theabfm.org/
The American Board of Family Medicine (ABFM) is the second largest medical specialty board in the United States. Founded in 1969, it is a voluntary, not-for-profit, private organization whose purposes include:

- Improving the quality of medical care available to the public
- Establishing and maintaining standards of excellence in the specialty of Family Medicine
- Improving the standards of medical education for training in Family Medicine

Georgia Medical Board http:// medicalboard.georgia.gov/
The Georgia Medical Board is the agency which licenses, monitors, disciplines, and guides the health care practitioners it regulates to assure their fitness and the competence.

Accreditation Council for Graduate Medical Education (ACGME): http://www.acgme.org/acWebsite/home/home.asp
The Accreditation Council for Graduate Medical Education is a private, non-profit council that evaluates and accredits medical residency programs in the United States. It is made up of individual Residency Review Committees which oversee each specialties residency requirements for accreditation. Accredited programs undergo site visits and reviews on cycles determined by the review committee.

United States Medical Licensing Exams (USMLE/COMLEX-USA)
http://www.USMLE.org/index.html. http://www.nbome.org
The USMLE/COMPLEX exams assess a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and disease and that constitute the basis of safe and effective patient care. Each of the three Steps of the USMLE/COMLEX-USAcomplements the others; no Step can stand alone in the assessment of readiness for medical licensure.

American Academy of Family Physicians (AAFP) http://www.aafp.org
Located in Kansas City, Missouri, this is an organization which represents the broad interest of the specialty of Family Medicine with regard to political, social and educational areas

The Georgia Academy of Family Physicians (NCAFP) http://www.gafp.org
The professional association representing Family Medicine physicians, residents and medical students across GA. Affiliated with the American Academy of Family Physicians, their goal is to advance the specialty of Family Medicine and advocate for the interests of family physicians in Georgia.

The American Osteopathic Association (AOA) http:// **www.osteopathic.org**
This is the accrediting agency for all osteopathic medical colleges and health care facilities. The AOA's mission is to advance the philosophy and practice of osteopathic medicine by promoting excellence in education, research, and the delivery of quality, cost-effective healthcare within a distinct, unified profession.