Southern New Mexico
Family Medicine
Residency Program
Established in 1996

RESIDENT MANUAL

Updated 07/12/2021

CONTENTS

I. Introduction

Welcome to the Southern New Mexico Family Medicine Residency Program! We are excited that you are joining us! These next few years will be challenging and enriching, both professionally and personally. It is during these years that you will truly develop into a physician, and thus, it is our responsibility to provide you with the resources and the guidance you require to attain your goal. Even though we are here to help and guide you along your journey, it is ultimately YOUR responsibility to provide the necessary effort to reach your destination.

Upon entering residency, you may feel overwhelmed and lost with the new environment, the personnel, and the new responsibilities. This manual will help guide you. It includes the specific policies and procedures that you must follow in order to successfully complete your training here.

Many of the policies, duties and responsibilities described within this manual are decreed in state law, others are ACGME requirements, others are policies of this institution, and finally others are obligations within the patient-physician relationship.

These policies and procedures are intended to protect the welfare of the patient and to ensure a positive learning environment for the resident. All faculty and staff are here to support you as you learn the policies and procedures and continue your medical education here. Please ask for help.

Mission/Vision

LifePoint Hospitals/Memorial Medical Center

Our Mission:
To care for our community with compassion and respect.

Our Vision:
To be a place where:
Patients choose to come for health care.
Physicians want to practice.
Team members want to work.

Southern New Mexico Family Medicine Residency Program

Mission: We teach, collaborate, lead, and inspire to transform the education and health of our whole community

Vision: To transform health care education and delivery to be socially responsible and eliminate health disparities in New Mexico.

Overall Educational Goals:

- Train fully competent and compassionate family physicians that are prepared to provide high quality, comprehensive primary care to families.
- Prepare physicians to practice in rural and underserved areas of New Mexico.
- Train physicians to work in the context of a collaborative team.
- Develop the physician into a lifelong adult learner and educator.
- Train physicians to assume leadership roles in local communities, New Mexico and the nation.
- Train physicians in social medicine so that they can move beyond the walls of the clinic and hospital to have upstream effects on the health of their communities.

II. Residency Life Cycle: Eligilibility, Appointment, Promotion, Transfers, Graduation

Eligibility:

Medical School Requirements

- Graduates of Liaison Committee on Medical Education (LCME) accredited medical schools in the USA and Canada.
- Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
- International graduates who have met all Educational Commission for Foreign Medical Graduates (ECFMG) requirements for graduate medical training in the United States or have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
- Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by a Liaison Committee on Medical Education (LCME) accredited medical school.
- New Mexico uses the California Medical Board list of approved schools. Therefore we can only consider students from these approved schools.

USMLE/COMLEX Requirements

- Only applicants who have successfully completed USMLE/COMLEX Step I will be considered or invited for an interview. Applicants who have not successfully completed USMLE/COMLEX Step II by the time of their interviews must present written notice of successful completion before the date the program must submit its rank list to the National Resident Matching Program (mid-February) to be included in the rank list.
- All applicants must be eligible to complete all three steps of the USMLE/COMLEX within a seven-year period as recommended in the USMLE/COMLEX bulletin.
- All applicants must complete each step with 3 or fewer attempts.

Five Year Rule

In order to assure appropriate clinical acumen, it is necessary that all applicants be enrolled in medical school or be a recent medical school graduate of no more than 5 years. It is also considered acceptable for a medical school graduate to have been clinically active within the last 5 years. If an applicant has graduated medical school greater than 5 years ago, the applicant must document recent clinical activity. All final applicant interviews will be at the discretion of the faculty and the Program Director.

Visas

Non-US citizens must recognize that all licensing of residents in New Mexico is controlled by the University of New Mexico (UNM). The Board of Trustees of UNM will only approve issuance of a training license to holders of J-1 Visas or those having Permanent Resident Status (Green Cards). Therefore, we cannot consider holders of H1-B or other visas.

Selection Criteria

The Southern New Mexico Family Medicine Residency Program (SNMFMRP) participates in the National Resident Matching Program (NRMP) for the selection of first-year residents into the program. The process of resident selection is as follows. Applications are scored and rated in the following areas: Medical school grades/transcripts, Dean's letter, Letters of recommendation, commitment to family medicine, and commitment to New Mexico.

On the basis of an application's rating, selected applicants are invited for interviews. Each interviewer rates the candidates he or she interviews based on the potential for the applicant to meet the needs of our community.

Memorial Medical Center does not discriminate on the basis of an applicant's race, color, religion, age, gender identity, ancestry, national origin, citizenship status, disability, sexual orientation, or any other status protected by applicable federal or state law.

Appointment

Final appointment of residents is made through the National Resident Matching Program (NRMP). Selection of applicants for the match list and ranking of applicants is determined by scores from our behavioral-based interview process and the application score. The match list is constructed according to the scores. Final approval of candidates is the responsibility of the Program Director. All final offers of employment are conditional pending successful passage of the post-offer drug screening and background checks.

The program accepts the results of the NRMP as final. Any unmatched positions, or second year positions that may become available, are filled outside the match using the criteria listed above to rate applicants.

Resident Promotion

For reappointment to the next level of training, each resident physician must have signed a new residency agreement (contract).

To be promoted to the next level of training and/or receive a certificate of successful completion of the program, a trainee must satisfactorily complete programmatic, administrative, patient care and educational requirements.

The Clinical Competency Committee (CCC) meets four times a year, monitors all resident performance, and makes recommendations to the Program Director for promotion, remediation, or termination. The CCC completes a mid-point evaluation in December of each year and a summary evaluation in June of each year, using the milestones for family medicine. The summary evaluation is used to make recommendations to the Program Director.

In the event of unsatisfactory performance in any area of training, promotion may be granted contingent upon satisfactory enrollment in and/or completion of remedial training according to a remedial plan approved by the CCC (See Evaluation and Remediation Policy).

Evaluations for promotion are based on the following criteria:

a) PGY 1 Promotion to PGY 2

- Satisfactory completion of all PGY1 rotations and all applicable longitudinal rotations.
- Maintenance of proper documentation of training experiences as required by the program.
- Fulfillment of responsibilities for patient care, including call responsibility and proper charting/ documentation of patient care.
- Demonstrated ability to work effectively as a member of a patient care team.
- Adherence to Memorial Medical Center employee policies and procedures as they apply to residents.
- Maintenance of ethical standards for patient care and professional behavior.

b) PGY 2 Promotion to PGY 3

- Satisfactory completion of all PGY1 rotations and all applicable longitudinal rotations.
- Maintenance of proper documentation of training experiences as required by the program.
- Fulfillment of responsibilities for patient care, including call responsibility and proper charting/ documentation of patient care.
- Fulfillment of responsibilities for supervision and teaching of junior residents.
- Demonstrated ability to work effectively as a member of a patient care team.
- Adherence to Memorial Medical Center employee policies and procedures as they apply to residents.
- Maintenance of ethical standards for patient care and professional behavior.
- Satisfactory completion of USMLE Step III.
- Completion of poster for research day (See “Research” section).

c) Graduation

The CCC will complete a summary evaluation of each resident at the end of the third year of training in order to record successful completion of the program. Criteria for completion of the third year of training and eligibility for graduation are:

- Satisfactory completion of all rotations and all applicable longitudinal rotations.
- Maintenance of proper documentation of training experiences as required by the program.
- Documented competence in procedures relevant to family medicine and the resident's practice plans as outlined.
- Fulfillment of responsibilities for patient care, including call responsibility and proper charting/ documentation of patient care.
- Fulfillment of responsibilities for supervision and teaching of junior residents.
- Demonstrated continuing ability to work effectively as a member of a patient care team.
- Adherence to Memorial Medical Center employee policies and procedures, as they apply to residents.
- Maintenance of ethical standards of patient care and professional behavior.
- Completion of a research or scholarly project with presentation and/or publication of project at local, state or national professional meeting.
- Completion of a quality improvement project.
- Requisition of a full and unrestricted license to practice medicine in a state of the resident's choosing.
- Sit for the ABFM board certification exam.

Resident Transfers

For residents transferring into this program at any other time other than the first year of training, the level of appointment within the training program will be determined by the number of years of post-graduate training which are approved by, and acceptable to, the Residency Review Committee in Family Medicine of the ACGME and the American Board of Family Medicine (ABFM). The ABFM requires that the last two years of residency are completed consecutively in the same institution (see www.theabfm.org). A resident will only be accepted in the program once a written or electronic verification of the resident's previous educational experience and a formal competency-based performance evaluation is obtained from their previous program.

Job Descriptions: PGY1, PGY2, PGY3, Chief Residents

PGY1

Under the supervision of the Program Director, the faculty or sub-specialty preceptor, the resident:

- Provides inpatient care at MMC under the supervision of an attending physician.
- Takes first call after hours as defined by the specialty service to which he or she is assigned, reporting to the appropriate attending physician.
- When assigned to the FMC, sees an average 4-6 patients per session, 1-2 half-days per week, under the supervision of family medicine faculty.
- When in the FMC, discusses patient encounters with a precepting FM physician according to Medicare billing guidelines and the policies of the residency program.
- Completes all charting duties within 24 hours.

- Attends inpatient teaching rounds appropriate to the service to which he or she is assigned.
- Attends wellness activities as scheduled unless prevented by clinical duties.
- Attends other activities required by the residency program unless prevented by clinical duties.
- Participates in the annual American Board of Family Medicine (ABFM) In-Training Examination.
- Participates in weekly didactic conferences.

PGY2

Under the supervision of the Program Director, the faculty or sub-specialty preceptor, the resident:

- Provides inpatient care at MMC under the supervision of an attending physician.
- Supervises and mentors PGY1 residents and other learners.
- Takes call after hours as defined by the specialty service to which he or she is assigned, reporting to the appropriate attending physician.
- When assigned after hours on-call, reports directly to the faculty attending on call for the appropriate service.
- Takes weekend call proportionate to the number of second and third-year residents in the program.
- Provides OB continuity care and takes call for OB patients under the supervision of OB physicians or FM physician with OB privileges.
- When assigned to the FMC, sees an average 6-8 patients per session, 3-4 half-days per week, under the supervision of FM faculty.
- When in the FMC, discusses patient encounters with a precepting FM physician according to Medicare billing guidelines and the policies of the residency program.
- Completes all charting duties within 24 hours.
- Attends wellness activities when scheduled unless prevented by clinical duties.
- Attends other activities required by the residency program unless prevented by clinical duties.
- Participates in the annual ABFM In-Training Examination.
- Participates in weekly didactic conferences.

PGY3

Under the supervision of the Program Director, the faculty or sub-specialty preceptor the resident:

- Provides inpatient care at MMC under the supervision of an attending physician.
- Supervises and mentors PGY1 residents and other learners.
- Takes call after hours as defined by the specialty service to which he or she is assigned, reporting to the appropriate attending physician.
- When assigned after hours on-call, reports directly to the faculty attending on call for the appropriate service.
- Takes weekend call proportionate to the number of second and third-year residents in the program.
- Provides OB continuity care and takes call of OB patients under the supervision of OB physicians or FM physicians with OB privileges.

- When assigned to the FMC, sees on average 8-12 patients per session, 4-5 half-days per week, under the supervision of FM faculty.
- When in the FMC, discusses patient encounters with a precepting FM physician according to Medicare billing guidelines and the policies of the residency program.
- Completes all charting duties within 24 hours.
- Attends wellness activities when scheduled unless prevented by other inpatient duties.
- Attends other activities required by the residency program unless prevented by clinical duties.
- Participates in the annual ABFM In-Training Examination.
- Participates in weekly didactic conferences.

Chief Residents

Selection of chief residents: The two chief residents are selected by a vote of the residents. Only those Residents who are in good standing are eligible to be chosen.

d) Eligibility:

- Candidates must have already passed Step 3
- Candidates are not on an action plan
- Candidates have a Baysian score above the 80th percentile on the ITE

Note: rare exceptions may be made with approval of the program director

The program recommends also considering the following interpersonal/additional criteria:

- Communication skills
- Teaching abilities
- Leadership capabilities
- Organizational skills
- Ability to represent the residents and the residency

e) Roles and Responsibilities

Under the supervision of the Program Director, the faculty or the PGY-3 Chief Resident(s):

(1) Administrative:

1. Works with the residency coordinator, to develop the yearly call, jeopardy, and block schedules.
2. Meets regularly with coordinator, administrative director and or clinical team lead, and program director to address concerns
3. Arranges call coverage for special situations/events as needed.
4. Develops call schedules and maintains a system of overseeing vacation and conference requests in accordance with residency program guidelines.
5. Resolves resident scheduling conflicts.
6. Takes an active role in recruitment and works in conjunction with the Coordinator as needed.
7. Ensures resident representation on appropriate hospital, clinic, and professional committees
8. Attends faculty meetings as directed, including faculty development
9. Assists in strategic planning each year, with specific goals noted.
10. Serves on Graduate Medical Education Committee as needed.

(2) Educational:

1. Serves as a role model for teaching, through both active teaching of residents and medical students and assisting junior residents in their teaching endeavors.
2. Directs didactic education, under the direction of didactic faculty advisor, and coordinates resident participation.
3. Provides prepared lectures as directed.
4. Acts as a resource for seminars and workshops given by and for the residents and coordinates resident participation in the workshops.
5. When possible, attends yearly at least one national meeting such as AAFP Chief Resident Workshop, STFM, RPS, or PDW
6. Assists in teaching, supervision and scheduling of medical students, under the direction of the medical student faculty advisor.
7. Provides feedback regarding curriculum and assists faculty in the ongoing program development process.
8. Organizes resident retreat
9. Assures residents are receiving regularly scheduled board preparation material

(3) Leadership:

1. Serves as a spokesperson for residents at faculty meetings, Resident/Faculty meetings, and other meetings as directed. This includes submitting agenda items prior to meetings.
2. Discusses procedural questions with residents on an acute basis.
3. The chief resident should serve as primary problem solver for resident issues regarding resident responsibilities of call, vacation, and CME. Residents are, whenever possible, to go to the chief resident with problems, and then to the faculty as necessary. The chief resident is encouraged to maintain close contact with the Director regarding any significant conflicts.
4. Participates in making clinic policies and serves as a spokesperson for the residents in initiating changes in the Family Medicine Center and in the residency program in general.
5. Directs the Res-Res meetings and relays appropriate information to the faculty and/or program director.
6. Coordinates activities of resident committees.
7. Serves as member on select residency and hospital committees.
8. Develops an atmosphere of cooperation among residents.
9. Provides leadership to residents and resolves conflicts among resident physicians.

(4) Supervision and Mentoring:

1. Takes active role in the orientation of interns
2. Orients medical students & visiting residents when time permits.
3. Provides feedback, as needed, regarding resident performance.

III. House Staff Policies and Regulations

Policies for Supervision

Levels of Supervision

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

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

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.

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.

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

Resident responsibilities for patient care

Residents in the first six (6) months of their PGY1 year will discuss all patients with the preceptor, and all patients will be physically seen and examined by the preceptor (Direct Supervision). After that time, the Clinical Competency Committee (CCC) may decide the resident can use his or her discretion in deciding which patients to discuss with the preceptor with the following exceptions:

- All level 4 or 5 visits must always be discussed with and seen by the faculty preceptor (direct supervision) regardless of training year. All Medicare patients must be discussed with the faculty preceptor. These responsibilities in compliance with the Medicare's "Guidelines for Teaching Physicians, Interns, and Residents."
- In addition, our program requires that residents discuss all HIV patients, high-risk OB patients, and patients on MAT with the faculty preceptor.

Progressive responsibility for patient management

As the skill of the resident increases, the responsibility for patient care will also increase as follows:

- All procedures will be directly supervised by the attending faculty.
- All patient care will be directly supervised by the attending in the FMC at least for the first six months. Then, as per the primary care exception rule, if the CCC agrees that the resident's skill level is appropriate, the Resident may, at his or her discretion, decide which patients the preceptor should see. All patients must be presented until the resident advances to the PGY 2 year. Regardless of year, all level 4 or 5 visits, high risk OB, HIV and Medicare patients must be discussed with the preceptor.

- PGY 1 residents will be the point of first contact in the hospital. All patient care on the FMS inpatient and OB services will be under direct supervision by the senior resident on the service and the attending faculty member.
- PGY2 residents will assume a teaching and supervisory role on the FMS inpatient and OB service upon successful completion of the PGY1 year, and agreement of the CCC.
- PGY3 residents will continue to hone their teaching and supervision skills and will assume more responsibility running the inpatient and OB services with the Attending acting in a consultative role. The Attending will see all patients on the inpatient service and appropriately document their involvement in the patient's care (Direct Supervision).

Basic structure for advancement/changes in supervision:

July

- PGY1 residents will be provided 4 patients per half day in the FMC.
- Faculty will see all patients seen by PGY1 residents in the clinic (Direct Supervision).
- PGY2 residents will be evaluated for advancement to 6-8 patients per half day in the FMC. All care will have Indirect Supervision with direct supervision immediately available. Except for procedures, which will require Direct Supervision.

January

- PGY1 residents will be evaluated for advancement to 6 patients per half day in the FMC.
- PGY 1 residents will no longer need faculty to see all patients in clinic, but will verbally present all patients (Indirect Supervision with direct supervision immediately available).
- PGY2 residents will be evaluated for their ability to precept only complex, critical, OB patients or patients with significant change in status to the attending physician at night in the hospital service (Indirect Supervision with direct supervision available).
- PGY2 residents will be evaluated for advancement to 10-12 patients per half day in the FMC.

Supervision of Patient Care

The faculty physician of record is responsible for the quality of all aspects of the clinical care services provided to their patients.

A resident may only provide patient care within the scope of the Family Medicine Residency Program when a faculty member is available on site or by telephone. Faculty attending physicians are assigned to the inpatient service, the Family Medicine Center, or other educational sites specifically for the purpose of teaching and supervision of the residents and direct patient care. If not available on the premises, an attending physician will be available 24 hours a day by telephone.

The program will post call schedules showing the responsible supervising faculty physician for the Family Medicine inpatient service and after-hours coverage of the FMC. Specifics on the process of supervision in the various settings in which educational activities take place are described as follows:

Circumstances and events in which residents must communicate with supervising faculty members:

- Admission of any patient to L&D
- Admission or transfer of any patient to an intensive care unit or step down unit.
- Status change of any patient that requires, or may require, a higher level of care.
- Prior to any procedure to be performed so that an attending physician may be present to directly supervise the procedure.
- Notification of any procedure performed in an emergency situation, in the absence of an attending physician.
- Death of a patient
- Any end-of-life decisions
- Any instance where the resident has questions or is concerned about the care of a patient.
- When resident fatigue or well-being may interfere with the provision of safe patient care.

In-patient
Responsibilities of attending physicians on the teaching services include:

- Discuss the patient's presentation and provide supervision in developing the diagnostic and management plan at the time of admission.
- Direct supervision of ALL procedures performed by the residents, both in- and out-patient settings.
- Daily contact with residents to discuss the patients' problems and associated care plans. This will occur during rounds.
- Writing orders as required for patient care.
- Approving all requests for consultations.
- Appropriate documentation of supervision and patient care in the medical record.
- Providing appropriate documentation and evaluation of resident performance.
- Informing patients of the involvement of residents in their care and of the nature of the resident's responsibilities.

At the Family Medicine Center
Services furnished in teaching settings are paid under the Medicare Physician Fee Schedule (MPFS) if the services are:

- Personally furnished by a physician who is not a resident;
- Furnished by a resident when a teaching physician is physically present during the critical or key portions of the service; or
- Furnished by residents under a primary care exception within an approved Graduate Medical Education (GME) Program.

All procedures performed in the FMC will be directly supervised by attending faculty.

All electronic medical records of patients seen by the residents at any level, need to be forwarded to the attending who was precepting for that session. The attending physician for that session will review all

charts and sign and document their involvement in the care of the patient following the documentation guidelines outlined by Medicare.

Policies for Transitions of Care/Handoff

Background:

The Southern New Mexico Family Medicine Residency Program provides for the safe transfer of responsibility for patient care through standardized handoffs/transfers of care. The program's standard is to ensure continuous, coordinated delivery of care in settings that are appropriate to patients' needs, including arrangements that extend beyond the inpatient setting into the community and the home.

A handoff is the process of transferring information, authority and responsibility for a patient during transitions of care. Transitions include changes in providers – whether from shift to shift, service to service, or hospital or clinic to home – or when a patient is moved from one location or level of service to another.

Both written and verbal handoffs are important, and each has a different purpose. Written handoffs can provide detailed information that serves as a reference for the receiving provider. Verbal handoffs allow discussion and cross-checking with the receiving provider to be certain that he/she has understood the information being provided.

Procedure:

The residency program's handoff policy outlines the expectations for transfer of responsibility for patient care in all the settings and situations in which handoffs occur. The amount of information to be included in the process will vary depending on the functional role of the resident or faculty in patient care. Below are the specific requirements for patient care hand off. All patients for whom a resident or fellow is responsible must be included in the handoff.

1. **Time and place of routine handoffs**

   Residents:

   Daily: Resident to resident-- 6am and 6pm in the 2nd floor "bat cave"
   Resident and faculty daily brief—9am in the "bat cave" or physician lounge

   Monthly: Friday before service change either:
   Face to face at 6pm "bat cave" sign out or over the phone
   Written interim summary (see #3 Transitions of service below)

   Faculty:

   Daily: 8am and 5pm face to face in FMC or over the phone
   Resident and faculty daily brief—9am in the "bat cave" or physician lounge
   Weekly: Sunday evening before service change over the phone

The handoff process MUST allow the receiving physician to ask questions, so written handoff alone is not acceptable. The time chosen should be as convenient as possible for all participants.

2. **The structure for handoffs.**
Verbal handoffs should follow a predictable structure. Residents should consistently follow the IPASS model:

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Time line and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

Physician Signout must be structured and organized so that information is provided in a predictable format or is readily available for each patient. Written information for residents and faculty providing continuous care and taking responsibility for order writing should include the following:

- Identifying information --Name, location, history number, hospital day
- Diagnosis, procedures, condition
- Problem list
- Allergies
- Medications and other treatments
- Pertinent laboratory results
- Pending laboratory and other studies
- Important contact information (e.g., patient's attending of record, family, referring physician)

The "scut sheets" are a good tool to provide the above information in an organized manner. All interns must use scut sheets for their first year to assist in learning how to organize information for each patient.

3. **Transitions of service:** An "interim summary" note must be written by the responsible resident when the entire resident care team rotates off service on the same day, and the team has cared for the patient for more than 48 hours (24 hours for ICU care). This note should provide a sufficient summary of the patient's hospitalization and proposed plans so that the next resident(s) can assume knowledgeable care of the patient in an efficient manner.

4. **Admissions:**
    - All H&Ps should be completed at time of admission.
    - Medication reconciliation should be verified with the patient on admission

5. **Discharges**
    - Discharge summaries must be dictated on the day of discharge by the discharging resident.
    - The discharging resident must ensure that prescriptions for discharge medications are written and available at the time of discharge.
    - Medication reconciliation should be verified with the patient on discharge.
    - Nursing home discharges must include the following additional tasks:
        - Telephonic notification of attending covering specific nursing home

Policies for Clinical Experience and Education Work Hours

The SNMFRP is committed to patient safety and resident well-being. To accomplish this, the program strictly follows the ACGME guidelines for Resident Clinical and Education Work Hours (see www.ACGME.org). Residents are required to record their individual clinical and educational activities monthly on New Innovations, and a report is created and submitted to the institutional compliance officer. All clinical and education work hours must be recorded by the resident within 14 days following the end of week for which hours were worked. If a violation of the clinical and education work hours is encountered, the violation is investigated and a corrective action plan is instituted. This action plan is then submitted to the institutional compliance officer. If a resident or faculty member does not follow the clinical and education work hour rules on a consistent basis, they may be subject to disciplinary action. Per the ACGME:

Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Clinical Work and Education

Residents should have eight hours off between scheduled clinical work and education periods. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. Residents

must be scheduled for a minimum of one day in seven free of clinical work and required education averaged over four weeks.

Maximum Clinical Work and Education Period Length

Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to resident during this time.

In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; humanistic attention to the needs of a patient or family; or to attend unique educational events. These additional hours of care or education will be counted toward the 80-hour weekly limit.

In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.

Policies for Resident and Faculty Well-Being

Fatigue

On an annual basis formal education is provided to all residents regarding fatigue. The SAFER (Sleep, Alertness, and Fatigue Education in Residency) program from the American Academy of Sleep Medicine is presented. All Residents are educated on the recognition of the signs of fatigue. If a resident or faculty member notices the signs of fatigue in a resident, actions will be taken to relieve the fatigued resident.

The FMS, OB and Night Float rotations all have junior and senior residents with attending faculty supervision. When fatigue has the potential to impact resident performance or patient care, the patients under the affected resident's care will be shifted to the senior resident on FMS, OB or Night Float. If this is not an option (i.e. senior resident not able to cover) the chief resident will be notified and the jeopardy system will be activated. If the jeopardy system does not resolve the issue, the supervising faculty will assume direct care of the patients.

Resident and Faculty Well-Being

The residency program is dedicated to resident and faculty well-being. In order to maintain overall well-being the residency wellness committee ensures that wellness is a component of all aspects of the residents' educational experience. The committees' efforts focus on enhancing the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; attention to scheduling, work intensity, and work compression that impacts resident well-being; evaluating workplace safety data and addressing the safety of residents and faculty members; as well as policies and programs that encourage optimal resident and faculty member well-being.

Residents and faculty members are encouraged to offer support to one another if they notice a colleague is struggling with well-being. In addition, residents and faculty members should alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.

Residents are given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

Please see the section "Where to Go for Help" for more details.

Moonlighting Policy

Moonlighting is discouraged in the program because it must be included in duty-hour limits. All moonlighting must be approved by the Program Director and the following criteria must be met:

- The resident must be in good standing.
- The resident must obtain and maintain professional liability insurance, malpractice coverage, and indemnification and submit certificates of such coverage to the Program Director.
- For activities outside the training program (i.e., moonlighting), residents must secure an individual DEA number.
- The resident must have an unrestricted license to practice medicine in the state of New Mexico.
- No moonlighting is permitted during hours when the resident is assigned to be on duty in the residency program.
- The resident will report all moonlighting hours to the Program Coordinator. These hours will be added to the duty-hour limits, and the resident hours must remain in compliance with the ACGME duty-hour requirements.
- All Moonlighting must follow the ACGME common program requirement: "Moonlighting must not interfere with the ability of the Resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety. Time spent by Residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. PGY-1 Residents are not permitted to moonlight."

Licensing, Credentialing, Contracts, and Certifications

USMLE Step III and Licensing

Satisfactory completion of licensing examinations and obtaining a license to practice medicine are crucial steps in the progression of a resident from medical student to practicing physician. Additionally, holding a valid and unrestricted license to practice medicine is necessary to register to take the American Board of Family Medicine Certification Examination. All residents must hold a valid and unrestricted license to practice medicine to be eligible to graduate from the residency program. It is in the best interest of the resident to complete these steps as early in his or her training as possible.

All residents will take the USMLE Step III at the end of the PGY1 year of residency or within the first 6 months of their PGY2 year. If a resident fails the examination, he or she will be required to re-take the examination at the next opportunity in order to advance and graduate on schedule. Residents will be allowed only three attempts to pass USMLE Step III during their residency. All residents must pass USMLE Step III to be given a contract for the PGY3 year of residency.

All second-year residents will be required to register for USMLE Step III no later than September 15th and provide this documentation to the Academic Coordinator. Residents must sit for the exam no later than December 31st. Please do not schedule the exam while on an inpatient rotation if at all possible.

For residents who attended schools of osteopathic medicine, the NBOME Part 3 will be acceptable in place of the USMLE Step III.

Residents may use their CME funds towards reimbursement of USMLE Step III fees.

DEA Number

The institutional DEA number assigned to residents covers all training program activities. For activities outside the training program (i.e., moonlighting), residents must secure an individual DEA number.

New Mexico Training License

The New Mexico Board of Medical Examiners issues a training license to house officers for participation in residency programs. This training license is renewed annually for the duration of the program (not to exceed eight years). For any activity outside the training program, e.g., Locum Tenens or moonlighting, a resident must have a New Mexico license to practice medicine.

In addition to training licenses, the New Mexico Board of Medical Examiners grants Public Service and unrestricted Professional licenses. To be eligible for an unrestricted license, the resident must have two (2) years of post-graduate training completed in the United States. A Public Service License is available to resident physicians after one (1) year of post-graduate training and successful completion of USMLE Step III, and with the written permission of the Program Director.

Contracts Residency Training Requirements for Board Certification Eligibility

Candidates for certification are required to complete 36 months of graduate medical education in an ACGME accredited Family Medicine residency program. In some situations, the training may be extended for additional time to meet the minimum requirements. All residents must have core clinical training that includes the breadth and depth of Family Medicine. These include, but are not limited to:

1. Residents are required to spend their PGY-2 and PGY-3 training in the same residency program's teaching practice, in order to provide sustained continuity of care to their patients
2. Each year of residency must include a minimum of 40 weeks of continuity clinic experience (exceptions may apply if the residency program has received a waiver of this requirement in connection with pilot projects assessing intentional variation in training requirements)
3. Residents are required to complete a minimum of 1650 in-person patient encounters in the continuity practice site to be eligible for ABFM certification.

At the end of training, the Program Director is expected to sign, on behalf of the program, that the resident has met all requirements for board eligibility and is ready for autonomous practice.

Residents' employment contracts are in effect for a period of one academic year. If the resident successfully completes all of the academic requirements for promotion, the resident will be offered a contract for the next training year. Where a prolonged illness or absence occur during the period of the contract, arrangements for adjusted duration of training interval must be made and the contract amended in accordance with established policies.

Certifications

Residents are required to have current certification in NRP, BLS, ACLS, PALS, and ALSO and these certifications are expected to be kept up to date. NRP, BLS, ACLS and PALS will be taught during the initial orientation month. All courses will be given free of charge to residents who take the course at MMC. If a resident chooses to take the course elsewhere, he or she will be responsible for the cost of the course and the time away will be deducted from their CME or vacation. If the resident wishes to have currency in other certifications such as ATLS etc., which are not absolutely necessary for their work here, the resident will be responsible for the cost of the course. Time for the course will come from their CME time or from their own scheduled vacation time.

Hospital Coverage and Call

Call

Call coverage is an expected patient care responsibility. Thus, the residents are expected to create a call schedule that covers patient care responsibilities on the family medicine service 24/7. The chief resident has the primary responsibility to create and maintain the residents' call schedule. Calls will be distributed as equally as possible for all residents and will follow the current ACGME guidelines for duty hours.

ER Response Times

Timely response to emergency room calls is essential. ER response times are a measurement of quality. Once it has been determined that a patient requires admission to the hospital, the patient's inpatient treatment should begin promptly. Thus, once called for an admission, the resident must promptly present to the ER to evaluate and admit the patient in question. This response time must be within 30 minutes or less. If the resident holding the on-call phone is busy with another patient care issue, he/she should ask one of their colleagues for assistance. If there is no one else available to respond to the ER, please inform the ER of the situation and provide them with your estimated time of arrival.

Call Changes

In the event the call schedule needs to be altered, all residents involved with the change will be notified as soon as possible, preferably 6 weeks in advance. If a call change is needed with less than 6 weeks notice, the residents will be notified as soon as possible prior to the call change to ensure availability.

Call changes may be made between residents, as long as they remain compliant with the ACGME duty hour rules, and with prior approval of the Program Coordinator and chief resident. If changes are to be made, it is essential to ensure that there are no scheduling conflicts (i.e. resident scheduled for afternoon clinic on post-call days) and the Resident Request/Change Form is submitted to the Program Coordinator.

Jeopardy Coverage System

The jeopardy coverage system was put into place to create a backup system to allow for unexpected coverage needs. This system was designed to provide resident coverage for unexpected absences (illness, fatigue, etc.) as well as to provide extra help to an overwhelmed system in times of high demand (flu season or disaster). At the beginning of each academic year, all residents will participate in lottery system facilitated by the chief resident. Using the lottery system, residents will be assigned a number, which will be the order they are contacted for coverage. If a resident on the jeopardy list can NOT provide the coverage needed (duty hour violation, away rotation), the subsequent person on the list will be contacted. This process will continue down the list until coverage is provided. Once a resident has provided coverage from the jeopardy list they move to the bottom of the list.

On-Call Quarters

On-call quarters ("Bat Cave") are located on the second floor of the hospital. All quarters are private and locked. All quarters include regular housekeeping service. It is however, incumbent on the resident to maintain the on-call room in a neat and orderly fashion.

FMS Cap

The program director has the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each resident based on that resident's PGY level, patient safety, resident education, severity and complexity of patient illness/condition, and available support services. As a rule of thumb each resident on the inpatient service should manage between 5 and 10 patients to maintain sufficient clinical experience. In the instance that the FMS service patient number falls below the minimum number, the hospitalist service will be contacted and ER admissions will be shifted to the FMS service.

Family Leave Policy and Time Away from Training

Vacation, Illness, and Other Short Term Absences

All Residents will receive 21 days paid time off during the training year. Paid time off for contracts with a term of less than twelve (12) months will be calculated on a pro-rated basis. Paid time off that is unused will not be carried forward to the new training year. No lump sum payment will be made for unused vacation upon termination.

Residents may take their 21 days paid time off during any rotation except during Orientation, OB, FMS, Night Float or the inpatient Pediatric rotation at UNM. No more than 5 days of paid time off can be requested per rotation block. Weekends may not be requested and are not guaranteed. PGY-3 residents may not request vacation the last week of June.

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

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.

Paid time off must be requested on the Resident Request/Change form and must be submitted six (6) weeks in advance. Residents will be informed via email if requests are approved. No request will be entertained if it is not completed and submitted on the form. All requests will be granted on a first come first serve basis. Changes may be made and these requests must be received a minimum of six (6) weeks in advance.

A denial may be given due to scheduling conflicts or for educational reasons (for example: requests will not be granted if it results in more than three senior residents being off on the same rotation during the same week and if it has a negative impact on patient care or if it takes away from a complete learning experience). Prior to leaving for vacation or time away, residents must complete the "Checklist for Residents Going On A Rural Rotation or Vacation" and have it signed by all the appropriate individuals indicate on the form.

If you are going to be absent from any of your rotations and/or clinic you must contact the program coordinator, and the community preceptor (if applicable). If your community preceptor is not available on a day that you are scheduled or sends you home early (more than ½ day) you must contact both your advisor and the program coordinator.

If you are going to be absent on an inpatient rotation, you must contact the chief residents, program coordinator, and senior resident. In order to ensure that a resident's educational requirements are met and that patient coverage is arranged, the people listed above must be contacted.

CME

PGY-2 and PGY-3 residents receive one week (5 days) of CME. This time is dedicated to professional, formal educational activity. The resident's faculty advisor and the program director must approve all CME. Because CME impacts the resident call schedule, the chief resident must also approve of the CME time off to assure adequate call coverage. Annual CME that is unused will not be carried forward to the new training year. No lump sum payment will be made for unused CME upon termination.

The same form should be used for requests for time away for CME conferences. These requests must be received a minimum of six (6) weeks in advance.

Residents may take CME on any month except on family medicine service, night float, OB rotations, or during the ITE exam day and Resident Research Day.

A denial may be given due to scheduling conflicts, for educational reasons (for example: CME will not be scheduled if more than one resident is off during the same week and it has a negative impact on patient care or if it takes away from a complete learning experience) or because the CME is not appropriate.

Currently residents receive $450 in the PGY 1 year, $600 in the PGY 2 year, and $750 in the PGY 3 year for CME. All funds can be used toward the USMLE step 3, CME activities or education material approved by the program director.

Time Allowed for Family Leave of Absence

Family leave within a training year:

Family leave will be provided in the same circumstances specified in the federal Family and Medical Family Leave Act (FMLA), including:

- The birth and care of a newborn, adopted, or foster child, including both birth- and non-birth parents of a newborn.
- The care of a family member with a serious health condition, including end of life care
- A resident's own serious health condition requiring prolonged evaluation and treatment

Definitions of "family member" and "serious health condition" will be determined by the Program Director and institutional policies

Residents are allowed up to 12 weeks away from the program in a given academic year without requiring an extension of training as long as the Program Director and the CCC agree that the resident is ready for advancement, and ultimately for autonomous practice. This *includes* up to 8 weeks total attributable to Family Leave, with any remaining time up to 4 weeks for other leave as allowed by the program (see above).

Total Time Away Across Training

A resident may take up to a maximum of 20 weeks of leave over the three years of residency without requiring an extension of training. If a resident's leave exceeds either 12 weeks away from the program in a given year, and/or a maximum of 20 weeks total, extension of the resident's training will be necessary to cover the duration of time that the individual was away from the program in excess of 20 weeks.

Family leave may cross over two academic years. In this circumstance, the Program Director and sponsoring institution will decide when the resident is advanced from one PGY-year to the next.

Residents are expected to take allotted time away from the program for other leave according to institutional policies. Foregoing this time by banking it in order to shorten the required 36 months of residency or to retroactively "make up" for time lost due to sickness or other absence is not permitted.

Required Resident Educational Experiences

Required

Each resident is assigned clinical rotations based on ACGME and ABFM requirements. All rotations must be successfully completed in order to advance to the next level of training. If any scheduled rotations are to be changed, this must be coordinated and approved by the resident's faculty advisor, program coordinator and the program director. All requested schedule changes must be made at least 6 weeks prior to the scheduled rotation.

Elective

Each resident will have at least three elective months during their three years of training, as outlined by the ACGME requirements. Before an elective rotation can be scheduled, the resident's faculty advisor must approve the rotation and ensure that a curriculum with educational goals and objectives is in place prior to the start of the rotation. It is essential that an individual with appropriate qualifications be identified to assume responsibility for supervision of any elective experiences. The Program Director must approve this individual prior to the rotation. In order to complete all needed documentation, the residents must make the request for the rotation to the academic coordinator at least 6 weeks in advance. The resident must notify the Program Director of any change in preceptor or elective structure during the elective rotation.

Procedures

Below is a list of the procedures or experiences that must be documented during residency training. All documentation must be in New Innovations in order to be counted toward promotion and graduation requirements. The number listed in parenthesis is the number required prior to graduation.

a) Required Procedures:	***(Number Required)***
Biopsy of Dermal Lesions	(6)
Circumcision	(6)
Cryosurgery of Skin	(6)
Curettage of Skin Lesion	(3)
Defibrilation (ACLS/CPR)	(must be current)
EKG Interpretation	(6)
Endometrial Biopsy	(3)
Endotracheal Intubation	(6)
Excisional of Subcutaneous Lesions	(6)
Incision and Drainage of Abscess	(6)
IUD Insertion	(6)
Joint Injection/Aspiration	(6)
Laceration Simple Repair	(6)
NST/CST Interpretation	(6)
Wet Mount	(1)
Pap Smear	(1)
Removal of Cerumen from Ear Canal	(3)
Splinting	(6)
Toenail Removal	(3)

Deliveries	Overall = 40 (Vaginal =30; Continuity = 10)

Required Experiences:

Management of Health Systems	100 hours or 1 month
Nursing Home	Required during entire 36 months of residency
Home Visits	3 with one being an older adult continuity patient
Sports Medicine	50 hours, 10 on field hours
Hospitalized Adult	600 hours or 6 months and 750 encounters
ICU	100 hours or 1 month or 15 patient encounters
Emergency department	200 hours or 2 months or 250 patient encounters
Older patient	100 hours or 1 month or 125 patient encounters
Care of ill children in the Hospital and/or emergency Department	200 hours or 2 months and 250 patient encounters (Min 75 patient encounters in the hospital and 75 in the emergency department)
Care of children in the ambulatory setting	200 hours or 2 months or 250 patient encounters
Newborn	40 patient encounters
Care of surgical patents	100 hours or 1 month
Orthopedics	200 hours or 2 months
GYN	100 hours or 1 month or 125 patient encounters
OB	4 months (ACGME requires 200 hours or 2 months)

Other:

Clinical experience and education hours must be logged within 14 days after end of week during which hours were worked

Continuity clinic patient	1650 patient encounters (at least 165 must be < 10 years of age) (at least 165 must be > 60 years of age)

Continuity patients do not need to be recorded in New Innovations. The residency program will track and report these numbers to the resident during each quarterly IEP.

Patient Care Continuity

Continuity of care is a recognized core value of the specialty of Family Medicine. Continuity of care extends outside the clinic to the home, nursing home, hospice, and the hospital but is not limited to these areas. Thus, the resident must provide continuity of care to their patients in these various settings. The required areas of experience are as follows:

- The nursing home experience, which must occur during the entire 36 months of residency.
- Each resident must perform at least two home visits with at least one being for an older adult continuity patient.
- When a patient from a resident's continuity panel is admitted to the hospital the resident must see the patient and write a PCP note in the patient's chart while the patient is in the hospital. It is the responsibility of the FMS resident assigned to the patient to notify the PCP of the patient's admission. At least one note must be written, but daily notes are preferred. The exception to this rule is if the resident is on vacation, on an away rotation, or on CME.

Additionally, all residents must have at least 40 deliveries (30 vaginal) with 10 continuity deliveries prior to graduation. Continuity visits for OB patients include delivery and any three of the following:

- Prenatal care (at least 2 visits)
- Postnatal care
- Care of the neonate in the hospital
- Care of the neonate in the FMC

A combination of at least four visits is required in order for this to be deemed continuity. It is understood that it may not be possible to make all deliveries, but it is an expectation that every effort be made to attend a delivery of a continuity patient. The decision to grant a continuity delivery to a Resident that misses a delivery will be at the discretion of the attending on service at the time of delivery. We feel that continuity is an essential aspect of Family Medicine and thus, this will be the only instance that may surpass the 8- hour rule provided the resident does not show any signs of fatigue.

Research

Research/scholarly activity is an ACGME requirement and an important part of a resident's education. Residents should complete two scholarly activities, at least one of which should be a quality improvement project. The resident's advisor and the research committee will supervise resident scholarly activity projects. All residents must meet all scholarly activity deadlines set during quarterly IEP meetings.

Conferences (Didactics, Grand Rounds, Tumor Board, Board Review etc.)

All residents must attend educational conferences unless they are on an away rotation or elective, vacation, or CME. Conference attendance is recorded using New Innovations. Attendance at a minimum of 75% of conferences, Tumor Board, Grand Rounds and other required activities is expected. Failure to attend the minimum percentage of these activities is academic misconduct and may require remediation. The majority of educational conferences are scheduled on Wednesday afternoons. Residents are responsible for planning required duties and work to accommodate these scheduled sessions.

The program conducts weekly board review sessions. Residents who fall below 90% on the Bayesian score predictor on the ITE must attend these sessions. The sessions are open to all residents, and many additional residents take advantage of these sessions to prepare for the boards.

Miscellaneous

House Staff Offices

Resident offices are located in the modular building adjacent to the FMC (the Annex or "Tank"). Residents must maintain their offices in a neat and orderly fashion as these are shared with other residents. Residents must keep offices locked at all times due to the presence of patient information and to maintain compliance with HIPAA guidelines. After hours and on weekends, when the Annex is to be vacated, the last person to leave the building must arm the alarm system. The offices also include locked overhead storage cabinets for all residents.

Meals/Cafeteria

Meals for residents on-call/in-house will be provided at Memorial Medical Center doctor's lounge.

Mail/Email

Residents must check their mailboxes, located in the Annex, on a regular basis. These mailboxes are used for clinic patient matters.

Email is the most common form of communication in this residency program, and residents should read their hospital email daily. Email must not have any HIPAA sensitive information. Any inappropriate use of email may be subject to disciplinary action.

Cell Phones and Laptops

All residents are assigned a laptop computer and a cell phone with a case. MMC will not upgrade equipment during the 3 year residency. This equipment is hospital property and its use is for the purpose of completing your employment duties. Please refer to the hospital policy on cellular phones in Section C-11. Residents must use this equipment in professional manner. Any inappropriate use may be subject to disciplinary action.

If a resident wishes to use their own personal phone, they must have a Verizon account and allow MMC to take over the billing. The resident must sign an Assumption of Liability form in order to MMC to take over the billing.

The resident must cover lost or damaged equipment insurance claims unless other coverage is approved by the program director.

Reimbursement Policy

All travel reimbursement will be paid in accordance with the MMC and LPNT reimbursement policies and are subject to pre-approval and submission on the correct pre-travel forms (see section F.). The policies can be accessed via the MMC intranet. Please be sure to have itemized receipts for all expenses.

Attendance Policy

Residents are expected to attend activities required by the residency program. Examples of such activities include, but are not limited to:

- Clinic
- Rounds
- Rotations
- Didactics
- Journal Club
- Tumor Board

Repeated absence is considered professional, academic and clinical misconduct and maybe subject to disciplinary action as per the hospital attendance/punctuality policy

Checkout Process for Vacation, Away Electives, and Graduation

a) Vacation, CME or Away Rotation Check Out

Before a resident leaves for either vacation or an away/rural rotation, they must meet the following requirements.

- The resident must be cleared through medical records by obtaining a signature from both the clinic AND the hospital medical records personnel.
- The resident must review both the call and clinic schedule to ensure that all calls and clinics are covered.
- The resident must identify a covering physician to care for his or her patients' needs in his or her absence including Rx refills. (as per team assignment)
- The resident must leave an emergency phone number where they can be reached. This number will only be used in case of emergency.
- The resident must place an out of office notice on eCW and on their Outlook email account.
- The resident must ensure that they clear all chart lag, phone notes, duty hours and paperwork from their mailbox.

b) Graduation Check Out

Prior to graduation:

- The resident must be cleared through medical records by obtaining a signature from both the clinic and the hospital medical records personnel.
- The resident must sign off nursing home patients to a new resident with a verification signature from the faculty in charge of overseeing the nursing home visits.
- The resident must turn in laptop, token, cell phone, keys, and ID Badge to the Academic Office.
- The resident must clear mailbox, desk and office of all personal belongings and have mail forwarded to the appropriate address.

IV. Evaluation and Remediation Policy

Evaluation

The key to successful education of residents is a well thought out and implemented evaluation system. The evaluation system should be designed in a manner that provides timely feedback to residents, so that they can improve their skill levels and act upon identified weaknesses. This is done by providing direct, specific and actionable feedback. Currently the residency uses many evaluation tools listed below.

IEP

The resident's advisor will conduct quarterly summary cumulative evaluations (Individual Educational Plans or IEP's). The advisor will put these evaluations in writing and discuss them with the resident. The resident will be required to acknowledge the evaluation. The advisor will evaluate the resident's knowledge, skills, clinical performance and professional growth and will update the CCC on the

resident's progress. The advisor may meet with a Resident more frequently, at the advisor's, or at the Resident's discretion.

New Innovations

New Innovations is an online tool for residency management. Evaluations and procedure logs are one component of this online tool. The resident is expected to record procedures and specific learning experiences in New Innovations including nursing home visits, didactics, management of health systems hours etc. Also many of the rotational evaluations will be in New Innovations.

360° Evaluations

360° evaluations are evaluations from patients, nursing/support staff and peers that focus on areas of the resident's sphere of influence other than faculty evaluations of resident performance. This type of evaluation will provide a better picture of the resident's functioning in the medical setting.

Rotation Evaluations

At the end of each clinical rotation, the precepting physician, prescribing psychologist or midwife, whether residency or community faculty, will complete an evaluation form for the resident. The evaluation form includes rotation-specific objectives, as well as areas for general discussion of the resident's performance. Rotation evaluations will be reviewed in the IEP.

Clinical Competency Committee (CCC)

The purpose of the Clinical Competency Committee (CCC) is to conduct meaningful assessments of the residents based on multiple sources of information including formative and summative evaluations, milestones-based assessments, and 360 degree evaluations in compliance with the ACGME requirements. These assessments are meant to provide meaningful performance evaluation and feedback to allow the program director to make informed decisions regarding resident progress including promotion, remediation, and dismissal. The role of the CCC is to make a consensus recommendation on the progress of each resident in achieving the relevant milestones.

- In accordance with the ACGME requirements, the program director will appoint the Clinical Competency Committee. At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. The program director may appoint additional members of the Clinical Competency Committee. These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings. While not part of the CCC, the program director may attend the meeting and be available for clarification, consultation, etc.

The Clinical Competency Committee will:

- Meet quarterly in September, December, March and June of each year. The CCC may meet more frequently as required by the needs of residents placed on concern status.
- Review all resident evaluations quarterly after the completion of the quarterly individual educational plans (IEP's).

- Assist the faculty advisor in creating and implementing action plans for resident in concern status.
- Prepare and assure the reporting of milestones evaluations of each resident semi-annually to the ACGME;
    - Reporting windows are:
        - November 1-December 31
        - May 1-June 15
- Set thresholds for promotion, remediation and dismissal. Interventions a program might consider include assigning a mentor with expertise in a given area of deficiency, additional required readings, sessions in a skills lab, and/or added rotations in a given area. If, after remediation, a resident still fails to advance sufficiently on one or more milestones, the CCC may consider remedies such as extending the length of the educational experience, or counseling the resident to consider another specialty or profession.
- Advise the program director by June and December of each year regarding resident progress, including promotion, remediation, and dismissal.
- Generate a report/recommendation letter to the program director for each resident.

The program director and/or the program coordinator will report the aggregate, de-identified information for all residents in the program to the ACGME via the ADS system.

The Program Director has final responsibility for the program and trainees' evaluation and promotion.

Evaluation	When They Occur	Who is Responsible for Administration	When They Will Be Reviewed with the Resident	Who Will Review with Resident
Rotation evaluations	After each block rotation	Rotation faculty member	At each IEP	Faculty advisor
IEP	Quarterly	Faculty advisor	At each IEP	Faculty advisor
CCC/Milestones	Quarterly	CCC	At each IEP	Faculty advisor
Peer-evaluations	After each block rotation	Program Coordinator	At each IEP	Faculty advisor
Self-Milestone evaluations	Quarterly	Resident will self-evaluate with direction by program coordinator	At each IEP	Faculty advisor

360 evaluations	Quarterly	Program Coordinator	At each IEP	Faculty advisor
ITE	Annually in October	ABFM and Program Coordinator	Annually in didactics	Program Director

Identification of struggling learner

The residency program has developed specific steps to provide support for learners who are struggling in any of the six core competencies. The identification of the struggling learner can happen in several ways:

1. By meeting outlined threshold
2. By self-referral
3. By faculty identification of struggling resident
4. Referral from other source

The steps faculty will take steps to address a voiced concern of a learner

Step 1. Request documentation and examples
Step 2. Notify and discuss the learner's performance with ONLY those who need to know
Step 3. Confirm the concern and collect more information as needed
Step 4. Decide

- Is this a trend that needs intervention?
- Is this an isolated serious problem that needs intervention?
- Does this concern warrant only monitoring at this point?

Step 5. Make sure the learner receives direct feedback of the deficit(s)

- Often, the faculty advisor provides this feedback You may have to do this yourself
- Examples of poor performance are essential, especially if the faculty advisor wasnot present when the deficit was noticed.

Please see Appendix A for specific thresholds utilized by faculty to determine whether a resident needs additional support.

When it is determined that thresholds for additional support have been met, the struggling learner is referred to the CCC to determine next steps. Please see Appendix B for details on the steps in this process and Appendix C for a flow diagram.

The CCC will determine the need for an action plan and/or a success team. Please see Appendix D for details on how the CCC, faculty advisor, and/or success team will develop an action plan. Please see Appendix E for a sample action plan.

Reassessment

Following remediation, the advisor or success team must formally assess the learner for the following criteria.

1. Has the resident shown significant improvement and caught up to her/ his level of training in the previously deficient competency(ies)?
2. Is the improvement sustainable?

The advisor or success team can reassess using any of the following assessment methods:

- Repeat the clinical block, or portion of the block with a new team
- Standardized patient encounters
- Objective structured clinical examinations
- Mini-clinical evaluation examinations
- Brief structured clinical examinations
- Simulation
- Directly observed encounters with actual patients
- Clinical evaluation exercises
- Multiple choice exams
- Written or web-based assessments
- Chart reviews and chart-stimulated recall
- Supervisor or peer observations
- Multi-source evaluations
- Patient and procedure logs
- Critique of journal articles
- Responses to self-assessment

See Appendix F for a table linking competency to reassessment methods.

6. Outcome

There are two possible main outcomes of remediation. One is successful remediation and return to good standing. The other is failed remediation with continued remediation, possible withdrawal, or termination. The process of reevaluation will provide the advisor and success team information to determine return to good standing (this will be the case for most learners). However, the difficult decision to stop remediation must be discussed in some cases. Below are some examples taken from *Remediation of the Struggling Medical Learner*, by Jeannette Guerrasio, MD published by the Association for Hospital Medical Education.

1. The learner is working at her/his fullest capacity and not making significant progress. This assumes that a complete remediation process has occurred (identification, triage and action plan creation and reassessment), and has discovered and attempted to treat all possible causes of her/his poor performance.
2. The learner is not invested in her/his remediation, despite multiple attempts to get her/him on board and address her/his individual barriers.
3. The learner is non-compliant with treatment of a severe psychiatric disorder or substance abuse or has a mental health or physical health problem that makes them unfit for duty (i.e. psychosis or seizures with stress or fatigue or accruing too many absences to be reliable or to learn).
4. The learner has timed out.
    a. Failed USMLE Step III 3 times and therefore has delayed training.
    b. Repeated more than 1 year of residency.
    c. Failed to advance in residency after more than 1 year of remediation.
    d. Institution will not support resident extension due to financial concerns.

Levels of Remediation/Corrective Action

When the issue a learner has requires corrective action, that action will happen at progressive levels as outlined below until remediation is successful or until termination.

Coaching

A non-threatening discussion between the resident and the resident's supervising physician or faculty advisor intended to improve overall performance. Coaching is used when work performance, academic performance, or other work-related conduct is not satisfactory. During coaching, the attending should point out the areas for improvement, suggest corrective action and ask the resident for an agreement to improve. The attending should document this in a memorandum of the discussion and place it in the resident's file.

Written Counseling Notices

The least severe form of formal remediation, written counseling notices are given to residents to notify the resident of the specific nature of the problem, what they must do to improve, and what action will be taken if the problem is not corrected. If the conduct is recurrent, or if the conduct is such that bypassing coaching is justified, this level of remediation may be used first. The attending or faculty advisor should maintain documentation of the counseling, including the date, persons present, and substance of the discussion and place it in the resident's file.

Written Warnings

Written warnings may be given for a violation of a work rule(s) or regulation(s). At this level, the Program Director should mandate corrective action and the expected timeframe in which the resident must take corrective action (see Concern Status). Such written warnings may include a final notice to the resident that disciplinary action, up to and including termination, may be taken if the problem is not corrected.

Concern Status/Action Plan

The CCC may place a resident may be placed on concern status for a period of up to 6 months. The program director will notify the Designated Institutional Official (DIO) that the resident is on concern status. The program director will also notify the resident of this decision. This notification will include specific goals, a plan for monitoring the resident's progress, and a fixed timeline, after which the resident's progress will be re-evaluated.

During the period of concern status, the faculty advisor shall evaluate the resident at least monthly and shall inform the resident in writing of the deficiencies and the expectations for remediation. The faculty advisor will notify the program director and the CCC of the resident's progress, and the CCC may remove the resident from concern status by written notice with copies to program director.

Administrative Leave (Suspension)

Administrative Leave (Suspension) from work, with or without pay, may be imposed when:

- Time is required to investigate the circumstances of a problem
- When a resident's presence on the job constitutes a threat to personnel or clients

- Where the alleged misconduct or offense is of such severity that termination may occur
- When an employee fails to correct performance after having been previously warned.

The Program Director or other authorized official may suspend a resident pending a decision as to the appropriate disciplinary action to be taken, if any.

Administrative Leave (Suspension) Pending Final Determination

Administrative Leave (Suspension) Pending Final Determination from work, without pay, can be imposed prior to any final disciplinary action of termination being taken. This step will allow the residency/facility representatives, including Director of Human Resources, or designee, to discuss the next step of action and request the resident to provide any information, such as written documentation, prior to a final decision being made.

Termination or Non-renewal of Contract

Termination from work may be imposed when a resident fails to correct or improve his/her behavior or work performance, or when the residency/facility determines that the seriousness of the resident's behavior warrants termination.

If a resident has been on concern status and has not completed the terms of his or her action plan to the satisfaction of the CCC, the program director, with consultation from the faculty, may terminate the resident's contract.

If the program director, in consultation with the faculty, determines that a resident's performance or mastery of required competencies or expected skills is not up to the program's standards, the program director may choose not to renew the resident's contract for the coming year. Alternatively, the program director may require remediation, including repetition of the year just completed.

Due Process

If a resident has been the subject of any disciplinary action, including termination, he or she has the right to appeal the decision. The appeal process is as follows:

- The resident must submit the appeal within ten (10) calendar days following the disciplinary action.
- The appeal must be in writing and must contain a statement of the disciplinary action, the charges upon which it is based, and the resident's response to the charges and action.
- The residency program will file the appeal with the DIO.
- The appeal will be heard by a committee consisting of (1) the grievant's Program Director, or, if the Program Director is personally involved in the subject, an alternate to serve in his/her place will be appointed, and (2) a person mutually acceptable to the other members of the committee, but such person must be a teacher in the field of clinical medical practice, and (3) Director of Human Resources. The DIO will be the chair of the committee, will attend to the administrative matters, and may participate in the deliberations, but will not have a vote. If the committee has not been formed within ten (10) days of the filing of the concern, the DIO will make the necessary appointment as soon as possible.

- The committee will hear the case as promptly as is practical with due notice to all parties. The parties agree to exert their best efforts to commence the hearing within twenty-one (21) calendar days after the concern is filed. Evidence and argument may be submitted in writing or personally, or both. The committee shall keep an informal record of the case and may tape record any oral presentation.
- The committee will decide whether the subject is grievable or not. If the committee decides that the matter is not grievable, the resident will be so notified and the proceedings stopped. The decision of the committee in this regard is final.
- The committee is authorized to decide the concern and to provide for a remedy to carry out its decision.

The appeal will be decided by a majority vote of the voting members of the committee. The decision will be in writing and will be delivered immediately to the resident personally, or if he or she is not immediately available, a copy of the decision will be placed in the resident's mail box at Memorial Medical Center and another copy will be sent by certified mail to the resident's address of record kept at Memorial Medical Center. The decision of the committee is final, including review of termination decisions made by the Program Director. Termination decisions are not subject to further appeal, such as described in the MMC HR Policy Manual or grievance procedures.

V. Assistance: Ombudsman, Counseling Services

Residents may consult any faculty or staff member in obtaining information and informal assistance. For more formal issues, questions or complaints, residents should pursue assistance by taking the steps listed below:

1. Talk to the chief resident
2. Talk to the Program Coordinator.
3. Talk to your faculty advisor.
4. As a last resort, the Program Director will get involved to resolve the situation.

Ombudsman

If residents feel uncomfortable talking to any member of the residency program, they may speak to the Ombudsman. The Ombudsman has agreed to help the residents in any manner where the resident does not feel comfortable utilizing the faculty or staff. Residents should only speak with the Ombudsman if they feel the options listed above aren't appropriate.

CONTACT INFORMATION: Jie Luo, MD
(575) 382-9292
jluo@bahcnm.org

Counseling Services and Disability Accommodations

To ensure that all residents have access to adequate behavioral health services as needed as well as accommodations for any disabilities, the program offers the following resources:

1. Confidential counseling and behavioral health services as needed, including pastoral services, the web-based Resources for Living (www.RFL.com), and the Employee Assistance Program
2. Adequate support and treatment in the event of self-disclosed physician impairment
3. Processes allowing residents to raise and resolve complaints in a safe and non-punitive environment in the event of any type of harassment
4. Accommodations for disabilities consistent with all applicable laws, regulations

If counseling or treatment is required, the program will help facilitate confidential counseling and medical and psychological support services. Faculty should not provide these services, which will allow the resident the most confidential services without the conflict of a dual role.

VI. Institutional (LifePoint/MMC) Policies

Dress Code, Sexual Harassment, Substance Abuse, Medical Records, Vaccines, Cell Phone Use and all other policies are available for review on the MMC Intranet. It is your responsibility to review and be familiar with these policies.

VII. ACGME/GMEC Policies

Policy for Disaster or Interruption of Patient Care

In the event of a disaster or any event that interrupts the ability of the institution to provide patient care and for which the institution cannot provide at least an adequate educational experience for each of its residents/fellows, Memorial Medical Center will notify the Program Director and the residents at the earliest possible time, so that arrangements can be made to continue the residents' education at alternative sites.

The following steps outline the procedure the program will take, which is in accord with the ACGME Plan to Address a Disaster that Significantly Alters the Residency Experience at One or More Residency Programs.

Communication with the ACGME:

The Designated Institutional Official will call or email the Institutional Review Committee Executive Director with information and/or requests for information as soon as possible after declaration of a disaster.

The Program Director will call or email the Family Medicine Review Committee Executive Director with information and/or requests for information as soon as possible after declaration of a disaster.

As per the ACGME Policy, the residents may also call or email the Family Medicine Review Committee Executive Director with information and/or requests for information after declaration of a disaster.

Continuation of Resident Education Options:

a) Resident Transfers and Program Reconfiguration:

- Insofar as a program/institution cannot provide at least an adequate educational experience for each of its residents/fellows because of a disaster, it will:
    - Arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows, or
    - Assist the residents in permanent transfers to other programs/institutions, i.e., enrolling in other ACGME-accredited programs in which they can continue their education.
- If more than one program/institution is available for temporary or permanent transfer of a particular resident, the preferences of each resident will be considered by the transferring program/institution.
- MMC and the accepting program will make the keep/transfer decision expeditiously so as to maximize the likelihood that each resident/fellow will complete the year in a timely fashion.

b) Temporary Resident Transfer:

- At the outset of a temporary Resident/fellow transfer, the program will inform each transferred resident of the minimum duration and the estimated actual duration of his/her temporary transfer and continue to keep each resident informed of such durations. If and when a program decides that a temporary transfer will continue to and/or through the end of a residency fellowship year, it will so inform each such transferred resident/fellow.
- As per the ACGME, within 10 days after the declaration of a disaster, the DIO of the sponsoring institution for the disaster-affected program (or another institutionally designated person if the institution determines that the designated institutional official is unavailable) will contact the ACGME to discuss due dates that the ACGME will establish for the program:
- To submit program reconfigurations to ACGME, and to inform each program's residents of resident transfer decisions. The due dates for submission shall be no later than 30 days after the disaster unless other due dates are approved by ACGME.

Changes in Participating Sites and Resident Complement:

- As per the ACGME, it will establish a fast track process for reviewing (and approving or not approving) submissions by programs relating to program changes to address disaster effects, including, without limitation:
    - The addition or deletion of a participating site;
    - Change in the format of the educational program; and,
    - Change in the approved resident complement.

Policy for Experimentation and Innovation

Experimentation and innovation in education is an important tool to improve the educational process. However, any new process must be rigorously monitored and evaluated so that the quality of resident education is maintained. The purpose of this policy is to outline steps to be taken if experimentation or innovation is to be considered in the program.

As per the ACGME "any innovative projects that may deviate from the institutional, common and/or specialty specific requirements must be approved in advance by the Review Committee. The sponsoring institution and program are jointly responsible for the quality of education offered to Residents for the duration of such a project".

Process steps include:

- Completion of innovative projects proposal form by the program director.
    - The proposal must include the following:
        - Description of the project,
        - Rationale for the project,
        - Method of evaluation,
        - Accreditation requirements from which the program/institution will deviate,
        - Description of any new, missing or variant on-line submission of information through the Accreditation Data System (ADS) that would require Review Committee approval,
        - Approval by the institutional graduate medical education committee
        - Signature of the designated institutional official.
        - Institutional endorsement
    - The sponsoring institution's graduate medical education committee must review and approve the proposal. The designated institutional official's signature will indicate approval.
    - The proposal is sent to the executive director of the appropriate ACGME review committee.

ACGME Review, Review Committee Appraisal, Monitoring

The ACGME review committee determines the form of monitoring, e.g., a progress report, a time study, a resident survey, a site visit, or other method.

Upon review of the results of the monitoring, the review committee will re-evaluate the rationale for the deviations from the requirements and may continue, deny, or modify approval of the project.

The review committee will report the status of innovative projects, including waiver of requirements (common, institutional and specialty specific) to the monitoring committee at the review committee's next scheduled review.

Policy for Closure of Program

In the event that Memorial Medical Center (MMC) determines that it cannot, for educational, financial, or any other reason(s), continue the Memorial Medical Center Family Medicine Residency Program (the Program), MMC will notify the Program Director and the residents at the earliest possible time, so that arrangements can be made to continue the residents' education at alternative sites.

Steps include:

Communication with the ACGME

- The Designated Institutional Official will call or email the Institutional Review Committee Executive Director to inform them of anticipated program closure.
- The Program Director will call or email the Family Medicine Review Committee Executive Director to inform them of anticipated program closure.

Continuation of Resident Education

- Resident Transfers and Program Reconfiguration:
    - The Program and the institution will:
        - Assist the residents in permanent transfers to other programs/institutions, i.e., enrolling in other ACGME-accredited programs in which they can continue their education.
        - If more than one program/institution is available for temporary or permanent transfer of a particular resident, the preferences of each Resident will be considered by the transferring program/institution.
        - MMC and the accepting program will make the keep/transfer decision expeditiously so as to maximize the likelihood that each resident/fellow will complete the year in a timely fashion.
        - If no alternative training programs can be found, MMC will continue the Program until all residents have completed all training requirements or have withdrawn from the Program. MMC will also ensure that the Program's faculty consists of at least the program director and the minimum faculty to resident ratio to maintain ACGME standards.

Non-competition/Restrictive Covenant Policy

To ensure that the residency program sponsoring institution complies with the requirements set forth by the ACGME with regard to non-competition guarantees/restrictive covenants within its ACGME-accredited training programs, neither the sponsoring institution nor any of its ACGME-accredited programs will require a resident to sign a non-competition guarantee or restrictive covenant.

Non-competition guarantees and restrictive covenants may not be included within the residents' training contracts. Restrictive covenants refer to contractual agreements that attempt to restrict an employee or owner's post-employment activities so as to limit his/her ability to compete. They are often signed in conjunction with physician employment contracts, or when a physician joins a practice group as an owner.

Policy on Interactions Between Vendor Representatives/Corporations and Residents and ACGME-Accredited Programs

The sponsoring institutions, MMC residents, and all ACGME-accredited training programs do not interact with vendor or pharmaceutical representatives or corporations.

The day-to-day operations in supply acquisition, purchase, and distribution are always adjudicated through normal Memorial Medical Center or Family Medicine Center procurement policies and procedures.

VIII. FAMILY MEDICINE CENTER POLICIES

*Please note, in addition to the FMC policies outlined below, residents are also responsible for meeting the policy requirements of Memorial Medical Center.

Hours of Operation

The Family Medicine Center operates Monday through Friday, 8:00 a.m. to 5:00 p.m. FMC may have extended clinic hours, which residents are required to staff while maintaining appropriate duty hours. The clinic is closed on weekends and hospital recognized holidays.

Clinic Attendance and Punctuality

Attendance and punctuality are expected in clinic and is a part of professional behavior. However, we know that due to the many responsibilities of residents, there will be times when patient care demands will cause a resident to be late or absent in clinic. It is essential that if this occurs, the resident must contact the program coordinator and their advisor.

Patient Termination Criteria

Clients may be terminated for the following reasons:

- Failure to keep appointments. Three (3) missed appointments in any given six (6) month period.
- Failure to adhere to instructions of medical providers.
- Failure to follow-through on medical recommendation of follow-up care/appointments
- Consistent and/or persistent failure to adhere to Family Medicine Center policies.
- Abusive language or violent behavior toward providers, staff or visitors.

Patient No Show Policy

If a patient is a "no-show", that information will be entered into their record. Written notification of missed appointments will be mailed to the patient at the provider's discretion. Second and third notices will be sent via certified mail. Termination notices will allow the patient a thirty (30) day grace period for emergency care while giving the patient adequate time to establish with another provider.

Medical Chart Completion/ FMC Lag Report Procedure

Every Monday morning a lag report will be generated and will be placed into each resident's personal box in the warm zone and e-mailed by the Office Manager. All resident charts are to be completed and

sent to faculty no later than 72-hours from completing the patient visits. The chart lock deadline for all charts to be sent to faculty is the 23rd of every month.

If residents do not complete their charts timely the process will be as follows:

- If the chart is still not completed after 7 days, the program coordinator will issue a verbal warning will be issued to the resident.
- If after 14 days the chart still is not complete, the faculty advisor or program coordinator will issue a written warning to the resident.
- If after 30 days the chart is still not complete, the program director will suspend the resident until charts are completed.

IX. Addendum: Definitions

AAFP American Academy of Family Physicians

The American Academy of Family Physicians is the national association of family doctors. It was founded in 1947 to promote and maintain high quality standards for family doctors who are providing continuing comprehensive health care to the public. Other major purposes of the Academy include:

- To provide responsible advocacy for and education of patients and the public in all health-related matters;
- To preserve and promote quality cost-effective health care;
- To promote the science and art of family medicine and to ensure an optimal supply of well-trained family physicians;
- To promote and maintain high standards among physicians who practice family medicine;
- To preserve the right of family physicians to engage in medical and surgical procedures for which they are qualified by training and experience;
- To provide advocacy, representation and leadership for the specialty of family medicine;
- To maintain and provide an organization with high standards to fulfill the above purposes and to represent the needs of its members.

ABFM American Board of Family Medicine (www.theabfm.org)

The American Board of Family Medicine 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
- Determining by evaluation the fitness of specialists in Family Medicine who apply for and hold certificates

ACGME Accreditation Council for Graduate Medical Education (www.acgme.org)

The Accreditation Council for Graduate Medical Education is a private, non-profit council that evaluates and accredits medical residency programs in the United States.

ACLS Advanced Cardiac Life Support

ALSO Advanced Life Support in Obstetrics

AOA American Osteopathic Association (www.osteopathic.org)

The AOA is a member association representing more than 64,000 osteopathic physicians (D.O.s). The AOA serves as the primary certifying body for D.O.s, and is the accrediting agency for all osteopathic medical colleges and health care facilities.

BLS Basic Life Support

CMO Chief Medical Officer

CCC Clinical Competency Committee

Responsible for the semi-annual evaluation, based on established milestones, of each resident. Advises the program director regarding resident progress, including promotion, remediation and dismissal.

DEA Drug Enforcement Agency

DIO Designated Institutional Officer

ECFMG Educational Commission for Foreign Medical Graduates (www.ecfmg.org)

Through its program of certification, the Educational Commission for Foreign Medical Graduates assesses the readiness of international medical graduates to enter residency or fellowship programs in the United States that are accredited by the Accreditation Council for Graduate Medical Education.

LCME Liaison Committee on Medical Education (www.lcme.org)

	Accreditation by the Liaison Committee on Medical Education is required for schools to receive federal grants for medical education and to participate in federal loan programs. Most state boards of licensure require that U.S. medical schools be accredited by the LCME, as a condition for licensure of their graduates. Eligibility of U.S. students to take the United States Medical Licensing Examination requires LCME accreditation of their school.
LPNT	LifePoint
MILESTONE	Milestones are competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by residents and fellows from the beginning of their education through graduation to the unsupervised practice of their specialties
MMC	Memorial Medical Center
NI	New Innovations
NRP	Neonatal Resuscitation Program
PALS	Pediatric Advanced Life Support
PD	Program Director
RRC-FP	Residency Review Committee in Family Medicine The ACGME has 28 review committees (one for each of the 26 specialties, one for a special one-year transitional-year general clinical program, and one for institutional review). Each residency committee comprises about 6 to 15 volunteer physicians. Members of the residency review committees are appointed by the AMA Council on Medical Education and the appropriate medical specialty boards and organizations.
SNMFMRP	Southern New Mexico Family Medicine Residency Program
USMLE	United Stated Medical Licensing Examination (www.usmle.org) In the United States and its territories, the individual medical licensing authorities ("state medical boards") of the various jurisdictions grant a license to practice medicine. Each medical licensing authority sets its own rules and regulations and requires passing an examination that demonstrates qualification for licensure. Results of the USMLE are reported to these authorities for use in granting the initial license to practice medicine. The USMLE provides them with a common evaluation system for applicants for initial medical licensure.

ACKNOWLEDGMENT

By signing below I acknowledge that I have been informed that the Resident Manual is available on the One Drive and that an overview of the general information has been reviewed with me. I also acknowledge that I will be held responsible for the full content of the information contained within the manual.

Resident Signature: _____ Date: _____

X. Appendices

Appendix A: Thresholds

Competency	Threshold
1. Medical Knowledge	If the ITE score is <90% of Bayesian score predictor resident will be assigned to board prep. If ITE score is <80% of Bayesian score predictor, then resident will be referred to CCC for triage.
2. Clinical Skills	Any one of the following... 2 or more evaluations with a rating below 2 for a 2nd year or 3 for a 3rd year Comment indicating poor skills OR Procedural Error OR Sparse Procedure Logs, failure to log, or too few procedures
3. Clinical Reasoning and Judgment	Any one of the following... 2 or more evaluations with a rating below 2 for a 2nd year or 3 for a 3rd year OR Comment indicating poor clinical reasoning and judgment
4. Time Management and Organization	Any one of the following... Violating work hour restrictions OR Not completing work on time OR

	Comment indicating poor time management and/or organization
5. Interpersonal skills	Any one of the following... 2 or more reported conflicts OR 2 or more evaluations with a rating below 2 OR Comment indicating poor interpersonal skills
6. Communication	Any one of the following... 2 or more evaluations with a rating below 2 OR Comment indicating poor communication
7. Professionalism	Any one of the following... >2 unexcused absences OR Failure to work with other team members in a respectful and cooperative manner
8. Practice-based Learning and Improvement	Any one of the following... Patient safety concern, not seeking help when needed OR 2 or more evaluations with a rating below 2 OR Comments indicating resistance to feedback OR

	Comments indicating lack of independent learning
9. Systems-Based Practice	Any one of the following... 2 or more evaluations with a rating below 2
10. Mental Well-being	Any one of the following... Inconsistent performance OR Not demonstrating improvement/Not receptive to teaching OR Mental Health impairing work performance
11. Milestones	Any one of the following... Below peers on more than 70% of sub-competencies established in CCC reviews. Failure to improve over 2 quarterly evaluations in areas that are below expectations

Appendix B: Steps in Remediation Process

1. First a struggling learner is identified and referred to the CCC for triage. This is done either by:
    a. Self-referral
    b. Meeting specified threshold identified above, through evaluation process outlined above
    c. Referred by faculty member, program director or CCC

2. Next the CCC will triage the referral to determine if the concern is clinical, non-clinical, or complex
    a. Clinical (isolated)
        i. Medical knowledge
        ii. Clinical skills
        iii. Clinical reasoning and judgment
        iv. Systems based practice

b. Non-clinical (isolated)
    i. Time management and organization
    ii. Interpersonal skills
    iii. Communication
    iv. Professionalism
    v. Practice based learning and improvement
    vi. Mental well-being
c. Complex or multiple

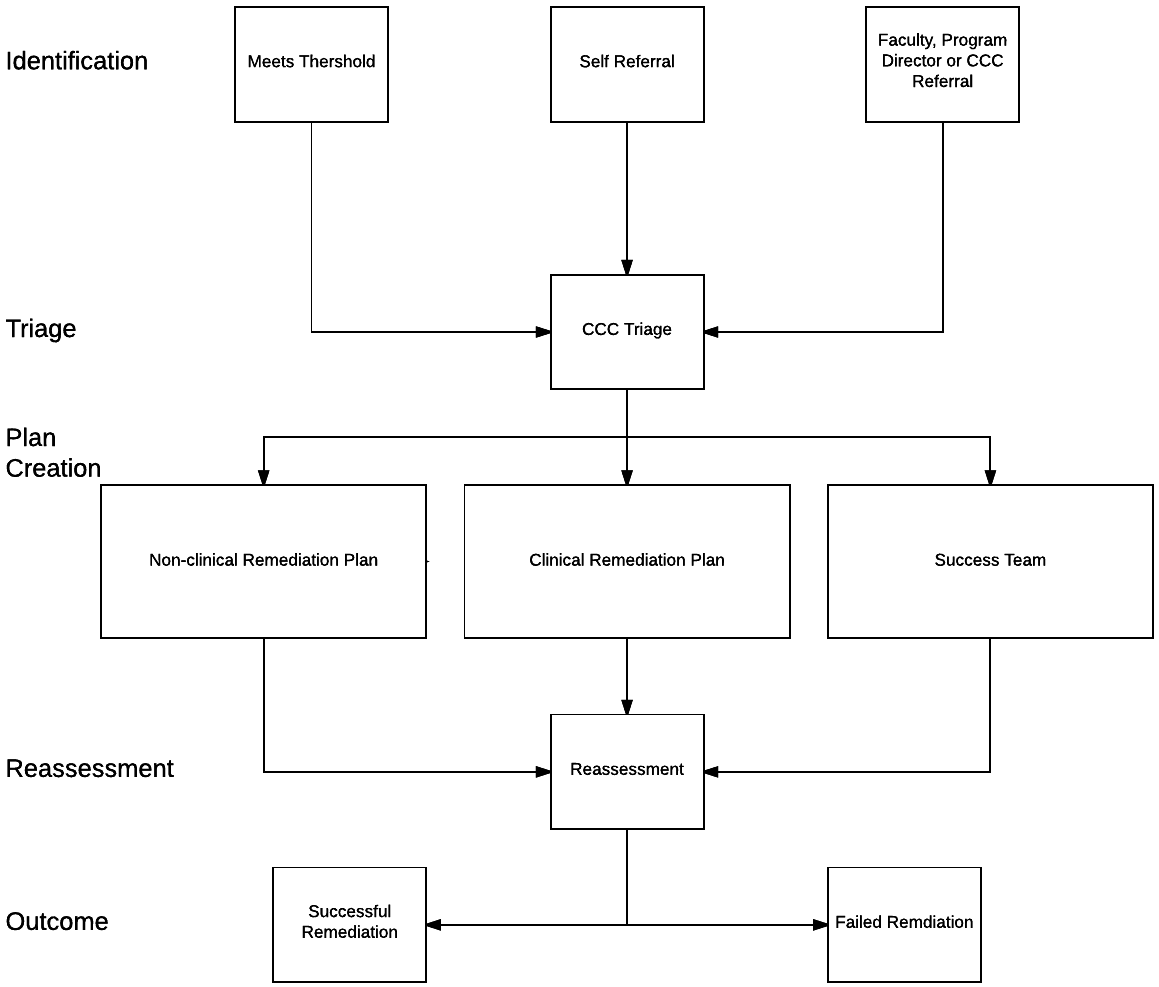
3. If the problem is determined to be isolated, then an appropriate action plan (clinical or non-clinical) is developed by the faculty advisor in consultation with the CCC. Isolated problems do not necessarily require a "Success Team", as these can often be addressed in the faculty-resident advising relationship. If there are multiple deficiencies or if the faculty advisor in consultation with the CCC determines the issue to be complex, then the faculty advisor will form a Success Team that will develop appropriate action plan in consultation with the CCC.
    a. Structure of Success Team
        i. Chief resident
        ii. CCC Chair
        iii. Faculty Advisor
        iv. Behavioral Health representative
        v. Academic representative
    b. Success team develops action plan using guidelines in section 4 of this document.

4. Next the program director, faculty advisor(s) and CCC chair will notify the learner in person and will provide the resident with a letter/action plan. The resident will review the action plan, and the faculty advisor, program director or CCC chair will answer any questions to ensure understanding of the actions steps required. The resident, faculty advisor, and CCC chair will then sign the document. The faculty advisor will provide a copy to the resident and will place a copy in the resident's file. The letter/action plan will outline the following:
    a. Change in academic status to "Concern Status"
    b. The specific problematic performance with dates
    c. The ACGME competency related to the deficiency
    d. Goals of remediation
    e. Measurable outcomes for success
    f. Timeline to demonstrate improvement
    g. Any restrictions
        i. away rotations
        ii. moonlighting
        iii. electives
    h. If a mental health evaluation is required
    i. The potential outcomes
        i. return to good standing
        ii. continued "Concern Status"

iii. Delays in training, suspension or termination if the learner fails to meet the conditions of the letter/action plan, or is an imminent risk to patients, self, or others.

5. The CCC and success team (if applicable) reassess the learner and determine if the remediation was successful or not. Details of reassessment are located in section 4 of this document.

Appendix C: Remediation process flow diagram



Appendix D: Remediation Strategies for Each Deficit Type (Plan Creation)

3 key elements are required for successful remediation:

1. Deliberate practice
2. Feedback
3. Self-assessment

Below is a table modified from “Remediation of the Struggling Medical Learner”. It provides deficiency specific strategies that can be matched to the learner’s specific deficits. You will notice that some of the items are not quantified or do not provide specific examples. This is due to the fact that it is not possible to specifically create a remediation plan that will “fit” all situations or learners. The table instead is a framework that is to be used as a tool to guide action plan development. All action items within the action plan must be specific and measurable.

Deficit	**Remediation Strategy**
Medical Knowledge	● Identify how learner learns best ● Assess level of knowledge ○ Global or focal deficit? ● Review what the learner is reading and recommend resources ● Emphasize learning WHY rather than what or how ● resident maintained ongoing list of items to look up ● Link patient cases to reading ● Give feedback ● Demonstrate techniques of self-evaluation of knowledge deficits ● Identify opportunities for resident to teach ● Schedule reassessments of learning.
Clinical Skills	● Identify skills gap ● Assign readings, videos, or other resources on physical exam or skills/procedures ● Videotape student and provide feedback ● Review videotape with learner and assess self-awareness ● Give more frequent feedback ● Repetition and practice of clinical skills ● Establish how he/she will be reassessed

Clinical Reasoning and Judgment	● Review new and old cases with learner
	● Create differential diagnosis
	  ○ include most likely
	  ○ include what you don't want to miss

	● Provide a framework for clinical reasoning
	● Identify relevant HPI questions, PE elements, and ROS questions
	● Have you seen or read about before?
	● Review diagnostic options
	  ○ do nothing
	  ○ order a lab or test
	  ○ prescribe a medication
	● Review treatment options
	● Resident maintained ongoing list of clinical questions to look up and apply to patient care
	● Teach learner to use resources and feedback
	● Chart stimulated recall with feedback
	● Have learner specify and compare the consequences of choices
	● Establish how he/she will be reassessed

Time Management and Organization	● Obtain learner's perspective and concerns ● Teach data organization system ● Model pre-rounding, have learner use same model with every patient ● Identify tasks to be completed ● Prioritize tasks ● Identify length of time for each task ● Have Learner keep a minute by minute log of daily activities ● Give feedback ● Have learner observe peers' and others' strategies and discuss ● Establish how he/she will be reassessed
Interpersonal Skills	● Review relevance of good interpersonal skills ● deficiencies or conflicts should be addressed directly and privately ● Give specific examples of interpersonal conflict(s) ● Have learner provide or model alternative examples of positive interaction in conflict ● Resident maintained self-reflection diary ● View videotape to observe personal interactions and increase self-awareness

	● Consider mental health evaluation ● Present consequences of failure to improve (Official warning, probation and/or send to NM Medical Board) ● Use faculty or 360 evaluations as indicated to measure progress. ● Establish how he/she will be reassessed

Communication	● Review importance of good communication
	● Have learner identify how communication throughout the workday can either facilitate or hinder patient care
	● Assign learning resources
	  ○ texts
	  ○ articles
	● Practice oral presentations emphasizing strong clinical reasoning
	● Practice summarizing complex cases
	● Practice specific skill sets e.g., giving bad news, interview about a sensitive topic, ask questions, etc…
	● View videotaped performance to enhance self-awareness.
	● Role modeling-observe preceptor
	● Teach learner to clarify communication throughout his/her day
	● Establish how he/she will be reassessed

Professionalism	● Learner should meet with remediation team ● Review the relevance of being professional from your perspective and her/his (remind her/him of the consequences of being perceived as unprofessional!) ● Set expectations ● Review specific examples of her/his unprofessional behavior ● Emphasize high level of accountability ● Promote self-reflection ● Present consequences of failure to improve (Official warning, probation and/or send to NM Medical Board) ● Limit setting ● Establish how s/he will be reassessed

Practice-Based learning and Improvement	● Ask the learner to identify her/his strengths and weaknesses which are identified in practice ● Ask the learner to explore and write about the benefits of continued learning ● Clarify the expectations for BPLI ● Ask the learner to write a self-reflection piece that includes the purposes of feedback and independent learning and a reflection on the feedback s/he has received ● Review how the resident responds to feedback and how her/his responses are perceived ● Discuss implementation of new knowledge from scientific studies and/or different strategies based on feedback ● Have learner complete quality improvement projects that will shed light on her/his practice ● Model appropriate responses to feedback and how to incorporate self-directed learning ● Establish how s/he will be reassessed
Systems-Based Practice	● Ask the learner to explore the benefits of interprofessional input and team collaboration ● Help the learner improve patient care by seeking health care resources, understanding how the healthcare system impacts care and the value of transitions of care ● Teach the learner to advocate for his patients ● Set expectations with a timeframe for meeting expectations ● Establish how s/he will be reassessed
Mental Well-Being	● Discuss concerns about the resident's wellbeing with student and her/his reflections ● Refer for psychiatric evaluation for learning disabilities, psychiatric diagnosis, and substance abuse (www.fsphp.org), or assess for fitness for duty, evaluation and treatment

	• Provide supportive environment and schedule • Teams and activities that promote camaraderie • Stress reduction • Skills to overcome deficits • Feedback • Establish how s/he will be reassessed

Appendix E: Sample Action Plan

Date:

Dear Dr... (Use SBAR to provide a brief summary of need for action plan)

Academic Status:

The specific problematic performance with dates:

The ACGME (plus) competency related to the deficiency:

Goals of remediation:

Measurable outcomes for success:

3 key elements are required for successful remediation:

1. Deliberate practice
   a. These will be the specific action steps outlined using the strategies in section 4 of the remediation policy.
2. Feedback
   a. Regularly scheduled feedback and review sessions must be outlined here.
3. Reassessment /Self-assessment
   a. This will be a discussion of the specific steps that will be used to reassess the learner and must include an ongoing self-assessment process.

Timeline to demonstrate improvement:

Restrictions:

1. Away rotations: (if any)
2. Moonlighting: (if any)
3. Electives: (if any)

If a mental health evaluation is required:

The potential outcomes:

1. Return to good standing

2. Continued “Concern Status”
3. Delays in training, suspension or termination of the learner fails to meet the conditions of the letter/action plan, or is an imminent risk to patients, self, or others.

Summary:

(Use SBAR to provide a briefly summarize the above)

Structure of Success Team:

1. Chief Resident
    a.
2. CCC Chair
    a.
3. Faculty Advisor
    a.
4. Behavioral Health
    a.
5. Academic Representative
    a.

Signed: _____ Date: _____

CCC Chair

Signed: _____ Date: _____

Faculty Advisor

Signed: _____ Date: _____

Resident

Appendix F: Competencies and Reassessment Methods

Competency	Reassessment Methods
Medical Knowledge	● Written or web-based knowledge assessments ● Multiple choice exams
Clinical Skills	● Objective structured clinical examinations (OSCE) or standardized patient encounters ● Simulation ● Repeating part or all of a rotation with evaluations appropriate to rotation ● Procedure logs
Clinical Reasoning and Judgment	● Written or web-based case-based assessments ● Standardized patient encounters or OSCE ● Mini-clinical evaluation examinations ● Chart-stimulated recall ● Repeating part or all of a rotation with evaluations appropriate to rotation
Time Management and Organization	● Direct observation ● Repeating part or all of a rotation with evaluations appropriate to rotation ● Multi-source evaluations ● Patient and procedure logs
Interpersonal Skills	● Direct observation ● Standardized patient encounters or OSCE ● Mini-clinical evaluation examinations ● Multi-source evaluations ● Responses to self-reflection
Communication	● Direct observation ● Standardized patient encounters or OSCE ● Mini-clinical evaluation examinations ● Multi-source evaluations
Professionalism	● Direct observation ● Multi-source evaluations of team participation and leadership ● Responses to self-reflection ● Patient and procedure logs

Practice-Based Learning and Improvement	● Responses to self-reflection ● Evaluation from supervisors ● Evaluation presentation of QI project ● Critique of journal articles
Systems-Based Practice	● Direct observation ● Multi-source evaluation ● Completion and evaluation of healthcare systems project
Mental Well-being	● Direct observation ● Evaluations from supervisors and peers ● Repeat part or all of a rotation ● Psychological re-evaluation, fitness for duty