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POLICY

AND

PROCEDURES

MANUAL

2020

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POLICY: Introduction to the Department

Mission Statement
The mission of the Department of Family Medicine at the University of South Alabama is to provide our patients and healthcare learners with the support and resources necessary to improve health through patient-centered, population driven care.

Department Values
- Patient centeredness
- Social determinates of health focused
- Quality Improvement
- Equity
- Access
- Wellness
- Community Focused

Family Medicine Training
The Department endeavors to increase the body of knowledge and to train learners in the discipline of Family Medicine. This discipline is the current expression of the true generalist tradition. This is uniquely defined by:
- A method and structure of patient care characterized by continuing, comprehensive care of the undifferentiated patient.
- The context in which the basic medical sciences are applied to includes individual, family and community where appropriate.
- A characteristic of this care is that it includes cooperation with other health care disciplines both within and outside of organized medicine.

Departmental Objectives
- We strive to maintain educational, research, and clinical programs that are of the highest standard as measured by internal review and external accrediting entities such as the ACGME, LCME, and pertinent patient care organizations.
- We will graduate six (6) Family Medicine residents per year with a competency in family medicine knowledge, skills and understanding sufficient to respond to the health needs of the public.
- We will contribute to the medical school's objective to graduate competent medical students with the knowledge, skills, and attitudes specific to family medicine and an understanding and appreciation of the concept of family medicine in meeting the needs of the public.
- Residents and students who train with us will, upon matriculation, possess knowledge, attitudes and skills to understand and provide medical services to the populations and communities that they serve.

- Through our scholarly activity, we will develop and disseminate new knowledge and answers to important questions, which will contribute to better patient care and to the academic discipline of family medicine as judged by peer review.
- We will participate in the education of the practicing family physicians in a continuing basis by participating in CME and other forms of postgraduate instruction.
- In the process of providing health care for patients we will model high quality patient-centered primary care using a family medicine model.
- We will use our resources wisely as shown by our ability to attract necessary funds, and provide and administer a budget, which enables us to meet our stated goals and objectives.
- We will secure, develop, and maintain faculty and staff sufficient to meet personal and developmental goals.
- We will strive to convince medical students of the value, both intrinsically and to society, and importance of practicing the intense, personal medicine characterized by primary care disciplines – especially family medicine. To this end, we see as our goal to have 50% of each class pursue advanced training in one of the primary care disciplines and at least 25% of each class to enter family medicine.
- In our interactions with the broader university community we will work towards influencing the important policies of the College of Medicine/University to reflect the departmental mission and to enable us to achieve the departmental goals and objectives.

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POLICY: **Appointment of Residents**

Residency Eligibility

The residency participates in ERAS for screening potential applicants and will only entertain admission for those applicants who apply through the Match process. All applications will be screened for eligibility and qualified applicants will be offered an interview prior to the Match deadline. Preference will be given to applicants that have graduated within the past 2 years.

Additional applicant qualifications are as follows:

A. Applicants must meet one of the following qualifications in order to be eligible for appointment at the PGY I level:

1. Graduate (or anticipated graduation prior to July 1 of application year) of a medical school accredited by the Liaison Committee on Medical Education (LCME).
2. Graduate (or anticipated graduation prior to July 1 of application year) of a medical school accredited by the American Osteopathic Association (AOA).
3. Graduate (or anticipated graduation prior to July 1 of application year)of a medical school outside the U.S., to be considered this applicant must have a currently valid certificate from the Education Commission for Foreign Medical Graduates (ECFMG) and be eligible for licensure form the state of Alabama upon completion of a residency program. Applicants must have taken USMLE Steps I and II: Passed (1st attempt and score of >210 preferred).

B. Occasionally a PGY II position will become available. At that time we will solicit applications for this (these) position(s) utilizing methods such as the AAMC “Find A Resident”. Applicant qualifications are as follows:

Applicants must meet one of the following qualifications in order to be eligible for appointment at the PGY II level:

1. Graduate of a medical school accredited by the Liaison Committee on Medical Education (LCME).
2. Graduate of a medical school accredited by the American Osteopathic Association (AOA).
3. Graduate of a medical school outside the U.S., to be considered this applicant must have a currently valid certificate from the Education Commission for Foreign Medical Graduates (ECFMG) and be eligible for licensure form the state of Alabama upon completion of a residency program. Applicants must have taken USMLE Steps I and II: Passed (1st attempt and score of >210 preferred).
4. Applicants who are in good standing in an ACGME accredited Family Medicine program at the PGY I year or who have completed the PGY I year within the past three (3) years will be given preference. Credit for other training may be given only in the amount that is compatible with the Program Requirements for Residency Education in Family Medicine and will be matched to specific rotations in our 36-month residency. Our program will consult with the American Board of Family Medicine on each case prior to making a final determination regarding the equivalence of such training.

Selection

Applicants for all positions will be selected from among those deemed eligible on the basis of his or her preparedness, ability, and interest in completion of the program without regard to race, age, creed, gender, or sexual preference. This process will consist of review of information as outlined in the application document, dean's letter, letters of recommendation, and personal interview. Aptitudes, academic credentials, personal characteristics, and ability to communicate will be strongly considered in the selection process. Applicants not expressing a strong interest in Family Medicine will not be considered for a PGY I position.

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POLICY: **Chief Resident**

The position of Chief Resident of the USA Family Medicine Residency Program functions to facilitate communication between residents and faculty and oversees the functioning of the residents within the program.

He/she assumes the responsibility of providing educational leadership and being a role model for other residents. The overall responsibility of the Family Medicine Chief Resident is to represent residents' interest as a whole and to serve as a spokesperson in relation to any other person or group.

He/she must possess exceptional leadership, communication, and organizational skills and be able to interact with staff, colleagues, and faculty in a professional manner. Time commitment for chief resident duties is approximately 10 hours/month when averaged over the 12-month commitment in addition to regular resident duties.

ELIGIBILITY:
Candidates for Chief Resident must:

- Be a second year resident in good standing:
  - Pass Step 3, first attempt
  - Possess In-training scores predictive of passing the ABFM certification exam on most recent attempt (usually >92% chance of passing based on the Bayesian score predictor)
  - No history of probation
  - Maintain compliance with residency professionalism minimum requirements
- Must be willing to commit to performing chief resident responsibilities.
- Must remain in good standing. Chief resident appointment can be rescinded for inadequate performance (including academic performance).

SELECTION OF CHIEF RESIDENTS:

- Upon receipt of the ITE scores, the program director will communicate with all second year residents meeting eligibility criteria to determine their willingness to perform the duties and responsibilities of the office. Those willing will have their names placed in nomination.
- Ballots with those eligible will be distributed to all residents and Faculty. Each resident will get two votes (may vote for same person twice). The Faculty collectively get 2 votes which will depend on the tally of their votes. The top two vote recipients will be named Co-Chief Residents. In the rare event that only one candidate is eligible, a co-chief resident will not be named for that academic year.

KEY AREAS OF RESPONSIBILTY:

Academic Responsibility:

- Beginning in spring, receive training by the current Chief Residents and the residency office.
- Work with the residency office in planning and organizing orientation for the new residents.
- Educate incoming residents regarding the call schedule and resident responsibilities, including lecture and conference attendance.
- Participate in bedside/office teaching of medical students and modeling for other residents.
- In conjunction with the program director, the Chief Residents are central figures for promoting positive resident morale accomplished by being the resident/faculty liaison and an advocate for resident success.

Administrative Responsibility:

- Reads, fully understands, and follows the Resident Policy and Procedure Manual.
- Address any/all concerns that exist for the on-call and backup call resident.
- Ensure residents are meeting deadlines, especially, learning modules and ACGME resident survey.
- Keeps current with New Innovations updates and is responsible for ongoing training of NI for all residents as needed.
- Participates in Residency Recruitment Fairs.
- Participates or assigns a proxy to represent residents at the Clinical Management Team when necessary.
- Present graduation honors.
- Assists in scheduling/organizing graduation.
- In concert with the Residency Coordinator, ensure that scheduled and requests for leave are optimized.
- Work with the Residency Coordinator and the faculty in curriculum development and revisions.
- Organize resident retreats.
- In concert with the Residency Coordinator, ensure that scheduled professional leave is optimized.
- Participate in the recruiting and interview process.
- Conduct monthly residents' meetings. Document and distribute minutes (resident only portion) to all residents. Assign another resident for these tasks if both Chiefs will be absent.
- Works with the residency staff to update the policy and procedure manual. As well as, assisting up-dates to rotation details and locations.
- Work closely with the residency coordinator and the program director to identify and resolve residency problems.
- Assists residents in adapting their learning experiences on an individual basis to accomplish their individual learning plans.
- Assist as needed with the rotation schedule for the up-coming academic year.
- Maintain discretion and confidentiality with regard to faculty meeting agendas, business matters and other issues unless expressly released for this requirement by the program director for a specific circumstance.
- Act as a resource for program director and meet with program director a minimum of once a month.
- Create call and backup schedule for the next academic year (and training the in-coming Chiefs).

- Schedule and organize (with assistance from residency coordinator) requests for physicals. (Payment helps with cost of annual retreat.)
- Performs other tasks as assigned on an ongoing basis.

Leadership Responsibility:

- Act as liaison between Family Medicine faculty and residents.
- Act as a liaison between Family Medicine and other USA Health departments
- Work as a mediator for resident, faculty, staff and/or patient conflicts.
- Encourage academic growth through example and formal instruction.
- Represent the residents by attending assigned meetings.
- Communicate pertinent information and issues to residents in a timely manner.

Clinical Responsibility

Maintain a practice in the Family Medicine Department seeing patients at the same level as other third year residents.

TRAINING RESOURCES

- Chief Resident Leadership Development Program sponsored by the American Academy of Family Physicians
- Other GME chief resident development meetings and resources.
- Out-going Chief Residents

REPORTING RELATIONSHIPS

- Reports to the Residency Program Director

BENEFITS

- Financial Stipend
- Attend Chief Resident conference
- Attend annual AAFP Scientific Assembly
- Hands-on leadership experience
- Recognition by faculty and fellow residents
- Added value to academic portfolio

Family Medicine Residency Yearly Planning Calendar

July	August	September	October
• **NCFMR-Kansas City** • **Remind PGY IIs to Sit for Step III before December** • **Update Program**	• Oder ABFM In-Training Exam • Prepare for Interviews • Check interview dates with Hotel	• ERAS opens September 1 • Book Interviews • Arrange Pre-Interview Functions • Remind residents	• Book interviews • In-Training Exam (last week) • Schedule 3rd year retreat • Make Rotation

Website • **Plan for Scientific Assembly Meeting**		and rotations of ITE • UM Residency Fair	Schedule for Upcoming Year
November	December	January	February
• **Interviews** • **2nd & 3rd Year Residents Renew Alabama License & ACSC** • **1st Years Complete Certificate of Qualification for a Limited License**	• Interviews • Schedule Rank Meeting • 3rd Year Retreat	• Interviews • NRMP Quota Change Deadline • Plan 1st and 2nd Year Retreat • 1st Year DEA application submitted by Jan 15	• Rank Meeting • NRMP Rank Order List Due • Select Chief Residents
March	April	May	June
• **NRMP Match Week** • **Order Diplomas** • **Hold New Chiefs/Old Chiefs Meeting** • **Begin work on Call Schedules** • **Register for Chief Resident Conference**	• Orientation Committee • Annual Program Eval • Policy and Procedure Manual Updated • Get Paperwork Done for Incoming Residents • Complete Orientation Schedule • Plan Graduation • 1st and 2nd Year Retreat • ACGME Survey • Make arrangements for Alabama Academy Meeting	• Order Plaques for Graduation • First Year Residents Should Schedule USMLE Step 3 or Equivalent	• NPI Numbers for Incoming Residents • Graduation • AAFP Census Deadline • Final Evaluation for Graduates • Alabama Academy Meeting (SanDestin)

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POLICY: **Clinical and Educational Hours (Duty Hours)**

The Work Environment
The program is committed to and is responsible for promoting patient safety and resident well-being and providing a supportive educational environment. The learning objectives of the program is educational in nature and should any resident feel there is excessive reliance on any rotation to fulfill service obligations they should report this concern to the program director (either in person or through the chief residents) for immediate correction. Didactic and clinical education has priority in the allotment of residents' time and energy. Assignments are scheduled such that faculty and residents collectively have responsibility for the safety and welfare of patients. Rotations are notified of these obligations by the program and all suspected problems should be reported.

Definition of Clinical and Educational Hours
Clinical and Educational hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Clinical and Educational hours do not include reading and preparation spent away from the duty site.

Absolute Limitation on Clinical and Educational Hours

- Clinical and Educational hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Rotations are arranged so that compliance is not a problem.
- Residents are provided at a minimum with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. Rotations are arranged so that compliance is not a problem.
- Adequate time for rest and personal activities is provided. The resident's rotation is designed such that there should be a 10-hour time-period, but must have an 8-hour time-period, provided between all daily duty periods and 14-hour time period after 24 hours of in-house call.
- Residents are limited to 24 hours on continuous duty, and up to 4 hours afterwards for stabilization and transferring of patient care – but not to include care of a new patient – and educational activities.
- For those rotations that are not under the control of the department, clinical and educational hours are established by rotation and are listed in the Goals and Objectives for the rotation. If the resident finds him or herself in a position where a potential violation may occur, he or she must report the situation at the time of discovery to the immediate supervisor for correction. Should the situation persist, the resident must then contact the program director who will facilitate compliance.
- **Residents are responsible for their patients, both on the Family Medicine hospital service and patients they have seen in the office, on a continuous, ongoing basis regardless of work hour status.** Family Medicine personnel

(residents, students, etc.) should complete their day's work prior to leaving for the day. It is not the responsibility of the on-call resident to "clean up" after the other residents. It is the responsibility of the resident to make sure that all "loose ends" have been tied up or that an effective and adequate hand-off has been made to the coverage team. Repeated instances of unanticipated problems will result in remediation.

Education on Fatigue

Residents and faculty will receive training on the detrimental effects of fatigue. Policies will remain in place to prevent work weeks of greater than 80 hours, no continuous duty of greater than 24 hours with an additional 4 hours for continuity and education for all residents, and an average of 1 out of every 7 days completely free of clinical duties. We will encourage residents to use alertness management strategies in the context of patient care responsibilities. Information regarding the effects of fatigue will be prominently posted. Any resident or physician found to be suffering the ill effects of fatigue will be excused from his or her clinical duties and an effort will be made to prevent recurrence. If a resident or physician is excused from his or her clinical duties, available residents, as listed in New Innovations, will be assigned to ensure continuity of care. If necessary, fatigued residents or physicians may rest in call rooms available at the hospital prior to leaving for home or a taxi service may be called at no cost to the resident.

Clinical and Educational Hours Documentation

All residents must maintain an accurate log of clinical and educational hours in New Innovations and must be completed for the previous month by the 7th of the following month. This is analyzed twice a month for compliance. Non-compliance can lead to a suspension from the program (including having to come before the GME Committee), extension of residency and a negative statement on the summative evaluation.

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POLICY: **Conference Attendance**

Purpose of Conferences
The conference schedule is designed as a longitudinal primary care based lecture series that in conjunction with the other training opportunities provide the learner with the framework to enter into an attitude of life-long learning. As such attendance is vital for the learning experience. Although there are other ways to acquire the information, the learning environment created through resident/student/faculty interaction with the speaker is valuable and every effort should be made by the learner to attend conference in addition to acquiring the information through other means. This policy identifies the conference attendance requirements and identifies penalties for residents that fail to meet the requirements.

Goals of Conferences
The resident should attend all conferences not precluded by clinical responsibilities or other valuable rotational experiences. Attendance requirements are set based on reasonable expectations for attendance during each rotation. These requirements include conferences missed as a consequence of vacation.

Objectives of Conferences

The rotations will be notified of the conference schedules and of the requirements for attendance.
- Rotations where 100% attendance has not been historically possible have been identified and exceptions are made for these rotations.
- Being involved in direct clinical patient care is an accepted excuse for missing conference.

Missed conferences for non-patient care reasons should be minimized.

Make-up opportunities will be made available for core conferences.
- If lunch is not provided, the resident should make some provision for food that allows attendance of conference.
- Residents who have failed to attend the minimum number of conferences by the middle of the third year will be offered the following make-up opportunities.
- For residents who will not be physically present, core conferences will be posted on the web site and the resident should review those missed and take the accompanying quiz and pass with a score of 75% or greater.

For those residents who neither meet the requirements nor participate in the make-up, their graduation certificates will be held until they satisfactorily complete a remedial action as negotiated with a committee of the department faculty as a whole.

The percentage of conferences attended must equal or exceed the number in the table below:

Year Level	Required
PGY I	65%
PGY II	70%
PGY III	75%

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POLICY: **The Evaluation Process**

Resident Performance will be Evaluated as Follows:

- Each resident will be assigned a schedule prior to the start of the academic year. An initial evaluation of the clinical skills of all residents entering the program will be completed within the first three months and placed in the resident's QA folder. At the end of each month an evaluation form will be expected from the resident's supervisor.
- Quarterly, the performance of each resident will be evaluated in the QA Committee based on all available assessments. The resident is required to review the summary with his or her advisor quarterly at least every 6 months.
- Every 6 months an assessment of competence as indicated by the milestones and based on all available data is made by the Clinical Competency Committee and forwarded to the resident. The resident is required to develop a learning plan.
- Annually the resident is evaluated based on departmental criteria as previously outlined for fitness for promotion to the next level.
- If areas of deficiency are identified the following process occurs:
    - Informal notification occurs if the deficiency is minor and the Committee feels that the resident can correct it without difficulty. This notification will occur either by the program director or the resident's advisor. The resident's progress will be monitored through the CCC Committee.
    - If the deficiency is major (failure of a core rotation, lapse in judgment potentially resulting in unsafe patient care, repeated patient care errors) the resident will be called in for counseling by the program director or his/her designee immediately upon discovery. Following a face-to-face meeting, a remediation plan (Letter of Counseling) will be outlined and a written copy will be placed in the resident's file. Mutually agreed upon benchmarks will be assigned. A faculty member will be assigned to monitor the resident's progress. Periodic reports will be given to the program director. Failure to achieve educational goals will result in further action.
    - If the deficiency is judged to be so severe that patient safety is of immediate concern, the resident will be removed from clinical duties until further action can be undertaken.

Disciplinary Action

- In accordance with the GME policy on disciplinary action, residents will receive timely notice of the impending action, disclosure of the evidence on which the action is based, and an opportunity to respond. The resident's scores will be available for review and the resident will have a right and opportunity to challenge the accuracy of the record. Resident records are confidential and are available only to faculty and administration with a need to know, unless released by the resident, or otherwise governed by laws concerning confidentiality.

- Except in cases where patient care is compromised by continued employment, residents will be offered an opportunity for remediation as determined by the residency director in association with the QA Committee and the Chair.
- Residents will be offered the following process prior to dismissal:

  1. Meeting and Letter of Counseling – This will review all deficiencies and exceptions which apply, outline ways the resident can improve, and give residents an opportunity to respond and help determine any outside factors that may be affecting the situation. The faculty will review monthly all residents who have been given a letter of counseling.

  2. Letter of Probation – This will state all deficiencies the individual has been counseled on and state that no improvement has occurred. It will state the period of probation, the expectations the resident is to meet, the assistance in meeting the expectations that will be offered, mechanism of evaluation that will be used, and the consequences if the expectations are not met. (It is understood that if the resident at any time after meeting the criteria of probation reverts to the pattern of behavior or deficiencies that provoked the probation, will immediately be placed on probation and will be at risk for dismissal).

  3. Letter of Dismissal – This will state that the resident has refused or failed to meet the criteria outlined in the Letter of Probation.

The residency program reserves the right to immediate probation or dismissal of any resident who engages in violent, dangerous or felonious activity during the residency or whose continuous contact with patients directly compromises patient care.

Evaluation of Faculty

All teaching faculty will be formally evaluated at least biannually. This is accomplished through semi-annual (June and January) basis on all FMC attendings, including part-time faculty and non-physician faculty. The form is designed to evaluate teaching ability, clinical knowledge, attitudes, and communication skills. These evaluations are compiled by the Residency Office and are strictly confidential. A composite evaluation will be reviewed by the Chair (or Dean if the Chair is being evaluated) and program director. Faculty members will be given feedback during his or her semi-annual review.

Evaluation of the Program

The educational effectiveness of each component of the program is evaluated in a systematic manner at least annually through the Curriculum Committee process. Included in this review are evaluation of the educational goals and objectives, the needs of the residents, teaching responsibilities of the faculty, and the availability of administrative and financial support and of adequate health care resources within the community. This evaluation includes an examination of the balance between education, research, and service. The committee meets bimonthly and all faculty and residents are invited to participate in the process. All information and findings are evaluated and assessed by the Program Director for incorporation. Evaluations by residents, faculty and feedback from the program's graduates are utilized in the process when available.

Evaluation of Patient Care

Patient care is evaluated through the QA process in both inpatient and outpatient settings. All residents are invited to participate through the Clinical Providers forum. Feedback is given to residents regarding the process and outcome of care that they took part in.

Evaluation of the Graduates

The residency regularly obtains feedback on demographic and practice profiles, licensure and board certification, the graduates' perceptions of the relevancy of training to practice, suggestions for improving the training, and ideas for new areas of curriculum. We utilize the ABFM graduate survey data and incorporate the information in the annual Program Evaluation Committee meeting.

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POLICY: **Family Medicine Call**

Night Call

- When scheduled for Family Medicine night call, residents are expected to be (by pager) available at **5:00 pm** during weekdays**.** The on-call resident is to communicate by 6:00 PM with the upper level resident on the in-patient service regarding a detailed checkout list of patients, anticipated events as well as possible complications that may arise on the service along with the management plans, and to report any other appropriate information or arrangements. The transition of care policy is to be followed during the checkout process (see Transitions of Care policy). Call ends after completion of morning report and patient rounds the following day. Weekend and holiday call runs from 8:00 a.m. to 8:00 a.m., also ending with morning report and patient rounds.
- PGY-II and PGY-III residents will stay in the hospital if there is an unstable patient, a patient in labor, and during the first 6 months of the year (July – January) if an intern is on call with them; otherwise, call may be taken from home if the resident lives within a reasonable distance (less than 10-minute drive) from the hospital. However, all care delivered by the intern must be directly supervised by the upper level resident.
- If there is any question regarding the need for in-hospital call, the attending on call should be consulted.
- The first-call resident must keep a record of all call activities, including phone calls, ER visits, OB triage visits, deliveries, and admissions, and share a copy with the care coordinator each morning after morning report.
- The attending on call should be notified of all admissions; any acute change of hospitalized patients or of any ER visits or phone calls that are not **absolutely** straightforward.

Back-up

- Back-up call may be called in for illness, when the primary call person cannot perform clinical duties, or when there are active patient management issues at multiple sites requiring the physicians to be present at the sites simultaneously. This should be discussed with the on-call faculty. Back-up schedule will be posted along with the regular schedule.

If a resident is required to come in for back-up call, the same duty hour rules will apply (see Clinical and Educational Hours policy).

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POLICY: **Fatigue Management**

Residents and faculty will receive training on the detrimental effects of fatigue annually. Policies will remain in place to prevent work weeks of greater than 80 hours when averaged over 4 weeks, no continuous duty greater than 24 hours with an additional 4 for continuity and education for residents, and an average of 1 out of every 7 days completely free of clinical duties.

We will encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly encouraged.

Information regarding the effects of fatigue will be prominently posted.

Any resident or physician found to be suffering the ill effects of fatigue will be excused from his or her clinical duties and an effort will be made to prevent recurrence. If a resident or physician is excused from his or her clinical duties, available residents, as listed in New Innovations, will be assigned to ensure continuity of care.

If necessary, fatigued residents or physicians may rest in call rooms available at the hospital prior to leaving for home. In addition, the hospital complimentary taxi service may be utilized. Residents wishing to utilize this service should call the hospital operator for assistance, a return voucher will be issued to the resident as well for the return trip to the hospital.

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POLICY: **House Staff Job Descriptions**

Level of Care Which Can be Provided by Residents in Their PGY-I Year
This encompasses the period of time from entrance into the program until judged capable of performing at the level of PGY II based on the requirements of the ABFM, performance on rotations, and direct personal observations of supervising residents and faculty.

Clinical Invasive

Repair simple laceration	Vent Management*	Skin Biopsy
Collect Blood Cultures	Thoracentesis*	Minor Skin Surgery*
Perform and Interpret EKG	Lumbar Puncture*	Endotracheal Intubation*
Vaginal Exam*	Paracentesis*	A-line Placement*
Joint Injection/Aspiration*	Central Line Placement*	I & D*
Sprain/Fracture/Dislocation Management*	Uncomplicated Pregnancy Management*	Remove Foreign Body From Ear and Nose
Circumcision*	Induction of Labor*	Cryotherapy of Cervix+

Clinical Diagnosis Management

Perform and Document History and Physical	Develop a Differential Diagnosis	Develop and Document Diagnostic Strategy
Develop and Document Treatment Plan	Order Diagnostic Tests+	Order Medications+
Order appropriate consults+		

Clinical Non-Invasive Management

Perform Complete and Focused Physical Exam	Order and Interpret Blood Tests	Order and Interpret Imaging Studies+
Order Invasive Radiology Studies*		

*A faculty physician or qualified upper level must be present physically or immediately available during the key portions of the procedure/surgery.

+Resident will gradually be awarded increasing independence from close supervision based on observation of performance and completion of performance objectives.

Level of Care Which Can be Provided by Residents in Their PGY II and III Years
This encompasses the period of time from completion of the PGY I experience until judged capable of performing at the level of Board eligible Family Physician based on the requirements of the ABFM, performance on rotations, and direct personal observations of supervising residents and faculty. Residents will be promoted to a PGY III level when they have completed the requirements of the PGY II year as well as have demonstrated increasing maturity and movement towards mastery of the core attributes of a Family Physician as identified above.

Clinical Invasive

Repair Simple Laceration	Vent Management	Skin Biopsy
Collect Blood Cultures	Thoracentesis	Minor Skin Surgery
Perform and Interpret EKG	Lumbar Puncture	Endotracheal Intubation*
Vaginal Exam	Paracentesis	A-line Placement
Joint Injection/Aspiration	Central Line Placement+	I & D
Sprain/Fracture/Dislocation Management+	Uncomplicated Pregnancy Management*	Remove Foreign Body from Ear and Nose
Circumcision*	Induction of Labor**	Cryotherapy of Cervix+
Colposcopy+	Cardiac Stress Test+	Colonoscopy+

Specific Settings for Evaluation and Management

Admission and/or management to regular floor	Evaluation and/or management in ED or Pediatric ED*	Admission and/or management in Special Care Unit*
Admission and/or management on Labor and Delivery+	Admission and/or management if uncomplicated newborn+	Evaluation and/or management in FMC+

Clinical Diagnosis Management

Perform and Document History and Physical	Develop a Differential Diagnosis	Develop and Document Diagnostic Strategy
Develop and Document Treatment Plan	Order Diagnostic Tests+	Order Medications+
Order appropriate consults+		

Clinical Non-Invasive Management

Perform Complete and Focused Physical Exam	Order and Interpret Blood Tests	Order and Interpret Imaging Studies
Order Invasive Radiology Studies**		

*A faculty physician or qualified upper level must be present physically or immediately available during the key portions of the procedure/surgery.
**The resident will maintain close contact with the attending physician regarding patient's clinical course. Attending physician will be immediately available for consultation.
+Resident will gradually be awarded increasing independence from close supervision based on observation of performance and completion of performance objectives.

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POLICY: Inpatient Clinical Care Provided by Family Medicine Residents

Family Medicine In-Patient Service

- The attending physician is professionally, legally and ethically responsible for all patients admitted to the Family Medicine Service.
- A complete H&P, patient orders, daily progress notes, and the discharge summary are the responsibility of the upper level residents on the Family Medicine Service.
- The PGY-I resident is responsible for the day-to-day management of up to 6 patients, but under direct supervision of the upper level resident and attending faculty.
- It is the responsibility of the PGY-II resident to assist with patient admissions, write a resident admission note, assure that all patients are seen prior to morning report, and supervise and teach the PGY-I residents and students.
- It is expected that Family Medicine faculty and residents will follow their own patients who are hospitalized on the Family Medicine Service whenever possible. The residents on the service are responsible for notifying each patient's primary care physician (PCP) upon admission and discharge. Each physician with a patient in the hospital should round on their patient prior to morning report and attend morning report to participate in the discussion of his/her patient unless they are unable to participate for valid reasons. Those reasons to not participate include when participation would place the resident in a duty hours' violation, or the resident is working at such a physical distance as to make it impractical. In these cases, the care team contacts the PCP and their management input is solicited in this manner. The primary physician is always included in discharge planning and a continuity note is sent to them via the EHR. **The continuity physician may choose to manage the patient in coordination with the ward team.**
- Before initiating therapy on all new admissions, the on-call upper level resident will review appropriate patient data with the hospital attending or the on-call faculty to confirm the diagnosis and management plan. This review should also take place before any significant modification in therapy, before a consultation is obtained, or prior to a patient's discharge.
- "Acting interns" (senior medical students) will function as PGY-I residents on the Family Medicine Service.
- Working rounds and team huddles will be made by residents prior to morning report and attending rounds.
- Daily notes are expected to be completed prior to attending rounds.
- Morning report begins at 8:00 a.m. daily in the Family Medicine rounding room. Prior to that, at 7:45 each morning, the attending will meet with the residents on call and wards team to discuss ER visits and phone calls. Residents and attendings are expected to be punctual.
- On weekends, a similar procedure will be followed with checkout rounds conducted both mornings. Weekend on-call residents are encouraged to attend morning report on Fridays and Mondays. Generally, weekend rounds begin at 8:00 a.m. with the group meeting in the designated Family Medicine rounding room.

- An admission of a Family Medicine patient to labor and delivery requires immediate notification of the attending faculty. Attending faculty will examine patient, record findings, and supervise labor and delivery as appropriate.
- The housestaff responsible for the patient's care will complete discharge summaries on the day of discharge.
- Patients from the family medicine in-patient service "referred" or "transferred" to another service will be seen daily by the PGY-II resident.
- Checkout will occur on a daily basis by 6:00 p.m. It is the responsibility of the on-call resident to contact the Family Medicine Service resident for face-to-face transition of care.
- Patients will be admitted only after approval of the PGY-II or PGY-III resident following consultation with the attending faculty.
- Patients admitted from the Family Medicine Center will be discussed with the Family Medicine Service resident. Patients will be admitted from the Family Medicine Center by the resident seeing them only after consultation with an attending. Routine admissions (non-emergent) should be scheduled for the morning except under special circumstances. The provider at the Family Medicine Center requesting admission of the patient is responsible for notifying the admitting office and the ward team. The clinic note should be completed prior to the arrival of the patient in the hospital. The patient should be admitted directly when feasible.
- Patients to be seen in the Emergency Room for evaluation should be instructed to identify themselves as Family Medicine patients. The emergency room is not to be used as a facility for routine admission work-up, but may be utilized if it is unclear whether a patient should be admitted or if the patient's condition necessitates an emergent evaluation or rapid intervention.
- The physician who sends a patient to the ER will notify the resident on call or on the Family Medicine Service. It is then the responsibility of the physician who will see the patient to notify the ER triage desk.
- PGY-I residents will be directly supervised by PGY-II or PGY-III residents and an ER attending on all activities in the ER. Care delivered during the Emergency room visit will be directly supervised by the ER department. The Family Medicine Attending will assume responsibility at the time of admission.

Policy Regarding Care of Complex and Critically Ill Patients

- The resident on the Family Medicine wards, at least twice daily, will chart on patients in critical care units (defined as L&D and the step-down units).
- A physician will be available in house when patients are unstable.
- When consultation is necessary the consultant will be personally called and all pertinent information will be reviewed with them.
- Consultants are called as soon as practical when the patient requires an intervention provided only by the consultant service.
- Consultants will be called when patients fail to respond as expected to therapeutic maneuvers or require aggressive, immediate intervention to avoid death or permanent disability.
- Consultants will be called when the patient's condition falls outside the realm of diseases usually managed by family physicians.
- Consultants will be asked specific management questions regarding the patient's care.
- Consultant recommendations will be monitored and followed as appropriate.
- When disagreement occurs between the primary care team and the consultant, the attending Family Medicine physician and the attending consultant will speak directly.
- When a decision is made to transfer the patient it shall be done as expediently as possible.

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POLICY: **Leave**

Absence
In the event of an unforeseen absence (i.e., illness, death in the family) the **RESIDENT** must contact as early in the day as possible:

- **Director of current rotation,**
- **Senior resident or fellow of current rotation,** if applicable,
- **Residency Coordinator** (currently Stacey Hartman) as records must be kept of leave taken.

Housestaff Leave
The program director or his or her designee must approve leave of any kind in advance. Educational requirements of the residency program will have precedence in all leave requests. Residency appointments may be extended with the program director's approval if residency program time requirements are not met due to a leave of absence.

Upon employment and with each anniversary, each resident is granted twenty (20) business days of paid leave per year. These days include vacation time, sick time, as well as time off needed for interviewing or attending educational programs not otherwise required by the residency. Vacation leave cannot be taken prior to the beginning of the academic year nor can it be carried over to subsequent years. There is no terminal pay for unused vacation leave. In order to avoid extension of residency training, residents are encouraged to schedule 3 weeks of vacation, leaving 6 days for all other time off needs.

The following departmental vacation policies also apply:

- Vacation requests are made several months prior to the beginning of the academic year for scheduling purposes and changes will require approval from the program director. Requests receive priority in relationship to the dates submitted.
- Vacation requests may not be in excess of five (5) weekdays in any given rotation. As a courtesy, you will not be scheduled for call on one of the weekends around this block of time. Please indicate the weekend that you wish to be off. Please note that residents do not get paid holidays. If a holiday falls during the vacation week, it is taken as a day of vacation.
- Vacation will not be approved during the last two weeks of residency of the **PGY III** year, for the day of the In-Training exam or during the annual resident retreat. Exceptions due to extenuating circumstances (such as starting a fellowship after graduation) will be reviewed on a case by case basis.
- Special requests or exceptions to the above should be directed to the residency director.

Meetings, Leave, etc. Scheduling Policy

All other requests for scheduled absences must be requested and approved by email at least 90 days (3 months) prior to the first of the month in which you are requesting time off. Example:

CME time desired for June 15-20, should be requested no later than March 1. Requests submitted less than 3 months in advance may be approved by the program director following an evaluation of the impact to the resident's education, rotation obligations as well as any potential disruption to patient care. For healthcare related visits (e.g. doctor's visits or dentist visits) not requiring a full day of absence, please get with the program coordinator for facilitation. Such visits will not count towards your 20 days.

Requests must be sent by email to program coordinator.

Family and Medical Leave

A leave of absence without pay may be granted upon request to residents who are unable to work as a result of medical reasons or as a result of pregnancy related conditions. Residents who have been employed by the university may qualify for the Family Medical Leave Act. The request must be in writing and supported by medical evidence. The resident must intend to return to his or her residency program. The duration of the medical leave will not exceed 90 calendar days, inclusive of sick leave. The University reserves the right to have the resident examined by a physician(s) of its choice.
Vacation leave may be used until all benefits are exhausted prior to taking the leave of absence. During pregnancy, residents may continue to work in their positions as long as they are physically able to perform their regular duties and have the consent of their physicians.

A resident on leave without pay may continue to participate in the group medical and life insurance programs for a period of 90 days. A resident who qualifies for leave under the Family Medical Leave Act will not be required to pay the University portion of the health insurance premium during the 90 days, but will be required to pay the individual portion. No additional vacation and sick leave will accrue or be paid during the unpaid leave of absence.

A resident who is unable to return to work may apply, at any time prior to the end of his or her leave of absence, for long-term disability benefits under the Group Long-Term Disability Program. Residents who are receiving long-term disability payments from the insurance company may elect to continue for 12-months, in the University's group medical insurance program by paying the entire monthly premium. Payment arrangements must be made with the payroll office. Failure to return from a leave of absence on the specified date is grounds for termination. Any leave taken beyond 20 business days will lead to extension of the resident's training.

Military Leave, Administrative Leave, on the Job Injury

The Program Director or designee may grant a leave with pay to residents in order to take any examination(s) or interview required for medical licensure in the State of Alabama. Military leave and on the job injury leave with pay would be granted consistent with University Staff Personnel Policies.

Professional Meetings/Continuing Education

At the program director's discretion and dependent on the resident's leave balance, residents may or may not be granted leave for attending professional and continuing education meetings as designated representatives of the department.

ABFM Guidelines

Note that the ABFM only allows a resident to be away from the program for a total of 4 weeks per year. Any resident away from the program more than the allowed 4 weeks (including family

medical leave) will have to extend residency on a day for day basis in order to maintain board eligibility.

An UNEXPLAINED or UNEXCUSED absence from your assigned work area is a serious offense. The first time this happens, you will be given a written warning. The second occurrence may result in termination from the program. It is the **resident's** responsibility to check the clinic schedule. The clinic schedule overrides any other schedule. The resident should check the schedule prior to the start of the month and any questions should be handled ahead of time (contact Stacey Hartman). Not checking your schedule will **NOT** be an EXCUSED absence.

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POLICY: License Procedure

PGY I

Your program requires you to independently write controlled substance prescriptions outside USA Medical Center or USA Children's & Women's Hospital.

You must apply for a limited license. Complete original Limited Certificate of Qualification and give it to your program as soon as possible.

Include:
Check for $175
Letter from Department
Certified Copy of Medical School Diploma
Certified Copy of ECFMG (when applicable)
Social Security number required
Verification of Citizenship

Once the Limited Certificate of Qualification is approved by the Board you should receive a Limited License Application to complete. This must be returned to the Board with a licensing fee of $75.00. You will also receive an application for an Alabama Controlled Substance Certificate. This must be completed and returned to the Board with a check for $150.00.

When you receive your Alabama Controlled Substance Certificate you should apply for your Federal DEA. (It is free as you are a state employee, unless you plan to moonlight.)

PGYII

International Medical Graduates
You must renew your Limited License by December 31. Complete Renewal of Limited Certificate of Qualification and a $15 check to the residency office in early October. Upon approval by the Board you should receive a Limited License Renewal Application that should be completed and returned to the Board with at licensing fee of $300. Annual ASCS renewal $150.00.

US Medical Graduates

Schedule USMLE Step 3 ***as soon as possible*** after completing your PGY1 year and request your Unrestricted License Application Packet from the Board at the same time (Appendix A)

If USMLE Step 3 ***IS*** taken and a passing score given to the residency office by October 10 (it takes approximately 6 weeks to obtain results): You must complete your application packet in October. This will allow two months for the Board to receive all of the information to present your application at the December meeting.

If you do not have a USMLE Step 3 passing score by October 10:

You must renew your Limited License by December 31. Complete Renewal of Limited Certificate of Qualification and a $15 check to the residency office in early October. Upon approval by the Board you should receive a Limited License Renewal Application that should be completed and returned to the Board with at licensing fee of $300. Annual ASCS renewal $150.00.

Passing USMLE Step 3 after October – you must apply for your full license the next calendar year.

PGY III

International Medical Graduates – Less than 36 months of training
You must renew your Limited License by December 31. Complete Renewal of Limited Certificate of Qualification and mail it with a $15 check to the Alabama Board of Medical Examiners in October. Upon approval by the Board you should receive a Limited License Renewal Application that should be completed and returned to the Board with at licensing fee of $300. Annual ASCS renewal $150.00.

US Medical Graduates
Unrestricted license renewal cards are sent out by the Board every year. Renewal of your unrestricted license can be done online and must be done by December 31. Annual MD/DO license renewal $300.00. Annual ACSC Renewal $150.00

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POLICY: **Departmental Moonlighting Policy**

Moonlighting is not a right but a privilege that **MAY** be extended to Family Medicine residents at the discretion of the Program Director. PGY-1 residents are not allowed to moonlight.

Documentation

- Permission to moonlight may be granted by the Residency Director as well as the Graduate Medical Education Committee (GMEC) following a written request from a resident. Residents requesting permission to moonlight must have an unrestricted license and must be a resident in good standing. The Chief Resident will maintain a roster as to the site, frequency, and hours of the experience. The Residency Director may withdraw this permission at his or her discretion or at the suggestion of the Residency Clinical Competency committee.
- Total work hours (duty and moonlighting hours) are limited to 80 hours per week, averaged over a four-week period of time. There are no exceptions to this rule.
- PGY I residents are not allowed to moonlight.
- Moonlighting is severely limited (no weeknights, Saturday only) when the resident is on the Family Medicine Service.

Limited in the Metropolitan Mobile Area

Family Medicine residents will not be allowed to provide office coverage for “vacationing” physicians in the Metropolitan Mobile area.

Moonlighting in Outlying Areas

The Program Director can make any exception to the policy in this section. Moonlighting may be carried out in outlying areas as long as:

- It is not detrimental to the educational, research, and patient care activities of the resident or the residency program, as determined by the Program Director.
- It does not interfere with the personal and family life of the resident.
- It poses no health threats to both the resident as well as the Family Medicine Department as determined by the program director.
- It has an educational value.
- It provides services to medically underserved areas of patients.
- It enhances community good will.
- It incurs no legal liability or risk to the University of South Alabama or the Department of Family Medicine (the resident must carry their own professional liability insurance for moonlighting purposes).

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POLICY: Offsite Exposure Mitigation Strategy

In an effort to reduce the risk of Covid-19 transmission as a result of the utilization of multiple learning sites, the USAFM program has assessed all its rotations and implemented the following to mitigate this risk. While resident experiences in the community may inadvertently expose them to patients with Covid-19, the majority of such risk will likely be occurring at USA Health facilities as a result of caring for patients in the clinic and hospital setting. In addition, Family Medicine training is inherently dependent on community engagement and outreach experiences not available within the USA system to prepare residents for independent practice. Consequently, the emphasis will predominantly concentrate on infection control and prevention strategies as recommended by USA Health policies in particular as it relates to PPE use, frequent handwashing, social distancing, and reporting any new symptoms or exposures to the department. As for the individual rotations, the following will be implemented:

Rotation	Description	Intervention
Orientation Rotation	Most experiences occur in USA Health facilities	Non-USA experiences will be postponed
Family Medicine Inpatients	All experiences occur in USA Health facilities	Non Needed
Obstetrics Rotations	All experiences occur in USA Health facilities	Non Needed
Surgery Rotation	Most experiences occur in USA Health facilities	The rotation at Victory Health occurs at the end of the day and the resident will not return to USA on that day
Pediatrics Inpatient	All experiences occur in USA Health facilities	Non Needed
Emergency Medicine	All experiences occur in USA Health facilities	Non Needed
Peds Emergency Medicine	All experiences occur in USA Health facilities	Non Needed
Newborn Nursery	All experiences occur in USA Health facilities	Non Needed
Community Medicine	4-week block rotation involving a combination of experiences in the community as well as required continuity clinic at the USA-FMC	The schedule has been modified. All non-USA experiences will either be consolidated or occur at the end of the day. The resident will not return to a USA facility until the following day.

Urology rotation	All experiences occur in USA Health facilities	Non Needed
Endocrinology rotation	All experiences occur in USA Health facilities	Non Needed
ICU rotations	All experiences occur in USA Health facilities	Non Needed
Internal Medicine wards	All experiences occur in USA Health facilities	Non Needed
Cardiology rotation	All experiences occur in USA Health facilities	Non Needed
Sports medicine rotations	4-week block rotation involving a combination of sports medicine experiences in the community as well as required continuity clinic at the USA-FMC and call at the UH and CW	Schedule has been modified. All non-USA experiences will either be consolidated or occurring at the end of the day. The resident will not return to USA facilities until the following day.
Gynecology rotation	All experiences occur in USA Health facilities	Non Needed
Geriatrics rotation	4-week block rotation involving a combination of experiences in the community that includes nursing homes as well as required continuity clinic at the USA-FMC	This rotation is on hold for now and will be postponed until the prevalence of Covid-19 in the community is significantly lower to avoid exposing at risk individuals.
Population Health rotation	4-week block rotation involving mainly experiences at the USAFM as well as call with minimal experiences in non-USA facilities (Viva)	The schedule will be modified. All non-USA experiences will either be consolidated or occur at the end of the day. The resident will not return to USA facilities until the following day.
Rural Health rotation	A 4-week rotation with 3 days a week at a remote rural site, 2 full days of continuity clinic at USA-FMC and hospital call on the weekends	The schedule has been altered so that no resident will attend experiences in more than one site on any given day. This rotation has also been held until the safety of infection control procedures at the site can be ascertained.

Elective Rotations	Variable experiences dependent on resident requests in preparation for their future practice	The schedule will take into account separating offsite experiences from those occurring at USA Health.

Residents will be encouraged to wash their clothes at the end of the day, particularly if returning from a community setting or a high-risk setting such as caring for patients in a Covid-19 unit at a USA Health facility. The department will continue to monitor community incidence and exposure risk for all their rotations and will continuously adapt to the changing situation.

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POLICY: Patient Care in the Family Medicine Clinic

Patient care begins at 8:30 am Monday through Friday unless otherwise noted on the schedule. On the rare occasions where you will be unavoidably late, please call and let someone know.

The morning patient care session ends when the last morning patient is seen. When a provider is done with their schedule, they may leave the premises once they have ascertained that there are no more unscheduled patients to be "worked-in" with them. Before leaving it is a courtesy to notify the clinic attending to see if he or she is aware of anything else that might need attention.

Faculty members are encouraged to attend resident conferences unless they have a scheduling conflict. They may have to make arrangements for lunch prior to the beginning of conference. Not being able to get away for lunch is not an acceptable excuse for missing conference. The conferences are at 12:30 pm.

Patient care in the afternoon begins at 1:30. If you will be delayed, you are expected to call and let the staff know what the situation is to allow rescheduling of your patients if necessary.

The evening patient care session ends when the last patient is seen. When a provider is done with their schedule, they may leave the premises once they have ascertained that there are no more unscheduled patients to be "worked-in" with them. Before leaving it is a courtesy to notify the clinic attending to see if he or she is aware of anything else that might need attention.

You will be expected to build a continuity practice. Because of the nature of your academic duties this is difficult to do at times. To compensate for lack of immediate availability, you should make an effort to check frequently for messages, return phone calls promptly, and be available for your patients. Your nurse will assist you in doing this. The Manager of Clinical Operations is the contact person should you have problems.

Some patients that you see are not strongly attached to a physician. You are expected to take responsibility for the patient that you see for the duration of their illness, and if they are suffering from a chronic illness, you may elect to take over their care. All paperwork regarding patient care will be directed to the primary care provider (PCP).

Some patients have seen one provider exclusively and may be seeing you because their provider is not available. You should try to encourage maintenance of the resident's continuity relationship with their patients. When you see a patient for an acute problem and they wish to return to their provider, you should direct all labs and paperwork to the patient's PCP.

All patients must have their medical records completed with permanent problems, past medical, family, and social history, and allergies listed.

All patients should have health maintenance issues addressed at **every** visit.

You are expected to assign the proper ICD-10 and CPT codes for the visit. These codes should cover any labs and x-rays ordered.

All tests and specialty consultations should be well thought out prior to making arrangements. This includes a working knowledge of the patient's condition and the documentation of the reason for test or the referral on the day the patient is seen. The referral is not completed until **ALL** information necessary to make the referral is given to the referral clerks.

Documentation will be done on a given encounter on the date of encounter if at all possible or no later than 72 hours. The medical director grants exceptions for unusual circumstances.

Duties of the Attending Physician

While attending, the dual responsibility of the faculty member is education and directing patient care. The educational component includes direct instruction to identify and remedy knowledge deficits, identifying and correcting barriers to efficient patient care, and identifying and correcting barriers to culturally competent care. The faculty member is expected to use multiple techniques to identify and correct deficits in knowledge, skills, and attitudes. These techniques will be taught to the faculty through the faculty development curriculum. The attending is also responsible for the quality of patient care being delivered to the individual patients. The faculty member should have a working knowledge of the learner's strengths and weaknesses and make an effort to assure that these do not impede quality patient care. The faculty preceptor is also responsible for assuring the efficient flow of patients through the practice. This will require knowledge of which residents are seeing patients and making themselves available to assist them in any way possible.

The attending physician is directly responsible for all patient care which occurs by residents during the session. Once the schedule is set, the attending is responsible for finding coverage should a conflict arise. The morning attending is required to be immediately available until the last morning patient is seen. The evening attending is required to be immediately available until 5:00 pm or until the last patient is seen, whichever occurs later.

There must be one attending for every four residents.

The attending may not have other scheduled activities during his or her attending time. Should a conflict arise, the attending may trade portions of the time to cover the other obligations. Physicians may only rarely be taken out of patient care for coverage of a conflict.

The attending physician is also required to provide guidance regarding phone messages and lab results for providers who are not physically present. In the interest of encouraging a continuity practice, the attending may defer answering a question and encourage contacting the primary care provider.

First year residents will be required to sign out 100% of their patients. 2nd and 3rd year residents will sign out a minimum of 50% of their patients. The attending physician will countersign all encounter notes.

You will be asked to provide written feedback on all the residents on a quarterly basis to assess their performance in the FMC.

For billing purposes, those patients with Medicare and certain other insurances must be signed out to you at the time of encounter. You must use the format provided and document the key portions of the history, physical, and decision-making in your hand or ensure the resident documents your participation within the body of their dictation.

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POLICY: **Patient Safety**

This policy provides a systematic approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; establishing reliable processes and approaching safety through the perspectives of the patients and families we serve.

USAFM supports an *environment* that:

- Allows patients, families, staff, and leaders to identify and manage actual and potential risks to patient safety
- Encourages recognition and acknowledgement of risks to patient safety and medical/health care errors
- Encourages initiation of actions to reduce these risks
- Reports internally what has been found and actions taken, including disclosure to patients/families when appropriate
- Focuses on processes and systems
- Minimizes individual blame and prevents retribution for involvement in a medical/health care error and strives to remove intimidation or unprofessional behavior that may undermine our culture of safety
- Encourages learning about medical/health care errors, potential errors and near misses/close calls
- Advancing knowledge, skills, and competence of staff and patient by recommending methods and processes to improve the reliability, quality, and safety of care, and adherence to evidence based practices and protocols

Mechanism for Integration of Components
As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple members of the healthcare team in establishing the plans, processes, and mechanisms that comprise the patient safety activities at USAFM.

Clinical Management Team Committee
The committee includes the following members:

- Medical Director
- Program director (or his/her designee)
- Clinical Nurse Manager
- Front Office representative
- USAFM project coordinator
- Other members as needed

Scope of the Safety and Error Reduction Committee
The committee's scope includes:

- Reporting to the Department Chair
- Coordinating process design/redesign, education, implementation, and monitoring of Patient Safety initiatives
- Reviewing current processes associated with actual and potential events, including sentinel events and near misses/close calls
- Overseeing conduction of root cause and safety analyses when opportunities are identified
- Identifying trends and initiates corrective action or forwards to responsible group for review and action
-

Just Culture Philosophy and Support Staff
An effective Patient Safety Program cannot exist without optimal reporting of medical/healthcare errors and occurrences. Therefore, it is the intent to adopt a just culture approach in its need for balance between reporting and accountability for strict compliance with safety processes.

Disclosure of Outcomes
Patients, and when appropriate, their families, are informed about the outcomes of care and unanticipated outcomes.

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POLICY: **Pharmaceutical Industry Relations**

Principles
USA FM exists to train residents to provide responsible, high-quality care for patients. An important educational goal for residents is the acquisition of the basic and advanced knowledge of pharmacotherapeutics, as well as the ability to critically evaluate new information about medications. Residents should learn to use unbiased, published reviews of therapeutic options as the primary basis for drug choice, and be able to evaluate commercially sponsored programs for their scientific accuracy and integrity. It is the responsibility of the residency director and faculty to ensure the quality of the residency program's educational structure and content.

Faculty
Faculty will model behavior consistent with ethical guidelines developed by responsible professional organizations (AMA, AAFP, ACCME) and which discuss appropriate relationships between physicians and pharmaceutical companies. To promote high quality, objective resident education, faculty are encouraged to avoid any appearance of conflict of interest. Consistent with this objective, faculty will disclose to peers and residents general financial or other relationships between a faculty member and pharmaceutical companies that might affect resident education.

Educational Conferences and Activities
Faculty are forbidden from accepting honoraria directly form pharmaceutical companies that might affect resident education. Faculty may serve as consultants to pharmaceutical or proprietary companies for clearly defined professional services. Faculty and residents will conduct or participate in pharmaceutical company-sponsored research only if the research: is scientifically valid, would be justifiable research even if company funding were not available, results are not subject to censorship, and the sponsoring company is publicly identified. The residency will accept and use pharmaceutical or other proprietary companies' financial support of residency education activities for the following activities:

1. We will offer companies the opportunity to sponsor pre-conference lunch. Should representatives desire to take advantage of this, they will be expected to sign up in advance and provide sufficient food for the expected group in attendance. They are allowed up to 10 minutes to present information regarding their product. All information disseminated will be subject to approval by the director or his/her designee.
2. Companies may choose to sponsor educational activities of the department. The director, other faculty members, or residents may solicit funds for these activities. All funds will be deposited in the (SAMSF) Medical Science Foundation account and be used for the activity designated. Any re-purposing of funds will be at the discretion of the Chair or his/her designee. Companies will be acknowledged for their contribution in a manner acceptable to the company and to the department.
3. The residency will not allow direct industry sponsorship of guest speakers for the conference series.

Gifts
Presentations should be primarily based on published or other research data and emphasize generic drug names when discussing medications. Industry representatives may offer residents gifts, which may support patient care and are of minimal value (pens, notepads, calipers, pregnancy dating devices, etc.) as well as educational materials of modest values, such as books, which may support residency education. To help avoid potential conflicts of interest, residents, faculty and staff affiliated with the residency program are encouraged:

1. Not to directly solicit or receive personal gifts from pharmaceutical companies.
2. Not to allow pharmaceutical representatives to conduct contests, drawings, raffles, or other activities that lead to personal gifts for residents or faculty.
3. Not to display gifts or other promotional materials directed to the physician and that advertise brand names for pharmaceutical products in patient care or waiting room areas. Residents and faculty may receive competitive national awards and scholarships funded by pharmaceutical companies if all control of recipient selection rests with an independent professional organization (e.g. AAFP, STFM).

Detailing
Direct contact between residents/faculty and pharmaceutical or other proprietary representatives for the purpose of discussing specific products, i.e. detailing is allowed under the following conditions:

1. Distribution of samples is not allowed.
2. In depth detailing will not interfere with patient care or other educational activities. It may occur should the provider desire during patient hours if there are no patients who are awaiting care. Otherwise it may occur from 12 until 12:25 in the conference room prior to lunch.
3. Providers may decline personal contact with pharmaceutical representatives if desired.
4. Representatives are on notice that use of personal appeals and factually incorrect or misleading information in detailing is unprofessional and will result in the representative being asked to refrain from visiting the practice if a pattern of such abuse is observed.
5. Detailing is only one component of an educational program designed to help residents critically assess new and existing information about products. The main educational component is under the control of the program faculty. Faculty will be present at conferences where pharmaceutical or other propriety representatives make presentations about products to offer analysis of the information presented by the representatives.

The residency educational program will assist residents in learning about promotional techniques used by industry representatives and will assist them in developing appropriate responses. Access for representatives is not conditioned on the giving of gifts or other incentives to the program by the pharmaceutical or proprietary company.

Samples
The program accepts medication coupons that are given to patients.

Literature
To help promote high quality patient education, patient education materials provided by pharmaceutical and other proprietary companies will be reviewed by appropriate faculty, residents, and/or office staff before distribution to patients. We will select patient education

materials that are accurate, that are written at appropriate patient readability levels, and that present balanced and objective information.

Medical Students
When medical students spend time rotating or working within the residency program, they should be made aware of and follow the residency guidelines on the relationship with pharmaceutical and other proprietary companies. Faculty and residents should help teach medical students about the unbiased acquisitions of pharmacotherapeutic knowledge including new medications, as well as the many roles that the pharmaceutical industry may play in undergraduate and postgraduate medical education.

Other
We do not control faculty and resident activities outside of working hours and during their non-residency time. Nonetheless, the faculty and senior residents are encouraged to inform other residents about the potential marketing intent of outside activities such as proprietary sponsored “educational”, social or sporting activities. Residency resources will not be used to support proprietary sponsored activities that occur independent of the educational structure of the residency program.

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POLICY: **PPE Procedure**

Objective
USA Health is instituting a local PPE maintenance program. Individual departments/programs will take on the responsibility of coordinating the distribution and reprocessing of PPE.

Procedure

- Resident and Faculty specific N95 respirators will be ready for sign-out from the FM administrative office. The clinical supervisor will coordinate the distribution and reprocessing of the respirators.
- Each resident will receive a bag prepared for them that contains three N95 masks of appropriate make / model based on fit testing. Each bag will also contain instruction for reuse and reprocessing.
- Prior to the first use, please label masks legibly with:
    - First and last name
    - J#
    - Date
    - Unit (Family Medicine - SPCC)
- The mask can we worn for the entire shift unless it becomes contaminated, wet/damp or otherwise unusable.
- At the end of the shift the physician will place the mask into a brown paper bag (will be dispensed to you as well) and label bag.
- Fold top of bag and secure with a single small piece of tape.
- Place into bin located in the small procedure room in the C-pod at the FMC.
- USA Health will pick up the soiled PPE for sterilization/decontamination
- USA Health will return the now decontaminated PPE in a white bag ready for reuse.
- The physician will pick up their white bag with reprocessed masks the following day.

Notes

- On average each mask can be preprocessed 5 times.
- If the mask is visibly soiled it should be disposed of appropriately.
- If the mask shows signs of deterioration (usually the elastic straps) during reprocessing it will be disposed of and a new N95 will be dispensed.
- No make-up should be worn with a mask as make-up often contains UV protection and we're decontaminating these masks with UV light.
- Reprocessing begins at 8:00am and is typically complete by noon.
- As a result of limited supplies of PAPRs, residents with facial hair are encouraged to shave and undergo fit testing for available N95 respirators.

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POLICY: **Program Evaluation Committee**

Background
The Accreditation Council on Graduate Medical Education (ACGME) considers the Program Evaluation Committee as critical in ensuring the quality of the program. The program director must appoint the Program Evaluation Committee. The members of the PEC may be the same or different from the members of the Clinical Competency Committee (CCC). At minimum the PEC should have as its members:

- at least 2 members of the residency faculty
- at least one resident member

Purpose and Scope of Responsibility
The PEC is tasked at minimum with systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE). The PEC should participate actively in:

- Planning, developing, implementing, and evaluating educational activities of the program
- Reviewing and making recommendations for revision of competency-based curriculum goals and objectives
- Addressing areas of non-compliance with ACGME standards
- Reviewing the program annually using evaluations of faculty, residents, and others, as specified below:
    - resident performance
    - faculty development
    - graduate performance, including performance of program graduates on the certification examination
    - progress on the previous year's action plan(s)
    - program quality as indicated on:
        - The annual written review of the program by the residents and faculty on the annual DFM survey
        - The annual written review of the program by the residents and faculty on the ACGME survey
        - Any written evaluation of the faculty of the program by the ACGME (when available)
- The PEC must formally document this evaluation process and is responsible for rendering a written Annual Program Evaluation (APE) as well as a written plan of action to document initiatives to improve performance in one or more of the areas measured.

PEC Membership
At USAFM, the core committee structure includes:

- All core physician faculty including the chairman, program director, and medical director.
- PhD Faculty
- Chief residents
- Ad hoc members on the PEC to include:

- Non-physician/non-PhD faculty
- Additional residents based on interest and need

The Program Director will chair the PEC.

The Program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and will render a full, written, annual program evaluation (APE). The annual program evaluation will be conducted in March of each year, unless rescheduled for other programmatic reasons. Approximately two months prior to the review date, the Program Director will:

- Facilitate the Program Evaluation Committee's process to establish and announce the date of the review meeting
- Assist the residency coordinator in organizing the data collection, review process, and report development
- Solicit written confidential evaluations from the entire Program faculty and Residents for consideration in the review (if not done previously for the academic year under review).

At the time of the initial meeting, the Committee will consider:

- Achievement of action plan improvement initiatives identified during the last annual program evaluation
- Achievement of correction of citations and concerns from last ACGME program survey
- Residency program goals and objectives
- Faculty members' confidential written evaluations of the program
- The Residents' annual confidential written evaluations of the program and faculty
- Resident performance and outcome assessment, as evidenced by:
  - Aggregate data from general competency assessments
  - In-training examination performance
  - Case/procedure logs
  - Other items that are pertinent to the program/specialty
  - Graduate performance, including performance on the certification examination and scope of practice
  - Faculty development/education needs and effectiveness of faculty development activities during the past year
  - Comparative residency data collected from the Residency Performance Index (RPI)

Additional meetings may be scheduled, as needed, to continue to review data, discuss concerns and potential improvement opportunities, and to make recommendations. Written minutes must be taken of all meetings.As a result of the information considered and subsequent discussion, the committee will prepare a written plan of action to document initiatives to improve performance in at least one or more of these areas:

- Resident performance
- Faculty development
- Graduate performance
- Program quality
- Continued progress on the previous year's action plan

The plan will delineate how those performance improvement initiatives will be measured and monitored. The final report and action plan will be reviewed and approved by the program's teaching faculty, and documented in faculty meeting minutes.

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POLICY: **Residency Faculty & Coordinator – Assignment, Responsibilities, Evaluation**

The Program Director and teaching staff are responsible for the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation and advancement of residents and the maintenance of records related to program accreditation. All members of the teaching staff must demonstrate a strong interest in the education of residents, sound clinical and teaching abilities, support of the goals and objective of the program, a commitment to their own continuing medical education, and participation in scholarly activities.

Program Director

There will be a single program director responsible for the residency. The program director at this time is Ehab Molokhia, M.D. The RRC will be notified promptly in writing upon the decision to make a change by the current program director or the Department Chairman. The director will be scheduled such that at least 70% of his or her time is available for education, supervision, and administration of the residency program.

Qualifications for the Program Director

The following are the requirements for any person named to the position of program director (either permanent or acting) at the University of South Alabama Family Medicine Residency Program.

- Academic and professional qualification: the director must be capable of administering the program in an effective manner and must be actively involved in the care of patients. Prior to assuming this position, the program director must have had a minimum of 3 years full-time professional activity in family medicine and should have had a minimum of 2 years' experience as a core faculty member teaching in a family medicine residency.
- Licensure: the director must be licensed to practice medicine in the State of Alabama.
- Certification requirements: the director must be currently certified by the American Board of Family Medicine.
- Medical staff appointment: the director must hold an appointment in good standing to the medical staff of the University of South Alabama Hospitals.

Responsibilities of the Program Director

The program director is responsible for the following, either directly or through delegation:

- Written educational goals and objectives.
- Selection of residents.
- Selection and supervision of teaching staff and other program personnel.
- Supervision of residents.
- Resident evaluations.
- Resident guidance and remediation.
- Resident well-being and provision of back-up support.
- Provide each resident with feedback of performance.

- Ensure compliance with grievance and due process as outlined in the GME Policy and Procedure Manual.
- Provide verification of residency education upon request.
- Implement policies and procedures consistent with the institutional and program requirements for Clinical and Educational hours and work environment including moonlighting, distribution, and monitoring and mitigating excess service demands.
- Compliance with institutional requirements.
- Compliance with ACGME and ABFM requirements.
- Provision of accurate information to appropriate governing bodies.
- Notification of major programmatic change.

Residency Coordinator

The department will provide support for the administrative duties of the residency. The position will answer to the Program Director and the duties and responsibilities are as follows:

- Functions as the primary and initial point of contact for faculty, residents/fellows, prospective residents/fellow, USA Housestaff office, GME office staff, and participating sites on matters related to the residency/fellowship training program.
- Collaborates with the residency PD and program evaluation committee in the development, dissemination, implementation, and annual review of policies, procedures, learning objectives, curriculum, training modules, assessments, and evaluations, to provide documentation of resident training in the required competencies and milestones; maintains the program's manual of policies and procedures.
- Monitors faculty and trainee compliance with established policies and procedures, including duty hour compliance, completion of annual surveys, education and employment requirements, and maintenance of related records.
- Maintains accurate and accessible records for, as well as personal knowledge of, current requirements for education, accreditation, recruitment, credentialing, appropriate specialty/subspecialty board certification, and reimbursement, including those related to the residents'/ fellows' training, the GME program, the sponsoring institution, and participating sites; such as non-hospital settings agreements and program letters of agreement; as well as the those related to the National Residency Matching Program (NRMP), Electronic Residency Application Service (ERAS), Accreditation Council for Graduate Medical Education (ACGME), Alabama Board of Medical Examiners (ALBME), appropriate American Board of Medical Specialties (ABMS), the American Association of Medical Colleges (AAMC), American Medical Association (AMA), and other entities as needed. Implements all modifications related to accreditation, credentialing, and certification.
- Maintains program and resident data in New Innovations residency management software as well as in online databases such as the ACGME's WebADs, the AAMC's GME Track, AAFP Census and AMA's FREIDA.
- Maintains confidential personnel and education records for all applicants as well as future, current and past residents in compliance with state and federal regulations, ACGME and board requirements, as well as University of South Alabama, USA Health System, USA GME and departmental policies and procedures, including ACGME milestone data and ILPs, ALBME licensure, DEA and Alabama controlled substance certification, NPI numbers, ACLS/BCLS/PALS certifications, records for ABMS eligibility, and verification of training completion.
- Oversees creation and dissemination of trainee required rotation, clinical, elective, call, and vacation schedules; maintains and updates schedules in New Innovations to assure coverage and maintain documentation of trainees' experiences.
- Oversees development, implementation and documentation of educational activities,

such as didactic conferences, grand rounds, journal club, board certification review courses, morbidity and mortality conferences, OSCEs, administration of in-training exams, simulation exercises, and training events, etc., as well as annual program events, such as orientation, retreats, and graduation, that support the program's curriculum and adhere to accreditation requirements.
- Prepares, updates, and maintains resident, faculty, and program evaluations as well as produce reports from the data as needed by the PD, clinical competency committee, program evaluation committee, department and /or GME Office.
- Attends and maintains minutes of program-related meetings, i.e. Resident Curriculum, Clinical Competency Committee, Program Evaluation Committee, etc.
- Initiates the recruitment process, maintains communication with prospective residents/fellows via telephone, email, and postal correspondence, conveys information regarding the program's application process, and distributes recruitment materials as well as communicates with applicants regarding interview decisions. Works toward successful recruitment of qualified residents/ fellows.
- Collaborates with the PD and selection committee on interview schedule, including arranging hotel accommodations, travel arrangements, meet-and-greet functions (evening before dinners, breakfast and lunch with current trainees), and local transportation needs for candidates.
- Plans, develops, and oversees updates, revisions, and distribution of residency-related literature, recruiting materials, and web presence (USA Health System webpages, program's social media presence, etc.).

Family Medicine Faculty

The program will maintain a core family physician faculty with the following attributes:
All physicians who are core faculty members including the Assistant Program Director will be scheduled such that at least 40% of his or her time is available for education, supervision, or administration of the residency program. All faculty members will have expertise and skills important to the training program. These skills currently include:
- Obstetrical skills.
- Ultrasonography.
- Dermatology.
- Geriatrics.
- Behavioral medicine.
- Nutrition.
- The use of medications and their interaction.

Core faculty will be available to teach general family medicine through direct instruction, bedside teaching in all settings, and mentoring. The family physician faculty must be currently certified or actively seeking certification by the American Board of Family Medicine.

General Rules for Residents and Faculty Members at USA Family Medicine
- PROFESSIONALISM – Our faculty physicians are expected to be exemplary physicians and educators, and function as emissaries for our profession to the medical school, community, and our profession as a whole. They are expected to demonstrate exceptional knowledge through maintaining Board certification and meeting the requirements for Academy membership as well as through demonstrated knowledge of recent medical literature and participation in CME. They are expected to be good corporate citizens through participation in committees at the local, state and national level. They are offered the opportunity to participate in scholarly inquiry and should be skeptical consumers of medical information.

- CONFIDENTIALITY – We are bound by an oath to maintain patient confidentiality. This means that you will not discuss patient information except with colleagues or office staff and then only in a manner that respects the patient's right to confidentiality.
- AVAILABILITY – You are expected to be available for questions regarding patient care issues by pager at all times during the work week and when on call.
- PHYSICIAN DRESS – The dress code is similar to that of the University. While ties are not required for men, they should dress in nice pressed shirts with collars, and pressed pants, shoes and socks. Woman are similarly expected to dress nicely. Jeans are not allowed. Lab coats are optional. "Scrubs" are to be worn only when there is no time to change from performing an evasive or potentially messy procedure. If you must wear scrubs, it is preferred that you wear your white coat as well.
- Patient care begins at 8:30 am Monday through Friday unless otherwise noted on the schedule. On the rare occasions where you will be unavoidably late, please call and let the GME coordinator know.
    - The morning patient care session ends when the last morning patient is seen. When a provider is done with their schedule, they may leave the premises once they have ascertained that there are no more unscheduled patients to be "worked-in" with them. Before leaving it is a courtesy for residents to notify the clinic attending to see if he or she is aware of anything else that might need attention.
- Faculty members are encouraged to attend conferences as residents are required to unless they have a scheduling conflict. He or she may have to make arrangements for lunch prior to the beginning of conference. Not being able to get away for lunch is not an acceptable excuse for missing conference. The conferences occur every weekday at 12:30 pm unless otherwise indicated.
- Patient care in the afternoon begins at 1:30. If you will be delayed, you are expected to call and let the GME coordinator know what the situation is to allow rescheduling of your patients if necessary.
- The evening patient care session ends when the last patient is seen. When a provider is done with their schedule, he or she may leave the premises once he or she have ascertained that there are no more unscheduled patients to be "worked-in" with them. Before leaving it is a courtesy for the resident to notify the clinic attending to see if he or she is aware of anything else that might need attention.
- The provider is given a schedule that is appropriate for his or her training year level and should be able to see the patients in the time allotted. If the provider is unable on a routine basis to accomplish this, he or she should seek out consultation from other faculty and staff to assist him or her.
- The providers are expected to build a continuity practice. Because of the nature of academic duties this is difficult to do at times. To compensate for lack of immediate availability, he or she should make an effort to check frequently for messages, return phone calls promptly, and be available for their patients. The physician's nurse will assist in doing this. The manager of clinical operations is the contact person should problems arise.
- All patients must have their medical records completed with permanent problems, past medical, family, and social history, and allergies listed.
- All patients should have health maintenance issues addressed at **every** visit whenever possible.
- The provider is expected to assign the proper ICD-10 and CPT codes for the visit. These codes should cover any labs and x-rays ordered.

- All tests and specialty consultations should be well thought out prior to making the arrangements. This includes a working knowledge of the patient's condition and the documentation of the reason for test or the referral on the day the patient is seen. The referral is not completed until **ALL** information necessary to make the referral is given to the referral clerks.

Documentation will be done on a given encounter on the date of encounter if at all possible or no later than 72 hours. The medical director grants exceptions for unusual circumstances. All notes will be done in the EHR.

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POLICY: **Special Certification**

Statement of Purpose
The department and the hospital have a vested interest in both the competency and the education of the Housestaff. Certification programs exist in various aspects of patient care and some of these programs are required for patient care. This policy is to identify which programs have been identified as a part of the core curriculum and how they will be viewed by the residency administration.

We will provide access to special certification programs at various times throughout the three-year training program. We will provide funding for certain of these which will vary depending on funding sources. We will provide time away from rotations to allow Housestaff to remain current.

Program	USAFM's Responsibility	Resident's Responsibility
ACLS	Will allow time for certification and recertification	Must be certified as soon as possible upon entering training. Recertification must be maintained throughout residency training.
PALS	Will allow time for certification and recertification.	Must be certified as soon as possible upon entering training. Recertification must be maintained throughout residency training.
NRP	Will allow time for certification and recertification.	Must be certified as soon as possible upon entering training.
ATLS	Will allow time for certification and recertification pending the needs of the practice	Responsible for finances and scheduling of the course in coordination with the residency office. USAFM may offer reimbursement if funding is available.
ALSO	Will allow time for certification and recertification.	USAFM may offer reimbursement if funding is available.

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POLICY: **Transition of Care**

It is essential for patient safety and resident education that effective transitions in care occur. Residents must remain on-site to accomplish these tasks; however, this period of time must be no longer than an additional four hours. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to:

- A single severely ill, unstable patient, or laboring patient.
- Provide humanistic attention to the needs of a patient or family.
- Attend unique educational events.

When this happens, a notation is made in the duty hour log with the justification.
In addition, the resident must:

- Appropriately hand over the care of all other patients to the team responsible for their continuing care
- Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

On a daily basis, the care of all patients who require hospitalization or other on-going attention from the practice will be discussed to facilitate ongoing coverage. These transitions will occur between 7:45 and 8:30 under the direct supervision of a senior resident and an attending physician. A second transition will occur between 5 pm and 6 pm with a direct discussion occurring between senior residents and indirectly with an attending physician. The coverage is dictated by the call schedule as listing in New Innovations and posted prominently in the call room and attending office. Information transmitted during checkout will include patient's name, room number, current medications, acute and chronic problems, outstanding information that needs attention, anticipated as well possible issues/complications that may arise during the call period and plans to manage them. This information will be maintained on a paper sheet as well as electronically on the hospital server.

A continuity note will be sent to the primary care provider as well as the clinical care coordinator for every Emergency room visit as well as every after hours call and hospital admissions and discharges to ensure an appropriate transition of care to the ambulatory setting.

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POLICY: **Wellness**

Purpose of Policy
This policy defines the ways in which providers including Resident physicians are supported in their efforts to become competent, caring and resilient physicians while completing Accreditation Council for Graduate Medical Education (ACGME)-accredited training programs at the University of South Alabama.

Definitions

Burnout: Long-term exhaustion and diminished interest in work. Dimensions of burnout include emotional exhaustion, depersonalization, and feelings of lack of competence or success in one's work. Burnout can lead to depression, anxiety and substance abuse disorders.
Resident: Any physician in an ACMGE-accredited graduate medical education program including residents and fellows.
Resilience: The ability to withstand and recover quickly from difficult conditions or situations. During training, Residents may face difficult patient care, educational or personal events which have the ability to negatively affect their Well-being. Decompressing after such situations, through conversation with peers, mentors or family, and self-care activities, can increase Resilience.
Well-being: Refers to the state of being healthy, happy and successful. Well-being may be positively increased by interacting with patients and colleagues at work, being intellectually stimulated and by feeling that one is making a difference/helping. In addition, self-care activities, including exercise, getting plenty of rest and connecting with others, is beneficial.

Policy Statement
Residents' physical, psychological and emotional Well-being is of paramount importance to the University of South Alabama Family Medicine Department. Residents are encouraged to lead healthy lives and make healthy choices that support them in their personal and professional growth. To that end, we provide the following strategies to support trainee health, Well-being and Resilience:

Institutional Support

USA JagFit provides USA Health employees with resources and services that motivate, encourage, and promote healthy lifestyles and foster Resilience. Services include:

- Health Improvement and Employee Wellness:
  - MindStrength mindfulness training
  - health and lifestyle coaching
  - diet and nutrition resources
  - fitness rooms
  - onsite fitness classes
- Employee Assistance Program: Confidential and free counseling services.

- Primary Care: Accessible primary care options for USA insured employees and their dependents.
- Occurrence Reporting: Patient and employee safety reporting for actual events and near misses.
- Residents have access to healthy food and beverage options at the USA Hospital cafeteria and from other nearby food vendors.
- All Residents participate in a formal Error Prevention course during training as well as online training in the fundamentals of physician wellness.

Graduate Medical Education Support

- The Office of GME sponsors several Resident and Fellow Appreciation Days throughout the year where Residents have the opportunity to participate in daily wellness activities and shared meals.
- Residents may become members of the Housestaff Council. This membership is composed of a group of peer-elected representatives from each of the core residency programs which comes together to discuss issues affecting Resident life. The council seeks to promote harmonious and collaborative relationships amongst Residents, faculty and staff and enhance the Resident community through advocacy, volunteer, and social activities.
- Meal funding support is also provided to Residents taking overnight in-house call and for Residents who must return to the hospital to provide care when scheduled to home call.
- Residents may take advantage of sleeping facilities in the hospital in the event that they are too fatigued to drive home after a clinical shift.
- All Residents and fellows complete an annual learning module on sleep alertness and fatigue mitigation.

Program Support

- There are circumstances in which Residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. USAFM has policies and procedures in place to ensure coverage of patient care in the event that a Resident may be unable to perform their patient care responsibilities. These polices will be implemented without fear of negative consequences for the Resident whom is unable to provide the clinical work.
- Residents have the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their work hours. Residents must follow the program's procedures for scheduling and notification of these appointments.
- Residents are encouraged to alert the Program Director, a faculty mentor or Chief Resident when they have concern for themselves, a Resident colleague or a faculty member displaying signs of Burnout, depression, substance abuse, suicidal ideation or potential for violence.