M E M O R A N D U M

DATE: July 1, 2023 ***CURRENT AS OF 11/21/23-AZ***

TO: Family Medicine Residents and Faculty

FROM: Aubrey Zakshevsky, MBA, Family Medicine Residency Coordinator

RE: Family Medicine Residency Administrative Policy Manual

THE MANUAL PUBLISHED ONLINE SUPERSEDES ALL OTHER MANUALS. AMENDMENTS AND CHANGES TO THE MANUAL, APPROVED BY THE PROGRAM DIRECTOR, MAY BE MADE FROM TIME TO TIME ON AN AS NEEDED BASIS.

YOU WILL BE NOTIFIED VIA EMAIL AND MEDHUB OF ANY CHANGES TO THE POLICY MANUAL.

I UNDERSTAND THAT I AM RESPONSIBLE FOR READING AND COMPLYING WITH

ALL ASPECTS OF THIS MANUAL.

PRINT NAME_____

SIGNED_____

DATE_____

NSU-KPCOM/EVARA HEALTH

FAMILY MEDICINE RESIDENCY ADMINISTRATIVE POLICY MANUAL

2023-2024

Carlos R. Rodríguez, MD, FAAFP- Program Director
Aubrey Zakshevsky, MBA- Program Coordinator

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ADMINISTRATIVE POLICIES
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NSU-KPCOM-EVARA HEALTH FAMILY MEDICINE

RESIDENCY ADMINISTRATIVE POLICY MANUAL

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ADMISSION POLICY

POLICY

Patients to be admitted to the residency inpatient service will have an admitting note/H&P and orders completed at the time of admission. Admitting residents will notify inpatient faculty of the admission and the case discussed.

Direct/Emergency Admissions

In situations where the patient can be directly admitted to the hospital, the admitting office will be notified to obtain room number. Orders and records will accompany the patient. Nursing staff has instructions for direct admission procedures. Appropriate transportation will be arranged. In emergency situations, 911 may be called. If the patient's personal family physician is not the admitting physician, then the patient's primary family physician will be notified of the admission.

CRR – 2/23

FAMILY MEDICINE CENTER PATIENT ADMISSIONS

Family Medicine Patients will follow the same admitting procedures. They will be admitted to the resident on the service and inpatient faculty. The inpatient resident(s) is/are responsible for initial evaluation and admission of Family Medicine patients. Patients will be followed by the inpatient resident team and faculty throughout the admission. For direct admissions from the FMC, the precepting faculty at the FMC and on duty inpatient faculty will be notified and patient discussed.

FMC COMMUNICATION POLICY

PHONE CALLS FROM FMC OUTPATIENTS AND INPATIENTS

After Hours

When assigned to the outpatient Family Medicine on-call rotation, the resident will take calls from Evara Health patients.

In the inpatient service, patients are to be signed-out to the incoming night resident and/or hospital faculty. The signing-out resident physician should indicate whether they desire to be called about their patients during the night. It is the responsibility of the in-house team to communicate and ensure each member of the team is aware of each patient in the inpatient service and the plan.

If the night resident and/or hospital faculty is called regarding an inpatient who has not been signed-out, the resident/faculty may elect to handle the query or problem or call the primary physician for guidance. Once notified the night resident/faculty is responsible for the patient for the remainder of the shift.

Failure to sign-out patients in the inpatient service may result in disciplinary actions as listed in the Corrective Action Policy.

CRR – 2/23

CONFERENCE ATTENDANCE POLICY

POLICY

Residents in the NSU-KPCOM Evara Health Family Medicine Residency are allotted funds every year to cover air/car travel, registration, and meals, and/or for books, board prep materials or other educational expenses and up to five days (CME) per academic year to attend professional conferences with prior approval of the Program Director as follows:

1. Five days of paid conference time per academic year.

2. Approved expenses to attend CME conference:
   PGY 1 - up to $1,500
   PGY 2 – up to $2,500
   PGY 3 & 4 – up to $3,000

Conference time and funds may **not** be accumulated and carried over from one academic year to the next. **Thus, payment requests received within 1 month of graduation or end of academic year will normally result in non-payment or payment from the next year CME conference monies.** The above conference reimbursement amount is subject to change.

Conference time may be used to travel to approved CME at the rate of 1 day for out of state travel and ½ day for in state travel.

If an approved conference is attended Saturday and Sunday a contiguous weekday may be requested as a personal day. The time for this day will be subtracted from allotted conference time.

Limited travel for educational and professional purposes is allowed during the Residency period. Educational travel is approved at the discretion of the Program Director. **All travel plans must be approved in advance**. It is the responsibility of the Program Director to inform, enforce, and monitor residents to ensure adherence to these guidelines and any subsequent additions, deletions, or modifications of these guidelines.

A pre-trip expense estimate ***must*** be prepared and submitted to the Program Director for pre-approval.

All expenditures should be submitted for reimbursement within ten days of travel. This must include: paid invoices for lodging, copy of plane ticket, meal receipts, car rental receipts, etc. Credit card receipts without an itemized invoice or bill **WILL NOT** be accepted. All travel arrangements must be made in accordance with Evara Health travel policies if any reimbursement is expected. Meals and other per diem reimbursement levels are set by Evara Health.

LODGING

1. Lodging is reimbursed at the conference rate
2. It will be the judgment of the Program Director as to when to allow a night's lodging before or after a meeting is scheduled. This judgment will be based on the location of the meeting with consideration as to its' distance from the FMC at High Point in Clearwater, the starting and ending times of the meeting as well as the availability of air flights.
3. Paid invoices for all expenses must be presented and attached to appropriate forms or reimbursement will not be approved.

AUTOMOBILE TRAVEL

Travel to and from conferences will be determined at a mileage rate as determined by federal per diem rate.

REGISTRATION FEES

Registration fees will be reimbursed in full provided that such fees relate only to the educational component of the meeting.

OTHER EXPENSES

1. Reasonable usage and expenses for use of taxicabs, buses or other transportation.
2. No reimbursement request will be considered approved and final without prior signatory approval of the Program Director or his/her designee.
3. Residents, with approval of the Program Director, may utilize unused travel funds for the purchase of educational materials (books, Apps, computer programs, medical subscriptions, etc.). **These non-traditional, enduring educational material requests, within 3 months of graduation may be denied due to the limited time left for educational value and requests during the last month of Residency will normally not be processed nor paid.**
4. The travel reimbursement aspects of this policy relate to professional meetings or short courses. Educational rotations that are conducted during extended periods of time as part of the structured program are not included herein.

EXPENSES NOT COVERED

1. Alcoholic beverages
2. Room service/spa
3. Room charges
4. Items for spouse or family

PROCEDURE FOR CME CONFERENCE ATTENDANCE

1. The resident physician will complete a "TIME AWAY" form and submit request in ADP for approval at least 60 days prior to conference. The Resident is responsible for arranging coverage for the time away, including any on-call, event coverage, and EHR inbox/task coverage. The signature of the Residents providing coverage, and appropriate rotation faculty are required on the leave request before it is submitted. The request is then routed to the Chief resident, Residency Coordinator, Schedule manager, FMC director and Program director for approval. **If conference time is requested, a copy of the conference brochure and a completed "travel and expense reimbursement form" with an estimate of expenses is to be attached to the time away request.** (You must comply with "Time Away" and "Travel Requisition" policies).

2. **AFTER** the CME "time away" and "travel requisition" are **APPROVED**; the Resident may make conference arrangements. After the conference resident must submit all receipts in order to be reimbursed.

3. Conferences need to meet the following criteria to be approved:

   a) Real speakers (not tapes).
   b) AMA, AAFP, ACOFP or equivalent accreditation.
   c) At least four accredited hours per day.

4. If more than 1/3 of residents wants to attend a conference the PD will approve the requests based on:

   a) Patient coverage needs
   b) If time away is allowed from rotation
   c) If presenting at conference
   d) Seniority
   e) If already attended previous conferences

Failure to submit a complete form and have the request approved prior to travel may result in delay or denial of reimbursement payments and time away.

All requirements and medical records need to be completed prior to "Time Away".

Revised: 9/2022 – CRR

DRESS CODE POLICY

POLICY

A professional appearance is always required. Maintenance of a neat, professional appearance is inherent to gaining and maintaining respect from both our hospital administration and medical staff. Likewise, it is very important to many of our patients and is necessary for promoting our medical services.

1. ID badges must be worn and remain visible at all times
2. Cleanliness is essential for all employees in every detail. All clothing, whether uniform (scrubs) or street clothes, shall be appropriate in size for all employee's frame and shall be cleaned, pressed, and in good condition. The style and color of the clothing are the individual's choice; however, an overall appearance that tends to attract undue attention to the individual is unsuitable. Clothing must be good taste and conductive to work function.
    a. Dress shirt (buttoned, tab collar shirt is acceptable).
    b. Tie is optional.
    c. Polo shirt provided by hospital or program.
    d. Dress or tailored slacks (jeans are not acceptable)
    e. Blouse and shirt of appropriate length
    f. Dress
    g. <u>Scrubs</u>
        i. Only Evara Health provided scrubs are approved to be worn when seeing patients in the Family Medicine Center
        ii. Other uniform scrubs are to be approved by program director or faculty
        iii. Hospital scrubs are not allowed
3. Hair should be clean, combed and neatly trimmed or arranged. Sideburns, mustaches and beards should be neatly trimmed.
4. Hair color and earrings (on both men and women) must be conservative.
5. Facial jewelry is not allowed at any time.
6. Tattoos must be kept covered at all times.
7. Fingernails should be neat, clean, and of moderate length. Artificial nails are prohibited for infection control reasons, for all patient care staff.
8. Appropriate shoes and socks– **NO OPENED TOED SHOES**
    a. (*It is an OSHA requirement that no "opened toed" shoes can be worn in any clinical area.)*

White coats are expected to be worn over non-Evara Health scrubs in the FMC and in the hospital when out of the operating room or delivery areas. They are not required over dress clothes when seeing patients in the Family Medicine Center but may be required at outside rotations.

Residents are expected to follow the above dress code policy when rotating at the offices of private practitioners who act as preceptors.

When in the Family Medicine Center on Fridays only, Evara Health has deemed Friday "casual day". Residents may wear agency logo shirts with casual slacks, dress jeans, or skirts. No shorts or attire with holes or tears are allowed. The more formal dress and white coats are still expected when visiting the offices of private practitioners, the V.A., Bayfront Baby Place, Johns Hopkins All Children's Hospital, and when rounding at Saint Joseph South Hospital.

Please use discretion with casual dress code.

Failure to comply may result in corrective action consideration.

Revised: CRR - 2/23

EVALUATION AND ADVANCEMENT POLICY

POLICY

The purpose of this policy is to ensure that the residency program at Evara Health meets the standards set forth and outlined by the ACGME.

1. Professional Evaluations of Residents Shall Include:

    a. Evaluation of all Residents by attending physician on mandatory or elective rotations.

    b. Evaluation by teaching consultants, preceptors and faculty, ambulatory center manager, nurse supervisor and patients regarding function of Residents in the Family Medicine Center.

    c. Annual in-training exam for Residents.

    d. Monthly monitoring of the Residents' timely completion of medical records.

    e. Regular evaluation of Resident attendance at didactic sessions.

    f. Annual Resident performance presentation to the Graduate Medical Education Committee with recommendations for graduation.

    g. Regularly scheduled Resident reviews to be conducted by the Residency faculty.

    h. Evaluations specified as the result of a corrective action proceeding.

2. Criteria for Professional Evaluation Shall Include:

    a. Fund of medical knowledge.

    b. Timely completion & Quality of medical records.

    c. Quality of oral presentations and effective communication skills.

    d. Rationale for management plans.

    e. Rapport and consideration with patient and family.

    f. Relation to colleagues, faculty, and hospital personnel.

    g. Attendance at conferences and rounds.

    h. Demonstrated competence in patient management and required procedures.

    i. In-training assessment examination scores.

    j. Professional appearance.

    k. Participation in Residency functions including new Resident recruitment and other administrative duties.

    l. Compliance with employment policies of Evara Health.

3. Professional and Academic-Evaluation Process:

    Evaluations will be open to the individual Resident at any time. A Clinical Competency Committee designated by the Program director will review the status and progress of the Resident at six-month intervals.

a. Timing of standard Resident Reviews will approximate the following schedule. In each year of residency the final resident review will address eligibility for graduation per sections 4.1 and 4.2.

   i. There will be two Resident reviews occurring in November and May of each academic year. At the final Resident review in May of PGY-3 the Resident will be considered for certification regarding family medicine procedures. Upon certification of such competency, the Resident will be recommended for graduation. The recommendations will be presented at the next regularly scheduled Graduate Medical Education Committee meeting.

b. Each Resident review will have the following components.

   i. **Procedure list review**. This is an ongoing process to ensure the Resident is gaining experience in those procedures required for Family Medicine and Resident Physician Education. The proper documentation will be accomplished by the Resident submitting a list of those procedures that have been performed. This will be logged on the procedure documentation sheet or an appropriate form in each Resident's file, as well as the faculty signing off on any procedures that the Resident has shown the competence necessary for certification to do independently. It will also involve a review of attendance records at regularly scheduled procedural workshops as provided by the Residency.

   ii. **Review of rotation evaluations.** These evaluations will be reviewed with the Resident for trends, problems, and accolades. The Education Coordinator will check the Residents' file prior to each evaluation to ensure that evaluations have been returned prior to each Resident review.

   iii. **Nursing evaluation of Resident interactions and behaviors.** This evaluation is submitted by the relevant nurses, and assesses the Resident in areas of availability, patient acceptance, enthusiasm and involvement, cooperation and communication, efficiency, and punctuality.

   iv. **Performance on the in-training assessment exam** will be reviewed with the Resident to assess areas of progress as well as possible areas of academic concerns. Recommendation will be made where necessary.

   v. **Attendance at weekly didactic conferences** will be reviewed for trends or deficiencies with a required 80% attendance record.

   vi. Review of **Moonlighting activities** including locations, frequency, and duration.

   vii. Review any **Community, quality improvement and scholarly activities.**

   viii. **"Faculty to Resident"** feedback will be provided such that the Resident understands his or her current standing within the Residency, and an education prescription will be discussed where appropriate. This will include areas of success as well as areas in need of improvement including clinical, behavioral, and/or professional development competencies. Recommendations on how to rectify any deficiencies will be expressed and encouraged.

   ix. The Resident will be given the opportunity to provide **"Resident-to-faculty"** feedback at the conclusion of each scheduled review. Structured feedback regarding rotation difficulties, operational difficulties, or psychosocial stressors will be requested.

c. The CCC will be responsible for reviewing the Resident's file and bringing salient issues to the attention of the program director. In addition, the CCC will prepare a review summary containing information on each of the above elements. This review summary will be presented by the program director to the Resident, signed by the Resident and faculty advisor and will be maintained in the Resident's permanent education file.

d. Prior to each Resident Review, the Program Coordinator will review the Resident's file and check for completeness and update those things not available in the chart. This check will include rotation

completion, procedure documentation, evaluations up to the current period, and previous summaries. The procedure list must be submitted by the resident one week prior to the Resident Review for updating the procedure documentation list in the record. Resident evaluations from various services will be checked to ensure that those that have been sent out have been returned and that the previous Resident Review summary is in the file and complete. Residents will be advised of file status at the time of Resident Review scheduling.

4. Criteria for Advancement and Graduation:

   a. For academic advancement and graduation, the Resident must demonstrate progressive scholarship and professional growth, including the ability to assume graded and increasing responsibility for patient care during the course of the Residency. Successful accomplishment of these criteria will be judged by the Program Director with the collective advice of the teaching faculty and staff.

   b. The following are the residency program's expectations in key areas of resident performance. Failure to meet these expectations may result in remediation, probation, delayed promotion or graduation, non-renewal of contract or dismissal from the program.

   c. Achievement of all ACGME Resident Core Competencies and Milestones appropriate for level of training

   d. Satisfactory progress towards meeting required numbers of patient continuity encounters, deliveries, adult inpatient encounters, inpatient child encounters, pediatric ER visits, newborn encounters, and home visits.

   e. Consistent documentation of procedures and satisfactory progress towards achieving required procedure volume.

   f. Passing performance on all block and longitudinal rotations

   g. Completion of academic achievement, conference attendance, longitudinal rotation documentation, and quality improvement requirements

   h. Completion of one ABFM Maintenance of Certification module by the end of each academic year, with one Part IV module by the end of the PGY-3 year

   i. Performance on the annual ABFM In-training Examination at or above program standards

   j. Provision of a passing score report for USMLE or COMLEX Step 3 by the end of the second year of residency

   k. Completion of the ABFM or AOBFM Certification Examination in April of the third year of residency and provision of a score report prior to the completion of training

   l. Maintenance of continuous certification in BLS, ACLS, PALS, and ALSO

   m. Compliance with all residency policies

   n. Satisfactory patient satisfaction data

   o. Satisfactory faculty advisor report

   p. Consensus by the faculty, Clinical Competency Committee, and Program Director that the resident is ready for promotion and/or graduation

CORRECTIVE ACTION POLICY

POLICY

Rules and regulations that provide guidelines for acceptable behavior of Resident physicians are necessary for the effective operation of the Residency, as well as, helping us fulfill our goal of quality physician education and patient care. Therefore, it is the policy of this medical center to support and sustain positive, progressive corrective actions.

Basic Principles of Corrective Action

1. The goal is to provide constructive coaching, in a timely manner, to facilitate the Resident physicians' professional development.

2. Resident physicians will receive a copy of the Residency policy manual at the start of their Residency training. They will be notified of changes and revisions as they occur for the duration of their training.

3. The Program Director and faculty have an obligation to thoroughly investigate and listen to all facts before corrective actions are taken.

Procedures

The following steps are designed to ensure that Resident physicians are given adequate notice of unacceptable performance or behavior with reasonable time to permit self-correction and improvement. These steps may include but are not limited to: 1) verbal warning, 2) special resident review, 3) probation, 4) suspension, and 5) termination. Adherence to the steps in the process and subsequent corrective action will be based on the severity and the frequency of the incident under investigation. Termination may be requested, skipping prior steps, based on the seriousness of the incident.

1. Verbal warning:

   a. Verbal coaching is an expected part of the supervisory relationship. When an incident occurs, indicating unacceptable performance or behavior, and the facts indicate corrective actions is needed, a verbal warning will be discussed between the director or designee and the Resident

   b. The discussion should constructively highlight the specific problem and include appropriate corrective actions and expectations of performance.

   c. The discussion should be documented as a verbal warning with a copy given to the Resident and a copy placed in the resident's personnel file.

   d. Examples (include but not limited to):
      i. Specific knowledge or skill deficits
      ii. Marginal rotation evaluations
      iii. Organizational issues
      iv. Pattern of not completing tasks in a timely manner- eg note signing, in basket clearance, evaluation completion
      v. Performance below program standards on the PGY-1 ABFM In-Training Examination
   e. Potential Consequences:
      i. May lead to Special Resident Review

2. Special Resident Review:

   a. In the event of situations that either have or may have a significant effect on the health, educational progress, or professional development of a Resident, the program director may convene a Special Resident review.

   b. This will consist of designated faculty as well as the Resident in question and will identify specific areas of concern. The Resident will be given the opportunity to respond to these concerns.

c. A performance improvement plan will be discussed with the Resident and evaluations will monitor Resident improvement in the problem areas.

d. This will be documented in the Resident's permanent file.

e. Examples (include but not limited to):
    i. Patient or staff complaints
    ii. Faculty or colleague concerns
    iii. Unsatisfactory rotation evaluations
    iv. Failure of one rotation
    v. Performance on the PGY-2-4 ABFM In-Training examination below program standards
    vi. Failure to meet program standards of conduct or professionalism
    vii. Failure to progress as expected
    viii. Failure to meet program expectations

f. Potential consequences (include but not limited to):
    i. May not stand for election as Chief Resident
    ii. Moonlighting not permitted
    iii. Away rotations not permitted, but requests consistent with the goals of an individual resident's performance improvement plan will be considered on a case-by-case basis
    iv. May lead to prolongation of training time
    v. Should the seriousness of the condition warrant, or if the Resident does not show a trend towards improvement, the director may place the Resident on probation, which may lead to termination. This will necessitate the calling of a Probation committee by the Program Director.

3. Probation Committee

a. The Director may appoint a Faculty Probation Committee to counsel the Resident and recommend remedial action.

b. There is a significant concern that the resident is not capable of being successful in residency

c. Reserved for a pattern of serious deficiencies or a single egregious event

d. May occur after an unsuccessful attempt at a Special Resident Review or performance improvement plan
    i. Once written notice of Probation has been received by the resident the decision may be appealed following the procedures outlined in the Grievance and Appeal policy.
    ii. The probation committee will consist of the resident's Faculty Advisor, one faculty selected by the Residency director, and one faculty selected by the Resident.
    iii. Once selected the Probation Committee will meet with the resident to:
        1. Discuss the nature of the deficiency
        2. Clarify the nature of probationary status
        3. Notify the resident that close monitoring of the identified issue will take place, including methods to be used to measure improvement
        4. Identify corrective actions that must take place to address the deficiency, including a formal educational plan developed in concert with the Clinical Competency Committee to assist the resident.
        5. Counsel the resident regarding implementation of the corrective actions, including review of what assistance is available
        6. Establish a time frame for accomplishing corrective action
        7. Notify the resident of what additional disciplinary action will occur if corrective action is not completed within the specified time frame
        8. The committee will develop a written summary of the points listed above to be signed by the resident, Faculty Advisor and Program Director and placed in the resident's personnel file.

e. The Probation Committee will meet with the Resident at least monthly during the probationary period.
    i. The resident may bring a resident peer advocate to the meetings.

f. The Probation Committee will closely monitor the progress of the Resident and reevaluate his or her performance, for a defined period not to exceed four months, with recommendations for final action.

g. Examples (include but not limited to):
    i. Failure of more than one rotation
    ii. Pattern of unprofessional behavior
    iii. Inability to progress to next level of training or indirect supervision
    iv. Dereliction of duty
    v. Significant breach in the standards of patient care
    vi. Major concerns for patient safety

h. Actions recommended by the Probation Committee may include but are not limited to any of the following options:
    i. The Resident must repeat part or all of the academic year.
    ii. The Resident must be assigned additional time on one or more rotations or electives.
        1. This may include additional time in the program beyond normal graduation.
    iii. The Resident may be required to undergo independent mental health evaluation and/or treatment.
    iv. The Resident may be suspended for a variable period of time.
    v. Non-renewal of contract
    vi. The Resident shall be terminated.

    Action described in (i), (iv), (v), or (vi) shall be reported to Graduate Medical Education Committee.

i. Other consequences (include but not limited to):
    i. May not stand for election as Chief Resident
    ii. Moonlighting not permitted
    iii. Away rotations not permitted

j. At the end of the Probationary period based on the degree to which the deficiencies outlined in the probationary agreement are addressed the resident will either return to good standing, continue probation, or be dismissed from the residency program.

k. Any period of Probationary Status will be reflected in the Program Director's exit summary, training verification forms and recommendations letters after graduation.

4. <u>Suspension</u>

a. Reasons for suspension:
    i. A major dereliction of duty or potentially major litigious action involving a Resident identified by the Designated Institutional Officer, Chief Medical Officer, Residency Director, faculty, or organization's Risk Manager
    ii. In the judgement of the Program director a resident is unable to provide safe care to patients or is unsafe in the workplace
    iii. In the judgment of the Program Director a resident disregards Evara, NSU KPCOM and/or hospital rules and regulations
    iv. Recommendation from the Probationary Committee
    v. Reversion to less than acceptable performance following a probationary period
    vi. Suspicion of impairment due to mental health, medical, or substance use issues
    vii. Engagement in unprofessional, illegal, or unethical behavior
    viii. For other reasons is felt not to be safe in the workplace

b. The Residency Director, in consultation with the Chief Medical Officer, may temporarily suspend the Resident from all or part of his duties pending completion of a full investigation with appropriate due process.

c. Where appropriate and in accordance with Evara Health policy, the Residency director or designee will notify the Risk Management Department of the incident under investigation.

d. The Faculty Advisor, Program Director and a Human Resources representative will meet with the resident as soon as possible to:
    i. Discuss the nature of the deficiency
    ii. Clarify the nature of suspension status
    iii. Identify the anticipated duration of suspension
    iv. Explain what further disciplinary action (if any) is anticipated
    v. Identify what criteria must be met before the resident may return to duty

e. Once written notice of Probation has been received by the resident the decision may be appealed following the procedures outlined in the Grievance and Appeal policy.

f. A special Resident review will be called by the Residency Director in accordance with section 2.

g. The Resident may be placed on probation in accordance with section 3.

h. Potential consequences include but are not limited to:
    i. May lead to prolongation of training time
    ii. Non-renewal of contract
    iii. Dismissal from the residency program

i. Any period of Suspension will be reflected in the Program Director's exit summary, training verification forms and recommendations letters after graduation.

5. <u>Termination</u>

Residents have the option of appealing a decision to terminate their employment with their Residency program. If an appeal is not requested within seven days of notification of termination, the DIO and Human Resources Director will review the decision for compliance with due process. If due process is intact, the Human Resources Director will complete the termination.

If the Resident wishes to appeal the decision, he or she must initiate the grievance procedure as outlined in the Grievance and Appeal Policy. The Grievance Committee may sustain or modify the termination decision. If the decision to terminate is sustained, the Human Resources Director will implement the decision. Similarly, if the termination is modified, the decisions of the committee will be returned to the Residency Program Director.

GRIEVANCE & APPEAL POLICY

There shall be a committee known as the Grievance Committee.

The Grievance committee shall serve an appellate function for Residents regarding academic or disciplinary decisions, and also serve to consider grievances originated by Residents or other sources of referral as listed in this policy. Grievances must concern Graduate Medical Education affairs of the organization.

The committee will be convened within seven working days of notification that a grievance or appeal has been filed. In the event that the hearing cannot be accomplished within the specified time, it must be convened at the earliest possible time thereafter but no longer than 21 working days from notification.

Requests to convene the Grievance Committee shall be presented in writing by the aggrieved to the Evara Health Director of Medical Education.

For the purposes of this policy, the aggrieved, or grievant, is the person initiating the grievance. The person accused by the grievant will be referred to as the defendant.

Process for a Grievance Hearing

The first step in the redress of a grievance will be to address the grievance at the Resident-faculty level. Therefore, during the seven working days between the receipt of the grievance and the grievance hearing, the Program Director will determine the participants of the grievance and have responsibility for convening this discussion to see if an amicable resolution can be reached without a formal hearing. If no resolution ensures, the hearing will proceed.

Composition of the Grievance Committee

The Designated Institutional Official may appoint a grievance subcommittee of the Graduate Medical Education Committee (GMEC) composed of two members of the Residency Faculty Staff (one of whom shall be designated by the DIO to be chairperson of the subcommittee), one peer-selected resident not associated with the grievance in any way, and one member of the residency administration.

Under no circumstances shall the person named in the grievance sit on the grievance hearing committee.

If two-thirds of the Grievance Committee members agree that a substantial conflict of interest exists between a member of the committee and either the grievant or defendant, the DIO will appoint an appropriate replacement.

Sources of referral to the Grievance Committee

A Program Director
An administrative officer of Evara Health
Any Resident
Any medical staff member

Grievance Hearing Procedure

The hearing will be comprised of two stages, consisting of the judgment phase, and if required, the intervention phase.

1. Judgment Phase
    a. Grievant's Presentation
        i. Grievant will be allowed to present any arguments he or she considers important to demonstrate to the committee that the accused has engaged in behavior inconsistent with the Policies and Procedures of the NSU- KPCOM Evara Health Family Medicine Residency Program. At the conclusion of the grievant's presentation, which may include representatives speaking on the grievant(s)' behalf, any member of the Grievance Committee will be free to ask questions concerning the factual background of the matter.
    b. Defendant's Presentation
        i. Following the grievant's presentation, the accused will be allowed to respond to the presentation of the grievant, and to otherwise make any arguments important for the

Committee to consider in reaching its decision. After the defendant's presentation, which may include representatives speaking on the defendant's behalf, any member of the committee may ask questions of the defendant concerning the issues at hand.

c. Grievant's Rebuttal

i. Following the defendant's presentation, the grievant will be allowed to make rebuttal statements concerning the presentation by the defendant.

d. Defendant's Rebuttal

i. Following the grievant's presentation; the defendant will be allowed to make rebuttal statements concerning the presentation by the grievant.

e. Cross Examination and Cross Conversations

i. There will be no cross-examination either by the grievant or the defendant, and all questions are to be directed to the Chairperson of the Committee rather than between either side in the grievance.

f. Deliberation

i. Following the defendant's closing remarks, the grievant, the defendant, and all other persons shall be excused. The Grievance Committee will then consider the allegations in private, and after discussion, develop a decision as whether or not the grievance has merit.

2. Intervention Phase

a. If the Grievance Committee determines that the grievance has merit, it will then reach a decision regarding an appropriate intervention.

b. Actions of the Grievance Committee

i. Actions of the Grievance Committee, other than determination of conflict of interest between a committee member and either grievant or defendant shall be decided by majority vote.

ii. Actions of the Grievance Committee shall be reported to the Graduate Medical Education Committee.

iii. The decision of the Grievance Committee is final and there is no further appeal.

iv. This grievance subcommittee will make recommendations for review and final decision by the DIO, Residency Program Director and Director of Human Resources.

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RESIDENT IMPAIRMENT POLICY

POLICY

The American Medical Association (AMA) defines the impaired physician as one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process, or loss of motor skill, or use of drugs including alcohol. This definition includes the impairment of a physician due to a mentally or emotionally disabling state.

PROCEDURE

Because high quality patient care and education require that physicians perform at their highest possible level, each physician should be vigilant of when they or their colleagues might be impaired. Evara Health prohibits the illegal use, possession, sale, manufacture, or distribution of drugs, alcohol, or other controlled substances on its property. It is also against this policy to report to work, or to work under the influence of drugs or alcohol. Any Resident who is taking a prescription drug which might impair safety, performance, or any motor functions, must advise his or her supervisor before reporting to work under such medication.

When any Resident has information to suggest that he, she, or another Resident may be impaired; the Resident should contact the supervising faculty, FMC manager, Program coordinator or Program Director and provide the details of the concern.

The Program Director, usually with the help of other faculty, will interview the Resident to determine whether impairment exists. If, in the judgment of the program director, no impairment exists, the matter is resolved.

If in the judgment of the program director credible evidence exists to suggest impairment, the program director will refer the resident to an independent physician for evaluation. If in the opinion of the independent evaluator impairment exists, the program director will institute one or several of the following:

A. periodic sessions with the Resident's faculty advisor, program director or both.
B. referral to an appropriate health professional including a psychiatrist or other mental health professional (including the Florida Impaired Physicians Program).

Interventions A or B above will remain strictly confidential within the residency, Evara Human Resources and will not become part of the Resident's personnel record.

C. testing of bodily fluids for misuse of chemical substances according to the section on Drug Testing described below.
D. institution of disciplinary action in accordance with the Corrective Action Policy described elsewhere.
E. a leave of absence in accordance with the Corrective Action Policy described elsewhere.
F. dismissal from the Residency or residency program in accordance with the Corrective Action Policy described elsewhere.

Impairment requiring any intervention from C through F will become part of the Resident's personnel record and reported in executive session to the Graduate Medical Education Committee, who shall monitor the progress of the Resident.

DRUG TESTING

A. Evara Health maintains a drug-free workplace through the adoption of its Drug-Free Workplace Program. This Program complies with the Florida law as set forth in Sections 440.101 and 440.102, Florida Statutes, and Chapter 59A-24 of the Florida Administrative Code.

B. As an employee of Evara Health, resident physicians injured in the course and scope of employment that refuse to submit to a test for drugs or alcohol, or is tested and has a positive confirmation of drug or alcohol use, forfeits his eligibility for medical and indemnity benefits under the Workers' Compensation Act.

C. As Evara Health employees, new Residents will be required to submit to a pre-employment drug screening, per the policy and procedures of the Evara Health Human Resources Department.

D. Because optimum patient care requires a consistently high standard of physician performance and because chemical substance (including alcohol, illicit and licit drugs) abuse may impair a physician's performance, tests for alcohol and chemical substances may be required whenever evidence suggests that a Resident may be impaired (for cause testing).

E. The Residency Program Director may also require a Resident to be tested for the presence of drugs if there is reasonable suspicion. This includes but is not limited to:
    a. evidence of misuse of prescription or OTC.
    b. evidence of use of alcohol or abuse drugs while on duty
    c. evidence of impairment while on duty
    d. failure to meet duties and responsibilities that other residents regularly fulfill
    e. repeated absences which are inadequately explained
    f. repeated tardiness for scheduled responsibilities
    g. bizarre or disruptive behavior
    h. any performance which is overly negligent
    i. physical or verbal abuse toward any colleague, hospital staff member, or patient
    j. any other circumstance which provides reasonable suspicion that chemical substance abuse is present

F. Residents who have been determined to have used drugs or alcohol and are permitted by Evara Health to return to work will be subject to unannounced follow-up drug tests.

G. Residents who cause, contribute, or are involved in an accident will be required to submit to a drug test.

H. Residents will be drug tested if the test is conducted as part of a routinely scheduled employee fitness-for-duty medical examination

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RESIDENT CLINICAL AND EDUCATION WORK HOURS POLICY

PURPOSE

This policy addresses Accreditation Council for Graduate Medical Education (ACGME) *Institutional Requirement IV.K. Clinical and Educational Work Hours:*

> *The Sponsoring Institution must maintain a clinical and educational work hour policy that ensures effective oversight of institutional and program-level compliance with ACGME clinical and educational work hour requirements. (Core)*

PROCEDURE

The NSU-KPCOM Evara Health Family Medicine Residency program abides by the resident duty hour regulations as mandated by the ACGME. As such, Residents will not be scheduled for more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.. The ACGME Duty Hours Policy can be found at acgme.org

To sustain compliance with these requirements, the following mechanisms are in place:

1. Residents will log hours using MedHub.

2. The Family Medicine Residency program will monitor compliance with Resident duty hours by monthly audits of Resident work hour logs.

3. The Family Medicine Director will submit a duty hour report monthly to the DIO and the GMEC

4. In addition, the Residency abides by the following ACGME guidelines regarding resident duty hours:

    a. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

    b. Residents will not be assigned in-house call more often than every third night, averaged over four weeks.

    c. Continuous time on duty is limited to 24 hours, with additional time up to four hours for inpatient and outpatient continuity, transfer of care, educational debriefing, and formal didactic activities. Residents may not assume responsibility for new patients after 24 hours. On rare circumstances, residents, of their own initiative, will be allowed to remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extension of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under these circumstances, the resident must:

        i. Appropriately hand over the care of all other patients to the team responsible for their continuing care.
        ii. Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the Program Director and the office of GME.
        iii. The Program Director will review the submission of each additional service and track both individual and program-wide episodes of additional duty and report this to the GMEC.

    d. Minimum Time Off between Scheduled Duty Periods

        i. Residents should have eight (8) hours, free of duty between scheduled duty periods.
        ii. Residents must have at least fourteen (14) hours free of clinical work and education after twenty-four (24) hours of in-house scheduled duty.

    e. If Residents take call from home, and are called into the hospital, the time spent in the hospital will be counted toward the weekly duty hour limit.

    f. Residents must not be scheduled for more than six consecutive nights of night float.

g. Clinical work done at home (i.e. completing charts, reviewing tasks and returning patient calls) counts towards daily and weekly limits.

h. Moonlighting must not interfere with the ability of the resident to achieve the goals outlined by the educational program. Time spent by residents in Internal and External Moonlighting must be counted towards the 80-Hour Maximum Weekly Limit. PGY-1 residents are not allowed to moonlight. (Refer to Policy on Resident Moonlighting).

i. During orientation and periodically thereafter during business meetings we review the hours policy with the Residents as a group. Residents can bring up any concerns during that format and to their chief residents during the Resident Advisory meeting held monthly. Duty hours are also monitored for each specific Resident during the Resident reviews.

If the residency program has residents not in compliance with the Common and specialty/subspecialty- specific Program Requirements, it will be required to submit an action plan addressing the areas of non-compliance to DIO and GMEC.

Repeated non-compliance with duty hour restrictions will subject the residency program to the GMEC's Special Review Protocol.

FATIGUE MITIGATION

Residents are strongly encouraged 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 PM and 8:00 AM, is strongly suggested.

The Residency Program must:

1. Educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation
2. Educate all faculty members and residents in alertness management and fatigue mitigation processes
3. Adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
4. Have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.
5. Ensure that there are adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

TRANSITIONS OF CARE

Critical to patient safety and resident education are effective transitions in care.

Residents may remain on-site four (4) additional hours in order to accomplish these tasks. This must be reported by the resident physician in writing with rationale to the Program Director and reviewed by the GMEC for monitoring individual residents and program.

The residency program must design clinical assignments to minimize the number of transitions in patient care. Sponsoring institutions and residency program must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Program must ensure that residents are competent in communicating with team members in the hand-over process. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

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FACULTY AND RESIDENT/FELLOW WELL-BEING POLICY

POLICY

This policy identifies the ways in which Residents and their Faculty are supported by the Sponsoring Institution and Program Leadership in their efforts to become competent, caring and resilient physicians while completing Accreditation Council for Graduate Medical Education (ACGME)-accredited training programs sponsored by Nova Southeastern University Dr. Kiran C. Patel College of Osteopathic Medicine (NSU-KPCOM).

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. The Evara Health Family Medicine Residency Program, in partnership with NSU-KPCOM, has the same responsibility to address well-being as they do to evaluate other aspects of resident competence. Residents' physical, psychological, spiritual, and emotional well-being is of paramount importance to Evara Health and NSU-KPCOM. Residents are encouraged to lead healthy lives and make healthy choices that support them in their personal and professional growth.

This policy applies to Residents, Faculty, Program Directors, Program Coordinators, and Graduate Medical Education (GME) staff at Evara Health.

PROCEDURE

Evara Health will provide the following strategies to support health, well-being, and resilience:

Evara Health Support

Evara Health's Residency Wellness Program provides faculty and resident employees with resources and services that motivate, encourage, and promote healthy lifestyle choices while taking a proactive approach to personal well-being as well as fostering resilience.

The Residency Wellness Program provides resources and educational opportunities focused on the complete integration of physical, mental, and spiritual well-being. Social, emotional, spiritual, environmental, occupational, intellectual, and physical well-being are all considered in our holistic approach to wellness.

Services include:

1. Health Improvement and Employee Wellness: including Health Risk and Wellness Assessment, wellness didactics.
2. Employee Assistance Program (EAP): Confidential and free counseling services which include up to three in-person visits/year and 24/7 telephonic counseling.

Sponsoring Institution-Level Support (KPCOM Office of GME)

1. The KPCOM Office of GME is committed to being a safe place where residents can ask for and receive help with various needs including academic counseling, coaching, and mentoring without fear of negative consequences.
2. The KPCOM Office of GME has established the Resident Council (RC) as a place for residents to come together and discuss issues affecting their residency and their lives. The RC seeks to promote harmonious and collaborative relationships amongst residents, faculty and staff and enhance the resident community through advocacy, volunteer, and social activities. The RC membership is composed of all KPCOM residents in all training programs. Annually, this group elects resident representatives from each of the core residency programs who will sit on the Graduate Medical Education Committee and bring forth issues discussed within the Forum.

3. Residents may take advantage of reimbursed taxi/Uber/Lyft/etc. service from the training site to home and back to the training site in the event that they are too fatigued to drive home after a clinical shift. Their program will reimburse the cost of the ride both ways.
4. All residents and core faculty must complete an annual learning module on sleep alertness and fatigue mitigation.
5. All residents and core faculty are encouraged to complete the Gallup Q12 annually.

Program-Level Support

1. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. The residency program 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 are implemented without negative consequences for the resident who is unable to provide the clinical work.
2. The residency program has policies and procedures in place to ensure 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.
3. 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.
4. During orientation the residency program educates their residents on the following:
    - Where and how to access food during clinical and educational assignments
    - Where the sleep/rest facilities, if available, are located for each clinical learning site
    - What safe transportation options are available along with how to access them and how to be reimbursed for their use
    - Where the lactation facilities are located along with the safe refrigeration resources for the storage of breast milk for each clinical learning site
    - What safety and security measures are available for each clinical learning site
    - The program's policies on accommodations for residents/fellows with disabilities.
5. The residency program sponsors wellbeing and wellness events on a regular basis to facilitate interaction between trainees and faculty. These events are reported to the GMEC.

USMLE and COMLEX-USA BOARD EXAMINATIONS POLICY

PURPOSE

This policy addresses the requirement that to be eligible to obtain a medical license in the United States, candidates must have taken and passed all three Steps/Levels of either the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA).

BACKGROUND

Both the USMLE for allopathic physicians and the COMLEX-USA for osteopathic physicians assess a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills that are important in health and disease and that constitute the basis of safe and effective patient care. Each of the three Steps of the USMLE and the three Levels of the COMLEX-USA complements the others; no Step or Levels can stand alone in the assessment of readiness for medical licensure.

POLICY

COMLEX-USA Levels 1 & 2 and USMLE Steps 1 & 2 Requirements Prior to Training:

Each new resident must have successfully completed Step 1 and Step 2 of the USMLE or Level 1 and Level 2 of the COMLEX prior to the beginning of residency training ("Residency"). Any agreement of appointment or offer letter will be contingent upon passing Steps 1 and 2 or Levels 1 and 2. Each resident is responsible for providing proof of passing Steps 1 and 2/Levels 1 and 2. Residents who have not passed Steps 1 and 2 or Level 1 and 2 by their PGY-1 appointment date will be released from their contract.

COMLEX-USA Level 3 and USMLE Step 3 Requirements During Training:

A. Residents must take and pass the USMLE Step 3 or the COMLEX-USA Level 3 to be eligible for promotion to the PGY-3 level in the program. While residents must adhere to this requirement, the program can set a more stringent timeline and requirement regarding the successful completion of this exam.

B. Residents transferring from another program must document a passing score on the USMLE Step 3 or the COMLEX-USA Level 3 within six months of the starting date of their resident contract or the start of their PGY-3 year, whichever is later.

C. Procedure

1. Residents shall submit documentation of a passing score on the USMLE Step 3 or the COMLEX-USA Level 3 or provide a copy of their full medical license to the program prior to the start date of their PGY-3 contract.

2. Residents are strongly encouraged to read and become familiar with the eligibility requirements, policies, and procedures of the USMLE or the COMLEX-USA.

3. Residents are strongly encouraged to take and pass the Step 3/Level 3 license examination well in advance of the start of their PGY-3 year. The recommended timing for taking the exam is at the end of the PGY-1 year. The test must be taken before the end of the PGY-2 year.

4. Residents who have not passed the required licensing examination prior to the start of their PGY-3 year will remain at the PGY-2 level for both compensation and academic/clinical responsibilities until either a passing score is earned, and proof provided, or the resident fails the maximum number of retakes for either exam.

5. The maximum number of retakes for the USMLE Step 3 or the COMLEX-USA Level 3 shall be defined by the USMLE and COMLEX-USA requirements. Candidates failing the maximum number of retakes of either examination are no longer eligible to complete the examination and are therefore not eligible to obtain a medical license in the United States. Candidates who fail the USMLE Step 3 or COMLEX-USA Level 3 after the maximum number of retakes will be terminated from the residency program in accordance with the terms of the resident GME Agreement.

PROFESSIONAL LIABILITY INSURANCE COVERAGE WHILE ON ASSIGNED ROTATIONS POLICY

POLICY

From time to time, Evara Health Residents on assigned rotations or preceptorships with designated faculty physicians will work in the physician's office, make rounds, or assist the physician in procedures or surgery in this or other hospitals.

DEFINITIONS

1. Federal Tort Claims Act (FTCA)- The Professional Liability Insurance coverage extended to the Residents by Evara Health on assigned rotations or preceptorships with designated faculty physicians

2. Faculty Physicians- those physicians who have been submitted to the Graduate Medical Education Committee and ACGME for designation as Evara Health's Family Medicine Residency Program Faculty and or have been approved through appropriate channels (for example, Faculty of the College of Osteopathic Medicine, NSU, Medical Staff at another hospital).

3. Resident- an employee of Evara Health involved in a full-time Residency program at Evara Health.

4. Assigned rotation or preceptorship- those activities approved in writing by the Director of the Residency Program.

PROCEDURE

During the assigned rotations, the Resident shall be clearly supervised by the assigned faculty physician(s).

Throughout such assigned rotation or preceptorship, the Resident is INSURED under FTCA but only for the Resident's legal liability arising from the performance of, or failure to perform duties related to the Residents training program in which enrolled.

In the event the Evara Health Resident assists or participates with a physician not as a part of a regularly assigned rotation or preceptorship, the resident is NOT INSURED under FTCA. The resident is not covered by FTCA for outside professional activities that do not relate to the organization's training program in which he is enrolled (i.e. Moonlighting).

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MOONLIGHTING POLICY

POLICY

The philosophy of NSU KPCOM Evara Health Family Medicine Residency program toward outside activities of the Residents ("moonlight") is as follows:

It is the responsibility of the Residents to render patient care in the pursuit of their education without additional remuneration based on productivity. This does not preclude them from earning income from patient care during unassigned hours provided this activity does not interfere with their health, rest, personal safety, education, work hour requirements and performance as Residents.

We realize that to meet the financial requirements for the Resident, additional support is often required. Therefore, in accordance with the Resident's agreement with the organization, approved avenues for outside activities shall be developed.

Eligibility

Moonlighting is a privilege for those residents who consistently show:

- The necessary clinical skills to work with patients with minimal supervision
- Solid professional behavior
- Good standing with the training program
- Ability to handle their training program workload without signs of fatigue.

First year residents (PGY-1) and second year residents (PGY-2) are not eligible to moonlight.

Limited Moonlighting may be allowed for trainees in the PGY-3 year or beyond at a program level basis. This program-level policy must be approved by the GMEC prior to approving any Moonlighting. Program-specific policies must be in the individual program handbooks.

The trainee must be in good standing**,** in order to be approved for moonlighting. Trainees on remediation, personalized improvement plans, or suspension for clinical or academic reasons are not eligible for moonlighting.

A program may prohibit moonlighting activities by all of its trainees as a matter of policy. As stated above, this must be included in the program-specific handbook and approved by the GMEC prior to implementation.

Licensure

All trainees engaged in moonlighting must be licensed for unsupervised medical practice in the state where the moonlighting occurs.

The trainee must also have a valid individual DEA registration or proof that such is provided by the organization offering moonlighting and any local or state registrations required.

Supervision

NSU, EVARA, and program teaching faculty may not have any role in the supervision of the professional activities of trainees when engaged in moonlighting.

Professional Liability Insurance

All trainees engaged in moonlighting must provide their Program Director a copy of their independent malpractice coverage or proof that such is provided by the organization offering moonlighting.

The malpractice protection provided by the Sponsoring Institution for the professional duties of the training program does not cover moonlighting activities.

It is the responsibility of the entity hiring the trainee to moonlight to determine whether their licensure is in place, adequate liability coverage is provided, and whether the trainee has the appropriate training and skills to carry out assigned duties.

Clinical and Educational Work Hours

Moonlighting hours must be counted toward the 80-hour weekly limit on work hours inclusive of all in-house clinical and educational activities, any clinical work done from home, and all moonlighting.

Because moonlighting assignments generally run concurrently with the routine obligations and responsibilities of the trainees to the program, the Program may limit the number of hours that can be spent moonlighting in a given month. Limits will be documented on the Moonlighting Request form prior to the initiation of any moonlighting activity.

Fatigue Mitigation

Moonlighting trainees are expected to be present, appropriately rested and prepared to carry out their obligations to their educational programs.

Monitoring

Moonlighting must not interfere with the trainee's ability to provide patient care.

PROCEDURE

A. Residents must obtain an unrestricted Florida Medical License (training license cannot be used) and a DEA number to obtain approval for moonlighting activities from the Program Director. **Each Resident will arrange individual professional liability coverage for any activities.**

B. At no time shall outside activities be allowed to interfere with the efficient performance of the duties and obligations of the Residency. Residents must be aware of work hours so as not to conflict with maximum work hour requirement.

C. "Moonlighting" activity without approval of the Director will be considered grounds for probation and potential dismissal from the program.

D. The Evara Health "Resident/Resident Moonlighting Reporting Form" must be completed when moonlighting begins and updated regularly when a new moonlighting activity is initiated, or a previous moonlighting activity is discontinued. An update will be required at each Resident review. Prior to submitting a moonlighting request, a trainee must have the follo0wing:

    a. A copy of the resident's full Florida Medical License (not a training license)
    b. A copy of the resident's DEA Number
    c. Copy of Malpractice policy that will cover the trainee during moonlighting.

APPROVAL PROCESS

Moonlighting permission must be specifically requested in writing using the Evara Health Moonlighting Request Form.

The Moonlighting Request Form must be submitted to the Program Coordinator at least two weeks prior to the next Clinical Competency Committee meeting (CCC). The Program Coordinator will verify that all the required documentation and information is included prior to forwarding the request to the Program Director and CCC. The CCC will discuss the Moonlighting Request at their next semi-annual meeting and document their decision in the resident's evaluation report. In determining whether a resident is approved for moonlighting or not, the CCC must consider all of the following:

- PRITE score (progressive performance)
- Milestones
- Faculty, Team, Peer & Patient Evaluations
- CSV evaluations
- Professional behavior
- Signs of fatigue
- Compliance with:
    - Required Assignments (modules, didactics, reading, presentations)
    - Keeping Patients logs up to date

- Individual Learning Plans - ILP
- Completing their administrative requirements on time

The Program Director will inform the trainee of the CCC decision and discuss the moonlighting during the CCC evaluation report review session.

After receiving approval to moonlight:

- Resident must notify the program director in writing about any changes in moonlighting activities
- The Program Director must keep the CCC up to date of any changes on moonlight activities
- During each semi-annual CCC evaluation meeting
  - Approved moonlighting activities for each resident must be reviewed
  - According to the resident progress the CCC can recommend for the resident to continue or stop moonlighting
- CCC committee report to PD their recommendations
- PD informs the decision to the resident during the discussion of CCC evaluation report.

Only Moonlighting Request Forms with all required paperwork, including but not limited to proof of professional liability insurance and valid licensure for unsupervised medical practice, will be reviewed.

Trainees may not start moonlighting prior to receiving written approval from the program

The Moonlighting Request form must be included as part of the institution's trainee file.

Loss of Moonlighting Privileges

Moonlighting may be disallowed if any adverse effects are documented. If a trainee experiences educational difficulty or excessive fatigue, the Program Director at his/her discretion may suspend moonlighting privileges.

A letter will be submitted by the Program Director to the trainee and the KPCOM Office of GME stating that the trainee is no longer permitted to moonlight.

Clinical and Educational Work Hours Monitoring

Work Hour compliance must be documented in and reviewed by the trainee with the Program Director on a monthly basis.

Failure to accurately document moonlighting hours will result in the suspension of moonlighting privileges.

RELATED GME POLICIES:

- Clinical and Educational Work Hours
- Fatigue Mitigation

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EVARA HEALTH
RESIDENT MOONLIGHTING REPORTING FORM

List all of your compensated activities as a Physician outside the required Residency Program activities.

1. Organization_____ Average # Hours/Month_____

Date (Month/Yr) Employed_____Position Held or Description of Duties_____
_____

Do you carry your own liability insurance for the above activities? Yes___ No___ If no, explain
_____

TOTAL Average number of hours spent on moonlighting per month _____

_____ _____
Signature Date

2. Organization_____ Average # Hours/Month_____

Date (Month/Yr) Employed_____Position Held or Description of Duties_____
_____

Do you carry your own liability insurance for the above activities? Yes___ No___ If no, explain
_____

TOTAL Average number of hours spent on moonlighting per month _____

_____ _____
Signature Date

3. Organization_____ Average # Hours/Month_____

Date (Month/Yr) Employed_____Position Held or Description of Duties_____
_____

Do you carry your own liability insurance for the above activities? Yes___ No___ If no, explain
_____

TOTAL Average number of hours spent on moonlighting per month _____

_____ _____
Signature Date

(Use Additional Sheets if Necessary)

NOTE: Any changes in the above should be reported promptly to the Program Director in writing.

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PRESCRIPTION WRITING POLICY

POLICY

Resident physicians will use their State of Florida Medical license number and DEA number for the purposes of Medical prescription writing. These numbers should appear on all prescriptions written by Resident physicians.

FAMILY MEDICINE CENTER CONTROLLED SUBSTANCE PRESCRIBING POLICY

1. We do not treat chronic non-malignant pain conditions requiring long-term use of narcotics or other controlled substances at Evara Health.

    a. Per Florida statutes and HB21 in order to treat chronic non-malignant pain a physician needs to be registered with the state as a chronic pain medication prescriber and follow the regulations of the statute.

    b. For non-registered providers, the statute allows for the treatment of acute pain. Prescription is limited to a three-day supply.

    c. The statute also allows non-registered physicians to treat chronic cancer related pain. Therefore, should a patient require management of **chronic non-malignant pain** they will be referred to a pain management specialist or practice.

    d. Prior to writing any prescription for controlled substance, the resident needs to access and review the PDMP. Review of PDMP must be documented in the patient's chart.

2. Residents should be very careful when writing controlled substances. Do not <u>suggest</u>, <u>promise,</u> or <u>write</u> these scripts until discussed with a faculty physician.

3. A copy of your DEA number certificate is also to be maintained in your Resident file in the Family Medicine Residency office.

4. Controlled substances should in most cases be approved by faculty, and **<u>never</u>** refilled at night or weekend.

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RESIDENT DEA USE POLICY

PURPOSE

To provide guidance regarding Resident prescribing of controlled substances. Specifically, to address the correct use by Residents of a facility's Institutional DEA Registration Number while the Resident is providing care in HCA Healthcare facilities.

USE OF DRUG ENFORCEMENT ADMINISTRATION NUMBER (DEA) FOR RESIDENTS WITH TEMPORARY TRAINING LICENSES

1. Temporary, facility specific, restricted DEA numbers are made available for residents holding a temporary license from the State of Florida and provide authorization to prescribe controlled substances only for patients treated in connection with residency duties at clinic/hospital that issued the correlating DEA number.

2. At each clinic/hospital, residents holding a temporary license must use a different temporary DEA number covered by the registration of that clinic/hospital. Under no circumstance may a resident use a DEA number across facilities when on rotations at affiliated hospitals.

3. All temporary DEA and Controlled Substance numbers expire following their assignment and are eliminated from the list of authorized numbers and from registration with various law enforcement bodies. New numbers must be assigned each academic year.

4. The DEA numbers assigned for temporary purposes may not be utilized for moonlighting or other purposes.

5. Residents who hold a permanent Florida medical license and a personal DEA number associated with that license must use their personal DEA number in lieu of a clinic/hospital assigned DEA number.

6. If a Resident has a permanent license, but does not have a personal DEA number, that resident may continue to use the hospital assigned DEA number for the duration of their residency training program in connection with residency duties at clinic/hospital that issued the correlating DEA number..

7. Misuse of a personal or hospital DEA number may subject the resident to disciplinary action by the Drug Enforcement Administration, The Florida Board of Medicine and/or the training program.

MOONLIGHTING ACTIVITIES

If a resident engages in any approved moonlighting activities, the resident must obtain a permanent license and his/her own personal DEA number. Obtaining a permanent license and a personal DEA number will not be paid for by the training program.

MISUSE OF DEA

Misuse of the clinic/hospital-assigned or personal DEA numbers includes, but is not limited to:

1. Using a clinic/hospital's specific DEA number to prescribe controlled substances to patients not followed within that hospital's system

2. Prescribing for self, family members, friends, hospital staff or other persons except as patients of the training program

3. Prescribing excessive amounts of controlled substances to any patient, including the writing of an excessive number of prescriptions for an addicting or potentially harmful drug to a patient

4. Any violations of the provisions of this policy.

Misuse of any DEA number will be reported directly to the Program Director, Designated Institutional Official and the GMEC and may result in disciplinary action up to and including dismissal from the training program.

CRR – 9/23

RESIDENT RECRUITMENT AND SELECTION POLICY

POLICY

Residents will be selected by participation in the National Residency Matching Program (NRMP).

PROCEDURE

1. Applications from eligible residents will be reviewed by the Residency Selection Committee, and selected applicants will be invited for interviews. The Electronic Residency Application Service (ERAS) is the preferred form for application.

2. Candidate selection

   A. The residency program will select resident candidates from among eligible applicants based on residency-related criteria such as their preparedness, ability, aptitude, academic credentials, communication skill, and personal qualities such as motivation and integrity.
   B. Resident applicants must meet the following qualifications for appointment to the residency program:
      a. Graduation from an accredited and acceptable medical school (MD or DO), as outlined by the Florida Board of Medicine or the Florida Board of Osteopathic Medicine. If graduation is from an acceptable medical school outside the United States or Canada resident must have the following:
         1. a current, valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment, and
         2. meet all criteria and eligibility for a full, unrestricted license to practice medicine in the State of Florida.
      b. The residency program reserves the right to reject any candidate at the point it is determined that they have matriculated from an unacceptable medical school.
      c. Meet the requirements set by the Florida Board of Medicine or Florida Board of Osteopathic Medicine for Initial Licensing of Resident Physicians, Interns, Fellows, and House Physicians.
      d. Evidence of passing COMLEX Level l and 2/USMLE Step I and II.
      e. Ability to demonstrate spoken, auditory, reading, and writing proficiency in the English language.
      f. Be able to meet with or without reasonable accommodation, all duties and responsibilities as described in our policy and procedure manual.
      g. Proof of legal employment status (i.e., birth certificate, passport, naturalization papers, valid visa, etc.).
   C. The residency program will not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status as required by the ACGME.

3. Interviews will be scheduled with a defined agenda that shall include:

   A. Interviews with the recruiting director, faculty, and residents. Each interviewer will prepare an evaluation of the applicant.
   B. The resident will tour the facility and may visit ancillary sites (Outpatient Health Center, Johns Hopkins All Children's Hospital, Bayfront Health Saint Petersburg, St. Joseph South Hospital) as appropriate.

4. As recruitment support the program will:

   A. Pay for one night's lodging for the visiting resident candidate(s).
   B. Pay for lunch for the resident candidate(s), the Resident host and faculty joining them. The total cost of the meal shall not exceed a predetermined amount, which will be announced at the beginning of the interview season.

5. The completed applications, supporting documents, and interview evaluation reports will be reviewed by chosen residents and faculty for input into the development of the ranking list.

6. The applicant rank list is prepared by the Residency Selection Committee based on the process described below. The results of that process will be submitted to the program director for review and subsequently submitted to the NRMP.

7. The residency program will participate and abide by the rules and regulations established by the NRMP.

8. The program director retains the right to modify the final rank list prior to submission to NRMP.

9. The Program Director will submit a report of the results of the match process to the GMEC.

RESIDENCY SELECTION COMMITTEE

This committee will consist of the program director, full-time core faculty, coordinator, and selected residents. They are charged with the responsibility of providing a preliminary review of all applications, and compilation of a proposed rank list. They will assist in the actual compilation of the final rank list.

PROCESS

1. This process shall adhere to ACGME requirements, the standards outlined in the "Essentials of Accredited Residencies in Graduate Medical Education" and in this policy

2. It is not the policy of NSU KPCOM Evara Health Family Medicine Residency to base considerations for admission to its Residency program on the basis of quotas.

3. It is the policy of NSU KPCOM Evara Health Family Medicine Residency to hire the most qualified applicants for each position. Selection will be based on the assessment of the individual's ability to meet the position requirements as well as values of the organization.

4. All selection procedures and practices are applied without regard to the applicant's race, religion, color, sex, national origin, disability, veteran, marital status or other protected status.

5. Completed applications, consisting of an application form, transcripts from all medical education, residency certification, three letters of recommendation, medical school performance evaluation/ Dean's letter, personal statement, USMLE or COMLEX transcript, and other requirements as listed in the ERAS application will be evaluated before an interview is normally offered.

6. As applications are completed, and if there are no concerns relative to the confidential information questionnaire, the Residency Coordinator will assign them to the designated reviewing faculty for initial review.

7. If the application passes the initial review, the Program Director will review the file and subsequently notify the coordinator if no concerns are noted. At this point, the candidate will be scheduled to interview with us.

8. If a decision is made to eliminate a candidate from consideration (i.e., not to interview), the candidate will be informed of the decision in a timely fashion.

9. Applicant review sessions. There will be periodic closed Residency meetings intended to review recent applicants. At that time evaluations of interviewers, observations from co-workers, etc. will be considered. At the end of the discussion, the applicant will be placed in a temporary rank list that compares his standing to the resident candidates who were previously reviewed.

10. Ranking. Based on their considerations and placement of applicants at the applicant review sessions, the Residency Selection Committee will submit a proposed rank list. Factors to be considered in the process include average ratings, percent of outstanding grades during medical school, percentile standing on the National Boards, personal statement, interest in family medicine, letter of recommendations and interview scores.

11. The actual ranking will be done in a similar fashion. Each resident and faculty member in the committee will be asked to rank each applicant. These ballots will be tabulated, and a final rank list calculated from them.

12. Final approval of the ranking list resides with the Residency Program Director.

13. The final rank list is extremely confidential. Violations of such confidentiality will be treated as unprofessional and unethical behavior.

RECRUITING AND INTERVIEWING GUIDELINES

Residents are the best placed people to recognize the characteristics of a successful resident applicant. The goal of the resident interview is not to assess an applicant's academic credentials. That is the role of the faculty. Instead, the resident's role is twofold:

1. To provide applicants with information on the program and community from the resident perspective.
2. To get to know the applicant and assess their compatibility with the program generally and residents specifically, and your enthusiasm for working with them.

It is generally best to start off with general open-ended questions to give the applicant a chance to talk, and then move on to specific questions. Consider dividing the interview time roughly in two, beginning with providing information, then moving on to information gathering.

Information provision questions

- What questions can I answer for you?
- What can I tell you about the residency program?
- What can I tell you about the learning environment?
- What can I tell you about the community?
- What can I tell you about the life of a resident here?
- What can I tell you about resident connectedness and life outside of work?

Information gathering questions

- Tell me a little about yourself.
- Tell me about what has led to choose Family Medicine as a career.
- What do you hope to be doing 10 years from now?
- What has led you to interview at our program?
- What are your interests outside of medicine?
- What are you most excited about as you enter residency?
- What do you think you will find most difficult about residency?
- Please give me an example of a time you worked effectively as part of a team?

Specific questions

- Tell me about the best resident you ever worked with. What was it about them that made them so enjoyable to work with?
- Tell me about a conflict you had with a colleague and how you resolved it?
- What are you passionate about outside of work?

Questions not to ask

Asking questions in the following areas could be viewed as discriminatory or a violation of Federal law or Match policies and therefore must not be approached. However, these subjects may be discussed if the applicant brings them up first:

- Age
- Race or national origin
- Religion, including need for special days off
- Political beliefs or affiliations
- Marital status or relationships with significant others
- Children or dependents
- Pregnancy or plans to become pregnant
- Sexual preferences or orientation
- Medical status or disability
- If the applicant is applying in specialties other than Family Medicine

- The names or locations of programs where applicant is applying or plans to interview
- Geographic locations or regions that the applicant is applying in
- The applicant's Match ranking preferences or plans

Interview etiquette

- You are the face of the program. Keep the mood upbeat and positive.
- Dress professionally.
- Be prompt. Notify the program coordinator and/or program director if an emergency comes up.
- Give the applicant your contact information at the end of the interview and encourage follow-up questions.

Writing it up

Your written notes are crucial to the ranking committee. Please complete them the day of the interview while your memory is fresh and return them to the program coordinator promptly. Provide details supporting your opinions, not just generic comments like "would be a good resident" or "rank high."

Suggested comments to include in your write-up:

- How did the applicant present themself? (meek, quiet, friendly, outgoing, aggressive, abrasive)
- How well do you think the applicant would fit in at Evara?
- How would you feel about working with this applicant?
- What sort of questions did the applicant ask?
- How does this applicant compare to others you have met?
- Do you have any concerns?

9/22 – CRR

RESIDENT SUPERVISION POLICY

PURPOSE

To ensure that the Residents are provided adequate and appropriate levels of supervision which comply with ACGME supervision requirements

POLICY

The education of physician trainees relies on an integration of didactic activities in a structured curriculum with the diagnosis and management of patients under appropriate levels of supervision. During training, all patient care and educational activities are to be under Program Faculty supervision. Each patient must have an identifiable, appropriately credentialed, and privileged attending physician or approved licensed independent practitioner who is ultimately responsible for their care. A patient's responsible Supervising Physician or licensed practitioner should be identified to trainees, faculty members and patients.
Trainees and faculty members should inform patients of their respective roles in each patient's care. The appropriate level of supervision depends on the individual trainee's level of competency as determined by their knowledge, skill, and attitudes. The appropriate level of Program Faculty supervision for each trainee is determined by the responsible Residency Faculty and Residency Program Director (Program Leadership). The GMEC is responsible for oversight and monitoring of this process of appropriate supervision and active investigation into issues of inadequate or inappropriate levels of trainee supervision, including oversight of levels of trainee supervision inconsistent with this GME Policy.

PROCEDURE

The quality of a trainee's GME experience involves a proper balance between educational quality and the quality of patient care. In all Programs and instances, the level of trainee supervision must ensure the highest quality, safety, and effectiveness of patient care. Appropriate levels of trainee supervision during educational and patient care activities include the following guidelines:

A. Level of Supervision

1. The level of trainee supervision must be consistent with the educational needs of the trainee. This also includes supervision of activities that may influence learner safety (i.e., duty hour limitations, stress).

2. The level of supervision must be appropriate for the individual trainee's progressive responsibility as determined by the trainee's level of education, competence, and experience. Residency program will ensure that the appropriate level of supervision is in place for all trainees.

3. PGY-1 trainees should be supervised either directly or indirectly with direct supervision immediately available. The achieved competencies under which PGY-1 trainees can progress to be supervised indirectly with direct supervision available are defined in the ACGME Program Requirements.

B. Determination of Progressive Responsibility

1. There are multiple layers of supervision of trainee educational and patient care activities, including supervision by an advanced-level trainee. Advanced-level trainee supervision is recognition of progress towards independence and demonstration of graded authority and responsibility. The final level of supervision is the responsibility of the Program Faculty and Program Director.

2. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each trainee and delegate to him/her the appropriate level of patient care authority and responsibility.

3. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each trainee must be assigned by the program director and faculty members. The program director must evaluate each trainee's abilities based on specific criteria guided by the Milestones. When available, evaluation should be guided by specific national standards-based criteria.

4. Faculty members functioning as supervising physicians should delegate portions of care to trainees based on the needs of the patient and the skills of the trainees.

5. Each trainee must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

C. Communication with Supervising Faculty

1. Certain situations require prompt communication between the resident/fellow and supervising attending. At a minimum, the resident/fellow must notify the supervising attending physician /licensed provider of any significant changes in the patient's condition, including but not limited to:

    i. Patient admission to the hospital
    ii. Transfer of a patient to a higher level of care including the intensive care unit
    iii. Cardiac arrest or significant changes in hemodynamic status
    iv. Development of significant neurological changes
    v. Development of major complications
    vi. Medication errors requiring clinical intervention
    vii. Any clinical problem that requires an emergent invasive procedure or surgery
    viii. Change in code status
    ix. Death

2. An integral part of the supervision of trainee educational and patient care activities always includes the availability and access to communication with Program Faculty (24 hours per day, 365 days annually).

D. Feedback

1. The formative evaluation of trainee activities as dictated by the ACGME Program Requirements is an important component of appropriate trainee supervision.

2. The review of trainee documentation of patient care is an important aspect of trainee supervision.

3. Any concerns about inadequate or inappropriate levels of supervision should be addressed by the Program Leadership, with involvement of the GME Office and GMEC if the issues are not appropriately addressed locally. Any individual can bring concerns about trainee supervision to the attention of the GME Leadership.

E. Classification Levels of Supervision

1. Direct Supervision -
    a. the supervising faculty member is physically present with the resident and patient or
        i. PGY-1 residents should progress to being supervised indirectly with direct supervision available only after demonstrating competence in:
            1. The ability and willingness to ask for help when indicated
            2. Gathering an appropriate history
            3. The ability to perform an emergent psychiatric assessment; and,
            4. Presenting patient findings and data accurately to a supervisor who has not seen the patient
    b. the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
        i. When a resident requiring direct supervision provides remote care, the supervising physician must be physically present with the resident.
2. Indirect Supervision – the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

3. Oversight – the supervising faculty member is available to provide review of procedures/encounters with feedback provided after care is delivered.

F. Outpatient Resident Precepting Guidelines

All patient visits must be precepted by the resident with the Teaching Physician either during or immediately following the patient encounter.

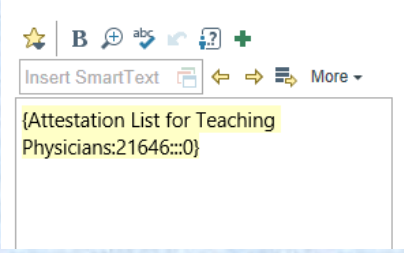
Teaching Physicians must document the following for each visit in a time-stamped Epic attestation note:

1. Their level of participation (reviewed care, interviewed and examined the patient and was present for the key portion of the visit, and/or was present during a procedure)

2. Brief summary of pertinent history, physical exam, lab or imaging findings

3. Diagnosis and plan of investigation and treatment.

To enter an attestation note the Teaching Physician should select the “Attest” note type which will insert an attestation box within the note:



Selecting F2 will open a yellow dialogue box and the teaching physician should select either “INTERVIEWED AND EXAMINED” or “DISCUSSED” which will insert standard supervision language. The teaching attending should then provide a brief synopsis of the treatment plan and note any disagreement with the resident’s findings, then click ”Sign.”

If a teaching physician is supervising care provided and documented by a student, the resident also participating in that patient’s care (with linking teaching physician addendum) must document a complete note following standard documentation guidelines

All prenatal visits must be precepted with an OB-credentialed faculty member, but physical presence of the preceptor is not required.

Precepting Requirements

	PGY-1 July-Dec	PGY-1 Jan-June PGY-2,3
Level 1-3 new or established	**I & E**	**RC**
Preventive care/Wellness	**I & E**	**RC**
Prenatal visits	**I & E**	**RC**
Level 4-5 new or established	**I & E**	**I & E**
Transition of care	**I & E**	**I & E**
Procedures	**I & E**	**I & E**
All other visits	**I & E**	**I & E**

RC = Reviewed care (physical presence with patient not required)

I&E = Interviewed and examined patient (physical presence with patient required)

VACATION, HOLIDAY AND LEAVES OF ABSENCE POLICY

Our absence policies are designed to ensure compliance with the following requirements of the American Board of Family Medicine (ABFM) and the Accreditation Council on Graduate Medical Education (ACGME).

OFFICE CONTINUITY (ACGME and ABFM)

1. Residents must be scheduled to see patients in our office during a minimum of 40 weeks in each year of training.
2. Rotational assignments must not interrupt office continuity for more than 8 weeks at any one time or in any academic year.
3. Residents must be scheduled to see patients in our office for a minimum of 4 weeks between periods of interruption of continuity.

PROLONGED ABSENCE (ABFM)

1. Absence in excess of the time described below within any academic year is considered a LOA.
2. ABFM will allow up to (12) weeks away from the program in a given academic year without requiring an extension of training, as long as the Program Director and CCC agree that the resident is ready for advancement, and ultimately for autonomous practice. This includes up to (8) weeks total attributable to Family Leave, with any remaining time up to (4) weeks for Other Leave as allowed by the program.

NOTE: *To be eligible to take the American Board of Family Medicine exam, the maximum time away from the residency for other leave is 4 weeks or 30 days per academic year. (This does not include time considered as LOA).* ***Other leave*** *refers to time off allotted by programs and their sponsoring institution for vacation, sick leave, holiday, educational leave, or other paid time off.*

VACATION / SICK / HOLIDAY / PERSONAL TIME AWAY

Each resident will receive paid vacation of four weeks (twenty working days), plus holidays. Residents receive the same holidays as all Evara employees. Please see Evara Health Employee leave for details. When required to be on-call on a holiday, the Resident will be given the day at an alternate date (call "comp"). You must notify the Family Medicine Residency office if you are scheduled to work any of these holidays. In addition, residents are allowed up to five conference days per year. Remember, vacation and conference requests are to be submitted **6** weeks (**42** days) in advance; and must be approved before the desired time-off. Emergencies will be considered on an individual basis.

1. Paid Leave Time Available

	Vacation	Holiday
PGY 1	20 Days	10 Days
PGY 2	20 Days	10 Days
PGY 3	20 Days	10 Days
FELLOW	20 Days	10 Days

In addition, Residents may take up to 5 conference days per year. Any bereavement, sick days are deducted from your vacation.

Time Away Policy:
Residents cannot take vacation more than 5 days at a time.

Emergency leave should be requested directly from the Residency Director. Time away for emergency leave will be deducted from vacation.

Holidays: Evara and Hospital holidays are counted as part of training. Trainees will receive holiday pay for holidays. If a trainee is on call during a holiday, the trainee must complete "on call" duty. Trainees who are not on call or who are not required to be at work may have the day off at the discretion of the Program Director. A holiday schedule may be enforced by the Program Director and must be adhered to. Every effort will be made to ensure fair and just allocation of days off for holidays over the course of the training period.

2. Time Away Request Form

2.1 A time away request form and a request in ADP must be completed for any time away from the program. In addition to vacation, this includes "comp time", conference time and absence due to Residency representation at meetings. Time away ***should*** be applied for at least **6 weeks (42 days)** in advance (defined as away beginning date greater than 6 weeks (42 days on same day) and must not interfere with assigned duties or rotations. ***Academic requirements, medical records and any outstanding requirements must be completed before leave time will be approved***. Any requests under **6 weeks (42 days)** must be submitted to be personally reviewed by the Medical Director of the Family Medicine Clinic. The Resident is responsible for negotiating continuity of care coverage during his vacation absence, including all Family Medicine patients, and any patients the resident has in the inpatient service.

2.2 All vacation time and conference time and expenses must be approved by the Program Director (see CME policy). Vacation time approval must be requested by completing a vacation request form that requires the signature of those Residents providing coverage for you, along with the signatures of the rotation coordinator. When completed, the form must be given to the ***Resident Coordinator*** who will log your time and then give the form to the ***Family Medicine Center Director***. Then the FMC Director will give the form to the ***Schedule Manager*** who will then block your schedule. Last, the ***Program Director*** will approve your time away. If the leave time has been approved, you will receive a copy of your time away request signed by the Director. ***If a Resident is requesting leave time from an elective or preceptorship month the elective or preceptorship arrangements for the month must be confirmed prior to vacation approval.***

3. Restrictions

3.1 Excessive time away from training may require the trainee to extend his/her training.

3.2 Residents cannot take more than two weeks of leave time during Period 13; **and are expected to be here during the last week of the Residency.**

3.3 Vacation, sick **and conference leave does not carry over from year to year.**

3.4 **No vacations are allowed during these times:**

a. The first and last week of residency
b. Orientation
c. In-Training Exams
d. In-patient medicine and in-patient pediatrics rotation

3.5 To receive credit for completion of a rotation, residents must be present for a minimum of 70% of templated workdays. Any absence for any reason that exceeds 30% of templated workdays must be made up.

3.6 Additional dates may be specified by the Program Director and included in the program handbook.

4. Sick Leave

4.1 Absence from Duty

4.1.1 If illness or other circumstances prohibit working, the following people must be notified: Family Medicine Center Director, rotation attending, residency coordinator, and Program Director. If patients are scheduled to be seen during the absence, the appropriate FM center director must be notified as well as the FM Residency office.

5. Bereavement Leave

5.1 Time Allowed

5.1.1 Leave with pay will be granted for a maximum of three consecutive scheduled workdays to coincide with the funeral for the death of an immediate family member. Relatives who constitute immediate family for purposes of bereavement leave are:

Spouse	Brother
Children	Sister
Parents	Mother-in-law
Legal Guardians	Father-in-law
Grandparents	Stepparents/Children
Grandchildren	

LEAVE OF ABSENCE (LOA)

ACGME REQUIREMENTS

1. Provide residents/fellows with a minimum of six weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program, starting the day the resident/fellow is required to report.

2. Provide residents/fellows with at least the equivalent of 100 percent of their salary for the **first** eight weeks of the **first** approved medical, parental, or caregiver leave(s) of absence taken.

3. Provide residents/fellows with a minimum of one week of paid time off reserved for use outside of the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken.

4. Ensure the continuation of health and disability insurance benefits for residents/fellows and their eligible dependents during any approved medical, parental, or caregiver leave(s) of absence.

Trainees are entitled to leave with pay as described in this policy

1. LOA may interrupt continuity of patient care in a given academic year for a maximum of 10 weeks (6 weeks of LOA and 4 weeks of vacation).

2. LOA may be interspersed throughout the year or taken in up to a 6-week block.

3. Program will provide residents with at least the equivalent of 100 percent of their salary for the **first** six weeks of the **first** approved medical, parental, or caregiver leave(s) of absence taken.

4. Any academic year containing less than 40 weeks in office continuity is a violation of the ABFM continuity of care requirement and may invalidate eligibility for Board Certification unless a waiver is obtained.

5. If a resident takes a LOA that falls under the conditions of the ABFM Family Leave Policy they may choose not to extend training time, but also have the option to extend their training beyond their graduation date by the length of their LOA.

6. Health and disability insurance benefits for residents/fellows and their eligible dependents will continue during any approved medical, parental, or caregiver leave(s) of absence.

7. All Residents must continue to meet the program requirements of providing care for patients in the Family Medicine Center (FMC) for a minimum of 40 weeks during each year of training, a minimum of 1000 hours in the care of FMC patients, all other numeric requirements, and the Clinical Competency Committee and Program Director must be able to attest that they have met all ACGME training requirements and are prepared for autonomous practice.

8. If a resident takes a LOA under the conditions of the ABFM Family Leave Policy without extension of training time, the rotations not completed due to the LOA must be either electives or track time. All residents must complete all required core rotations prior to graduation.

9. In keeping with the intent of ABFM policies, if a resident takes a LOA under the conditions of the ABFM Family Leave Policy without extension of training time, they will not be required to make up on call shifts for which they would otherwise have been scheduled. However, if a resident takes a LOA with extension of training, they will be expected to continue to take on call shifts during their extension of training to maintain equity with other residents.

10. All LOAs require prior approval and a meeting with the Program Director and the Resident's Advisor to develop a written leave plan that outlines the terms of the planned LOA and a preliminary assessment of its impact on program requirements and how they can be met after the resident's return.

11. All residents returning from a LOA must meet with the Program Director and their Advisor as soon as possible after their return to document their return-to-work plan, the impact of their LOA on their graduation date, eligibility to sit the ABFM Certification Examination, and plan for achieving all program requirements prior to their projected graduation date. A written summary of this conversation will be provided to the resident and entered into their personnel file.

12. Additionally, as Evara Health employees, trainees are entitled to leave without pay through the Family and Medical Leave Act (FMLA). Information on this can be obtained from Human Resources.

The maximum time a trainee can be away from a program in any given year is determined by the requirements of the specialty board involved. If specialty board regulations for vacation and sick leave accrual and usage differ from that outlined in this policy, the Program Director will provide the DIO written notice of the applicable specialty board regulation and seek approval for a modification of this policy for that program.

GME-Specific Policies:

A. Time Away from Residency

1. Excessive time away from training may require the trainee to extend his/her training.

2. The KPCOM GMEC will annually approve a Salary and Benefits package for all GME training programs that includes information on allowed vacation and sick time. Program Directors are responsible for annually communicating this information to their trainees, as well as the maximum number of allowed days away from training for their program.

3. Program Director must follow the specifications of the Accreditation Council for Graduate Medical Education's Common Program requirements and Specialty requirements for their Specialty regarding time lost from training.

4. If a trainee exceeds the maximum allotted time away from training, the trainee may be required to extend his/her training to fulfill requirements. Decisions regarding the need to extend training may not be made at the time the Leave is requested or when the trainee returns from Leave. During the final year of training, the Program Director and the program's Clinical Competency Committee will determine whether a given resident has met the competency-based training requirements or must extend their period of training.

5. Remuneration for extended training time is not guaranteed and will be at the discretion of the Program Director and DIO and may be based on the availability of funding.

6. All requests for additional paid time off or paid training extensions must be approved by the DIO prior to the initiation of the additional training time.

Approved "Time Away" may be revoked or altered at the discretion of the Program Director.

CR 6/23

FAMILY MEDICINE RESIDENCY
RESIDENT *TIME AWAY* REQUEST

RESIDENT NAME: _____ **TODAY'S DATE**:_____

I would like to **request** ____ **days** of *(please check one at the right & below if appropriate)*

☐ **VACATION** *(You are responsible for having enough Vacation/Personal/Emergency in compliance with HR Policy)*

☐ **CONFERENCE** *(Must attach conf. info. & Travel requisition with expected expenses)*

☐ **AWAY ROTATION** *(You must submit Goals & Objectives, approved by your Faculty Advisor, as well as Preceptor Information)*

☐ **OTHER** *(Discussion with Director is REQUIRED PRIOR to submitting)*

Comp Time

☐ New Years	☐ MLK
☐ Good Friday	☐ Memorial Day
☐ July 4th	☐ Labor Day
☐ Thanksgiving	☐ Thanksgiving Fr
☐ Christmas	☐ Christmas +1

Time Away **will begin on** _____ I will **return to duty on:** _____

I will **be on** _____ **rotation** and I have arranged signature/coverage as follows**:**

Faculty/Preceptor Permission & Signature *REQUIRED*: OB/GYN, JHACH EM, Adult EM			**Resident Providing Coverage *MUST SIGN* below.:**		
OB/GYN	*Signature* *N/A*	*Date*	EHR Inbox/Tasks	*Signature* *N/A*	*Date*
			CALL	*Signature* *N/A*	*Date*
ROTATION PRECEPTOR CONTACTED	**YES NO**		*Preceptor Name*	*Date Contacted Preceptor*	

Will You Miss Any Of The Following: *(circle one - if YES, please indicate when you will make it up)*		
DIDACTIC WORKSHOPS	**YES NO**	*Comments*
HOME VISITS	**YES NO**	*Comments*
RESIDENT REVIEW	**YES NO**	*Comments*
THIRD YR LECTURE	**YES NO**	*Comments*
INTERVIEWS, ETC	**YES NO**	*Comments*

COMMENTS: _____

_____

Resident Signature	*Date*

After everything above has been completed & signatures are obtained, give form to the Chief Resident

OFFICIAL USE ONLY

#1 CHIEF	*Signature*	*Date*	**#3 FMC Director**	*Signature*	*Date*
#2 RES COOR	*Signature*	*Date*	**#4 PROGRAM DIR**	*Signature*	*Date*

Schedule Blocked? YES NO N/A

COMMENTS: _____

Instructions on back

Request for time away must be completed in full and submitted to the Residency coordinator. Also enter your time away request in ADP. *To avoid rerouting delays Do Not submit incomplete requests.*

Step 1: Residency coordinator will submit to FHC Medical Director at least once weekly.

Step 2*:* FHC Medical Director will submit to personnel in charge of schedules for schedule review, ADP approval and blocking as appropriate.

Step 3*:* Personnel in charge of schedules will submit to Program Director or Acting Director for final signature/approval.

RESIDENT/FELLOW LEAVE OF ABSENCE (LOA) REQUEST FORM

To be Completed by Resident/Fellow :

Name: _____ Program: _____

Address During Leave: _____

Street Address City State Zip Code

Phone During Leave: _____ E-mail During Leave: _____

Classification: ☐ Resident ☐ Fellow

Reason for Leave: _____

Unused Days: Vacation Days_____ Sick Days_____

Last Day Worked: _____ Anticipated Date of Return: _____

Program Director/Coordinator: _____ Date: _____

(please print)

Coverage Plans: _____

To be Completed by GME and Human Resources

Type of LOA:

☐FMLA – Medical LOA ☐FMLA – Personal LOA ☐Inactive; Suspend Pay (Benefits will terminate)

☐FMLA – Parental LOA ☐Military LOA (includes Reserve/National Guard) ☐LOA – Resident/Clinical Fellow

☐Other

Completed	Department	Date Received	Authorized Signature of Representative
☐	Program Coordinator	_____	_____
☐	Program Director	_____	_____
☐	Designated Institutional Official	_____	_____
☐	Evara or NSU Human Resources, if applicable	_____	_____

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SOCIAL MEDIA POLICY

PURPOSE

NSU-KPCOM and Evara Health recognize that online social networking has become an increasingly important means of facilitating communication. While social networking has provided unique opportunities to interact, it has also created a forum for potential issues for future physicians. As professionals bound by social contracts and professional and ethical obligations, residents must be cognizant of the public nature of social networking forums and the permanent nature of postings therein. Even though these sites offer terrific potential to bolster communication with friends and colleagues, they may also serve as a forum for lapses of professionalism and professional behavior that may be freely visible by many people, despite the impression of privacy these sites portray.

The policies and guidelines set forth in the Social Media Policy are intended to ensure compliance with legal and regulatory restrictions on the use of Protected Health Information, as well as applicable privacy and confidentiality agreements. The policies and guidelines set forth in this Social Media Policy apply to an employee's use of both Evara Health-Hosted Websites and Non-Hosted Websites when such employee's affiliation with Evara Health is identified, known or presumed. This Social Media Policy is not, however, intended to restrict an employee's right to participate in lawful, personal activities on Social Media Websites.

DEFINITIONS

Evara Health-Hosted Website(s)- Social media websites created by, affiliated with, and/or maintained by Evara Health. Examples include, but are not limited to, Evara Health Facebook and Twitter accounts.

Social network site- is a place on the internet where users can create a profile and connect that profile to others (whether it be individuals or entities) to establish a personal or professional network. Examples include, but are not limited to, Instagram, Facebook, LinkedIn, Twitter, and You Tube.

Weblog, or a "blog,"- is a website, usually in the form of an online journal, maintained by an individual or group, with regular commentary on any number of subjects which may incorporate text, audio, video clips, and any other types of media.

POLICY

The following section outlines "best practice guidelines" for medical professionals-in-training at NSU- KPCOM/ Evara Health during their residency training. They apply to all residents who participate in social networking sites, online weblogs, or any other forms of online communications and interactions. Residents should follow these guidelines whether participating in social networks personally or professionally; whether they are participating in social networking or any other form of online communication on-site at NSU, Evara, or off-site; or whether they are using personal technology or technological resources owned or operated by Nova Southeastern University, NSU-KPCOM and/or Evara Health

Potential Consequences of Online Unprofessional Behavior

The permanence and written nature of online postings may cause them to be subject to higher levels of scrutiny than many other forms of communication. Therefore, postings made on social networking sites are subject to the same standards of professionalism as any other personal or professional interaction and will be treated as if made in a public forum. Postings made on social networking sites can have educational ramifications. Conduct that violates residency policies or procedures may result in disciplinary action.

The use of social networking sites or weblogs can also have legal ramifications. Comments made regarding the care of patients, or that portray you or a colleague in an unprofessional manner, may be used in court as evidence of a variety of claims (including, but not limited to, libel, slander, defamation of character, negligence, and others) or

in other disciplinary proceedings (e.g. State Medical Licensing Boards). Other potential consequences include the suspension or termination of your residency training, or sanctions by a professional licensing board.

Also, the statements and media posted within these sites are potentially viewable by program directors, future employers, and patients or clients. It is not uncommon for future employers to search for the social networking profiles of potential employees and to use the discovered information in making selection decisions.

Individuals have been denied licensing and other employment opportunities as a result of material found on social networking sites.

With respect to confidentiality, the Health Insurance Portability and Accountability Act (HIPAA) applies to social networking sites, and violators may be subject to the same prosecution as with other HIPAA violations.

In addition, cyber stalking and other inappropriate postings can be considered forms of sexual harassment.

Best Practice Guidelines for Online Social Networking

1. The lines between public and private, as well as personal and professional are often blurred in online social networks. By identifying yourself as an NSU-KPCOM/ Evara resident, you may influence perceptions about NSU-KPCOM and Evara Health by those who have access to your social network profile or weblog. All content associated with you should be consistent with your position at the residency program and with NSU-KPCOM/Evara Health's values and professional standards.

2. Unprofessional postings by others on your page may reflect very poorly on you. Monitor others' postings on your site and strive to ensure that the content would not be viewed as unprofessional. It may be useful to block postings from individuals who post unprofessional content.

3. Help monitor your peers by alerting colleagues to unprofessional or potentially offensive comments made online to avoid future indiscretions and refer them to this document.

4. Always avoid giving medical advice as this could result in a violation of HIPAA, could potentially risk liability under state licensing laws, and may cause danger to others. Make sure that you differentiate medical opinions from medical facts and articulate which statements reflect your personal beliefs.

5. Due to continuous changes in these sites, you should closely monitor the privacy settings of your social network accounts to optimize their privacy and security. Restrict your settings so that only individuals you have authorized to access your profile can see your information. Also, you should not share or post any identification numbers or demographic information online.

6. Others may post photos of you and may "tag" you in each of the photos. It is your responsibility to make sure that these photos are appropriate and are not professionally compromising. As a general rule, it is wise to "untag" yourself from any photos, and to refrain from tagging others unless you have explicit permission from them to do so. Privacy or account settings may allow you to prevent photos from being "tagged" with your information or may prevent others from seeing your tags.

7. Online discussions of specific patients is prohibited, even if all identifying information is excluded. It is possible that someone could recognize the patient to whom you are referring based upon the context in which it is presented.

8. Do not use or disclose PHI or confidential patient information of any kind on any Social Media Website, unless it is expressly authorized in writing by Evara Health's Compliance and Marketing Departments pursuant to the express written authorization of the affected patient.

9. Under no circumstances should media of patients or media depicting the body parts of patients be displayed online (e.g., photographs, video clips, audio clips). Remember, even if you have permission, such media may be downloadable and forwarded by others. Once you post, the actions of others could lead to legal or professional consequences for you personally.

10. Consider, with care, who you add or accept as a “friend” or “connection” on your social networking site(s).

11. Do not have interactions with patients on social networking sites. This provides an opportunity for a dual relationship, which may damage the doctor-patient relationship and may have legal consequences.

12. Do not infringe upon another’s copyrighted or trademarked materials. If you post content, photos, or other media, you are acknowledging that you own or have the right to use these items.

13. Refrain from accessing social networking sites while in class, at work, or in clinical-work areas.

14. Do not use a Social Media Website to disclose proprietary Evara Health Information (“Confidential Information”) to a third-party. Such confidential Information shall include, but is not limited to, reports, financial information, protocols, policies and procedures, billing, marketing materials, trade secrets, know-how, methodology, or any other proprietary information belonging to Evara Health or the affiliates, vendors or suppliers.

15. Do not use your Evara Health email address to register on Social Media Websites intended for personal use.

16. Evara Health Resident Employees are prohibited from making posts containing statements, photographs, video, or audio that could reasonably be viewed as malicious, obscene, threatening, or intimidating, and/or that might constitute harassment or bullying.

17. Generally, in connection with a personal social medial profile, employees should refrain from identifying themselves as employees of Evara Health to the extent practicable. If an Employee chooses to identify his/her employment or affiliation with Evara Health on a personal social media profile, such profile should include a disclaimer that the views expressed therein are the employee’s own personal views and do not represent the views of Evara Health.

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VENDOR INTERACTIONS POLICY

PURPOSE

This policy addresses Accreditation Council for Graduate Medical Education (ACGME) *Institutional Requirements IV.L. Vendors*

BACKGROUND

On occasion, vendors, contractors, patients or others may offer gifts or gratuities to residents. All such offerings represent a potential for conflicts of interest, or the appearance of such, on part of the resident, NSU KPCOM and Evara Health. Such gifts and gratuities are not part of NSU KPCOPM or Evara Health's operational environment. As such, the acceptance of such gifts and or gratuities would constitute a risk to the integrity of NSU KPCOM, Evara Health and its employees.

In addition, pharmaceutical and medical device companies may use non-monetary gifts, financial compensation, personal visits, educational events, and other strategies in an attempt to influence prescribing or other medical practices.

POLICY

All GME personnel, including program directors and trainees, must abide by the:

- NSU Conflict of Interest - Declaration & Disclosure Policy in the NSU Employee Policy Manual - found at: *nova.edu/portal/hr/policies/conflict-of-interest.html* (must log in to NSU employee portal to access)
- NSU Financial Conflict of Interest with Respect to Sponsored Projects in the NSU Employee Policy Manual - found at: *nova.edu/portal/hr/policies/financial-conflict-of- interest-sponsored-programs.html* (must log in to NSU employee portal to access)
- Evara Health's Conflict of Interest/Appropriate Conduct section in the Employee Handbook.
- NSU-COM Policy on Conflicts of Interest and Healthcare Industry Policy found in the NSU-COM Faculty Handbook.

PROCEDURE

A. All trainee physicians and residency programs will be aware of and follow the vendor interaction policies in any facility where they rotate. Trainees will also be aware of and follow vendor interaction policies at any outside facilities in which they rotate.

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ACCOMMODATIONS FOR DISABILITIES POLICY

PURPOSE

This policy addresses Accreditation Council for Graduate Medical Education (ACGME) *Institutional Requirements IV.I.4. Accommodation for Disabilities*

POLICY

Nova Southeastern University, the Office of Graduate Medical Education, and Evara Health are committed to a policy ensuring persons with disabilities are not unlawfully discriminated against and are committed to guaranteeing equal opportunity and equal access to all the rights and privileges enjoyed by those who are not disabled. Nova Southeastern University and Evara Health will comply with all provisions of the Americans with Disabilities Act of 1990 and will provide, upon request, reasonable accommodations to qualified individuals with a disability.

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CONFIDENTIAL COUNSELING AND BEHAVIORAL HEALTH SERVICES POLICY

PURPOSE

This policy addresses Accreditation Council for Graduate Medical Education (ACGME) *Institutional Requirements IV.I.1. Behavioral Health:*

BACKGROUND

Evara Health recognizes that problems of a personal nature can have an adverse effect on employee job performance. In addition to regular health and disability insurance, Evara Health provides the Employee Assistance Program (EAP) for employee's and their eligible dependents to use in resolving personal/family or job relates problems through professional, confidential assistance. Additionally, Evara Health has established the Employee Wellness Program that provides resources and educational opportunities focused on the complete integration of physical, mental, and spiritual well-being

The EAP is a voluntary, confidential service that that provides professional counseling and referral services designed to help you with personal, job or family related problems. Your EAP can help you and your dependent family members identify, resolve and gain control over personal problems that may be interfering with work and daily life. It is available to all benefit eligible Evara Health employees.

What problems can the EAP help with?

Through short-term counseling, the EAP can help you understand what options are available for virtually any issue or problem that may arise. Some of the common concerns include:

- Emotional well-being
- Family and relationships
- Legal and financial
- Healthy lifestyles
- Work and life transitions

POLICY

All Family Medicine Residents who are full-time employees of Evara Health and their eligible dependents have access to the EAP and Employee Wellness Program.

PROCEDURE

Unlimited telephone access to EAP professionals 24 hours a day, seven days a week at no charge to employees. If a referral to an outside provider is needed, your counselor will recommend carefully selected resources. You have three (3) face to face visits (per household per calendar year), one of which can be used for legal counsel. Your health insurance and other financial factors will be considered to help ensure that needed services are affordable.

Legal assistance and financial services

- Online will preparation
- Legal library & online forms
- Telephonic financial consultation

Resources for:

- Financial tools & resources
- Substance abuse and other addictions

- Dependent and elder care assistance & referral services

Access to a library of educational articles, handouts and resources via *mutualofomaha.com/eap*

Any request for assistance and any information that may be shared is between you and your counselor. All EAP records are kept strictly confidential. The EAP does not communicate with your employer about your situation unless there is a risk of harm to you or others.

Contact a counselor by dialing 800.316.2796

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CORE CURRICULUM AND THE CORE COMPETENCIES POLICY

PURPOSE

This policy addresses Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements IV.B. ACGME Core Competencies

BACKGROUND

ACGME requires every residency program to provide an educational program curriculum that contains competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form. The competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the competencies are articulated through the Milestones for each specialty.

POLICY

The curriculum is designed to meet the required core competencies as defined by the ACGME whereby each resident must be trained and evaluated under the 6 core competencies. The core curriculum serves as the foundational guidelines for each training program in the formulation of specific curriculum objectives relevant to the nature of its specialty. All residents will acquire learning experiences in the core curriculum during their training as specified by the Program Director. The curriculum assures the teaching and assessment of these competencies. Core competency-related teaching and assessment that is specific to individual rotations will be identified in the "Objectives" section of the curriculum for each rotation.

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

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

C. Medical Knowledge: Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

D. Practice-based Learning and Improvement: Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

E. Interpersonal and Communication Skills: Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

F. Systems-based Practice: Residents must demonstrate an awareness of and responsibilities to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

ELECTRONIC OR WRITTEN INFORMATION PROVIDED TO APPLICANTS POLICY

PURPOSE

This policy addresses Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements IV.B.3:

> An applicant invited to interview for a resident/fellow position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointments.

BACKGROUND

The NRMP requires that applicants for residency positions through the NRMP who are invited to interview must be given complete and accurate information regarding the policies and procedures governing their training programs.

POLICY

Any applicant invited to interview for a resident position will be informed, in writing or by electronic means, of the terms, conditions and benefits of appointment to the ACGME- accredited program, either in effect at the time of the interview or that will be in effect at the time of his/her eventual appointment.

Information that is provided must include:

a. financial support

b. vacations, parental, sick and other leaves of absence

c. professional liability

d. hospitalization, health, disability and other insurance accessible to residents/fellows and their eligible dependents.

PROCEDURE

It is the responsibility of the program director and DIO to ensure that all required information is updated and approved by the GMEC prior to the beginning of the interview season. The Office of GME will ensure that each applicant invited to interview will be supplied with all necessary information as required by the ACGME Institutional, Common, and Program requirements.

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HEALTH AND DISABILITY INSURANCE POLICY

PURPOSE

This policy addresses Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements IV.G. Health and Disability Insurance:

IV.G.1. The Sponsoring Institution must provide health insurance benefits for residents/fellows and their eligible dependents beginning on the first day of insurance eligibility. (Core)

IV.G.1.a) If the first day of health insurance eligibility is not the first day that residents/fellows are required to report, then the residents/fellows must be given advanced access to information regarding interim coverage so that they can purchase coverage if desired.(Core)

IV.G.2. The Sponsoring Institution must provide disability insurance benefits for residents/fellows beginning on the first day of disability insurance eligibility. (Core)

IV.G.2.a) If the first day of disability insurance eligibility is not the first day that residents/fellows are required to report, then the residents I fellows must be given advanced access to information regarding interim coverage so that they can purchase coverage if desired. (Core)

BACKGROUND

As per the ACGME institutional requirements, Evara Health must provide health and disability insurance benefits for residents/fellows and their eligible dependents beginning on the first day of insurance eligibility.

POLICY

As Benefit-Eligible Employees with Evara Health, GME trainees will have access to all health and disability insurance benefits afforded Evara Health employees.

For health and disability insurance information:

- Evara Health Human Resources – found at: Evara Health Benefits at a Glance
- Evara Health Human Resources – Life Insurance and Disability Benefits - found at: Evara Health Benefits at a Glance
- Evara Health Human Resources – Employee Wellness - found at: Employee Wellness

Evara's eligibility is the 1st of the month after 60 days of employment. Since the first day of health insurance eligibility is not the first day that trainees are required to report, the trainees will be given advanced access to information regarding interim coverage so that they can purchase coverage if desired.

PROCEDURE

The Program Director, Program Coordinator and Human Resources will ensure that current health and disability insurance information is communicated with all trainees upon initial hiring and annually thereafter at each Evara Health Open Enrollment Period.

IMMUNIZATION AND OCCUPATIONAL HAZARDS POLICY

PURPOSE

This policy addresses Evara Health's immunization policy requiring interns and residents to show evidence of vaccinations for protection from contagious diseases by the deadlines set by the Office of Graduate Medical Education. It also addresses Evara Health's Occupational Hazard/Post Exposure Policy to delineate individual responsibilities in the event of a significant exposure to blood and/or body fluids to an Evara employee or non-Evara employee.

BACKGROUND

Residents may be exposed to infectious agents in the course of their patient care and medical education through contact, inhalation, or percutaneous routes. Likewise, residents may expose patients to infectious agents during the course of patient care.

POLICY

Prior to the start of training, all residents are required to undergo physician examination and tuberculosis screening. Employee health appointments will be scheduled for you during your document processing, instructions will be provided by the Program Coordinator.

Tuberculosis

Initial screening for TB:

A. Complete TB screening form
    a. If positive for sign/symptoms of TB, employee will be sent to Contracted Referral Agency with Authorization letter form Human Resources to be evaluated and assessed for treatment which includes a baseline Chest X-ray if not previously documented.
    b. If screen is negative TB screening with the two step PPD will be performed.
        i. The first test will be during resident orientation and read 48-72 hours
        ii. If resident has a documented negative skin test in the previous 12 months this will be considered the baseline test.
        iii. The second test is to be performed in 1 month later and read in 48-72 hours.

Annual screening for TB:

A. All employees will have an annual Symptom Assessment for TB.
    a. If positive responses as indicated on form employee will be referred for further evaluation.
    b. All employees with a negative history of Positive PPD will also have an annual PPD placed (one step test).
    c. Employee with a history of a positive PPD or previous treatment for latent TB will have the Annual Symptom Assessment for TB completed. Further TB skin testing is not necessary. Repeat Chest x-rays are not necessary unless employee has signs and symptoms of active TB disease as indicated on the Symptom Assessment form

Evara Health Post-Exposure Policy and Procedure is available at:

- Evara Health (sharepoint.com)> Documents> Evara Health policies> Personnel- Employee Health- Tuberculosis

Hepatitis B

Residents will provide proof of immunization or titer. If none of these are available resident will be tested for antibodies against Hepatitis.

A. If you have not already been vaccinated against Hepatitis B, you should begin the three-dose series of injections as soon as possible. If you refuse vaccination, you are required to sign a declination form with employee health.

Measles, Mumps, Rubella (MMR)

Residents will provide proof of immunization or titer. If none of these are available resident will be tested for antibodies to MMR.

A. If you have not already been vaccinated against MMR, you should begin the two-dose series of injections as soon as possible. If you refuse vaccination, you are required to sign a declination form with employee health.

B. In the event of an outbreak declared by the Health Department, non-immune staff will be removed from work

Varicella

Residents will provide proof of immunization or titer. If none of these are available resident will be tested for antibodies to Varicella.

A. If you have not already been vaccinated against Varicella, you should begin the two-dose series of injections as soon as possible. If you refuse vaccination, you are required to sign a declination form with employee health.

Evara Immunization Policy and Procedure is available at:

- Evara Health (sharepoint.com)> Documents> Evara Health policies> Personnel- Employee Health- Immunization Program

Respirators/Masks

Residents will be fit-tested for N-95 respirators (or others as determined appropriate by Employee Health) and wear respirator for all patients with verified or suspected pulmonary TB, H1N1, SARS, COVID-19, Monkeypox or other disease as required.

Needle Stick

It is the policy of Evara Health to monitor all blood and/or body fluid exposures for proper medical treatment and follow-up, to take appropriate corrective actions to prevent recurrences, and to maintain documentation for compliance with Federal, State and local laws.

Evara Health Post-Exposure Policy and Procedure is available at:

- Evara Health (sharepoint.com)> Documents> Evara Health policies> Environment of Care- Infection Control

Exposure to Contagious Diseases

An occupational exposure is considered an urgent medical concern which requires immediate attention for proper medical management. Residents exposed to, or diagnosed with any of the following diseases, must immediately advise their Program director or their designee:

- Chicken Pox/Herpes Zoster
- Conjunctivitis
- COVID-19
- Ebola
- Hepatitis (all types)
- Lice

- Measles
- Mumps
- Pertussis
- Rubella
- Salmonella
- Scabies
- Shigella
- Tuberculosis
- Monkeypox

Upon assessment of the exposure, the Program director in collaboration with Employee Health (and other medical professionals as appropriate) will advise the resident as to management of the exposure. It is the responsibility of the Program director to:

1. Determine which resident(s) and/or personnel sustained a significant exposure.
2. Notify the Employee Clinic of the resident(s) and/or personnel who sustained significant exposure immediately.
3. Instruct the resident and/or personnel to complete Employee Incident Report and call/report the incident to the Employee Clinic for evaluation and management.

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NON-COMPETITION POLICY

PURPOSE

This policy addresses Accreditation Council for Graduate Medical Education (ACGME) *Institutional Requirements IV.M. Non-competition:*

> *The Sponsoring Institution must maintain a policy which states that neither the Sponsoring Institution nor any of its ACGME-accredited programs will require a resident/fellow to sign a non-competition guarantee or restrictive covenant. (Core)*

BACKGROUND

The ACGME prohibits any sponsoring institution from requiring residents or fellows to sign a non-competition clause or restrictive covenant as part of their employment contract.

POLICY

Neither NSU, as the Sponsoring Institution, nor its Evara Health ACGME-accredited programs, will require a resident trainee to sign a restrictive covenant or non-competition guarantee as part of his or her resident contract.

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FINANCIAL & RESOURCE SUPPORT OF RESIDENTS POLICY

PURPOSE

This policy addresses Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirement II.D. Resident Salary and Benefits:

> The Sponsoring Institution, in collaboration with each of its ACGME-accredited programs and participating sites, must provide all residents/fellows with financial support and benefits to ensure that they are able to fulfill the responsibilities of their ACGME- accredited program(s).

POLICY

NSU-KPCOM Evara Health Family Medicine Residency Program is committed to offering a competitive salary and benefits package to residents/fellows in keeping with the ACGME-accreditation requirements and the Evara Health Office of Human Resources.

Payment to residents shall be in accordance with Evara Health's regular payroll and expense reimbursement protocols.

1. Resident Salary and Chief Resident Stipend: See 2023-2024 Salary and Benefits.
2. Leave of Absence, Sick Leave, and Vacation (Paid Time Off – PTO):
    a. See the Vacation, Holiday and Leaves of Absence Policy in the EVARA HEALTH-NSU KPCOM FAMILY MEDICINE RESIDENCY ADMINISTRATIVE POLICY MANUAL.
3. Malpractice
    a. See the Professional Liability Insurance Policy in the EVARA HEALTH-NSU KPCOM FAMILY MEDICINE RESIDENCY ADMINISTRATIVE POLICY MANUAL.
4. Employee Benefits
    a. Resident shall be eligible for Health, Dental, Vision, Group term life, Long-term and Short-term disability insurance, consistent with such benefits offered to Evara Health employees in the resident job category.
5. On-Call Rooms
    a. Resident will be entitled to utilize designated on-call rooms when on-call.
6. Meals
    a. Residents will have access to the cafeteria while on duty at the hospital.
7. White Coats
    a. Two (2) Lab coats will be provided during the PGY-1 year.
8. Continuing Medical Education
    a. See the Conference Policy in the EVARA HEALTH-NSU KPCOM FAMILY MEDICINE RESIDENCY ADMINISTRATIVE POLICY MANUAL.
9. Workspace
    a. Residents will be given workspace in the FMC to complete their residency duties

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HARASSMENT POLICY

PURPOSE

This policy addresses Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements IV.I.3. Harassment:

> The Sponsoring Institution must have a policy, not necessarily GME-specific, covering sexual and other forms of harassment, which allows residents/fellows access to processes to raise and resolve complaints in a safe and non-punitive environment consistent with applicable laws and regulations. (Core)

BACKGROUND

NSU KPCOM Evara Health Family Residency Program's position is that discriminatory behavior or harassment is a form of misconduct that undermines the integrity of the employment relationship. None of the listed forms of harassment will be tolerated.

Specifically, regarding sexual harassment, no employee, either male or female, should be subject to unsolicited and unwelcome sexual overtures or conduct, either verbal or physical. Sexual harassment does not refer to occasional compliments of a socially acceptable nature. It refers to behavior that is not welcome, that is personally offensive, and that debilitates morale, and therefore, interferes with work effectiveness. Such behavior will result in discipline action up to and including termination.

POLICY

The NSU KPCOM Evara Health Family Medicine Residency Program adopted the following policy, which is that all employees have the right to work in an environment free from racial, religious, national origin, gender, sexual harassment, sexual orientation, age, disability and pregnancy discrimination. The policy establishes guidelines that are consistent with Federal, state and local laws.

For policy statements:

a. Evara Health's Policy: Personnel: Employee Relations: Harassment - found at: Sharepoint
   - https://hcn.sharepoint.com/:b:/r/sites/CHCP/Administration/Shared%20Documents/Evara%20Health%20Policies/Personnel%20-%20Employee%20Relations/Harassment%20%20-%20June%202021.pdf?csf=1&web=1&e=CbeKaQ

b. Evara Health's Policy: Personnel: Quality Recruitment and Selection: Equal Opportunity - found at: Sharepoint
   - https://hcn.sharepoint.com/:b:/r/sites/CHCP/Administration/Shared%20Documents/Evara%20Health%20Policies/Personnel%20-%20Quality%20Recruitment/Equal%20Employment%20Opportunity%20-%20June%202021.pdf?csf=1&web=1&e=Qh2xyB

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GLOSSARY OF TERMS

ABFM- American Board of Family Medicine

ACGME- Accreditation Council for Graduate Medical Education

AOBFM- American Osteopathic Board of Family Medicine

CCC- Clinical Competency Committee

DIO- Designated Institutional Official

ERAS- Electronic Residency Application Service

FMC- Family Medicine Center

GMEC- Graduate Medical Education Committee

LOA- Leave of Absence

NRMP- National Residency Matching Program

PEC- Program Evaluation Committee

NSU-KPCOM/EVARA HEALTH

FAMILY MEDICINE RESIDENCY HANDBOOK

2023-2024

Carlos R. Rodriguez, MD- Program Director
Aubrey Zakshevsky, MBA- Program Coordinator

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NSU-KPCOM-EVARA HEALTH FAMILY MEDICINE RESIDENCY MANUAL

INTRODUCTION

Welcome to your Residency. The NOVA KPCOM-Evara Health Family Residency Program is a program dedicated to the training of outstanding Family Physicians who will deliver high quality, compassionate care to our community. The residency is base in a Federally Qualified Health Center (FQHC) and is part of a national initiative to expand medical education and help close identified health care gaps in our society.

The Residency offers education through a diversity of excellent training sites that will encompass the entire spectrum of Family Medicine. What you learn from your Residency is largely up to you. Your learning resources are the other Residents, the nursing and support staff, the advanced practice providers, the attending faculty, electronic medical education resources, the families, and patients themselves as you observe their diagnosis, management, and outcome. How well you take advantage of these resources will mark your future success as a Family Medicine physician.

It is extremely important to develop a highly organized method of information handling for your own use. The importance of documentation of your own activities as a Resident physician cannot be overemphasized and will be audited on a regular basis.

You will learn details of the Residency, schedules, locations, and requirements as you progress through the various sections of this manual. Some of the items included in this manual may be covered in detail in other Residency documents available through the Family Medicine Residency office. This manual is meant to include essential summaries of information you will refer to frequently. Again, welcome to your NSU-KPCOM Family Medicine Residency at Evara Health, may your years here exceed your expectations.

Residency Program Director:	Carlos R. Rodriguez, MD, FAAFP cbrrodriguez@hcnetwork.org (727) 824-8181 ext. 5226 (office) (727) 517-6169 (cell)
Residency Associate Program Director:	Sarah Kelley, MD skelley@hcnetwork.org
Residency Program Coordinator:	Aubrey Zakshevsky, MBA AZakshevsky@HCNetwork.org (727) 824-8181 Ext. 5242 (office) (813) 495-7672 (cell)
Designated Institutional Official:	Leslie Ross, EdD lesross@nova.edu (813) 574-5253 (office)

FAMILY MEDICINE RESIDENCY'S MISSION STATEMENT

The NSU-KPCOM Family Medicine Residency at Evara Health is dedicated to the training, education and development of caring, mature, professionally competent and board eligible Family Medicine physicians, while delivering the highest quality comprehensive, evidence-based, compassionate patient-centered care to the community, and remaining sensitive to the community's health care problems and resources. Our mission is to innovate beyond the barriers that limit access to quality healthcare, ensuring everyone can receive industry-leading services from professional teams that care as much as family.

12/15/21

FAMILY MEDICINE RESIDENCY VALUES

Excellence in all we do. Regardless of circumstances putting patient care above self-interests.
Collegial and participative educational environment.
Respecting all people through interactions characterized by honesty, cooperation, and reliability.
Patient care that is comprehensive, continuous, and available.

FAMILY MEDICINE RESIDENCY PROGRAM AIMS

1. Provide a comprehensive three-year curriculum to produce competent, independent Family Medicine board eligible physicians with a strong emphasis on primary care clinical practice.
2. Train physicians who are sensitive to the communities and patients' needs.
3. Train physicians with expertise in the roles and responsibilities of Federally Qualified Health Centers in their communities and the treatment and care of the medically underserved.
4. Educate residents to be excellent practitioners in a Patient Centered Medical Home.
5. Educate residents to be able to meet nationally recognized clinical and quality standards in their practice.
6. Ensure that our graduates will have the knowledge and training to become local and national leaders in the areas of advocacy, public health, and academic medicine.

FAMILY MEDICINE RESIDENCY PRINCIPLES OF EDUCATION AND PRACTICE

1. We use an organized and written curriculum.
2. We teach and deliver patient care based upon the best scientific evidence available.
3. We realize the best care is practiced as an art and a science.
4. We use educational methods that assess needs, states expectations, demonstrates the skill, allows practice and then constructive feedback.
5. We allow learners autonomy to use different approaches to problems but expect a rational defense of these methods.
6. We give clear expectations for our Residents and demonstrate these by role modeling.
7. We realize Residents have different learning styles and needs and try to adjust our teaching styles accordingly.
8. We stress the mastery of basic clinical skills.
9. We continuously evaluate our future, threats and opportunities, and plan prospectively for it.
10. Whenever possible, we objectively measure the achievement of our Resident's learning goals.
11. We use the Family Health Center to demonstrate a model Family Medicine office.
12. We are financially responsible.
13. We remain available to our alumni for support and continuing education.
14. We promote the professional and personal development of our Residents and ourselves.
15. We continually search for innovative ways to improve and develop our Residency Program and work together to refine and implement these improvements.

FAMILY MEDICINE RESIDENCY DIVERSITY STATEMENT

The residency program at Evara Health recruits trainees from diverse backgrounds and perspectives and trains them to make a positive impact on healthcare while offering culturally competent compassionate care. We strive to develop leaders who provide this culturally sensitive care to an inclusive patient population and who will develop innovative approaches to widen the pipeline for quality healthcare and promote the advancement of health equity.

GENERAL RESPONSIBILITIES OF ALL FAMILY MEDICINE RESIDENTS

RESPONSIBILITIES TO FAMILY HEALTH CENTER PATIENTS:

1. Resident will be assigned, on average, to Family Health Center four half days per week or as necessary to reach educational objectives.

2. Resident will be assigned to one of our centers for their continuity clinic.

3. Resident will serve as primary care physician for a panel of patients.

4. All Family Health Center patients will follow the same admitting procedures.

Revised 5/22 CR

ACGME CORE COMPETENCIES

Patient Care and Procedural skills that are compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Medical Knowledge about established and evolving biomedical, clinical, epidemiological and social behavioral sciences and the application of this knowledge to patient care.

Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals.

Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Puts patient care above self-interests.

Systems-Based Practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Revised: 5/22 CR

GENERAL INFORMATION

AVAILABILITY

Patient care is a 24-hour a day responsibility. The FHC building is open a fixed amount of time, however, the responsibility for care of our patients does not end at the end of a shift or office hours and requires that we remain available. Although we take care to provide time away from the rigors of this responsibility, patient care comes before other activities. You **must** complete your work, check out and be properly relieved before leaving. Be prepared when "in office" or "on-call" to assist others who may not be available. Be professional!

CELL PHONES

Your cell phone will be a method of receiving calls and you will receive a bi-weekly cell phone stipend for its use. Availability is part of being a physician and thus extremely important. Prompt return of calls is a must. Phones should be left on at all times in case you need to be reached during an emergency. This is even with proper relief of duties and checkout each weekday (this is to allow any last-minute questions and to allow for early and late call backs). You are not required to answer calls when on vacation or off-duty.

MAIL and E-MAIL

Mail is sent to the Family Health Center where mailboxes are maintained for each resident. Residents are also given a corporate Email address through Information Systems at Evara Health and are expected to maintain email addresses assigned by Evara Health; and checked regularly. All communications to the Residents are placed in this box or via corporate Email and **it is essential that you check daily for important information**. All memos placed in your mailboxes or sent via corporate Email are considered to be read by you, whether you read them or not. Some information will be sent to you through the MedHub Residency Management Suite and it is important that you check that site daily for additional information. As with Email and mailboxes, information in MedHub is considered read by you, whether you read it or not.

MEALS

Breakfast and lunch are provided in the doctor's dining room of Morton Plant Hospital, Bayfront Health Saint Petersburg, while on rotations there, Monday through Friday. Otherwise, Residents may purchase meals in the hospital cafeteria for periods when the Resident is required to be in the hospital for calls/shifts. No meals are provided at the Bay Pines VA Hospital, but you can purchase meals in the cafeteria.

NOTIFICATION OF PENDING LEGAL, LAW ENFORCEMENT, OR REGULATORY ACTION

Such information must be referred immediately to the Residency Program Director, the Evara Health Risk Management Office and to NSU's Risk Management Office. You should contact Crystal Wells, Director Risk Management Evara at crbanks@hcnetwork.org 727-337-0644 and email Elizabeth Guimaraes , Director of Risk Management NSU at guimarae@nova.edu to report such instances.

ORGANIZATIONS AND PROFESSIONAL MEMBERSHIPS

Each Family Medicine Resident is expected to belong to the AAFP or ACOFP with membership dues paid by the program. The Resident is invited to become an "in-training" member of the Pinellas County Medical Society or the Pinellas County Osteopathic Medical Society. Residents elected to represent the program at certain specified organizations or meetings will have related expenses paid, ***on approval up to $500.00***, to these meetings and without reduction of their conference time.

PARKING

Parking is available at the grounds of the Family Health Center and other Evara Health offices. Parking information for all participating sites is provided to you in your rotation manuals.

REQUEST FOR INFORMATION BY THE PUBLIC MEDIA

Request for information by the public media should always be referred to the Public Relations office at Evara and NSU. They may be contacted by emailing Byron Tucker, Marketing Director Evara at btucker@hcnetwork.org or 727-316-2616 and communications@nova.edu or by calling Joe Donzelli, Associate Director of Media Relations at 954-262-2159. You

are not to speak directly to public media personnel even off the record, unless requested by our media department. Please let the Program Director know when you are involved with our media department.

A FINAL NOTE

Residencies are dynamic organizations. The faculty, nurses, and residents are constantly striving to improve your experience. This manual is updated yearly, to summarize these changes, but the program and policies continue to evolve. With your help it will be a better program because of your efforts.

RESIDENCY ORGANIZATION

EXAMINATIONS

Sometime in October all Residents are required to take the "In-Training Assessment" Examination. This examination is prepared by the American Board of Family Medicine (ABFM) and serves as a baseline for the Resident's current knowledge of family medicine. This examination can be completed online.

All resident will sign up and take the ABFM or AOBFM Certification Examination in April of their PGY-3 year.

EVALUATIONS

Resident will meet quarterly with their assigned Faculty Advisor to go over evaluations, progress and to identify any areas of concern and improvement. . Residents are formally evaluated twice a year to review their progress by the Clinical Competency Committee (CCC). Residents are evaluated by their faculty preceptors at the end of each rotation as well as others involved in their work and training, including staff, peers, and patients. All of these evaluations are considered by the CCC during their semiannual review of resident progress.

GRADUATE MEDICAL EDUCATION COMMITTEE

The organization's staff committee responsible for supervision of the Family Medicine Residency is the Graduate Medical Education Committee made up of the DIO, Program Directors, Patient Safety Officers, and Peer-Selected Residents from the sponsored residencies, plus appointed and elected members from the medical staff. This committee is charged with the responsibility of approval of all general policies of the residency, monitoring and approval of faculty members, approving evaluation of residents for graduation, and consideration of disciplinary problems referred to it. You will select resident representatives annually to represent you on this committee. This committee meets every month.

RESEARCH AND WRITING

Each Resident is required to take part in a Research project, either individually or as a member of a group, during his Residency. Presentation at a local conference, national conference, AAFP or ACOFP annual conferences is encouraged.

RESIDENT FORUM AND RESIDENT COUNCIL

The Resident Administrative Committee (RAC) is composed of all residents and Residents and is run by the current chief residents. This meeting is the primary place for the residents to voice concerns and make suggestions. It meets at least once each month and generates minutes to be presented to faculty at the monthly faculty meeting by the chief residents.

Nova Southeastern University, and the KPCOM Office of Graduate Medical Education, is committed to a ensuring that Residents and Fellows are afforded a confidential forum whereby concerns and issues can be raised and discussed without the presence of the DIO and respective Program Directors present.

In order to assure these requirements are met, the Office of Graduate Medical Education has established a Resident Forum at the program level and a Resident Council at the institution level to allow residents within a program and from all NSU KPCOM GME programs to gather and address issues in a confidential manner. These meetings will happen approximately ten times per year, prior to each GMEC meeting, and may be held face-to-face or electronically.

The structure for these two groups is as follows:

Resident Forum

The Resident Forum is comprised of all residents within a program. Every effort will be made to schedule meetings at a time that has the least impact on patient care and other training responsibilities. The GMEC fully supports the resident forum and encourages all program directors to provide protected time for residents to attend these meetings.

A. At the start of each academic year, the Resident Forum will elect two peer-selected residents who will represent the Resident Forum in the Resident Council. These residents will serve as the President and Vice-President/Secretary of the Resident Forum and will call and preside over all Resident Forum meetings for their program. The Resident Forum will determine if issues raised are best addressed at the

program or institution level. Issues determined to be addressed at the institution level are brought to the Resident Council by the two peer-selected residents.

B. Prior to each meeting, the President or Vice-President/Secretary, or their designee, will call for agenda items.

C. The Vice-President/Secretary, in the absence of the President, shall preside over the meeting.

D. The Vice-President/Secretary shall record the minutes.

Resident Council

The Resident Council is comprised of all peer-selected residents from all KPCOM sponsored programs. Every effort will be made to schedule meetings at a time that has the least impact on patient care and other training responsibilities. The GMEC fully supports the resident forum and encourages all program directors to provide protected time for residents to attend these meetings.

A. At the start of each academic year, the Resident Council will identify a President, Vice-President/Secretary, and two peer-selected residents who will sit on the GMEC. These peer-selected residents may be the President, Vice-President/Secretary. The peer-selected residents in the Resident Council are voting members of the GMEC and provide an oral report of the most recent meetings of the Council and any areas of concern or requests upon which the GMEC would vote or provide further information or guidance.

B. Prior to each meeting, the President or Vice-President, or their designee, will call for agenda items.

C. The Vice-President, in the absence of the President, shall preside over the meeting.

D. The Vice-President/Secretary shall record the minutes.

E. The KPCOM GME Office provides support in scheduling Resident Council meetings and assisting with communication as requested by the President. The President and Vice-President/Secretary of the Resident Council are responsible for meeting communication, the meeting agenda, and maintenance of the minutes.

Resident's Participation on Institutional Committees

Residents must have appropriate representation on institutional committees and councils whose actions affect their education and/or patient care. Residents must be aware of, and participate as appropriate, in institutional programs and medical staff activities. They must be knowledgeable about and adhere to established practices, procedures, and policies of each institution participating in the educational experiences and activities of their training program.

During their course of training, each resident should have the opportunity to participate on committees including, but not limited to, the following:

1. Graduate Medical Education Committee (GMEC)
    a. The GMEC must include a minimum of two peer-selected residents/fellows from among its ACGME-accredited programs. Each meeting of the GMEC must include attendance by at least one resident/fellow member.

2. Graduate Medical Education Sub-Committee
    a. Any GME sub-committees that are created in order to carry out portions of the GMEC's responsibilities must include a peer-selected resident/fellow. Sub-committee actions that address required GMEC responsibilities must be reviewed and approved by the GMEC.

3. Program Evaluation Committee
    a. One resident per training year will be appointed to this committee by his/her peers. The committee members will participate actively in 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; and, reviewing the program annually using evaluations of faculty, residents, and others.

THE FAMILY HEALTH CENTER

The Family Health Center is the heart of a family medicine residency. Most family physicians spend a significant portion of their lives in an outpatient office. Residents and faculty spend many hours in our Family Medicine Center. In addition to the physicians, many nurses and support staff work in the Family Medicine Center. There are approximately 150,000 patient visits at Evara Health per year. This volume of activity requires an organized approach to maximize efficiency. There also needs to be fair and consistent mechanisms to maintain patient satisfaction and physician and staff moral.

COMMUNICATION

The Resident is expected to return calls from patients with a minimum of delay, and to document instructions. All calls received from patients shall be documented in the EHR. All outside phone calls occurring after hours will be received and/or triaged by the resident on call. When an FHC patient calls the resident on-call at night, the resident may call the patient's own physician for suggestions but should not refer the patient to the Resident at home.

COMPUTERIZED INFORMATION

Each Resident is supplied with a company laptop. These computers allow the Resident to accept and send Email, document experiences and procedures, access interactive learning and FP Notebook, MedHub, MedLine and Up-To-Date, prepare talks, share data, and many other functions. Please read and abide by the confidentiality rules and regulations.

CLINIC

The resident spends on average four half days per week in outpatient clinic throughout his/her residency.

Interns in Family Medicine:

During the first few weeks, Interns will be scheduled in the FHC with faculty or senior residents. They will see the faculty or resident patients, present and discuss care plans. This way Interns will have one on one teaching and observation by faculty or senior residents and the opportunity to learn about clinic mechanics, coding, scheduling, electronic health records, etc.

Then Interns will begin seeing their own patients. Patients will be scheduled for forty-five minutes appointments during the first 6 months of the PGY-1 year of residency. Following the first 6 months, patients may be scheduled in thirty minute appointments at the faculty's and director's discretion.

It is important to note that during the first six months of residency all patients seen at the Family Medicine Center by the Interns will be precepted and seen by the supervising faculty member (Direct supervision). After the first six months all patients seen are precepted and discussed, but the supervising faculty only has to personally see those with a level four or higher billing code.

Second- and Third-Year Residents in Family Medicine:

Second year residents will be scheduled for thirty minutes patient appointments. Third year residents will be scheduled for thirty-minute visits for new patients and for fifteen-minute visits for established patients.

All patients seen are precepted and discussed with supervising faculty. The supervising faculty has to personally see only those with a level four or higher billing code.

Referrals:

Once a resident has determined that a referral is required, a faculty's initials should be obtained on the referral form. The properly filled out referral form should be assigned to the appropriate team for follow up.

DISCHARGING PATIENTS FROM THE CLINIC:

Patients may be discharged from the FHC for a number of reasons. This includes noncompliance, not keeping appointments (subset of noncompliance), verbal abuse or physical threat to anyone in the Family Medicine Center. Evara Health discharge policy is located in the SharePoint intranet at Administration - Terminating the Provider Patient Relationship - June 2021.pdf - All Documents (sharepoint.com)

Please refer to this policy to follow the appropriate procedure and file the appropriate forms to be filed with the CMO.

PATIENT COMPLAINTS:

Patient complaints about nurses and staff are to be referred to the appropriate manager.

Patient complaints regarding physicians or medical care are to be referred to the patient's physician. The patient's physician and faculty are to resolve the complaint in a way that is in the best interest of Resident education, the residency, and Evara Health. The faculty member will give written notice (email preferred) to the FHC Medical Director of how the complaint was resolved and file an incident report.

CLINIC HOURS:

Physician hours in the clinic are from 8:00 am to noon for the morning session and 1:00 pm to 5:00 pm for the afternoon session

PRECEPTING:

As discussed above

FACULTY RESPONSIBILITIES:

The primary job of the supervising faculty is to guide the professional development of the Residents in the clinic. The faculty is to resolve complaints about Residents assigned to them. The method for resolution is at the discretion of the faculty. The resolution is to be submitted to the Residency Director in writing, who will forward it to the CMO for tracking purposes.

FACULTY PRECEPTOR:

The faculty preceptor has authority, delegated during their assigned clinic session by the Family Medicine Center Medical Director; to oversee care and scheduling of patient's during that session. The faculty preceptor may also be called upon to resolve urgent patient complaints.

HOSPITAL RELATIONSHIPS

CONSULTATIONS

Requests for Consultations on hospitalized patients should always be discussed with the senior residents and/or faculty on the service, and in every case should be arranged by means of a personal call to the consultant with discussion of the case. Whenever possible, the Resident requesting consultation should be present when the consultant sees the patient.

MEDICAL RECORDS

Good medical records are the hallmark of good medical care. Family Medicine Residents' records should be a model for the medical staff. Admission notes must be done at the time of admission and progress notes written daily, and all consultations, procedures, and facets of care should be completely documented. All progress notes should be in a problem oriented "SOAP" format. History & Physical, Consults, Procedure/Operative Notes, and Discharge Summaries must be in proper format. Discharge summaries are to be completed at the time of discharge. The record will be reviewed and signed by the attending physician. Per Hospital regulations, Staff and resident physicians are placed on a suspension list when completion of their medical records are greater than 45 days delinquent. A family medicine resident on the suspension list is totally unacceptable. A written letter of counseling will accompany the first occurrence. This letter will be placed in your Resident file. The second occurrence will initiate a special review.

MEDICAL STAFF MEETINGS

Residents are expected and encouraged to attend, participate in the general medical staff meetings and the meetings of the Family Medicine Department at Evara Health and Morton Plant Hospital.

PROFESSIONAL CONDUCT

Residents should at no time criticize a member of the medical staff or hospital support staff or any patient casually or to other staff members or non-concerned individuals. Grievances should be made to the residency faculty who shall forward the comments to the appropriate staff committees.

2023-2024 NSU-KPCOM-EVARA HEALTH FAMILY MEDICINE CURRICULUM

CORE CURRICULUM: The curriculum is designed to provide the Resident with a comprehensive exposure to family medicine. The core curriculum and rotations are listed in the Family Medicine Program Goals and Objectives.

OTHER ELECTIVE ROTATIONS: Residents can design individual learning experiences to meet specific areas of concentrated learning or needs. To arrange electives outside of those listed in the core curriculum, the Resident must submit a rotation description. This description should include goals, objectives, mechanics, supervision, and methods of evaluation. Such electives must be approved by the Program Director prior to beginning the rotation.

HOME STUDY/INDEPENDENT STUDY: At times residents need to create an at home independent study elective to meet specific needs (e.g., after a maternity leave). The Residency Program Director must approve these proposals that should include the following components:

1. Goals and objectives.
2. Clinical responsibilities, amount of clinic time and coverage of inpatients and nursing home patients.
3. The equivalent of 4 hours of academic work per day.
4. The supervising faculty and the methods of evaluation.

FAMILY MEDICINE RESIDENCY ROTATION CONTACTS

Rotation	*Contact information*	*Attending*
INPATIENT ADULT MEDICINE	Dr. Srivastava (727) 644-1540 dr.sunitsrivastava@gmail.com	**Sunit Srivastava, MD** **Legacy Hospitalist Group**
NEPHROLOGY	Dr.Dassani (727) 385-0589 nehaldassani@gmail.com	**Nehal Dassani, MD** **Baycare Nephrology Associates**
ORTHOPEDICS	Kathleen (727) 369-5030 Dr. Canizares (727) 560-0205	**George Canizares, MD** **All Florida Orthopedics/FOI**
CARDIOLOGY	Dr. Sanchez (727) 439-5601 robert.sanchez7@hcahealthcare.com	**Robert Sanchez, MD** **Heart Institute**
OUPATIENT PEDIATRICS	Dr. Kelley (918) 398-3737 skelley@hcnetwork.org	**Sarah Kelley, MD** **Evara Health**
OBSTETRICS AND GYNECOLOGY	Dr. Gabriel (678) 358-9365 AJgabriel@hcnetwork.org	**Amy Gabriel, MD** **Evara Health/Bayfront Health**
PAIN MANAGEMENT	Dr. Hanna (727) 422-2546 nopainhanna@yahoo.com	**Ashraf Hanna, MD** **Florida Spine Institute**
GENERAL SURGERY- VA	Dr. Franz michael.franz2@va.gov	**Michael G. Franz, MD** **Bay Pines VA Medical Center**
EMERGENCY MEDICINE- VA	Dr. Leiding daniel.leiding@va.gov	**Daniel Leiding, MD** **Bay Pines VA Medical Center**
PEDIATRIC EMERGENCY MEDICINE	Dr. Odendal lodenda1@jhmi.edu	**Lisa Odendal, MD** **Johns Hopkins All Children's**
RADIOLOGY	Dr. Mangat (727) 512-7801 gmangat@gatewayradiology.com	**Gagandeep Mangat, MD** **Gateway Radiology**
OPHTHALMOLOGY	Dr. Weinstock (727) 244-1958 krista.hailwood@eyespecialist.com	**Robert J. Weinstock, MD** **Eye Institute of West Florida**
FHC CONTINUITY CLINIC	Aubrey Paffenroth (813) 495-7672 apaffenr@nova.edu Dr. Lungren (816) 516-3117 hlungren@hcnetwork.org	**Family Medicine Faculty**
INPATIENT PEDIATRICS	Dr. Alexander Balexa16@jhmi.edu	**Brandon Alexander, DO** **Johns Hopkins All Children's**
ENT	Dr. Barna (727) 460-0934 Osteomeatl@aol.com	**James Barna, MD** **ENT Associates**
GERIATRICS	Dr. Stephens Dsteph14@tampabay.rr.com	**Donna Stephens, MD** **E & S Family Medicine**

Nova Southeastern University Dr. Kiran C. Patel College of Osteopathic Medicine

Evara Health Family Medicine Residency Program

PGY 1

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1, 2 & 3	Site 1, 2 & 3	Site 1, 2 & 3	Site 1 & 4	Site 1 & 4	Site 5	Site 5	Site 5	Site 6	Site 6	Site 7	Site 7
Rotation Name	Gyn	FM Clinic	FM Clinic	FM Clinic	Obstetrics	Outpt Ped/Nurs	Inpt Adult	Inpt Adult	Inpt Adult	ER Adult	Gen Surg	ER Peds	Inpt Peds
Continuity Clinic (1/2 days per week)	2	4	4	4	2	2	1	1	1	1	2	1	1
% Outpatient	100%	100%	100%	100%	60%	60%	10%	10%	10%	100%	20%	100%	0%
% Research	0%	10%	10%	10%	0%	0%	0%	0%	0%	0%	0%	0%	0%

PGY 2

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1	Site 1, 2 & 3	Site 1, 2 & 3	Site 1 & 4	Site 5	Site 5	Site 5	Site 8	Site 9 & 10	Site 11	-	-
Rotation Name	Outpt Peds	Procedures	FM Clinic	FM Clinic	Obstetrics	Inpt Med Adult	Inpt Med Adult	Inpt Med Adult	Cardio	Ophtho/ ENT	Ortho/SM	Elective	Elective
Continuity Clinic (1/2 days per week)	2	2	4	4	3	2	2	2	3	3	2	0-5	0-5
% Outpatient	100%	100%	100%	100%	60%	20%	20%	20%	100%	100%	100%	0-100%	0-100%
% Research	0%	10%	10%	10%	0%	0%	0%	0%	0%	0%	0%	25%	25%

PGY 3

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1	Site 1	Site 1	Site 5	Site 5	Site 5	Site 12	Site 13	-	-	-	-
Rotation Name	Outpt Peds	FM Clinic	FM Clinic	FM Clinic	Inpt Med Adult	Inpt Med Adult	Inpt Med Adult	Nephrology	Geriatrics	Elective	Elective	Elective	Elective
Continuity Clinic (1/2 days per week)	2	6	6	6	2	2	2	3	2	0-5	0-5	0-5	0-5
% Outpatient	100%	100%	100%	100%	20%	20%	20%	100%	100%	0-100%	0-100%	0-100%	0-100%
% Research	0%	10%	10%	10%	0%	0%	0%	0%	0%	25%	25%	25%	25%

Site 1 – Evara Health (formerly Community Health Centers of Pinellas)
Site 2 – Gateway Radiology
Site 3 – Florida Spine Institute
Site 4 –Bayfront Health St. Petersburg Baby Place
Site 5 – Morton Plant Hospital
Site 6 – Bay Pines VA Healthcare System
Site 7 – Johns Hopkins All Children's Hospital
Site 8 – Heart Institute
Site 9– Eye Institute of West Florida
Site 10 – ENT Associates
Site 11– All Florida Orthopedic
Site 12 – Baycare Medical Group Nephrology
Site 13 – E and S Family Medicine Physicians

Available Electives: Cardiology, Nephrology, Endocrinology, Gastroenterology, Infectious Diseases, Critical Care Medicine, Neurology, Hematology/Oncology, Pulmonology, Pediatrics, Obstetrics and Gynecology, Otolaryngology, Dermatology, Orthopedics, General Surgery, Radiology, Urology, Rheumatology, Ophthalmology, Geriatrics, Behavioral Health, Emergency Medicine, Pain Management

Note: For PGY-3 FM residents not meeting patient encounter number requirements for graduation, elective rotations may be substituted for required rotations to satisfy the encounter numbers prior to graduation. 25% Research time is allowed during Elective rotations for residents to complete their scholarly activities (including Quality Improvement Projects). Vacations may not be taken during Inpatient Adult Medicine (except 1-week away period 6 only), Inpatient Pediatrics, Ob/Gyn rotations. Critical care experience is embedded in Inpatient adult medicine rotations.

DEATH CERTIFICATES

Over the years the formal Death Certificate has undergone changes with changes in the rules and regulations of the Medical Examiner and Office of Vital Statistics. Residents will receive a didactic on filling out Death Certificates during their course of their residency.

This memo summarizes some of these rules.

1. A death at home is routinely investigated by police and referred to the Medical Examiner unless the attending physician can certify that death was expected. He/she will sign the certificates.

2. The certificate is prepared by the undertaker who is responsible for all information down to 22a. The certificate "must be signed within 24 hours" but this does not always happen. It is usually brought by the undertaker to be signed but occasionally sent by mail.

3. All signatures and comments must be in black ink.

4. You can sign certificate for another physician but be sure to name the attending physician in 22d.

5. Item 26, Part 1a, is the primary cause of death but it must be explained by the underlying cause listed on Lines b, and c.

6. If accident or injury is mentioned anywhere on the certificate, all Items 32a - 32f must be filled in.

All Death Certificates **MUST** be signed same day requested. If you are asked you must assure this is **DONE**. **NEVER** ask support staff or medical records personnel to find someone else. It is your responsibility.

Revised: CRR – 5/22

FAMILY MEDICINE CENTER PRIVATE INPATIENT CARE

1. All Family Medicine in-patients will be seen at least once daily by the patient's resident physician or inpatient team.

2. All Family Medicine Patients will follow the same admitting procedures. They will be admitted to the senior on the service and faculty of the day. The physicians at Legacy Hospitalist Group at Morton Plant Hospital are the attendings on the in-patient Family Medicine service. The residency coordinator will coordinate with the group the attending staff rotation. Residents will notify the hospital attending personally of each admission -- no matter what time of day. Do not have nurses notify the attending. Do not wait until the next day to notify the attending. All major changes in patient condition transfers to critical care units or deaths are to be made known immediately to the hospital attending.

3. The hospital service team is responsible for initial evaluation and admission of Family Medicine patients.

4. All calls go to the in-house service during the day and to the covering physician on call after PM checkout on weekdays plus weekends and holidays. The on-call covering physician will be responsible for all care delivered to the patient until off call turnover is made.

5. A note is to be written on all patients seen by Family Medicine residents when on call.

6. All patients are to be signed out to the on-call physician daily.

7. All FHC in-patients should be seen daily by the inpatient team in the morning before FM Rounds.

8. Histories and Physicals must be dictated/documented at the time of admission and be on the chart by 24 hours after admission. Past medical history and a review of systems should be completed for all patients. "See old records" is not appropriate for listing past medical history. A complete history and physical with a diagnostic impression(s) with related differential diagnosis is to be present. A brief, but concise written admission note highlighting your plans and reasoning should be placed in the chart at time of admission.

9. Discharge summaries should be dictated/documented at the time of hospital discharge. Delinquent in-patient medical records are unacceptable.

10. Requests for consultant evaluation of an inpatient are to be approved by the attending before the request is made, except in emergency situations.

Revised: 8/23 CR

FLORIDA LICENSE

Under no circumstances will an unlicensed Resident be permitted to practice medicine at Evara Health. It is the responsibility of each Resident to monitor licensure status, and to comply with regulatory procedures to ensure that one's status with the state is uninterrupted. Training licenses will be obtained for all residents starting the program. Please cooperate with the Residency Coordinator during this process in order to expedite your license application.

Evara Health Family Medicine Residents are required to hold a current license to practice medicine issued by the State of Florida. When writing prescriptions, Residents may use either their personal DEA number or the organizations training DEA number followed by an identifying number. A full and unrestricted Florida license is expected by your second year of Residency.

Because it is vitally important to the Residency program that there be no lapse in licensure, it is our policy that the Residency Coordinator will prepare, and/or approve, and submit all applications for Resident licensure. Residents may prepare their own applications, but they must be approved and submitted by the designated Residency Coordinator.

Florida licensure is a **long, tedious** process (**again, do not procrastinate).** A copy of your Florida license once received, and your DEA number is to be maintained in your Resident file in the Family Medicine Residency office.

CME REQUIREMENTS FOR LICENSURE

Once Residents acquire medical licensure, the issue of acquiring required CME becomes relevant. Obviously, these requirements vary across jurisdictions, but in Florida, we are told that anyone with a license is expected to accrue the mandatory CME contact hours. Typically, these are for HIV, domestic abuse, bioterrorism, prescription of controlled substances, and medical errors. See State of Florida Licensure CME requirements at Florida Board of Medicine » Licensing and Registration- Healthcare Practitioner Licensing and Regulation (flboardofmedicine.gov).

Residents are expected to maintain compliance with these requirements. Therefore, Evara Health will provide them as part of the CME program for Residents at no charge. Additionally, Residents may use CME funds allocated to them to acquire the required courses.

As a final caveat, please be advised that it is the physician's responsibility to ensure that the contact hours offered has CME accreditation, and to appropriately sign in and evaluate the program.

You may also contact the **Florida Medical Association (FMA) @ (850) 224-6496 or *www.fmaonline.org*** for a list of providers of CME. Other resources for CME are the **American Medical Association (AMA) @ (312) 464-4952, or Medical Educational Group Learning Systems (MEGLAS) @ (800)547-0308.**

MEDICAL RECORDS

All Residents must comply with requirements in the areas of medical records. Details of these requirements are outlined below. ***Failure to comply with these requirements may result in disciplinary action being taken against the Resident, including suspension of training duties pending satisfactory completion of any given requirement.***

Residents are required to complete medical records (including medical records at affiliates). Staff and Resident physicians are placed on suspension when their records are delinquent greater than 45 days. Among house staff, the first suspension will result in a letter of counseling being placed in the Resident's personal file. The second incident may initiate a special Resident review. Failure to complete medical records may be considered an egregious breach of contractual responsibility and may result in ***suspension without pay.*** (Suspension means you may not be allowed to work as a Resident and cannot admit until the suspension has been lifted).

Medical Records
All records regarding patients seen at Evara Health or its affiliates are the property of Evara Health System. Original medical records shall not leave Evara Health, except in accordance with contractual arrangements with affiliated facilities or, unless under court order, subpoenas, or statute. Information from the medical record shall not be released to persons not otherwise authorized to receive this information without written permission of the patient or of the patient's legally authorized representative.

All medical record entries and documents that are to be completed by house staff must be completed within the guidelines as stated in Evara Health or hospital's Rules and Regulations.

The Guidelines are as follows:

- Admission notes are to be written at the time of admission and dictated/documented history on physical examinations are to be completed within 24 hours of admission by the admitting resident.
- Operative/Procedure Report must be dictated or documented immediately, or no later than 24 hours after surgery or procedure by the performing resident and noting supervising resident or attending.
- Discharge Summary is expected to be completed by discharging physician at time of discharge but must be completed within 7 days of patient discharge.
- All signatures completed within 14 days of patient discharge.
- Verbal orders must be signed within 24 hours by the ordering physician with date and time of signature.
- Written and dictated entries to medical chart must follow format guidelines (see FORMATS).

All entries in the medical record are also to be ***timed, dated, and signed.*** Residents are strongly encouraged to print their names near their signatures. Progress notes are to be in the SOAP format. Errors in documentation should have a single line drawn through the error and it should be initialed and dated. Senior residents will co-sign all medical student notes and must co-sign all student orders before they are submitted for implementation. The record will be reviewed and signed by the attending physician.

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MEDICAL RECORDS IN THE FAMILY HEALTH CENTER

Residents are held to the same standards for Medical Records at the Family Health Center as previously described for Evara Health. The Resident must comply with all requirements.

At the Family Health Center, an electronic medical record is compiled for each patient. All documentation for that patient is placed into the EHR. At each visit by the patient, documentation must be completed. All test results, referrals, authorizations, messages, correspondence, and consultation notes will also become part of this record.

Joint Commission standard IM.6.40 “For patients receiving continuing ambulatory care services, the medical record contains a summary list of all significant diagnoses, procedures, drug allergies, and medications.” will be followed by all Residents.

All requests for any copies of the medical record will be referred to the Medical Record Department. At no time will a Resident copy any part of the record to give to anyone.

WEEKLY DIDACTIC CONFERENCE

Attendance (virtual or in person) at the weekly didactic Family Medicine conference and Hospital Grand Rounds is expected of all Residents. However, residents on Pediatrics rotations may attend conferences prepared by these programs for attendance credit. Residents are required to attend a cumulative attendance average of 80% at conferences and Grand Rounds. Tracking is done by sign-in sheets. ***PLEASE SIGN IN***. Residents attending virtually will be marked as present by the residency coordinator.

Weekly conferences will start at 1:15 sharp. Any Pharmaceutical reps or outside agencies will do their introduction between1:00-1:15.

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PROCEDURES REQUIRED FOR PROMOTION AND GRADUATION

FAMILY MEDICINE RESIDENCY
PROCEDURE DOCUMENTATION REQUIREMENTS FOR PROMOTION AND GRADUATION

The minimums below are required:

Quant.	Procedure
3	Anesthesia Local Application
2	Biopsies (punch, shave)
2	Contraceptive implant insertion/removal
5	Destruction of skin tissue lesion (including warts) using cryosurgery, RF/electrocautery, chemical ablation, or intralesional injection
2	Endometrial biopsy
3	Excisional Biopsy
3	Incision and drainage of abscess
5	Injection/aspiration of joint, bursa, ganglion cyst, tendon sheath, or trigger point (at least 1 knee and 1 subacromial/subdeltoid bursa)
3	intrauterine device insertion and removal (at least 1 removal)
1	Lower extremity splint and/or cast
3	Removal of ingrown nail, or full toenail (includes digital block); nail triming, clipping or debridement; other nail procedures
1	Removal of skin tags
3	Simple laceration repair with sutures
1	Upper extremity splint and/or cast
5	Ultrasound guidance for needle placement (includes paracentesis, thoracentesis, US guided injections, and US guided central line placement)
20	Vaginal Deliveries (some with experience in continuity)

You are required to maintain **BLS, PALS, ACLS, ALSO** and if selected **ATLS**.

Note: The ability to perform a procedure satisfactorily is not sufficient for competence. The physician must clearly demonstrate knowledge of risks and benefits as well as the ability to recognize and manage complications. This includes sound judgment in reference to consultation.

The need for documentation may vary extensively in different locations and types of practice. You should document any procedure that you may wish to perform in your future practice.

Documentation is not only for future privileges but also for program monitoring of educational experience. These are required and updated at each Resident review.

You must keep a record of procedures including the date, the name of the patient, any complications, and the supervising physician. All procedures must be entered into ***MedHub***. This provides documentation of your supervised performance of procedures, important for Residency and hospital accreditation use as well as future documentation of your procedural proficiency. You will be expected to provide an updated procedure documentation listing **prior** to each Resident review session with the faculty. Promotion and graduation are dependent on documentation of adequate experience. Residents will be expected to have performed minimums of the required procedures before being recommended for graduation (See Clinical Policies).

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CLINICAL COMPETENCY COMMITTEE

The program director has primary responsibility for monitoring the competence and professionalism of residents for the purposes of recommending promotion and certification as well as for initial counseling, probation or other remedial or adverse action. The CCC has responsibility for corrective action, remediation and graduation, promotion, and disciplinary actions for residents in the Training Program.

Committee Charge:
The Clinical Competence Committee of the Residency Program is charged with monitoring resident recommendations to the program director. At all times, the procedures and policies of the CCC will comply with those of the residency program and the GMEC.

Responsibilities of the Clinical Competency Committee:

1. Residents will be evaluated using the Core Competencies and specialty-specific milestones. The CCC will review all assessment data (end of rotation faculty evaluations; peer evaluations; procedural simulation; self-assessments; case logs; etc.).

    a) In addition to global assessments, the CCC will review all other evaluation tools used by the program (e.g. OSCE, CEX, in-training exams, medical record audits, multisource, case logs, etc.). The CCC will take data from these evaluations and apply them to the milestones to mark the progress of a resident.

2. Residents will also be accountable for compliance with program and hospital policies, which include but are not limited to:
    a) computer ethics
    b) sexual harassment
    c) conflict of interest
    d) intellectual property
    e) Medicare compliance rules
    f) moonlighting
    g) infection control
    h) drug free workplace
    i) pre-employment drug testing
    j) completion of medical records

3. The CCC will provide a group narrative summary for each resident's progress and will assist in early identification of areas of needed improvement.

4. The CCC will use data from evaluation tools to prepare and assure the reporting of the milestone evaluations of each resident semi-annually to the ACGME system.

    a) Where circumstances warrant, the members of the committee may be required to excuse themselves to avoid a potential conflict of interest or to protect the privacy of a resident.

PROCEDURE

1. Membership:
    a) The CCC for any program must be composed of at least three members of the program faculty. All members of the CCC are appointed by the Program Director.
    b) The Chair of the CCC is appointed by the Program Director.
    c) Members of the Committee must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings.
    d) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the CCC.
    e) CCC membership is reviewed and updated annually at the beginning of each academic year. Advisors should be present during discussions pertaining to their advisee.

f) Program coordinators are not members. However, they may attend and participate in discussions, but do not have a vote.

2. Attendance:
   a) Committee members are expected to attend 75% of all meetings.
   b) The NSU-COM Office of Graduate Medical Education will provide yearly education for all members of the CCC.
   c) Members are expected to attend all regularly scheduled and ad hoc meetings unless their schedule prevents them from doing so. Faculty who will NOT be able to attend, are expected to contact their chair or another committee member to provide input regarding a resident's performance.

3. Structure:
   a) A quorum (>50% of members) must be present in order to conduct official business and allow voting.
   b) Prior to the meeting, members of the Committee may seek opinions and counsel from other program faculty regarding the performance of residents who are listed on the planned agenda. These discussions provide valuable contextual data to the Committee's deliberations.
   c) A faculty member will be asked to review and present each resident. This will be followed by discussion and feedback from others.
   d) All members of the Committee must keep resident, program performance data, and discussion strictly confidential and anonymous. Members of the Committee must not discuss other Committee members' opinions or comments with residents or other faculty members.
   e) In addition to semi-annual performance reviews, at each meeting the Committee will review progress of residents, who are currently on a Corrective Action Plan or remediation and make recommendations to the Program Director regarding continuance or cessation. Residents previously on remediation may be continually discussed to ensure maintenance of performance expectations. All praise and early concern notes received in the period between meetings will be reviewed at each meeting.
   f) The Coordinator will keep detailed minutes of all meetings. The minutes and decisions of the CCC must be kept in the Residency Program office with a copy to the Office of Graduate Medical Education.

4. Types of Performance Reviews
   a) Routine Semi-Annual Reviews
      1. The Program must provide written summary to residents at least semi-annually. The review includes the resident's experience in the milestones, competence in performing clinical procedures, and overall progress in meeting program requirements. A review of the resident's progress in meeting board certification and program requirements must also be performed at this time.
      2. Summary performance reviews may be written by the Program Director or members of the CCC. The resident must acknowledge receipt of the summary performance review in writing.
   b) Promotion Review
      1. Those residents who have achieved competency in the requirements for a specific level of training may be promoted to the next higher level of responsibility.
      2. No resident can remain at the same level of training for more than 24 months (exclusive of leave). A resident with satisfactory performance based on the milestone criteria may advance until the completion of the program/certification requirements. Promotion or graduation decisions require a recommendation by the Program Director and a majority vote by the CCC.
      3. Residents Must Meet the Following Promotion Standards:
         - The resident must exhibit clinical academic performance and competence consistent with the curricular standards and the level of training undergone.
         - The resident must satisfactorily complete all assigned rotations, as supported by evaluation documentation, in each Post Graduate Year (PGY).
         - The resident must demonstrate professionalism, including the possession of a positive attitude and behavior, along with moral and ethical qualities that can be objectively measured in an academic and/or clinical environment.
      4. The Program Director and the CCC must certify that the resident has fulfilled all criteria, to move to the next level in the program.

5. Upon a resident's successful completion of the criteria listed above, the Program Director will certify by placing the semi-annual evaluations and the promotion document into the resident's file indicating that the resident has successfully met the requirements for promotion to the next educational level. If this is a graduating resident, the Program Director should place the Final Summative Assessment in the resident's file.

c) Special Review

1. A resident may be brought up for discussion by the CCC for any of the following reasons:
    - Recommendation by the Program Director for any reason,
    - Consistently low or unsatisfactory evaluation scores,
    - Consistent lack of adherence to program requirements, or
    - A specific incident that requires review by the CCC for possible probation or dismissal.
2. Faculty members who wish to initiate an additional review may request this from the Program Director.

d) Follow-up Reviews

1. At each meeting, the Committee will review progress of residents who are currently on a performance improvement plan, remediation or probation, and decide to lift or continue the probation. Residents previously on probation may be reviewed for clinical and programmatic performance.

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PROGRAM EVALUATION COMMITTEE

The Program Evaluation Committee (PEC) is appointed by the Program Director and functions in compliance with both the common program and specific program requirements as delineated by the ACGME Family Medicine Residency Review Committee (RRC). The goal of the PEC is to oversee curriculum development and program evaluations for the family medicine residency program. The Associate Program Director serves as the chair of the PEC. The PEC is composed of two faculty members, at least one of whom is a core faculty member, and one resident from each of the program's training years chosen by peers in the program. The program coordinator will also participate in the PEC.

The PEC's responsibilities are listed below:

1. Plan, develop, implement, and evaluate educational activities of the residency
2. Review and make recommendations for revision of competency-based curriculum goals and objectives
3. Address areas of noncompliance with ACGME standards
4. Review the program annually using evaluations of faculty and residents
5. Document on behalf of the program, formal, systemic evaluations of the curriculum at least annually and render a written Annual Program Evaluation (APE) which must be submitted to the GMEC annually.
6. Monitor and track each of the following: resident performance, faculty development, graduate performance (including placement and success in future residency training), program quality, and progress in achieving goals set forth in previous year's action plan
7. Review recommendations from the CCC
8. Consider recommendations for changes in evaluation tools
9. Review action plans from prior years to assess compliance and completion of recommendations for improvement

The PEC will be provided with confidential and aggregated resident and faculty evaluation data by the Program Coordinator in order to conduct committee business. The Program Director is ultimately responsible for the work of the PEC. The Program Director will assure that the annual action plan is reviewed by the program's teaching faculty. This approval will be documented in meeting minutes. The program's annual action plan and report on the program's progress on initiatives from the previous year's action plan will be sent to the Office of Graduate Medical Education

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Use of MedHub

In an effort to communicate easily and regularly with faculty and residents, the Family Medicine Residency Program utilizes MedHub, a residency management software program. Residents and faculty must check it regularly.

Information available in MedHub includes, but is not limited to, the following:

1. Schedules
    - Block schedules for each resident's annual clinical assignments
    - Block schedules for each resident's on call duties and backup coverage
    - Block schedules for each resident's supervision
    - In "Conferences," conference review materials may be loaded by presenters

2. Milestones, Goals and Objectives
    - Overall Educational Goals of the Residency Program
    - Competency-based Goals and Objectives for each clinical assignment at each PGY level
    - Family Medicine Milestones including progressive responsibilities for patient care

3. Assessment Forms
    - All Assessment forms for resident evaluation, including Milestones
    - All Assessment forms of faculty
    - All Assessment forms of clinical rotations
    - "Clinical Skills Verifications" and "Clinical Skills Assessments"

4. Required Resident Documentation
    - Clinical and Educational Work Hours
    - Resident Portfolio
        i. Clinical Log of Patients Encounters and of Procedures: Residents must be sure to provide accurate and complete data entry in clinical log, without patient ID data.
        ii. Self-study plan
        iii. Description of own participation in a Quality Improvement project