

# RESIDENT HANDBOOK

## 2020-2021



### PURPOSE

The purpose of the Resident Handbook is to summarize information, policies and responsibilities regarding the Altru Family Medicine Residency. Much of the material is reviewed during Orientation Week and at other times during the residency. This Handbook should allow each resident to review core material whenever necessary. The handbook is also available in electronic form at [altru.org/fmr](http://altru.org/fmr). **Please refer to [altru.org/fmr](http://altru.org/fmr) for complete information in each of the sections highlighted in the handbook.**

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# **General Program Information**

## OUTLINE

***MISSION STATEMENT: Altru Family Medicine Residency trains family medicine physicians to practice full scope comprehensive medicine across the spectrum of health care. This will be achieved with a commitment to provide the skills and background to care for patients in all settings, including the unique challenge of rural medicine.***

### **General Overview**

Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, professionalism, and scholarship.

Graduate medical education transforms medical students into physician scholars who care for the patient, family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

## **PROGRAM GOALS AND OBJECTIVES**

### **Goals:**

To develop family physicians capable of, and dedicated to, meeting the needs of patients in challenging circumstances, with self sufficiency and reliance and commitment to professional growth.

### **Objectives:**

- An optimal learning environment based on strong ambulatory and inpatient experiences.
- Clinical curiosity and self-evaluation skills.
- Attainment of competence in medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.
- Appropriate self confidence by encouraging autonomy commensurate with development.
- Strong role modeling from experienced clinicians combining scholarship and substantial practice.
- A commitment to improve the quality and safety of patient care.
- Emphasis on the responsibility of the physician to maintain personal well-being and support other members of the health care team.
- Practices that focus on mission-driven, ongoing systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows, and faculty members.

### **Rationale:**

Family physicians enjoy a relationship with patient and family that includes trust and obligation. The most effective possess strong interpersonal and communication skills and their care shows responsibility and professionalism. Effective care requires sound medical knowledge and rigorous clinical logic. Further, since contemporary practice involves complex, systems of health care delivery, experience of systems and resource utilization is fundamental. Finally, since knowledge changes constantly, physicians must be adept at reading scientific literature, be able to separate the good from the bad, and be able to integrate those advances that are genuinely beneficial into daily practice.

## EDUCATIONAL GOAL

Our Educational Goal is to develop Family Physicians competent in the six competencies of medical education and the procedures commonly performed by Family Physicians in clinical practice.

The Residency Program believes that Family Medicine represents the entry point into the health care system for approximately 85% of the populace and that family physicians should be able to look after 90% of the problems presented to them by their patients. For the things, which they can't handle, they should serve as the patient's advocate and case manager. The two principle activities associated with primary care are prevention and early intervention and based on his/her knowledge of the patient and his family, the family physician is in an excellent position to prevent or minimize disease by alerting his/her patient to adverse biological, environmental and lifestyle factors. The family physician is also trained to incorporate the principles of wellness, nutrition, immunization, psychological well-being, and patient education in the provision of primary medical care. Additionally, he/she can appreciate that the diagnosis and management of a patient's distress is not limited to organic causes and to consider the stresses and support qualities inherent in the family system. Since family dynamics figure significantly in the health of an individual, the family physician administers patient care and treatment within the context of the family, nuclear or communal.

The Program strives to prepare medical school graduates for careers as family physicians, enabling them to enter practice with the knowledge and skill necessary to provide optimal primary care. It also strives to motivate them to:

1. Deliver high quality primary care
2. Remain board certified and relicensed through continuing medical education
3. Recognize their responsibilities to family, associates and community

The Program also believes that the graduate is ultimately responsible for his/her continuing medical education. Hence, emphasis is placed on developing ongoing self-directed techniques which will enable the graduate to adapt to changing medical practice. Residents are dissuaded from developing protocols but are instead encouraged to leave audit trails which reflect logical cost effective, clinical reasoning.

The most effective learning requires reinforcement provided by the opportunity to practice new found skills with as much clinical responsibility as is compatible with good patient care.

To achieve these goals, the Family Medicine Residency Program has developed as an integrated model, with the community faculty delivering the major portion of clinical teaching and support. Community faculty are selected from respected role models within the community who have demonstrated a sustained interest in medical education.

## TEACHING FACILITIES

### **Family Medicine Residency**

#### General Description

Location: 725 Hamline Street, Grand Forks, North Dakota 58203

Hours: Appointments – 9:00 am – 5:00 pm  
Patient Care – 8:30 am – 12:00 pm and 1:30 pm – 5:00 pm (last appointment made at 4:30 pm, telephone answered 24 hours day)

#### Building Security

Altru Family Medicine Residency must be secure during non-working hours. Should you discover a security problem, please notify UND Police at 777-2591 and Altru Security 780-5000.

Pass cards will be issued. Each resident will receive one pass card. This will open the front and rear doors of the Center. Do not lose your pass card or loan it to another resident as it is registered to you by number.

### **Altru Hospital**

352 beds, more than 25,000 ER visits

Built in 1976

Site for most of in-hospital educational program

Each licensed resident (PGY-2, PGY-3) may apply for staff designation and appropriate privileges

#### Hospital Privileges

PGY-1 is unlicensed and broadly viewed as an Altru employee or student

PGY-2 and PGY-3 may apply for “Staff Appointment” at Altru

### **Altru Rehabilitation Hospital**

In-patient beds

Large out-patient clinics for in depth neurologic, psychiatric and rehabilitation evaluations of children and adults

## BEEPERS

The beepers that you carry belong to Altru Health System. Batteries may be obtained at the Altru Health System front desk or from the residency coordinator at the center.

Loss or destruction of your beeper will cost you the replacement which is \$230.00.

If you feel that your beeper is not working properly, take it to Information Services or the switchboard at Altru Health System for repair or the Program Coordinator in the FMR clinic.

**Must be on 24/7 unless you are on official vacation or post-call in which case your cell phone number may be provided to the OB floor if you choose to be contacted for a continuity OB patient.**

# **General Resident Information**

## ACGME SIX COMPETENCIES

In 1999, the ACGME Outcome Project introduced six domains on which residency programs would be mandated to focus their efforts to improve educational and assessment processes. These competencies are *Patient Care, Medical Knowledge, Professionalism, Systems-based Practice, Practice-based Learning and Improvement and Interpersonal and Communications Skills*. Objective assessments of the six core competencies areas will be mapped to the family medicine specific milestones provided by the ACGME as a progressive assessment of resident performance.

Currently, programs are expected to demonstrate that they are developing educational activities and assessment tools that provide useful and increasingly valid, reliable evidence that their residents are achieving competency-based objectives and that the programs themselves are effective in preparing residents for medical practice.

### Description

#### **Patient Care and Procedural Skills**

Ability to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life. Residents are expected to:

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

#### **Medical Knowledge**

Knowledge of established and evolving biomedical, clinical and social sciences, as well as the application of this knowledge to patient care and the education of others. Residents are expected to:

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

#### **Practice-Based Learning and Improvement**

Ability to use scientific methods and evidence to investigate, evaluate and improve their patient care practices. Residents are expected to:

- Analyze practice experience and perform practice-based improvement activities using a systematic methodology
- Locate, appraise and assimilate evidence from scientific studies related to their patients' health problems

- Obtain and use information about their own population of patients and the larger population from which their patients are drawn
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- Use information technology to manage information, access online medical information and support their own education
- Facilitate the learning of students and other health care professionals
- Identifying strengths, deficiencies, and limits in one's knowledge and expertise, setting learning and improvement goals, systematically analyzing practice using quality improvement methods, implementing changes with the goal of practice improvement, incorporating feedback and formative evaluation into daily practice, assimilating evidence from scientific studies related to their patients' health problems, and using information technology to optimize learning.

### **Interpersonal and Communication Skills**

Demonstration of interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families and other members of health care teams. Residents are expected to:

- Create and sustain a therapeutic and ethically sound relationship with patients
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning and writing skills
- Work effectively with others as a member or leader of a health care team or other professional group educating patients, families, students, residents, and other health professionals.
- Effectively communicate with patients and families to partner with them to assess their care goals, including when appropriate, end-of-life goals.

### **Professionalism**

Residents must demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession and society. Residents are expected to:

- Demonstrate respect, compassion and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society and the profession; and a commitment to excellence and ongoing professional development
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent and business practices
- Demonstrate respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; ability to recognize and develop a plan for one's own personal and professional well-being; and, appropriately disclosing and addressing conflict or duality of interest.

### **Systems-Based Practice**

Demonstration of an understanding of the contexts and systems in which health care is provided, including the social determinants of health, as well as the ability to apply this knowledge to improve and optimize health care.

Residents are expected to:

- Understand how their patient care and other professional practices affect other health care professionals, the health care organization and the larger society, as well as how these elements of the system affect their own practice
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources

- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for quality patient care and assist patients in dealing with system complexities
- Know how to partner with health care managers and health care providers to assess, coordinate and improve health care and know how these activities can affect system performance

## RESIDENT EVALUATION

### Overview

The Altru Family Medicine Residency Program is committed to early, continuing, and progressive evaluation of resident competencies using a framework of developmental steps that relies upon clinical faculty to collect data, supplemented by academic faculty members' own observations, while charging academic faculty with the responsibility of evaluation through the Clinical Competency Committee. The milestone evaluation is explicit and understanding the developmental stages is stressed during residents' orientation and is also available on-line at the residency program's website and at E-value.net.

### Methodology

The program will provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and system-based practice based on the milestones through multiple forms of evaluation. On-line data collection instruments map the evaluations to the milestones to simplify clinical faculty data collection and improve consistency. These completed evaluations are available online to residents. The use will allow each resident to appraise personal strengths and weaknesses together with indicating the path toward remediation or advancement. In addition, assessment will include direct observation of resident patient encounters. At a minimum, six observations for the first year, four in the second year, and three in the third year.

### Process

An early evaluation of all incoming residents is carried out to appropriately assess performance within the six core competency areas. This evaluation involves core faculty, select behavioral science faculty and nursing, together with self-evaluation by the resident. A simulated patient may be used, using a presentation of sufficient complexity to permit recognition of more advanced skills, and using the observation capabilities of the simulation laboratory of the School of Medicine and Health Sciences. Upon successful completion of the orientation process, the resident will progress into the core curriculum of residency training. Evaluations forms assessing the six core competencies as well as skill sets identified on the milestones will be completed by appropriate personnel (i.e. physicians, nursing staff, etc.) at the completion of each scheduled rotation. Separately, the educational experience is evaluated by the resident. Resident will be further evaluated by peers, residency clinic nursing staff, patients, and additional members of the health care team throughout all years of training. Additionally, self-evaluation is encouraged to be continuous process throughout training to foster the development of skills necessary to become a family physician. This form of evaluation requires maturation throughout training and, while felt to be a daily exercise, it will also be formally completed at least twice yearly at required resident evaluation meetings with a core faculty member. All evaluations are maintained within the resident's written file as well as through an online secure database that is accessible always for review. Additionally, all evaluations will be reviewed within the Clinical Competency Committee to document progressive resident performance through the utilization of family medicine specific milestones. Evaluations and milestone assessment will be reviewed with the resident at least twice yearly with a faculty member assisting residents in developing individualized learning plans to capitalize on their strengths, identify areas for growth, and develop plans for residents failing to progress, following institutional policies and procedures. *Residents on remediation will be evaluated every three months.*

A summative evaluation and case log will be completed by the Program Director at the completion of residency.

### **Performance Improvement**

Formative evaluations, sentinel or “near-miss” event, concern from teaching faculty, peers, nursing staff or patients regarding resident’s performance, and/or inadequate performance in general measures (In-training Exam, Boards) will be used to identify a possible resident deficiency in one or more areas of the six core competencies. If a concern is identified, the resident will be referred to the Resident Progress Committee (RPC). If a deficiency is noted in one of the six core competency areas, it will be stated explicitly, and their correction focused. An academic action plan will be initiated and reviewed until appropriate advancement in the core competencies is obtained. A written record of the academic action plan will be completed and signed by the RPC chair and the resident. An initial period of one to three months, at the discretion of the RPC, for correction of deficiencies will be allotted.

At the discretion of the faculty, and if progress has been demonstrated, one further period of remediation not to exceed three months may be provided. Failure to reach explicit goals at that stage is considered academic failure and referral to the Program Director will occur.

On any occasion when action that could **affect** a resident's academic standing is contemplated, discussed, or implemented, an academic action plan will be placed in the resident's academic record. Further, such discussion will be noted in the minutes of the faculty meeting and that minute will be reviewed and approved or amended by the faculty no later than the following faculty meeting.

### **Program Director's Final Evaluation**

Towards the completion of training, the resident will meet with the program director for a summative evaluation. It is a review of the resident’s performance throughout residency. Family medicine specific milestones will be used as one of the tools to ensure that the resident is able to practice core professional activities without supervision upon completion of the program. This written evaluation will be part of the resident’s permanent record, maintained by Altru Health System, and accessible for review by the resident.

## **RESIDENT PROGRESS COMMITTEE (RPC)**

### **Rationale**

Provides a structured methodology for identifying and intervening with issues related to resident performance and conduct.

### **Goals**

1. Early identification of concerns related to resident performance or conduct through a systematic, easily identifiable indication for referral to the resident progress committee
2. Develop a diagnosis and treatment plan of action, with involvement of the resident, to rectify an issue related to performance or conduct through a completed academic action plan
3. Consistent, structured follow up within the committee to improve accountability and longitudinal reassessment
4. RPC reports to the faculty meeting twice a month providing an overall assessment of resident performance
5. All proceedings related to the RPC will remain confidential and a paper trail of the proceedings will not be placed in the resident's folder, unless the committee deems it appropriate, and not without prior notification to the resident.

### **Committee Members**

The committee will be composed of at least (2) Assistant Program Directors, (1) Faculty Behavioral Scientist, and (1) Third Year Resident (chosen by the core faculty physicians).

The committee will elect each year a committee chairperson and secretary.

A resident advocate will be chosen by core faculty to serve as an ad hoc member of the RPC. The advocate will be a well-respected community faculty member. Residents may use the resident advocate if he/she has concerns regarding the residency program but is uncomfortable addressing concerns with residency faculty or supporting staff. The resident advocate will attend RPC meetings at the discretion of a concerned resident or per the request of the RPC.

### **Meeting Arrangements**

The committee will meet the second Wednesday at 12:15 p.m. of each month, as necessary, in the residency conference room and at additional times, as necessary. Lunch will be provided. Resident files will be available for review. The meeting minutes will be recorded by the committee secretary and will be reviewed at the beginning of the subsequent meeting.

### **Potential Indications for Referral**

#### **Academic**

- Negative comment on evaluation form
- Academic related performance issues
- Negative response on a patient evaluation
- Failure to pass Step 3 or the American Board of Family Medicine Examination
- Core Faculty members concerns

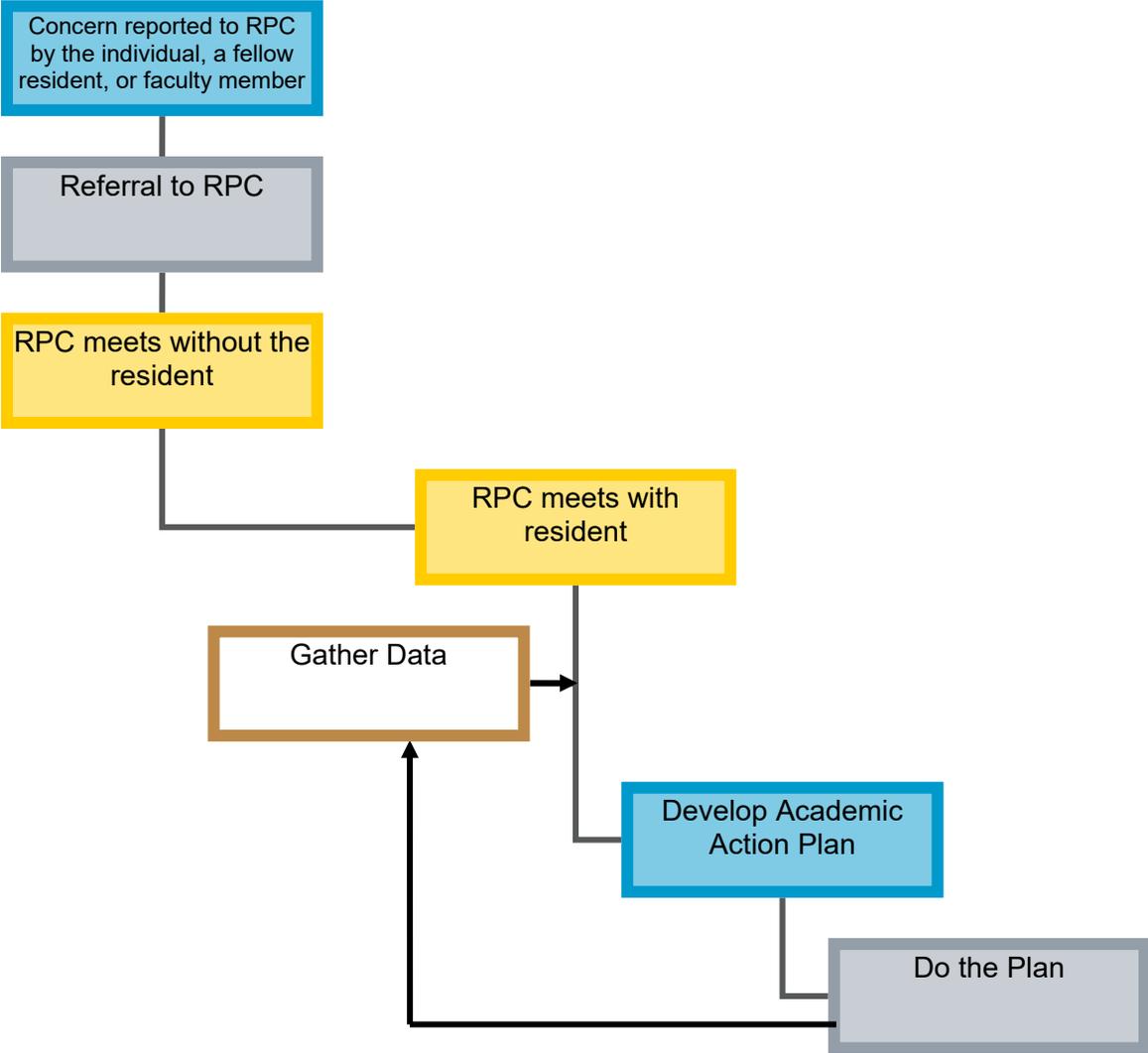
#### **Professional**

- Non-compliance per professionalism policy

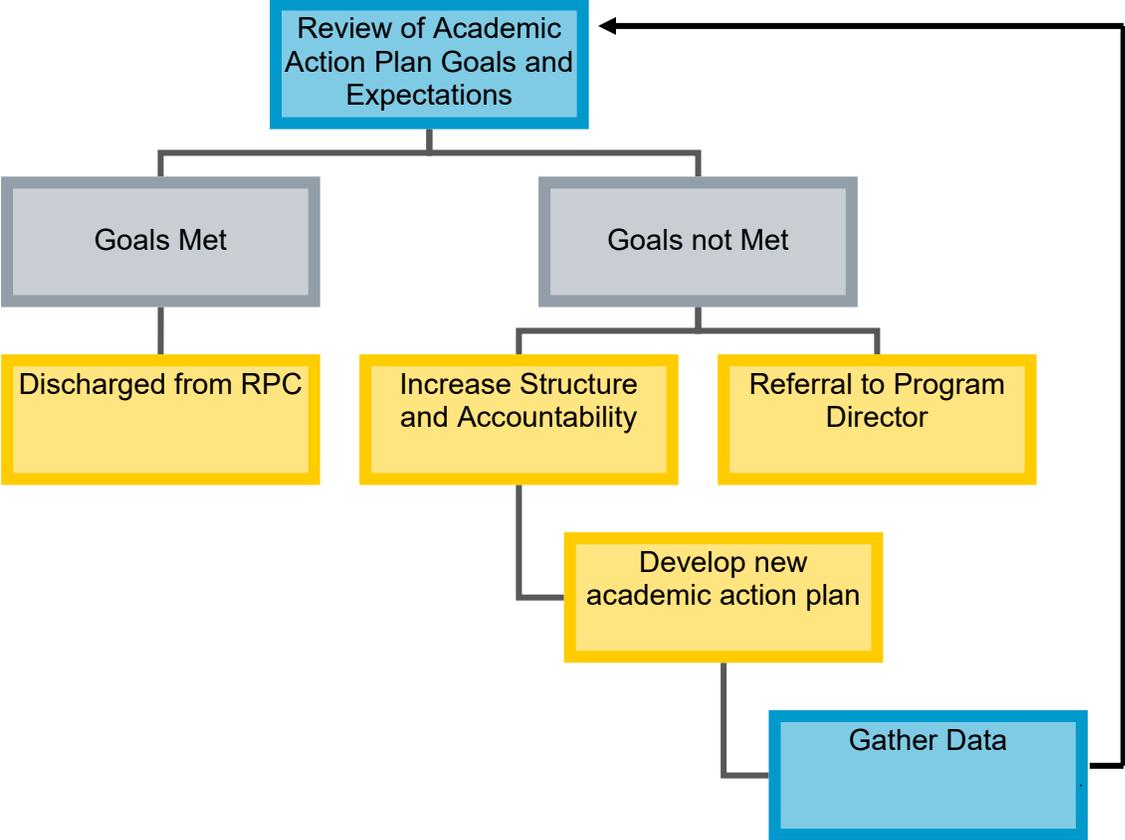
#### **Interpersonal**

- Disrespectful to colleagues, staff, or patients
- Creating a hostile work environment
- Mental health concerns i.e., depression, anxiety

**Flowchart for RPC:**



**Review of Goals**





## **LIFE SUPPORT CERTIFICATION**

All Family Medicine Residents are required to have current **Basic Life Support (BLS)**, **Advanced Cardiac Life Support (ACLS)**, **Neonatal Resuscitation Program (NRP) Pediatric Advanced Life Support (PALS) certification**, and **Advance Trauma Life Support (ATLS)**, **Advance Life Support in Obstetrics certification** and **STABLE**.

These are paid for by Family Medicine Residency.

## **PAYROLL**

All residents are paid through Altru Health System. Pay dates are every other Friday and will be sent to your house or direct deposited on each payday.

Problems with payroll functions should be directed to the residency coordinator.

# ROTATIONS

A complete listing of required rotations with accompanying goals and objectives can be found at [altru.org/fmr](http://altru.org/fmr) and will not be duplicated in this handbook. Some rotations require additional logistical instructions and for this reason, they are highlighted below.

## MEANINGFUL ENCOUNTERS

FPTS, Internal Medicine, Pediatrics, pediatric/adult encounters in the ER, Newborn Nursery and NICU rotations require residents to achieve specific numbers of meaningful patient encounters during their residency.

Meaningful encounters required include the following:

1. 750 patient encounters dedicated to the care of the hospitalized adult
2. 250 patient encounters dedicated to the care of the ill child including at least 75 encounters for inpatient pediatric patients and 75 encounters for pediatric emergency care patients
3. 250 adult encounters in the emergency department
4. 40 newborn patient encounters

A meaningful encounter shall be defined as resident involvement in patient care including gathering history, physical exam, ordering and interpreting testing, and subsequent assessment and plan. A single patient may meet criteria for one or more meaningful encounters on a single day. A “meaningful encounter” tab is on the resident’s dashboard in EPIC. Given above criteria for a meaningful encounter, the resident will click on “meaningful encounter” and document the date and time. A report will be generated quarterly and distributed to the residents for tracking purposes.

## EMERGENCY MEDICINE

1. Service attendings are the emergency room staff physicians.
2. Minimal rotation requirements are **fourteen** - 12 hour shifts in the **first year** and **twelve** - 12 hours shifts in the **second year** with a combination of days, evenings, nights, and weekends, preferably, from the hours of 2 pm to 2 am including two weekends. Residents should schedule time in the emergency department when emergency room staff physicians who are more likely to teach are working. Five shifts in each ER rotation should be scheduled in the ER Fast Track. Time schedules should be arranged with Dr. Odegard who is the ER Coordinator. Schedules should be posted in the ER PRIOR TO THE START OF THE ROTATION.
3. Residents must record meaningful encounters for all patients they have seen during the ER rotation. Residents must see, at minimum, 250 adults and 75 pediatric patients during the two rotations.

## FAMILY PRACTICE TEACHING SERVICE (FPTS)

### General

1. Patients placed on a teaching service are managed by the service residents and attending physician. Orders should be written by residents. Admissions to the teaching service must be accepted by the Chief Resident or the resident on call after 5:00 pm. Staff physicians may not admit to the teaching service without clearing through one of the above-named parties. If problems arise, it should be handled by the Program Faculty or the Chief Resident. Adult medical and clinical admissions to FPTS must be cleared through Faculty on call.
2. Discharge rounds occur on the Family Care Unit from 8:00-8:30 am and include the resident, bedside nurse, patient care navigator, and pharmacist. FPTS "Teaching Rounds," which function as "sign-out rounds" for the post-call resident, occur from 8:30-10:30 am and includes the Chief Resident, junior residents on the FPTS and the Family Medicine attending physician (Family Medicine Residency (FMR) faculty or Family Medicine Center (FMC) physicians from the community). All new patients will have a history and physical presented during morning rounds. Patients currently on the service will have an updated history, physical exam, and plan of care presented. "Teaching Rounds" offer an opportunity to discuss patient management learning issues and to perform formal rounds on the patient floors. Interdisciplinary team rounds occur from 10:30-10:50 am. Residents may voluntarily attend interdisciplinary team rounds.
3. Unless circumstances are unusual, you should see your patients on your own before morning rounds. This is required by the attendings.
4. Patients are to be assigned to a specific resident as soon as possible after admission. The patient's chart should be designated in the EPIC chart the patient is on the FPTS.
5. All admissions to the FPTS prior to 4:30 PM will be carried out by the designated in-house resident. Such resident will also admit pediatric patients when the pediatric resident is unavailable. Admissions at or after 4:30 PM will be carried out by the resident responsible for overnight call. The resident responsible for overnight call will also be responsible for weekend admissions. Patients with ongoing care needs on the FPTS will receive a face-to-face evaluation by his/her resident prior to sign-out rounds. The Chief Resident, the PGY-3 resident on-call, and all residents on the FPTS will be present at sign-out rounds at 5 PM on weekdays, in the common area by the resident call rooms, with the exception of any resident on post-call respite. Any resident who will

- be unavoidably delayed will notify the Chief Resident and the resident on-call and will be responsible for his/her patients' care until such time that formal handover has taken place. Prior to sign-out rounds, each resident will complete the standardized electronic log that contains pertinent patient information and specifically indicates whether a patient will require an evening visit by the resident responsible for overnight call, or not. This visit will take place regardless of intervening circumstances.
6. PGY3 residents providing call coverage for FPTS are responsible for rounding on patients admitted to the hospital during their call coverage. The resident is then required to attend teaching rounds allowing satisfactory transition of care.
  7. Meaningful encounters on the FPTS include: H&Ps, daily progress notes, afternoon round notes that results in a change of plan of care, documentation of the care of an unstable patient, and discharge summaries. Each meaningful encounter must be sent to the attending physician for co-signature.
  8. When requesting a consultation, be sure that the request is clear and specific (i.e. advice on patient's problem, assume total care, etc.) Consultations must be requested in EPIC and a phone call to the physician and/or their office. The patient's primary physician should be notified of these plans.
  9. Some patients on the FPTS require procedures to be done while they are hospitalized such as an LP, etc. which the resident is permitted to perform with the discretion and proper supervision of the attending physician. The individual resident is responsible to take the initiative to coordinate this.
  10. Only residents can write orders on service patients unless there is an emergent situation.
  11. Schedule:
    - The chief resident is responsible for its construction
    - Requests for time off while on call should be submitted 40 days prior to the first day of the month on call
    - Any call schedule changes must be coordinated between residents. Changes must be given to the residency coordinator no later than the 15th of the preceding month
    - Any changes must conform to the Program policies on vacation
  12. Service attendings rotate in two-week blocks from Monday am to Monday am.
  13. Dr. Lyste with the Chief Resident is responsible for coordinating FPTS activities.
  14. Patients are received from the following:
    - Service attendings private patients
    - Patients of other Altru physicians considered to have educational value to the service
    - All patients of the Family Medicine Residency physicians (It is the individual resident's responsibility to assume care)

A chief resident plays a critical role in the educational mission of residency program. Duties involved as the chief resident including managing administrative, educational, and clinical tasks of the residency. Serving as the chief resident provides an excellent opportunity for a third-year resident to continue to develop and remodel leadership and teamwork. This document provides a framework of the expected duties of the chief as well as the expectations of managing the Family Practice Teaching Service (FPTS).

#### **Chief Duties:**

1. Manage the FPTS according to the expectations listed below.
2. Maintain the call schedule for FPTS.

3. Organize the monthly chief conference.
4. Take attendance at noon conferences. Excused absences are only for a resident who is away on vacation or attending to patient care duties.
5. Manage evening/night phone calls. Calls should only be taken for FMR patients and Life Skills Transitional Center.
6. Arrange call coverage if a resident is unable to provide it.
7. Arrange post resident education support group and bring concerns to faculty.
8. Attend faculty meetings and provide chief update on FPTS and resident concerns.
9. Arrange meetings with Altru presenters. Chief resident will receive email notification from the Program Director.
10. The chief resident will provide a list of cases appropriate for a root-cause and apparent cause analysis to the Program Director.
11. Track census of FPTS daily.

### **Chief Expectations:**

#### General FPTS Expectations:

1. Update the FPTS list including, at a minimum, the patient room number, MRUN, name, code status, attending physician, PCP, admission date, vital signs and resident comments which will include all the following: hospital diagnosis, expected discharge date, significant PMH, diet, IVF pertinent labs and plan. All list updates include anticipated follow-up required following the transition of care.
2. All patients on the FPTS will be designated as "visit required" or "visit not required". All patients designated as "visit required" will be seen by the day or night shift resident.
3. Monitor resident notes on FPTS with special attention to 1<sup>st</sup> year residents
4. Develop presentation skills with individual residents
5. Check in with post call resident to evaluate their level of fatigue and provide relief if necessary. The chief resident should use discretion to round on patients when a resident appears to be overwhelmed. PGY-1 residents should have no more than 8 patients and PGY-2 residents should have no more than 10 patients.
6. Encourage meaningful encounter data entry.
7. Reinforce professional behavior to all residents, including on-time arrival for morning rounds.
8. The chief resident will encourage residents to submit Clarity reports when appropriate.
9. Monitor compliance with 80-hour work week for residents on the FPTS.
10. The chief has the responsibility of demonstrating POCUS on appropriate FPTS patients.

#### Admissions:

1. Chief is expected to notify residents of admissions or consults.
2. The chief resident will notify residents for admission during daytime hours. If the resident is overwhelmed with other patient care obligations, the chief may choose to assign the patient to a different resident. Ultimately, there is joint discussion but not joint decision regarding patient assignment to residents.
3. Assign cases to medical students (approximately 2 patients per 3<sup>rd</sup> year student and 3 patients per 4<sup>th</sup> year student). Patients followed by medical students need to have a resident follow with the patient as well. Residents may copy the medical student note and paste into their daily progress note, acknowledging the original author.
4. Admissions after 4:30 PM should be done by the on-call resident.

5. Admissions from 7-8:30 AM should be done by the chief resident who may then reassign the patient to a junior resident.
6. If the PGY-1 resident has 3 or more admissions in 2 hours or the PGY-2 resident has 4 or more admissions in 2 hours, the chief resident will be in-house to assist.
7. In-house PGY-3 resident on-call will round on all admits occurring between 8 PM and 7 AM. Admits occurring before 8 PM will be reassigned to residents on the FPTS.
8. The FPTS will not take admissions from 12-5 PM on resident education days. Attending physicians will write admission orders and document H&P during this time. The attending physician may contact the Chief Residents if they would prefer the patient to be followed by the FPTS.
9. FMR detox/alcohol patients will be admitted to the FPTS. FMC and Sanford detox/alcohol patients should not be admitted to the FPTS unless an FMR faculty member is on-call and chooses to have the patient on the FPTS.
10. The chief may "close the FPTS for admissions" if residents are overwhelmed with patient care duties and with discussion with the Program Director or the Associate Program Director. FMR patients are always admitted to the FPTS. This should only occur on rare instances.

#### Morning Rounds:

1. Actively guide learning issues on morning rounds. Each resident should have four learning issues per block. If junior residents are busy with patient care, the Chief resident should present learning issue. At least one learning issue should be presented daily.
2. Post round with 1<sup>st</sup> year residents for the first two weeks they are on the FPTS.
3. The chief resident should attend Interdisciplinary Team rounds for the teaching unit at 10:30 AM whenever possible.
4. The chief resident will post-round on the observation unit following Interdisciplinary Team rounds. The chief resident should discuss FPTS patients with the charge nurse during this time.
5. The chief resident will attend the GMLOS meeting every Tuesday and Thursday from 1:00-1:30 pm. The program coordinator will send a link via Outlook to attend the meeting virtually via Microsoft Teams.
6. The chief will encourage residents to read attestations prior to calling the attending physician.

#### Evening/Sign Out Rounds:

1. Chief resident and the third-year resident on-call are required to attend sign-out rounds.
2. In-house residents will see their patients as well as the post call resident's patients for evenings rounds. Otherwise residents do their own PM rounds and can write their PM notes after rounds, if needed.
3. Encourage the use of "read-back" technique during sign-out rounds

#### **Attending Physician Expectations**

Attending physicians are crucial in the development of resident physicians. Attending physician role modeling is an integral component of medical education and a principal factor in shaping the values, attitudes, and behaviors of resident physicians. Attending physicians must demonstrate the following:

1. Allow the resident to function with autonomy.
2. Expect the resident to develop a differential diagnosis and management plan.
3. Contribute additional information or advice when needed.
4. Treat residents with respect.
5. Role model appropriate physician behavior.

Attending physicians who do not meet the above expectations will not have their patients on the FPTS. Further, if patient care ordered by the attending physician is not concordant with the residents most recent evaluation, and through discussion discrepancies between the residents and attending physician cannot be resolved, the patient may be removed from the FPTS.

### ADMITTING PATIENTS FROM THE CLINIC TO ALTRU HOSPITAL

#### **General**

1. Nurse will call the bed coordinator.
2. Nurse will give name, age, physician of record, service, admitting diagnosis and any request for floor or unit.
3. Admitting clerk on individual floor will assign a room.
4. May need to call the assigned floor or enter in EPIC preliminary orders (at least the diagnosis, diet and activity).
5. The first orders that are written should include:  
Admit to (room, floor) for Dr. (personal or attending) on (FPTS), (Resident who will follow), (beeper #).

#### **Admitting from the office (daytime)**

1. To FPTS from Altru--Personal physician usually calls the Chief Resident first who, in turn, calls the junior resident on the service. All admits are shared by residents on the service.
2. To FPTS from the Family Medicine Residency – All residents should assume care of their own patients unless unable to do so and prior arrangements are made.

#### **Admitting from the ER**

1. Patient of Altru--By prior arrangement, the patient is seen in the ER by his personal physician or his backup. That physician calls the in-house resident to admit the patient to the appropriate teaching service. Patients are not admitted by a resident unless they will remain on a teaching service and orders are to be written by residents.

Patients presenting without prior arrangement, are seen by the ER physician who may decide that the patient merits admission. The patient's personal or on-call physician is called, and he calls the resident to admit the patient.

Admissions from the FMR should be to the FPTS but managed by that patient's physician. If that patient's physician is unavailable, the admitting physician may manage the case along with the FPTS.

When a resident sees a patient in clinic who needs admission, it is his/her responsibility to see that the patient is properly cared for, and that all necessary arrangements are made, including H&P, admit notes, orders, etc.

## HALVORSON HOME VISIT

### Preamble

Physician home visits are no longer a routine part of the physician work schedule. Hospital stays have become shorter. Medical care has become increasingly complex resulting in patient non-compliance or inability to follow the outlined treatment plan. Further, the number of medical services available to patients is continually expanding; however, patients are unfamiliar with services available with consequent underutilization of resources. The goal of the Halvorson Home Visit program is to follow high-risk patients as they transition from the hospital to their home environment. Home visits provide a unique interface between physician, patient and support system, allowing physicians to provide care in the patient's environment, observe barriers to care that has been outlined, and insure appropriate utilization of health care resources. This program will work closely with existing healthcare resources such as Home Health, Respiratory Services, Yorhom and Social Services to provide a comprehensive home plan. As the U.S. population continues to age, the demand for home visits will increase exponentially. Utilization of an effective home visit program will reduce the number of readmissions to the hospital by assessing home safety medication management and coordination of appropriate services, allowing patients to continue to live in their home environment. The Home Visit Program provides Family Medicine Residents an invaluable interface to increase knowledge regarding care medical care of complex patients in the home environment.

## **Goals**

### Patient – improved care

- Resolution of conflicting-confusing hospital discharge instructions
- Removal of unnecessary or conflicting medication
- Rationalization of medications with patient's economic resources
- Recognition of potential hazards at home
- Recognition of obstacles to further care
- Continuity of inpatient and outpatient services
- Utilization of appropriate health care resources
- Clarify advance directives

### Physician – improved capability

- Increased awareness of the 'total' patient, unobtainable from the most detailed hospital admission history, including an understanding of the patient's environment and support system.
- Improved, individualized care plans
- Strengthened sense of purpose and identity

## **Procedure**

- PGY-3 residents will have a 6-8 week home visit rotation. Addendum A
  - Residents may take no greater than one week of vacation during their rotation. Halvorson Home Visits will not occur in the absence of the resident scheduled for the rotation.
  - The FMR PCMH nurse is responsible for blocking the Halvorson Home Visit schedule in the anticipated absence of the resident.
- Predictive analytics and physician gestalt will determine which FPTs patients require a home visit.
  - Home visits that cannot be accommodated utilizing the "Halvorson Home Visit" will be completed with an order placed for the "Hospital Transition Program."
- Home visits will occur in a 15-mile radius of Grand Forks.
- The need for a home visit will be communicated to staff at IDT by the Chief Resident
- Order will be placed in EPIC: "Halvorson Home Visit"
- Appointment for the home visit will be scheduled by the HUC. Appointments will be available at 9, 10, and 11AM, Monday thru Thursday. Patients will be notified this is +/- 30 minutes.
- The chief resident will notify the FMR Medical Home nurse
- The medical home nurse and PGY-3 home visit resident will visit the patient in their home.
  - The first two home visits performed by a resident will have direct supervision from FMR faculty
  - Questions regarding medical care of the patient should first be directed to PCP. If PCP is unavailable, the resident should consult with a precepting physician at FMR
  - Documentation for the home visit will occur via standardized EPIC template and sent to the PCP
- Venipuncture may be performed at the time of the home visit.
  - BSQ certification for "venipuncture" must be completed prior to starting the Halvorson Home Visit rotation.
- Suggested resident conduct
  - Understand your position as a guest in the home

- Take off shoes
- Sit a patient's bedside – move furniture as needed and replace when done
- Establish closeness and degree of intimacy
- Lay on hands and listen
- Comment on photographs and memorabilia that seem to be of significance
- Materials required for home visit
  - Alcohol hand rub
  - Gloves
  - Dressing change material if appropriate
  - Protective gowns
  - Masks
  - Infection Control Kit (refer to Home Care Infection Policy)
  - Canister Sani-Cloth
  - Stethoscope
  - Otoscope and tips
  - Tongue depressor
  - BP cuffs
  - Pulse oximeter
  - Copy of the after-visit summary (AVS)
  - Tablet with hot-spot

### **If All Else Fails**

I will practice my profession with **conscience and dignity**;

The **health of my patient** will be my **first consideration**;

I will **respect the secrets** that are confided in me, even after the patient has died

**I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;**

I will maintain the utmost **respect for human life**

**(Declaration of Geneva 1948)**

## OBSTETRICS

The OB schedule is arranged by the OB fellow or chief resident in coordination with those residents on OB rotations. Care is provided by those residents who are on OB rotations and the OB fellow(s) with supplemented care from a second or third year resident when necessary to provide adequate coverage.

The resident is responsible for the obstetrical floor in the hospital including triaging possible admissions, actively being involved with laboring patients and first assisting with C-sections and providing post-partum care. OB fellows may also be available on Labor and Delivery to precept patients.

Weekdays - Rounds in the morning will be divided between the post-call resident and the new resident starting a shift. The post call resident will stay until 7 am to assist with rounds. The incoming resident will arrive at 6 am to allow time for rounds. Rounds should be completed by 7:00 am. If no resident was on call the night before, find the charge nurse for update on patients.

Weekends - If there was no resident on the previous night, the resident coming on call will have to round on all patients with attending so that he/she is aware of any potential problems. Before going off call, the resident will round on all patients.

The attending physician will be responsible for dictating H&P's for scheduled elective C-sections. The resident on the floor will do those on patients on the floor for which they are caring. The resident assisting with a C-section, will be responsible for the discharge summary. The resident must complete one ABFM Part II obstetrics module during his/her first or second obstetrics rotation.

### Continuity Obstetrical Care

The goal of all Family Medicine residents is to follow **eight (8)** obstetrical continuity patients. After residency, each individual may personally determine whether to practice obstetrics. However, in residency everyone will obtain the necessary training and represent our program well.

Residents must accept OB patients during their training, regardless of total number of deliveries, for due date one month prior to anticipated graduation date. Residents who will continue in group practice in Grand Forks may accept OB patients with due date post-graduation so long as patient coverage can be provided in the graduate's absence.

During residency, each resident is required to provide continuity care to obstetrical patients through the prenatal, perinatal, and post-partum course. Residents are required to:

1. Staff the initial OB with the preceptor in the Clinic. The patient may designate a faculty member, or you may precept with the preceptor that day.
2. Staff with the preceptor in the Clinic again at 28 and 36 weeks and at any time a resident determines the prenatal course is deviating from routine care.
3. Staff any contemplated consultations with the preceptor in the clinic prior to arranging for these consultations.
4. Any inductions **MUST** be staffed with a faculty member prior to admission.

5. When admitting the patient, admit them under the name of the faculty member on call (if faculty member has not been previously assigned to this patient) or assigned faculty member.
6. Notify the faculty member on call when a patient is admitted.
7. If you have any problems or questions during labor, please discuss with the faculty member on call before seeking obstetrical consultation, unless it is a dire emergency.

### **SIGN-OUT TEMPLATE FOR OBSTETRICS**

1. Every patient list needs to include the following columns: Room/Bed; Patient Name; Attending Physician; Gestational Age; Dilation; Effacement; Station; Resident Comments
2. Resident comments for postpartum patients need to include: postoperative/postpartum day number; type of delivery; gravida/para; other pertinent information; anything that needs to be followed up on; time at which patient needs to be re-evaluated
  - a. **Example:** PPD#1, NSVD, G3P2, induction for gestational HTN; F/U on blood pressures every 2 hours; Reassess patient tomorrow AM
3. Resident comments for intrapartum patients need to include: gravida/para, reason for admission (active labor/induction), epidural/no epidural, other pertinent information; time at which patient needs to be evaluated
  - a. **Example:** G1P0, induction for post-dates, has epidural; received 1 dose Cytotec and now on Pitocin; Recheck cervix at 1400
4. Resident comments for antepartum patients need to include: gravida/para; reason for admission; medications given/needed; other pertinent information; time at which patient needs to be evaluated
  - a. **Example:** G5P4, admitted on 7/15 for PPRM at 30w3d; received 2 doses betamethasone; received mag sulfate; received IV and oral abx; monitor for infection/labor; plan to delivery at 34 weeks; Reassess patient tomorrow AM
5. Resident comments for triage patients need to include: reason for triage; pending lab results; other pertinent information; time at which patient needs to be evaluated
  - a. **Example:** Rule-out labor; vaginitis pending; U/A negative; Cervix 1.5/60/-3; Reassess cervix at 1345

Residents/Fellows PLEASE update your lists (you can have additional columns but must have the ones listed above). Make sure resident comments are updated regularly. At a minimum, they must be updated prior to sign-out.

## PEDIATRICS

If you are sick or have another unexpected absence, you need to call the pediatrics floor at 780-5660 and let the HUC know so that they can indicate that on the calendar and inform the physicians. If you have vacation during the month, please remind the attendings at rounds the day before you are off.

### **Weekdays**

Rounds: Pediatrics rounds begin at 8:00 am in room 408 on pediatrics. Be prepared to present all patients admitted to pediatric physicians or being seen by pediatric physicians in consult. Exceptions include those being seen by the medical student(s), and nursery or NICU babies who have been transferred to pediatrics, you will not see these.

To have enough time, you may need to call pediatrics the night before to find out how many patients are admitted so you can see them all prior to rounds.

Being prepared includes reviewing any orders written overnight, talking to the nurses for updates, reviewing the vital signs, labs, intake and output, examining the patient and talking with patients/parents and formulating a plan for the day.

When presenting on rounds, you should give the complete history and physical on the first day after the patient has been admitted. If you did not admit the patient yourself, please read the history and physical prior to rounds so you are familiar with the patient before presenting.

Subsequent days of hospitalization, the presentations can be started with a one to two sentence introduction of the patient's age, day of hospitalization and admitting diagnosis followed by the events overnight. (For example: Johnny is a three- year-old male on hospital day #2 admitted for pneumonia and asthma exacerbation).

Be prepared with an assessment and plan for each patient. Even if you have not yet talked to the attending, you should have formulated your own plan for the day and be able to explain your reasoning behind it.

**Make sure you talk to the attending for every patient every day.** (If that attending is not on rounds, page them after rounds).

Medications should be presented in mg/kg dosing (Example: a child who weighs 10kg and is receiving 400mg of Amoxicillin bid should be presented as 80mg/kg/day divided bid).

IV fluids should be presented as what IV portion of maintenance the child is receiving and what fluids they are on. (Example: D5 ¼ normal saline at maintenance rate)

Urine output should be presented in cc/kg/hour for children on strict ins and outs.

Daily notes: You will write daily progress notes on all patients you round on. All notes should be dated. All history and physical and progress notes should be ended with the phrase "The patient's chief complaint, history and examination were done by myself and Dr. \_\_\_\_\_." Assessment and plan are per Dr. \_\_\_\_\_ and this dictation is being scribed for Dr. \_\_\_\_\_." All notes that are considered meaningful encounters that occur on a pediatric inpatient rotation should all be sent to the appropriate attending physician for co-signing.

## **Weekend**

When you are on call on Friday, Saturday or Sunday, you are responsible for seeing the pediatrics patients on Saturday (Friday or Saturday call) and Sunday (Saturday or Sunday call). When you have completed rounding on the patients and are ready to discuss them, please page the on-call attending.

## **Call**

Call is from home. You will have six nights of home call. One of these will be a Friday (you will come in and round on Saturday morning) and one will be a Saturday (you will round on both Saturday and Sunday mornings).

If you are on call, you are expected to be available to come in and do admissions for pediatricians who are admitting patients. The pediatrician or floor nurse will page you to let you know there is an admission. When you are done taking your history and examining the patient, page the attending to discuss the admission.

## **Computer patient list**

Access the pediatrics team list on EPIC. Any patients admitted in the nursery, NICU or to the neonatologist on the pediatrics floor are not your responsibility. Pediatric patients on psych are not seen by us unless there is a formal consult. If a patient is on another floor and admitted to pediatrics or we are consulted, you will round on them. For example, we are occasionally consulted on patients in the SCCU or have a patient on fifth floor for telemetry.

## **Discharge summaries**

Discharge summaries must be completed within 24 hours of a patient's discharge. If it is also serving as their progress note for the day, it must include a discharge physical examination and be completed at the same time as the other progress notes that day. If a patient you have been following has been discharged after you are gone for the day, you need to complete the discharge summary the following day.

**Clinic notes: When completing clinic notes, please mark your progress note as incomplete and leave the chart open for your attending to complete. Make sure these are also dated and have your supervision phrase at the end.**

Residents will also complete the two ABFM Part II Pediatric KSA modules prior to completion of pediatric rotations.

## **RURAL ROTATION**

### Purpose

The purpose of this rotation is to enable residents to experience family medicine in a rural healthcare setting. Rural practices have a unique set of challenges, including but not limited to physician shortages, patients unable to travel, and lack of immediate access to specialists. During this rotation, each resident will see a wide variety of patients many of which have limited resources and very complex medical conditions. Our goal is to have the resident work as a member of the health care team during their time here. Ultimately, practicing in a rural setting requires providers to have sense of purpose greater than themselves.

1. Resident will cover clinic hours (9 AM-5 PM) for family practice department.

- a. Residents will have the option to choose certain types of patients they would like to see more of, including pediatrics, internal medicine, obstetrics, musculoskeletal, or urgent care.
  - b. The clinic will do its best to provide the resident with the types of patients they feel would be most beneficial for their education.
2. Resident will take call one-week day each week of the rotation and one weekend (Friday-Sunday).
  - a. On the day of call, the resident should be available for admissions starting at 7 AM.
  - b. Residents have the option of doing family practice with OB call or family practice call and a 6-hour night shift in the Emergency Room on each weekday they are on-call.
  - c. For their weekend call, residents have the option of taking family practice with OB call for the whole weekend or doing family practice call in addition to 24 hours in the emergency room.
  - d. Resident will be responsible for rounding on any admissions/deliveries that they participate in each day prior to the start of clinic. The care of these patients should be discussed with the attending physician for that patient.
3. Each week, the resident will have a supervising physician to whom they will submit their notes.
  - a. Week 1 – Dr. Foughty
  - b. Week 2 – Dr. Wayman
  - c. Week 3 – Dr. Martin
  - d. Week 4 – Dr. Bittner
4. Residents will see patients every 20 minutes during clinic hours with no appointment type restrictions. Clinic will be from 9AM to 12PM and 1:20 PM to 5PM with the last scheduled appointment at 4:20 PM.
  - a. Questions regarding patients should first be discussed with the PCP if available. If the PCP is unavailable, resident may discuss the patient's care with any of the attending physicians.
  - b. Residents must notify an attending physician if they are doing any procedures. Attending physicians will observe most if not all procedures that the resident performs.
    - i. Any procedures on Medicare patients must be observed in entirety for billing purposes.
  - c. The residents will see a maximum of 10 patients per half day. Additional patients may be added at the resident's discretion.
    - i. The resident nurse may ask if a resident is willing to see an extra patient during the day. The decision to see or not see extra patients is up to the discretion of the resident; however, we do ask that you keep the purpose of this rotation in mind when this request occurs.
5. Residents will also spend part of one afternoon of clinic, tentatively during the first week of the rotation, with Dr. Martin touring the reservation and surrounding area.
6. During the last week of the rotation, the resident will do a brief presentation with the family medicine physicians. This presentation should review an interesting case, social situation, etc. that was encountered during the rotation.
7. If you have any concerns or questions regarding your rotation, please contact Dr. Foughty. If she is not available, please contact any of the attending physicians you feel comfortable speaking to.

**Residents may choose to do an additional elective block in a rural setting granted the following conditions are met:**

1. The rotation is granted at the discretion of the faculty.
2. Graduating third-year residents may not be absent from continuity of care obligations in the final month of their training.
3. Residents are free to have exploratory discussions with clinics in rural sites, but may not enter into agreements until program faculty have reviewed the request. In general, the requested rotation should have some obvious, unique, educational, value to the residents - such as experience of genuinely rural practice.
4. The sponsoring practice site must agree to pay the revenue loss which the residency program anticipates as a result of the resident's absence. In addition, the sponsoring site must make arrangements with the resident, concerning travel expenses, room and board. The sponsoring site must also make arrangements, which the program faculty considers appropriate, for availability of local consultation and support from site physicians. On no account may a resident be left in an unsupervised position.
5. The resident is responsible for ensuring that all legal requirements, such as licensure, are met before the rural experience is initiated. Evidence of meeting such requirements must be presented to faculty for approval.
6. Rural rotations in non-contiguous states will not be approved unless the circumstances provide a unique educational experience, which cannot be replicated elsewhere.

# **FMR Clinic**

## CLINIC SCHEDULE GUIDELINES

1. A minimum of three residents, preferably four, will be in clinic always, unless special provisions have been made.
2. Clinic days:
  - PGY-3: 4-5 half-days per week
  - PGY-2: 3-4 half-days per week
  - PGY-1: 1-2 half-days per week
3. Frequency of appointments
  - PGY-3: 20 minutes
  - PGY-2: 30 minutes
  - PGY-1:
    - May not see Medicare patients until January 1<sup>st</sup> of PGY-1
    - All PGY-1 residents will have 60-minute appointments until discussion has occurred with the resident, nurse, and Program Coordinator advancing scheduling to 40/60-minute book.
4. The maximum number of patients seen by any resident for ½ day of clinic is 10.
5. Residents may not refuse to see a patient if the patient is late for the scheduled appointment.
6. Residents may not review their schedule and ask scheduled appointments to be removed without consent of the Program Coordinator.
7. NICU rotation is no AM morning clinic.
8. Family Practice Teaching Service (FPTS) rotation is PM only.
9. Patients are scheduled beginning at 9:00 am to 11:30 am and from 1:15 pm to 4:30 pm except on the teaching service the residents will end at 3:15 pm for 1<sup>st</sup> years, 3:35 for 2<sup>nd</sup> years and 3:45 for 3<sup>rd</sup> years.
10. "Establish care" appointments should not be made for PGY-3 residents graduating in the next three months unless future employment is in Grand Forks.

## NURSES STATION & EXAMINATION ROOMS

1. Telephones
  - The nursing station is equipped with outside lines.
2. Flag System
  - Each patient room is equipped with a flag system to identify which doctor's patient is being seen. Every physician who practices at the Family Medicine Residency has a different combination of flag colors. A yellow and red flag means the nurse is in with your patient. She/he will lay them down when the patient is ready for the physician and display the physician's colors. When physicians have finished with their patients, they should lay all the flags down to signify the room is empty.
3. **No** eating or drinking is allowed at the nursing station.
4. Charts are **not** to be left at the nursing station. Use your own desk.

## APPOINTMENTS

The Family Medicine Residency employs schedulers and registration employees who are primarily responsible for patient scheduling. Appointments are made by telephone or direct contact with the patient. When making appointments, secures the following information:

- Patient name

- Reason for the appointment

- Physician preferred/or last seen

- Telephone number where the patient can be reached in the event the appointment must be canceled and/or rescheduled

### **Patient Scheduling**

For first-year residents, patients are scheduled every hour, unless requested otherwise. For routine visits, second-year residents are scheduled every 30 minutes and third-year residents are scheduled every 20 minutes. Procedures that are known by the receptionists to take a longer amount of time will be scheduled accordingly.

Any special requests by a physician regarding scheduling are brought to the attention of the residency program coordinator.

If a physician asks an unscheduled patient to come to the clinic, the front desk and your nurse must be notified.

Residents are expected to stay in the clinic area during their scheduled hours to cover any walk-ins or late scheduling of patients. Residents who do not have hospital-patient care responsibilities, must stay in the clinic until 5:00 PM.

If a physician is delayed for a scheduled appointment at the clinic, always notify the residency program coordinator and your nurse.

### **Check In**

As the patient arrives, he/she will register with the front desk personnel who will check them in through the EPIC system. All pertinent information is rechecked with the patient to assure proper billing. It is the responsibility of the receptionists, nurses, lab and x-ray technicians to monitor the patient schedules and insure that patients wait a minimum amount of time in the waiting room and are escorted properly to an examination room as soon as possible.

Patients who fail to arrive for scheduled appointments are listed as a "no show" on the schedule and this is documented in the patient chart. After three "no shows", the patient may be notified by the physician that they can be seen at the Center on a walk-in basis only. They will be worked in for an appointment, only after all regularly scheduled patients have been seen. The nurses are notified of any "walk-in" patients and are responsible for appropriate scheduling. The original copy of the appointment schedule (nurse's copy) is retained by the Family Medicine Residency as a permanent record of patient visits through the EPIC system.

## PATIENT FLOW

1. When a patient checks in, the receptionist registers the patient in EPIC and an entry is made into the electronic medical record that the patient has arrived. This is available for the physician and nurse to visualize and the nurses will room the patient as quickly as possible.
2. If lab work is requested, the physician will order labs in EPIC and the patient will be escorted to the lab by the nurse or physician.
3. The nurse will prepare for any necessary supplies. All supplies, with the exception of agar plates, are kept in the rooms.
  - a. Pap Smears – thin preps will be set-up when scheduled. A broom, thin prep vial of solution set out. Rotate brush in cervix five times, rotate brush/broom in bottom of vial ten times, brush bristles should separate while rotating, then swirl vigorously and discard brush.
  - b. GC Culture -- kits are available in patient rooms
  - c. Wet Mounts -- each room is stocked with cotton tipped applicators
  - d. Cultures -- culturette tubes and sterile dacron swabs are in each room; Herpes culture transport media are available from the lab
  - e. KOH -- skin scraping slides are stocked in each exam room
  - f. Any supplies used to obtain a specimen (pipettes, swabs, cervical brushes, etc., must be thrown into the red bag, biohazard garbage receptacle)
  - g. All specimens taken to lab must be labeled with patient's name. All specimens must also be accompanied by a lab order in EPIC
  - h. Outside lab results will be put in the residents' mailboxes. If lab tests are important enough to obtain, they are important enough to tell the patient. Do NOT tell the patient to call the nurses for their lab results. You may call the patient, send a letter, or give them the date of your next clinic day so they can call you. All lab results must be signed before being filed in the patient chart.
  - i. When lab work is ordered for a future date, the physician will fill out a lab order in EPIC with an expected date of return for the lab work
4. Before the patient is seen by the physician, vital signs are taken and documented in EPIC. The patient will be asked to disrobe and gown if the nurse feels it is appropriate. The nurse will document chief complaint in EPIC.
5. Resident delays in arrival for patient care activities are deplored by the faculty. They feel 20 minutes is the longest any patient should wait to see a physician. Residents are paged on the arrival of their first patient if they are not in the clinic. After 15 minutes, the resident will be paged again. After half hour the patient will be given the option to see someone else or wait. In the case of deliveries; the patient is to be rescheduled or see another resident. The nurses cannot give the patient the option to wait.
6. Chart appears in holder outside exam room when ancillary services completed. The physician must keep track of his schedule and check to see if patients are ready.

## TELEPHONE CALLS

Telephone calls to physicians should be handled as follows:

1. The physician should be contacted immediately if the caller is:
  - Another physician
  - The physician's spouse or family member
  - Reporting a medical emergency. In this case the chart should be documented with details and dates

If you are unable to contact the physician immediately, contact the Chief Resident immediately and document details and date in the patient chart.

2. Calls from the following sources should be route to the nurses:
  - Hospital
  - Nursing home
  - Long-distance calls
  - A pharmacy
3. In the event a patient calls and insists on speaking to the physician, or it seems to be an emergency, the phone call should be routed to the nurse. If the patient's call needs the attention of a physician, the nurse will attend to it. If a message is taken it is placed on the physician's desk and the physician is paged with messages between the hours of 11:00 am to 12:00 noon or between 3:00-4:00 pm. If it appears to be a medical emergency, the physician should be contacted immediately.
4. In case of routine patient calls, lab results, inquiries, and prescription refills, the nurse will forward the information to the physician in EPIC.
5. Overnight -- or call hours
  - a. Patients are instructed to call the regular clinic number to reach the resident on call.
  - b. The Family Medicine Residency Center uses Altru Health System telephone answering service for after hour calls. Each month we send them a copy of our on-call schedule. The staff will call the answering service with changes on the schedule which are brought to our attention during the normal 8 am - 5pm, Monday to Friday work week. If a change is made after hours or on a weekend it is the responsibility of the resident making the change to notify the answering service.
  - c. The answering service then automatically answers any incoming calls on 780-6800. The operator takes the patient's name, telephone number and chief complaint (if stated).
  - d. The third-year residents will take all evening phone calls.

## LABORATORY

The lab is equipped to perform routine hematology, routine urinalysis, wet preps, strep screens, skin scrapings, pregnancy tests, monospot tests and limited chemistries to include glucose.

### Lab Orders

1. Lab orders are requested in EPIC.
2. Lab personnel are to be notified when a patient is brought to the lab.

### Results

1. Lab results of tests which are performed at FMR are kept on record in the lab as well as in the patient's chart.
2. Results will be routed to the physician through the results tab in the EPIC inbox. Residents are expected to check this frequently, contact the patient with the results either in person or through a letter or telephone call, and mark the lab results as reviewed.
3. CRITICAL VALUES will be posted in the laboratory and when results meet the critical value criteria, the lab personnel will contact the physician or his nurse with results and document this in the "panic" log book.

### Reference Labs

1. Altru Hospital is our main reference labs. Altru courier service is provided at 12:30 pm and 3:30 pm daily. If a STAT procedure is necessary, the lab personnel may also be asked to hand carry the specimen to Altru Hospital laboratory if testing is not done "in house" or contact the Altru courier to come to the clinic for an urgent lab specimen. Turnaround time is within one day for chemistries, 48 hours for microbiology.
  - Positive chlamydia and gonorrhea results are called to the physician.
  - All positive sexually transmitted diseases must be reported to the Department of Health so that all sexual partners can be contacted and treated for the disease. The laboratory will take care of reporting positives. Department of Health may still contact you to assure proper treatment.
  - A consent form must be signed by the patient before the HIV specimen is drawn. They must understand the policy about confidentiality.

### Pap Smears/Cytology

1. Thin preps are read at Altru Cytology, turnaround approximately 2-5 days. Woman's Way and Third Street Clinic pap smears are read at Altru Department of Cytology.
2. Results: All reports are reviewed by physicians and the physician is responsible for notifying the patient of the results. Frequently "normal" reports are mailed to the patients.

**NO EATING OR DRINKING IS ALLOWED IN THE LABORATORY! ALL SPECIMENS THAT ARE BROUGHT TO THE LAB MUST BE LABELED WITH PATIENT'S NAME, PHYSICIAN'S NAME AND THE DATE.**

## **X-RAY**

### **X-ray Procedures Provided**

#### **Basic radiographs**

- Chest
- Extremities
- Spine
- Skull
- Plain films of abdomen

### **X-ray Procedures Provided by Altru Health Care System**

- Upper GI
- Barium enemas
- IVP's
- Special procedures

### **X-ray Request**

- X-rays are to be ordered in the Epic system
- The patient will be accompanied to the x-ray department by the physician or nurse. The radiology technician will be notified of the patient's arrival. The radiology technician will accompany the patient back to the exam room upon completion of the x-ray.

### **Radiologist Services**

X-rays are read by radiology the day of the exam. The official radiology report is resulted in the ordering physician's results folder in the EPIC inbox.

### **X-ray Policies**

X-rays are part of the medical record and cannot be released to a third party without a signed medical records release form. These forms must be signed by the patient and given to the records department.

## PATIENT EDUCATION

The Family Medicine Residency has the following Patient Education resources available:

- Patient Education Handouts - concerning all facets of Health and Nutrition are available at FMR. In addition, residents may access patient education material via Up To Date or AAFP.org.
- Patient Information Brochures - developed specially to inform our patients of our educational training and various Center services that are available

## CODE PROCEDURE

### Purpose

To get needed personnel and equipment to the aid of the patient as efficiently and quickly as possible.

### Equipment/Supplies

- Crash cart
- AED
- Oxygen
- I.V. standard
- Suction
- All equipment/supplies are located in stress room

### Procedure

1. Whoever comes upon a code situation will notify the nearest person that help is needed urgently and initiate CPR.
2. All nurses will report to the Nurses Station and instructed as to the location of the code. One nurse will call 3333 to contact Altru of an emergent situation.
  - Nurses will be responsible for getting the equipment/supplies to the code site
  - One nurse will take notes
  - One nurse will assist as needed
  - All other nurses will report back to the Nurses Station and attend to the other patients
3. Escort the ambulance to the code site when they arrive.
4. All residents will report to the Nurses Station and will be informed of the code site.
5. **REMAIN CALM!!** For all other patients in the clinic, we should resume previous duties as usual.

## **MEDICAL RECORDS**

### **Chart Information**

Each family has an account number. Each member of the family is given a patient number and an individual chart.

### **Routing of Charts**

Charts are maintained in the electronic medical record system, EPIC. A patient checks in at the front desk and the status of patient will be changed to arrive and the time the patient arrived is visible in the provider's home screen. Once the nurse rooms the patient, the status will be changed to exam room. The nurse will complete vitals, reconcile the medication list, update allergies, and obtain the chief complaint from the patient and enters the information into the EPIC system. The patient is seen by the physician and once the physician completes the progress note and determines the level of service for the visit the encounter can be closed and the patient's status for this encounter is now closed. Any changes to the visit after this point would need to be done as an addendum.

### **Medical and Hospital Reports**

Reports generated within the Altru Health System are sent to the appropriate folder within the physician's EPIC inbox. Medical records or reports from an outside facility are placed in the physician's mailbox in the clinic. The report is initialed and dated by the physician, placed into the medical records mailbox who then scans the report and it will be available electronically under scanned reports.

### **Transferring Medical Records**

A written consent must be completed by the patient for all transfer of records. (Exceptions: Litigations for legal purposes, federally assisted or controlled Drug Abuse or Alcohol Abuse Program, and programs administered by/or under ND Social Services Board). Any questions regarding release of patient's records will be answered by the patient's physician or the Chief Resident (if the patient's physician is not available). Upon physician approval, Medical Records personnel will copy and forward records.

If the request is from an attorney's office or insurance company, a faculty physician will approve the request.

### **Medical Records**

Charts must be kept current at least weekly. Failure to comply may result in loss of resident's academic credits. All charts are currently available to be reviewed and signed electronically. Residents have individual in boxes in EPIC which must be checked daily and appropriate follow up and contact to a patient as necessary based on test results or patient phone calls is to occur within 48 hours when at all possible.

### **Hospital**

Admission and discharge records should be done the day of admission or discharge, and procedure notes should be done promptly after the procedure. Each morning prior to teaching service rounds, the resident is to have a APSO note documented in each patient's chart that they have been assigned responsibility for the patient's care. All H&P's, progress notes, procedures, discharge summaries or any other meaningful note must be sent to the attending physician for cosigning.

## Clinic

Residents are expected to complete clinic progress notes in the EPIC medical record system within 24 hours from a visit though ideally residents are strongly encouraged to complete the notes on the same day as the clinic visit. Failure to complete a clinic note(s) within seven days will result in a removal for a half day from a scheduled rotation and the resident will be charged with the loss of one half day of vacation to facilitate time to complete outdated charts.

**Letters and phone calls:** Letters and phone calls are to be documented in the EPIC system in a timely manner, ideally within 48 hours for results.

## Problem-Oriented Medical Record

Charting in the Family Medicine Residency is based on the Problem-Orientation Method. It is felt that this method will provide the maximum utilization of the material obtained from the patient's history.

The chart should provide a clear and concise picture of the patient. This is accomplished by means of data base which consists of four parts. The parts are as follows:

1. Patient profile
2. Patient history
3. Physical examination
4. Laboratory and x-ray reports

This part of the chart is well done except for the patient profile section. Most charts do not provide a concise picture of the patient as a person.

The second function of Problem-Oriented Method of Charting is to do exactly as the name implies. It orients your thinking in relationship to the patient's problems, their priorities and lays out a comprehensive list of what the patient's needs are.

This leads directly to the third function of the Problem-Orientation Method of Charting which is to develop comprehensive PLANNING to care for the patient. This is broken down into three separate and distinct parts which are:

1. **DIAGNOSIS** - where clarification of a problem is brought to fruition by ruling out the major differential diagnosis and delineating the ramifications of a particular diagnosis.
2. **MANAGEMENT** - this follows naturally from the diagnosis and is the area where therapy in whatever modalities are appropriate are outlined.
3. **PATIENT INFORMATION** - this delineates the plans for educating the patient and his family about the problems they may encounter.

This chart is a communicative instrument and as such, it is more important in our Family Medicine Residency's than in most other practices. In the Centers, the patients start over with new doctors every two to three years and therefore it is necessary and essential that every possible means of the patient's care be communicated to the succession of doctors that will care for the patient. The chart is therefore the basis for continuity of care and it is this continuity of care which is essential to our teaching program.

The chart is a teaching instrument by which the resident learns. The well-organized chart is easy to review and any discrepancies in care of diagnosis can be easily spotted. It also provides a basis for audit. Audit is discussed more fully in this section. Finally, we must remember that health care maintenance is a specific problem which should be unique to family

practice. This is the antithesis of episodic care provided to the individual. To provide comprehensive care to the individual, the family must be a part of the treatment milieu. This includes recognition of genetic predispositions, cultural entities, and family environment risks, which can be either emotional or physical. To deal with a family effectively, the preventative aspects must be stressed. The objective is to shift the responsibility for health care to the family, by appropriate educational means.

## **Chart Documentation**

### Electronic Medical Record

- Note completed in the electronic form. Dictation within the EPIC system is available if necessary. Residents are to be aware of avoiding "cutting and pasting" other providers notes which is a much easier phenomenon with the advent of the electronic medical record. Residents are also to be aware that the medical record contains information that was gathered or performed at the patient visit. Care must be taken that templates, populated lists, etc. used in the medical record represent an accurate assessment of the visit.
- Organize notes in the SOAP or APSO format
  - S. subjective or history
  - O. objective or examination
  - A. assessment or diagnosis
  - P. plan or therapy (indicate if the patient needs to be off from work)

### 2. Letters

- All letters are to be typed or dictated in the electronic medical record and route to the family medicine residency transcription pool. They will print the letter and envelope and give it to the physician's nurse. The nurse will place the letter on the physician's desk to be signed and the nurse will then mail the letter to the patient.
- When you are dictating a letter, please dictate the date, name and address (if available). Dictating punctuation isn't necessary but paragraphing is appreciated.

# **In-training Examination & Board Certification**

## IN-TRAINING EXAMINATION

The American Board of Family Medicine In-Training Examination is a cognitive examination given annually on the last week of October. All residents are released from other rotational responsibilities to be present for the examination. The examinations are scored by the Board, but the results are reported to the Program Director.

The In-Training Examination is similar in emphasis and format to the Certification Examination. It consists of items written to test the core of knowledge and patient management skills in eight major areas: Internal Medicine, Surgery, Obstetrics, Community Medicine, Pediatrics, Psychiatry and Behavioral Sciences, Geriatrics and Gynecology. The physicians who write the test items, as well as the members of the special committee who review them, include both practicing clinicians and teachers in Family Medicine residency programs.

The Program Director and faculty will review both current and past test results to determine if a resident is demonstrating improvement on each successive year's results and to ensure that a resident is ready for the Certification Examination at the end of his/her residency training.

Because of the above, together with the Program's commitment to the ideal of life-long learning, the Program specifies the following:

- Using the Bayesian score predictor provided with the In-training Examination, residents are expected to score at a level that is equal to or greater than 90.0% prediction of passing the certification exam.
- Failure to score above this benchmark requires additional course work.
- Residents scoring under this benchmark are required to complete the Core Content examination monthly (when available). The test booklet and answer booklet will be provided to the resident prior to the examination time. The exam will be held the first Wednesday of every available month at noon at the Family Medicine Residency Conference room. If the resident is unable to attend at the scheduled time, he/she must make arrangements to take the examination within a week of the scheduled time with the residency program coordinator.
- In addition, residents in their **third year** of post-graduate training scoring under the benchmark are also required to complete a board review course. This is an independent study program. The residency program will provide the board review course materials. The resident may choose to use their CME money to attend a live Board Review course which would also satisfy the additional course requirement.
- Residents will be notified via in person and through a signed letter if they are required to complete additional course work as described above.

If a resident is unable to be present for the In-Training Examination, he/she must receive permission from the Program prior to the date of the exam to be granted an excused absence. Residents in the first two years of training, who were unable to take the exam and provided an excused absence, will be enrolled in the additional course work automatically for the academic year. If a third-year resident is unable to take the examination and has an excused absence, they will be provided the option to take the examination later under the supervision of the program. The examination will be hand scored by the Program and a Bayesian score predictor result will be provided to the resident. If the resident scored 90.0% or above, they will not be required to complete a board review course.

## BOARD CERTIFICATION

### Eligibility Requirements for Certification

Residents are required to take the American Board of Family Medicine examination to obtain board certification in April of their final year of training. Third year residents receive a total of \$2000 for CME and it is expected that a portion of the CME money is allocated to offset the ABFM examination fee.

Resident may apply and be permitted to take the examination prior to completion of residency training and prior to obtaining a full and unrestricted medical license. However, all requirements including the medical license and verification of training must be submitted by the final submission deadline to obtain certification.

To become certified by the ABFM, the following requirements must be met:

- Completion of 50 MC-FP points which includes:
  - Minimum of one (3) Knowledge Self-Assessment (KSA)-10 points each
  - Minimum of one (1) Performance in Practice Module (Part IV) with data from a patient population-20 points each
- Application and full examination fee for the MC-FP examination
- Attainment of a full, valid, unrestricted and permanent medical license and compliance with the Guidelines on Professionalism, Licensure, and Personal Conduct
- Successful completion of family medicine residency training
- Successful completion of the MC-FP examination

Deadline for Completion of Training - Residents who are expected to complete training by June 30 are automatically provided the application link for the April examination. Residents who are expected to complete training between July 1 and October 31 may be declared eligible to apply for the April examination based on a recommendation from their residency program director. Residents who are expected to complete after October 31 and before December 31 will be permitted to apply for the November exam.

### Satisfactory Completion of Residency

The Board prefers all three years of post-graduate training to be in the same ACGME-accredited Family Medicine program; however, other training may be considered as equivalent (e.g., Flexible/Transitional Year, AOA Osteopathic Internship, etc.). In these cases and for physicians who have had international training, the American Board of Family Medicine requires residency programs to notify the ABFM of residents who have entering training with advanced placement credit. If the Program Director fails to comply, the Board will determine the amount of transfer credit at the time of its discovery of the transfer. Consequently, the resident may receive less credit toward certification than anticipated and may be required to extend the duration of training.

The last two years of Family Medicine residency training must be completed in the same accredited program. Transfers after the beginning of the PGY-2 year are approved only in extraordinary circumstances.

All candidates' education and training experiences are subject to review and approval by the ABFM.

For more information, please visit the Home Page for the American Board of Family Medicine at <http://theabfm.org>

# Procedures

## PROCEDURE DOCUMENTATION

Family Medicine residents can perform many procedures in both the inpatient and outpatient setting on many rotations throughout the course of training. Each resident will need to track and record all procedures on the current database program. A printed document of procedural data can be generated and downloaded from this database. It is the resident's responsibility to record and maintain the procedure log. This log book will be the basis for whether a resident is given hospital privileges to perform procedures upon graduation.

A database of resident's clinical and procedural experience, both in hospital and in the ambulatory settings is maintained. Most privileges are now granted on an experiential basis, so it is essential that this database be maintained accurately and kept current. While it is the program's responsibility to make such a system available, it is the resident's responsibility to utilize it and enter their procedure activities on the computer.

Procedures are an important part of family medicine. Reductionism in the practice of medicine frequently "streamlines" procedures that could be easily performed in the office to a custom-built center, which is almost invariably more expensive, and less convenient to the patient, than an office setting. Notwithstanding, the procedures that a resident should hope to master will inevitably be directed by that resident's eventual practice site and the needs of his/her patient population. As far as the teaching of procedural skills during residency is concerned, the Program divides them into core, graduation requirement, and elective. A procedural elective is available.

Residents are required to log all procedures, using the database supplied through E-value. Each procedure has a "Basic Skills Qualification" describing the procedure and an assessment form to verify procedure competency. "Basic Skills Qualifications" are available on E-Value. Prior to seeking BSQ certification, a resident should be confident in their skills. The "Basic Skills Qualification" is printed and given to the supervising physician, where after, the resident performs the procedure under direct observation of the supervising physician. The competency assessment is completed by the supervising physician with their signature and given back to the resident. The resident then returns the competency assessment to the Academic Coordinator.

## Procedures/BSQ Curriculum

Focus	Core	BSQ	Elective	BSQ
<b>Derm</b>	<input type="checkbox"/> Incision & Drainage, abscess <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Biopsy, skin, excisional <input type="checkbox"/> Biopsy, skin, punch <input type="checkbox"/> Biopsy, skin, shave <input type="checkbox"/> Laceration, repair <input type="checkbox"/> One-hand knot tying	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Removal <input type="checkbox"/> cyst, inclusion <input type="checkbox"/> lipoma, simple	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>HEENT</b>	<input type="checkbox"/> Eye, fluorescein exam	<input type="checkbox"/>	<input type="checkbox"/> Eye, slit lamp exam <input type="checkbox"/> Removal, foreign body <input type="checkbox"/> nares <input type="checkbox"/> ear canal <input type="checkbox"/> cornea, superficial	<input type="checkbox"/>
<b>GI</b>			<input type="checkbox"/> Anoscopy <input type="checkbox"/> Excision, hemorrhoid, thrombosed <input type="checkbox"/> Sigmoidoscopy, flexible <input type="checkbox"/> Colonoscopy	<input type="checkbox"/>
<b>Ob/Gyn</b>	<input type="checkbox"/> Amniotomy <input type="checkbox"/> Repair, laceration, perineal <input type="checkbox"/> Pap smear	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Biopsy, endometrial <input type="checkbox"/> Colposcopy w/biopsy <input type="checkbox"/> Insertion, electrode, scalp, fetal <input type="checkbox"/> Insertion, intra-uterine, device <input type="checkbox"/> Insertion & removal, Nexplanon <input type="checkbox"/> Insertion, IUPC <input type="checkbox"/> LEEP	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Urology</b>			<input type="checkbox"/> Circumcision <input type="checkbox"/> Vasectomy	<input type="checkbox"/> <input type="checkbox"/>
<b>Inpatient</b>			<input type="checkbox"/> Lumbar puncture <input type="checkbox"/> Intubation, endotracheal <input type="checkbox"/> Insertion, catheter, vein, central <input type="checkbox"/> Paracentesis <input type="checkbox"/> Thoracentesis <input type="checkbox"/> NG tube placement	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Nail</b>			<input type="checkbox"/> Excision, nail plate, ingrowing <input type="checkbox"/> Hematoma, subungual, evacuation	<input type="checkbox"/>
<b>Ortho</b>	<input type="checkbox"/> Arthrocentesis/Injection, joint, major <input type="checkbox"/> Splinting and Casting	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Injection/aspiration <input type="checkbox"/> carpal tunnel <input type="checkbox"/> trigger finger <input type="checkbox"/> DeQuervain's <input type="checkbox"/> Reduction, dislocation <input type="checkbox"/> shoulder <input type="checkbox"/> finger <input type="checkbox"/> Reduction, nursemaid's elbow <input type="checkbox"/> Injection/aspiration <input type="checkbox"/> epicondyle <input type="checkbox"/> trigger point	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Pulm</b>	<input type="checkbox"/> Spirometry, office	<input type="checkbox"/>		<input type="checkbox"/>
<b>Cardio</b>	<input type="checkbox"/> EKG interpretation <input type="checkbox"/> Venipuncture	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Exercise stress test	<input type="checkbox"/>
<b>U/S</b>	<input type="checkbox"/> U/S OB, basic	<input type="checkbox"/>	<input type="checkbox"/> U/S FAST, basic <input type="checkbox"/> U/S MSK, basic <input type="checkbox"/> Injection/aspiration, major joint, U/S guided <input type="checkbox"/> U/S Venous access	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

## CONFERENCES

### Attendance

All residents are expected to attend 80% of all scheduled conferences and required meetings to include noon conference, sports medicine conference, journal club and resident education.

1. To be counted present you must be in attendance no later than 15 minutes from the beginning of the posted start time (i.e., 12:30 pm for noon conference, etc.)
2. If you cannot attend because of rotation conflicts or otherwise, you must report it to the chief resident prior to or shortly following the meeting. The chief resident will then determine if the excuse is valid.
3. All unexcused absences which exceed 80% for a given month will be assessed a loss of one vacation day or an additional day of call.
4. Dental appointment, daycare, etc., are not excused absences, that is what the remaining 20% of lectures are for.
5. It is the chief resident's responsibility to take attendance at all meetings, if they cannot; it is their responsibility to contact another third-year resident to do it for them. Attendance sheets should be turned into the Academic Coordinator in a timely manner.
6. Remember...scheduled meetings are part of your job description...do your job.
7. If a resident is on vacation, they are not expected to be at conferences, it is excused.
8. If you are not on vacation but have the day off per your preceptor, you are still expected to attend conference.

### Meals at Conferences

Meals will be paid for by the Altru Family Medicine Residency program for all conferences sponsored by the residency program. If the conference is cancelled, there is no provided meal. Wednesday Altru conference has a meal provided for them. If you are on call in the hospital, the hospital will provide you with meals while on call.

## PRACTICE MANAGEMENT

A defined curriculum is in place. Additionally, monthly business meetings, at which time practice management matters are discussed, take place.

## COMMITTEES

### **Recruiting Committee**

The purpose of the Recruiting Committee is to provide input to the Family Medicine Residency Program on development of programming to encourage the specialty of Family Medicine and the residency program among medical students and potential applicants. All first-year residents will serve on the recruiting committee.

Activities include:

- Review policies and procedures for interviewing potential residency applicants.
- Participate in planning, developing, and coordinating educational events regularly for medical students.
- Promoting the residency program through conferences and meetings designed to expose medical students to opportunities in Family Medicine.

### **Hospital and Professional Committees**

- Each second and third-year resident will be a member of a health system or professional group committee.
- Committee assignments are determined by the faculty one month prior to the start of the second and third year of residency training.
- Residents will also be required to present an update of their respective committee at business meeting after each committee meeting.

## SCHOLARLY ACTIVITY

***Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning.***

***The program and faculty will create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application and teaching.***

***The program's scholarship will reflect the mission and aims of the residency and the community it serves.***

The residents at the Family Medicine Residency are taught literature search skills and then put them into practice and are evaluated on these skills in journal club, through the completion of scholarly activities, and on clinical rotations.

Each resident will be required to complete at least two scholarly activities throughout the three years of residency training.

Each resident will be required to be the primary presenter for an Internal Medicine topic of their choice as part of the ongoing Internal Medicine lecture series at Altru Health System. Each presentation will meet criteria to be eligible for CME hours for physicians in attendance and will adhere to guidelines necessary to qualify as a CME activity.

A second project will be a quality improvement project via a Part IV module completed through the ABFM. Completion of a Part IV module is required during the third year of residency.

Additional scholarly activities by the residents are encouraged.

All necessary support from the Altru Health System will be provided to allow for successful and meaningful completion of the scholarly activities.

# Policies

## CLINICAL COMPETENCY COMMITTEE POLICY

### Policy

1. The Clinical Competency Committee (CCC) should:  
review all resident evaluations semi-annually;
  - a. determine each resident's progress on achievement of specialty-specific Milestones; and,
  - b. meet prior to the resident' semi-annual evaluations and advise the program director regarding each resident's progress.; and
  - c. develop objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the family medicine milestone.

### Procedure

1. The Program Director must appoint the CCC.
  - a. The CCC will be composed of at least three members of the program faculty, at least one of whom is a core faculty.
  - b. Additional members must be faculty members from the program or other health professional who have extensive contact and experience with the program's residents.
    - The CCC will meet, at minimum, every six months. Additional meetings may be scheduled for ongoing review of resident evaluations
    - The academic coordinator will be responsible for gathering all data for the CCC, coordinating all meetings, and documenting all meetings in the form of minutes
    - Following each CCC meeting, a summary of activity will be presented at the weekly faculty meeting

Approved by GMEC 11/25/14

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## COMMUNICATION POLICY

Residents are required to provide patient care in a safe environment. Autonomy is encouraged. PGY-3 residents should be actively involved in providing supervision for PGY-1 and 2 residents and should be utilized as progressive supervision with the attending physician. PGY-3 involvement does not replace the supervising physician's responsibility.

Circumstances and events in which residents must communicate with the supervising physician:

- Admission to the hospital
- Significant change in patient status necessitating transfer to another level of care
- Cardiac arrest
- Unplanned intubation or ventilatory support
- Development of significant neurologic change (i.e. suspected CVA, seizure, new paralysis, etc.)
- In the absence of an urgent situation, prior to consulting with a specialist, residents are required to discuss the care plan with the attending physician
- Consideration of change in code status
- When hospital staff have questions regarding patient care which cannot be resolved with the residents providing care
- At the request of a nurse, physician, or patient
- For all labor and delivery patients:
  - OB triage patient
  - OB admission
  - Any deviation from normal labor management
  - Anticipated delivery
- Anytime the resident feels a situation is more complicated than he/she can manage

Approved by Faculty 6/14/19

Approved by GMEC 8/27/19

## DISASTER PLANNING POLICY

### Policy

- This Disaster Planning is intended to augment existing sponsoring institutional policy. It is intended to protect the well-being, safety, and educational experiences of the residents/fellows.

### Procedure

- Following declaration of a disaster, the Designated Institutional Official (DIO), Graduate Medical Education Committee (GMEC), Program Director(s) and other sponsoring institution leadership will strive to restructure or reconstitute the educational experience as quickly as possible following the disaster.
- To maximize the likelihood that trainees will be able to complete program requirements within the standard time required for certification in that specialty, steps will be taken to transfer the affected trainees to other local sites. If leadership determines that the sponsoring institution can no longer provide adequate educational experience for its trainees, the sponsoring institution will, to the best of their ability, arrange for temporary transfer of trainees to programs at other sponsoring institutions until the sponsoring institution is able to resume providing the educational experience.
- The Program Director will then give the trainees, who temporarily transfer to other programs because of a disaster, an estimated time that relocation to another program will be necessary. Should that initial time need to be extended, the trainees will be notified by their Program Director using written or electronic means identifying the estimated time of the extension.
- If the disaster prevents the sponsoring institution from re-establishing an adequate educational experience within a reasonable amount of time following the disaster, then permanent transfers will be arranged.
- The Program Director will be the primary institutional contact with the ACGME and the Institutional Review Committee Executive Director regarding disaster plan implementation and needs within the sponsoring institution.
- During and/or immediately following a disaster, the Sponsoring Institution will make every effort to ensure that the trainees continue to receive their salary and fringe benefits during any disaster event recovery period, and/or accumulate salary and benefits until utility restoration allows for fund transfer.
- Longer term funding will be determined based on the expected operations of the teaching sites, CMS and governmental regulations and the damage to the infrastructure of the finance and hospital operations.

Approved by Faculty 2/6/19  
Approved by GMEC 2/26/19

## **DIRECT OBSERVATION OF RESIDENT POLICY**

### **General**

The Altru Family Medicine Residency will utilize direct observation via closed circuit monitoring to assess communication and physical exam skills of the residents.

### **Policy**

PGY1 residents will be directly observed on two occasions by a faculty member and once by a behavioral science faculty member at the start of Block 2 of the academic year. Thereafter, they will be observed by one faculty member in each Block 3-13. Also, all PGY1 residents need to have direct observation of two (2) sports physicals in Block 1.

PGY2 residents will be directly observed six (6) times throughout the academic year by one faculty member. Blocks 2, 4, 6, 8, 10 and 12.

PGY3 residents will be directly observed four (4) times throughout the academic year by one faculty member. Blocks 3, 6, 9 and 12.

The Academic Coordinator (Wanda) is responsible for monitoring when a direct observation is to occur, and documenting when a direct observation is complete. Each resident's nurse will be notified by Wanda when a direct observation for a resident is required. After a patient, has been roomed, and the closed-circuit monitor has been activated, the nurse will find a precepting faculty physician to directly observe the patient encounter. The nurse will notify Wanda when the direct observation is complete. Wanda will send a link to the faculty member from E-value to be completed. If for some reason, Wanda is not available, a note or email should be forwarded to her with the relevant information.

Patient consent for observation is obtained yearly, and scanned to the patients EHR. In addition, signage is placed in each exam room to notify the patient that closed-circuit monitoring may be performed. If a nurse is asked by a patient not to have closed circuit monitoring activated, the patients request will be honored.

Approved by Graduate Medical Education Committee (GMEC): November 2014

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## EDUCATIONAL LEAVE POLICY

Each resident is allowed \$1,000 for educational conferences in each calendar year. An additional \$1,000 is allocated in the third year to offset the expense of American Board of Family Medicine examination fees. To receive this allowance, the resident must be in good academic standing. The following steps must be followed.

1. Leave requests must be signed by the Chief Resident and residency program coordinator six weeks prior to dates requested.
2. The resident will have to pay the registration fee and be reimbursed after the conference.
3. Residents are responsible for making their own travel arrangements.
4. All travel and lodging receipts must be kept and turned in to the residency coordinator to be reimbursed from Altru Health System. This includes:
  - hotel receipt
  - airline ticket stubs
  - canceled check for registration fee\*
  - rental car/taxi
5. Altru Health System will provide reimbursement of the following expenses incurred by resident physicians:
  - Tuition, travel and lodging, relating to meetings and educational courses which carry AMA and/or specialty approved credit
  - Professional journals and books
  - National AMA dues, professional society dues, non-North Dakota and Minnesota license fees and DEA registration fees
  - Continuing medical education materials which have MA and/or specialty-approved credit, not to include electronic devices and hardware
  - Meals will be reimbursed per IRS guidelines
  - Reimbursement will be provided for the following business-related expenses
  - Stethoscope
6. **The following provisions will govern the reimbursement of the expenses:**
  - Expenses will be reimbursed for costs incurred only by the requesting doctor, i.e., expenses incurred for a doctor's spouse or other persons, are not reimbursable
  - All expenses reimbursed must be verified with proper receipts **and submitted to the residency program coordinator who will submit the expenses** to Altru Health System. Credit card statements or records of credit card charges do not qualify as adequate substantiation of expenses because they do not provide detail
  - Reimbursement for business/education travel will be limited to domestic travel within the 50 United States
  - Travel expenses for Continuing Medical Education (CME) credits which can be obtained online, or in any manner where travel to another destination is not required to receive CME credit, i.e., Travel Medical Seminars, will be disallowed
  -

**\*Travel expenses will not be reimbursed if these steps have not been followed.**

Approved by Faculty 2/6/19  
Approved by GMEC 2/26/19

## **FATIGUE AWARENESS & PREVENTION POLICY**

Altru's Family Medicine Residency Program requires that faculty and residents are educated in recognizing the signs of fatigue. Education will include use of the American Academy of Sleep Medicine: Sleep, Alertness, and Fatigue Education in Residency (SAFER) program. Every faculty member and resident will participate in this program and in addition will sign receipt and understanding of this Fatigue Awareness & Prevention Policy.

There is a growing awareness that fatigue has an adverse effect on performance.

### **Fatigued residents typically have difficulty with:**

- Appreciating a complex situation while avoiding distraction
- Keeping track of the current situation and updating strategies
- Thinking laterally and being innovative
- Assessing risk and/or anticipating consequence
- Maintaining interest in outcome
- Controlling mood and avoiding inappropriate behavior

### **Signs of Fatigue Include**

- Involuntary nodding off
- Waves of sleepiness
- Problems focusing
- Lethargy
- Irritability
- Mood lability
- Poor coordination
- Difficulty with short-term recall
- Tardiness or absences at work
- Inattentiveness to details
- Impaired awareness

### **High Risk Times for Fatigue-Related Symptoms**

- Midnight to 6 am
- Early hours of day shift
- First night shift or call night after a break
- Change of service
- First 2 to 3 hours of a shift or end of shift
- Early in residency or when new to night call

### **Response**

Excess fatigue and/or stress may occur in patient care settings as well as non-patient care settings such as lecture and conference. In patient care settings, patient safety and well-being of the patient mandates implementation of an immediate and proper response sequence.

#### Attending physician

- If the attending physician or supervising resident notices evidence of excessive fatigue and/or stress, the attending must release the resident from any further patient care responsibilities at time of recognition.

- The attending or supervising resident should privately discuss their opinion with the resident, attempt to identify the underlying reason for the fatigue, and discuss the amount of rest needed to alleviate the situation.
- The attending or supervising resident will coordinate the distribution of patient care responsibilities among the team and is expected to participate actively in completing the work.
- The resident should use the options of rest at the hospital (call room) prior to driving home, obtaining a taxi to get home or having a fellow resident or other individual drive them home.

**Residents**

- Other residents who notice a colleague’s fatigue have the professional responsibility to notify the supervising attending or chief resident without fear of reprisal.
- A resident who feels fatigued has the professional responsibility to notify the supervising attending or chief resident without fear of reprisal.

**Program Director**

- If the removed resident’s absence results in immediate effect on other residents (i.e. call) this should be accounted for immediately.
- The resident’s call schedule, duty hour report, patient care responsibilities, and personal problems/stressors will be discussed.
- The rotation will be reviewed for potential changes and improvements if deemed necessary.
- If the problem is recurrent or not resolved in a timely manner, the resident may be removed from patient care responsibilities indefinitely and will likely be reviewed at the Clinical Competency Committee meeting to assist in determining what further evaluation needs to occur.

**FATIGUE AWARENESS AND PREVENTION**

I have read, understand and am in agreement with the Fatigue Awareness & Prevention Policy of Altru Health System – Family Medicine Residency.

\_\_\_\_\_  
Resident Printed Name

\_\_\_\_\_  
Resident Signature

\_\_\_\_\_  
Date

Approved by Graduate Medical Education Committee (GMEC): November 2014

# GRADUATE MEDICAL EDUCATION POLICY

## Policy

- Graduate Medical Education Committee (GMEC) oversight includes:
  - the ACGME accreditation status of the Sponsoring Institution and its ACGME-accredited program;
  - the quality of the GME learning and working environment;
  - the quality of educational experiences in the ACGME- accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty-/subspecialty-specific Program Requirements;
  - the ACGME-accredited program's annual program evaluations and self-studies;
  - all processes related to reductions and closures of the ACGME-accredited program, major participating sites, and the Sponsoring Institution; and,
  - the provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided.
- The GMEC will review and approve:
  - institutional GME policies and procedures;
  - annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits;
  - applications for ACGME accreditation of new programs;
  - requests for permanent changes in resident/fellow complement;
  - major changes in the ACGME-accredited program's structure or duration of education;
  - additions and deletions of the ACGME-accredited program's participating sites;
  - appointment of new program directors;
  - progress reports requested by a Review Committee;
  - responses to Clinical Learning Environment Review (CLER) reports;
  - requests for exceptions to clinical and educational work hour requirements;
  - voluntary withdrawal of ACGME program accreditation;
  - requests for appeal of an adverse action by a Review Committee; and,
  - appeal presentations to an ACGME Appeals Panel.
- The GMEC will demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR).
  - The GMEC will identify institutional performance indicators for the AIR, to include, at minimum:
    - the most recent ACGME institutional letter of notification;
    - results of ACGME surveys of residents/fellows and core faculty members;
    - and, each of its ACGME-accredited programs' ACGME accreditation information, including accreditation statuses and citations.

## Procedure

- GMEC members will include:
  - DIO;
  - Program Director;
  - A minimum of two peer selected residents/fellows;
  - The individual or designee responsible for monitoring quality improvement and patient safety; and,
  - One or more individuals from a different department than that of Family Medicine.
- The GMEC will meet a minimum of once every quarter during each academic year.
  - Each meeting of the GMEC will include attendance by at least one resident/fellow member.
  - The GMEC will maintain meeting minutes that document execution of all required GMEC functions and responsibilities.

Approved by Faculty 2/6/19  
Approved by GMEC 2/26/19

## MEDICAL RECORDS

### Office Charting and Coding

- Residents are encouraged to complete outpatient clinic records within 24 hours of the patient encounter. A delinquency will be noted for any charts not completed within seven days of the encounter. A resident with an outstanding chart(s) greater than seven days will be removed from their scheduled rotation and will require being present at the FMR clinic to complete the overdue chart(s). The resident will be charged with ½ day of vacation.
- Altru Family Medicine Residency coders can identify unusual work patterns entering their coding queues as these increases in workflow commonly representing backlogs or delinquent charts. These are identified by resident name and reported to the Program Director.

### Hospital Charting

- The medical records department routinely advises faculty of delinquencies with expectation that such delinquencies will be addressed.
- Admission H&P's and daily progress notes should be completed at the time of service. Discharge summaries should optimally be completed within 48 hours from the time of discharge.
- Any medical records within the hospital not completed within seven days, the resident will be contacted by the Program Director.

Approved by GMEC 11/24/14

## MOONLIGHTING POLICY

Only residents with a current full, unrestricted license to practice medicine are permitted to moonlight. Prior to moonlighting the resident must request and receive a letter from the Program Director granting them permission to do so. **All moonlighting hours must be below the 80-hour duty hour limit when added to their residency duty hours.**

**Residents are responsible for assuring they have malpractice insurance coverage for all moonlighting activities.**

Moonlighting activity must not interfere with residency activities, either directly by overlapping schedules, or indirectly by undue fatigue and stress. Specifically, residents may not use sick leave to recover from moonlighting activities. If a resident was moonlighting and it interfered with clinical expectations this would be addressed with a meeting between the resident and the Program Director or a designee of the Director. Any comments made by other residents, by the Chief Resident or by attendings, either submitted verbally, written or listed on the monthly rotations evaluation would be addressed with the resident individually.

Approved by Graduate Medical Education Committee (GMEC): 8/23/05

Revised 6/24/11

Revised & approved by GMEC: May 2012, November 2014

## NON-COMPETITION POLICY

### Policy

- The residency/fellowship (trainee) agreement is a required, binding contract between the trainee and the institution. The effective date of the initial agreement is the first mandatory date the trainee is required to report to their GME training program.
- If the resident/fellow is in satisfactory standing, the agreement will be automatically renewed on an annual basis for the duration of the training program.
- There are no restrictive covenants on the post-training employment opportunities of trainees. Residents/fellows are free to compete for any physician or academic positions in any geographic area following completion of their training.

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## **NURSING HOME ROUNDS POLICY**

Geriatric nursing home rounds are part of the required geriatric requirement mandated by the Residency Review Committee.

Each resident is assigned two nursing home patients that are shared with a faculty member or community physician. Your listing includes the co-physician and the location of your patient. If there is not a residency listed, you can assume the patient is at Valley Eldercare. The room numbers should be listed there.

Rounds need to be made bi-monthly. If you are meeting the patient for the first time your note should essentially be a H & P. The physical does not have to equal an “annual” but should have an appropriate exam portion. The purpose of this is for you to get acquainted with your patient’s medical and social background and for you to learn as much about them as you can. Bi-monthly rounds are then to follow-up and address any problems. If there is an acute problem, the resident is to be paged by the nurse and then evaluate the patient. If the resident responsible for the nursing home patient is not available, the patient will be seen by the Chief Resident. Communication with the patient’s attending physician should occur after all patient encounters.

Your notes can be done on EPIC. Copies of your notes should be placed on Dr. Hoverson’s desk, so she can track your visits. If you cannot access a note online or find one filed, you cannot receive credit for those visits. Consistently missed visits may result in a two-week Geriatric rotation that is taken in place of an elective. You may also be required to pick up additional call shifts for teaching service or OB.

Please place your pager and nurse’s number on the chart so that if there are questions or issues with the patient, the staff would be able to contact you.

If your nursing home patient is transferred or deceased, you need to let Dr. Hoverson know so that another can be re-assigned to you.

For those residents who have had prior assignments; please check to make sure the listed assignments are correct.

Approved by GMEC 11/25/14

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## PATIENT DISMISSAL POLICY

### Reasons for Dismissal

- Persistent failures
- Noncompliance with treatment plan (prescription agreement plans)
- Rude, disruptive, unreasonably demanding, or threatening behavior
- Seductive behavior toward staff or physician
- Sentinel event (verbal threat, violence, criminal activity)
  - o Ground for termination with only one violation
- Other violations deemed appropriate by physician

### Procedure for dismissal and policy

- Written notice (certified mail) of letter outlining practice dismissal and ability to be available for emergent basis for medical needs for next 30 days.
- Letter template is available in epic (“A Medication Agreement Dismissal Letter”). Modify letter appropriately if cause for termination is other than “Medication Agreement” violation.
- If there is a combination of three dismissals from FMR, FMC, FM EGF, or FMS the patient “will no longer be seen by Altru Family Medicine.” This statement should be added to the letter.
  - o The “three strike policy” is from 1/30/14 onward
- If the physician feels that a single dismissal is cause for patient to no longer be seen by Altru Family Medicine, they can have case reviewed with Department Chair and Medical Director for review and decision. (not needed for sentinel events)
- Residents who determine that dismissal is necessary must discuss the case with the Program Director, write the dismissal letter, and review the letter with the Program Director. The Program Director will then place an FYI in the patient’s medical record specifying “patient may no longer be seen by residents,” or “patient will no longer be seen by Altru Family Medicine.”

Approved at the Faculty 2/15/17

## PROFESSIONALISM POLICY

### Goal

Physicians, fellows, residents, and medical educators are expected to consistently demonstrate professional behavior. Professional competence is the habitual use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served. Altru FMR endeavors to achieve professional competence.

### Policy

- Residents, fellows, and faculty will demonstrate respect, compassion, and integrity
- Residents, fellows, and faculty will demonstrate a responsiveness to the needs of patients that supersedes self-interest and a commitment to excellence and on-going professional development
- Residents, fellows, and faculty will demonstrate a commitment to ethical principles, confidentiality of patient information, informed consent and business practices
- Residents, fellows, and faculty will demonstrate sensitivity and responsiveness to patient' culture, age, gender, and disabilities
- Residents fellows, and faculty will recognize impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team
- The Residency, in partnership with their Sponsoring Institutions, will provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff.

### Expectations

- Work hard and put forth best effort always.
- Be on time to all rotations, educational opportunities, meetings, patient care activities, rounds, etc. If a resident is going to be late due to an unavoidable circumstance, they will notify the person in charge as soon as reasonably possible that they will be late and when they expect to arrive.
- Be diligent in patient care activities and address issues in a timely fashion (except when away on vacation or on an away rotation). Residents will adhere to the following guidelines.
  - Address routine patient telephone and medication requests by 5:00 pm of the next business day.
  - Address urgent patient telephone, lab or medication requests by 5:00 pm daily.
  - Notify patients of all test results (immediately by phone for life-threatening results, within 24 hours by phone for those that are significantly abnormal, all others within one week by phone, letter, or My Chart). Document notification appropriately.
  - Finish documentation of office encounters and forwarded to the attending preceptor within 24 hours to ensure they are closed within 72 hours.
  - Complete patient paperwork or forms as necessary.
- Be attentive and actively engaged in all educational activities (e.g., rounds, conferences).
- Be prepared and ready for discussions related to patients.
- Complete assignments in a timely fashion.

- Treat patients, medical students, residents, staff, and faculty with courtesy, respect and dignity.
- Praise others in public, provide constructive feedback in private, and avoid gossip.
- Commit to total honesty and integrity. Examples include the following.
  - Residents are where they are supposed to be.
  - Document only what is performed and what occurred.
  - Do what is right even when nobody is looking.
  - Residents are accountable for what they do and don't do
  - Do not blame others.
  - Do not lie.
  - Show up prepared.
- Commit to teamwork, evidenced by the following.
  - As part of teamwork, residents will be responsible for their work first. If someone needs help, they will willingly assist without complaining.
  - Residents will recognize and appreciate contributions of all team members.
  - Residents will help set and understand team goals.
  - Residents will learn how to give and receive feedback graciously.
- Commit to excellence in patient care.
- Demonstrate "ownership" of patients.
- Place the safety of patients first and before personal interests.
- Conduct safe and complete patient handoffs.
- Make an honest effort to read daily on something medically-related, and engage in a pattern of life-long learning by actively asking and answering questions.
- Use sick leave for which it is intended – a personal or family illness.
- Assurance of personal fitness for work, including:
  - Management of time before, during, and after clinical assignments
  - Recognition of impairment, including from illness, fatigue, and substance use in themselves, their peers, and other members of the health care team
- **The potential hazards of copy-forward will be recognized. Copy-forward increases efficiency for documentation purposes; however, copy-forward can result in documentation that is inaccurate and does not reflect care that was provided and/or misrepresent current patient status. Copy-forward may be utilized, however, information must be authenticated.**
- Read and follow all policies as outlined in the Residency Handbook.

## Procedure

- The Program Director will meet with incoming residents/fellows during orientation to discuss punctuality, timely completion of medical records, on-call responsibilities, communication, unusual sick leave patterns, confidentiality, falsification of information in EMR, adherence to ethical principles, compassion, integrity, respect, and responsiveness to patient needs
- All rotation evaluations completed by the attending physician will have questions pertaining to professionalism. In addition, evaluations on resident/fellow performance will be completed by other residents for select rotations, and nursing staff at FMR. Residents/fellows may review the monthly evaluation. All evaluations are reviewed monthly by all faculty members. In addition, the Clinical Competency Committee reviews all monthly evaluations to provide a summative evaluation no-less-than twice yearly. The summative evaluation will be reviewed with the resident or fellow by a scheduled meeting with a faculty member

- Patient satisfaction survey questions will address professionalism. Survey results will be shared with the residents and fellows at the bimonthly business meeting
- Residents/fellows will receive directive regarding professionalism at monthly practice management and bimonthly ethics conferences
- Breeches in professionalism will result in referral to the Resident Progress Committee
- **Untruthfulness may result in immediate termination from the residency or fellowship at the discretion of the Program Director**
- Residents are expected to perform no less than two scholarly activities during training as a means of ongoing professional development. Scholarly activity fulfillment will be reviewed with faculty at twice-yearly evaluation

Approved at the Faculty Meeting 3/29/16; Approved at the Faculty Curriculum Retreat 6/17/16

Approved by GMEC 5/21/16

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

### **PROGRAM CLOSURE/SIZE REDUCTION POLICY**

In the event of the Sponsoring Institution reduces the size or closes the residency, the Sponsoring Institution will:

- inform the GMEC, DIO, and affected residents/fellows as soon as possible; and
- allow residents/fellows already in an affected ACGME-accredited program(s) to complete their education at the Sponsoring Institution, or assist them in enrolling in (an)other ACGME- accredited program(s) in which they can continue their education.

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## PROGRAM EVALUATION COMMITTEE POLICY

### **Program Evaluation Committee (PEC) responsibilities will include:**

- ⊖ Acting as an advisor to the program director, through program oversight;
- ⊖ Review of the program's self-determined goals and progress toward meeting them;
- ⊖ Guiding ongoing program improvement, including development of new goals, based upon outcomes; and,
- ⊖ Review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.
- The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats.
- The PEC will be appointed by the Program Director and include at least two faculty, at least one of whom is a core faculty, and at least one resident
- The PEC must meet at least twice a year and additional meetings may be scheduled to continue to review data and formulate action items as needed
- The Program Coordinator will be responsible for gathering all data for the PEC, coordinating all meetings, documenting all meetings in the form of minutes and disseminating all pertinent findings
- The PEC, must document formal, systematic evaluation of the curriculum and is responsible for rendering a written Annual Program Evaluation (APE)
- The PEC must create an action plan for the following year
- Minutes will be taken at each meeting
- Following each PEC meeting, a summary of activity will be presented at the weekly faculty meeting

### **Annual Program Evaluation (APE)**

- The annual program evaluation will be performed by the PEC annually as part of the program's continuous improvement process
- The Annual Program evaluation will consider the following:
  - ⊖ Curriculum;
  - ⊖ Outcomes from prior Annual Program Evaluation(s);
  - ⊖ ACGME letters of notification, including citations, areas for improvement, and comments;
  - ⊖ Quality and Safety of patient care;
  - ⊖ Aggregate resident and faculty:
    - Well-being;
    - Recruitment and retention;
    - Workforce diversity;
    - Engagement in quality improvement and patient safety;
    - Scholarly activity;
    - ACGME Resident and Faculty Surveys; and,
    - Written evaluations of the program.
  - ⊖ Aggregate resident:
    - Achievement of the Milestones;
    - In-training examinations;
    - Board pass and certification; and,
    - Graduate Performance.
  - ⊖ Aggregate faculty:
    - Evaluation; and,
    - Professional development.
- The annual review, including the action plan, will be distributed to and discussed with;
  - Members of the teaching faculty;
  - Residents; and,
  - Submitted to the DIO.

Approved by GMEC 11/25/14

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## QUALITY AND SAFETY POLICY

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Altru FMR will prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents will demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures. It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

A faculty member will be selected by the Program Director as the FMR Director of Quality and Safety

### Definitions

- **Near-miss:** an unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Only a fortuitous break in the chain of events prevented an injury, fatality or damage; in other words, a **miss** that was nonetheless very **near**
- **Adverse event:** medical errors that healthcare facilities could and should have avoided

### Policy

#### SAFETY

- Educate residents and faculty on the difference between near-miss and adverse event
- Educate residents and faculty of the importance of identifying near misses within the practice environment AKA “good catch”
- Create an opportunity to report near-misses and adverse events in a structured and open environment
- Develop initiatives to improve quality through a root cause analysis of near-misses and adverse events
- Residents and faculty will participate in inter-professional teams to promote and enhance safe care
- Residents, fellows and faculty will receive training in how to disclose adverse events to patients and families. They will have the opportunity to participate in disclosure of patient safety events, real or simulated

#### QUALITY

- Residents and faculty will participate in Altru’s quality improvement programs, including an understanding of health care disparities
- Residents and faculty will participate in quality improvement initiatives at FMR and demonstrate impact.
- Residents and faculty will receive feedback on individual and system performance for quality initiatives
- As requested by Altru Quality and Patient Safety, residents and a faculty member will participate in hospital-based RCA’s
- RCA’s will be done at FMR on an as-needed basis

## Procedure

### SAFETY

- Residents and faculty will report near-misses and adverse events at FMR via Clarity
  - Clarity submissions will be reported to the Academic Coordinator
  - Clarity submissions will be reviewed at the quarterly near-miss/adverse event forum. All clinic staff including the nurses, ancillary supporting staff, Academic Coordinator, Program Coordinator, residents, and faculty will be in attendance. Near-misses and adverse events will be discussed. Consensus opinion will determine which Clarity submissions require root-cause analysis. Teams of residents will be assigned with a faculty member to perform root-cause analysis and present their findings at the following near-miss/adverse event forum
  - Encourage ongoing reporting by offering incentives for the first reported near-miss or adverse event and every five thereafter. Also, once quarterly a random drawing for a gift certificate will occur from each reported near-miss from the previous quarter.
- Residents and faculty will report errors, unsafe conditions, and near-misses at Altru Hospital.
  - Residents and faculty will file reports through Clarity
  - Reports through Clarity will be handled per hospital protocol
  - If it is determined that the submitted report requires root cause analysis, residents and/or faculty will be involved in the hospital process, and report findings at the near-miss/adverse event forum
- Twelve didactic noon lectures are dedicated to discussing patient safety/quality initiatives.
  - Educational Lecture discussing the importance of identifying near misses
  - Quarterly, a team of three residents will identify an area of interest pertaining to patient safety. Seventy-five charts will be reviewed. Prior to chart review, residents will determine the threshold they believe is necessary to satisfy that FMR is providing “safe care.” Quarterly, a quality-safety forum will be held where the team of residents will educate other faculty and residents on the safety issue of interest. Results will be discussed from the chart review. If FMR has not achieved the threshold set by the residents, another chart review will occur 6 months following to establish that “safe care” is being provided
  - Quarterly, a near-miss/adverse event forum will occur
  - Other lectures will be reserved for further review of root-cause analysis that has been performed
- A second and third year resident will serve on the Patient Safety and Antibiotic Stewardship committees at Altru. They will provide committee reports at bimonthly business meetings.

### QUALITY

- Twelve didactic noon lectures are dedicated to discussing patient safety/quality initiatives.
  - Quarterly, a team of three residents will identify an area of interest pertaining to quality patient care. Seventy-five charts will be reviewed. Prior to chart review, residents will determine the threshold they believe is necessary to satisfy that FMR is providing “quality care.” Quarterly, a quality-safety forum will be held where the team of residents will educate other faculty and residents on the quality issue of interest. Results will be discussed from the chart review. If FMR

has not achieved the threshold set by the residents, another chart review will occur 6 months following to establish that “quality care” is being provided.

- Dashboard data, patient satisfaction data, performance on CMS Quality Measures, and individual/clinic CG-CAHPS scores will be reviewed with the residents at bimonthly business meetings.
- A second and third year resident will serve on the Altru Quality Council and readmission committee. They will provide committee reports at bimonthly business meetings.
- Understanding healthcare disparities will be discussed during bimonthly ethics conference and care provided at the jail, Third Street Clinic, Valley Health, New American physicals, and patients from the Douglas Place.

Approved at the Faculty Meeting, 3/29/16

Approved by GMEC 5/21/16

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## RESIDENT/ADVISOR MENTOR POLICY

Effective Date: July 1, 2014

### Policy

1. Advisors
  - a. Are **assigned** to assist the resident in creating, progressing, and attaining their goals and objectives
  - b. Collaborate with other program faculty to build relationships
  - c. Address resident's needs and concerns
2. Mentors
  - a. Are **chosen** by residents and will function for the same purpose as the advisor

### Procedure

1. First year residents will be randomly assigned an advisor by the Program Coordinator
2. Following completion of PGY -1, residents will be contacted by the Program Coordinator and given the option of continuing their advisor as a mentor or changing to a different mentor.
3. Faculty members will not be assigned more than three advisees or mentees.
4. If the relationship between the advisor/advisee or mentor/mentee is not satisfactory to either, the Program Coordinator will assign a new advisor/mentor
5. Following a known resident adverse event, the Program Coordinator will notify the advisor/mentor as necessary
6. Advisors/mentors will meet with their assigned residents twice yearly, at minimum, for general discussion

Approved by GMEC 11/25/14

Approved by Faculty Meeting, 2/6/19

Approved by GMEC 2/26/19

Approved by Faculty 6/14/19

## RESIDENT COMPLETION OF USMLE STEP 3 AND LICENSURE POLICY

All residents participating in the Family Medicine Residency (FMR) program must receive a North Dakota Resident Training License to begin training.

All FMR residents must pass the USMLE Step 3 exam within 18 months of beginning their first post-graduate year of training. Residents who enter the Altru Family Medicine Residency program in other than the PGY-1 year must pass the exam within six months of entry. This applies to U.S. and international medical school graduates alike. A grace period of additional six months may be granted by ~~individual~~ the residency program director if, in the director's judgment, extenuating circumstances have affected a resident's ability to meet the requirement. Failure to pass Step 3 on the first attempt will necessitate a referral to the Resident Progress Committee. Failure to pass Step 3 on the second attempt will result in termination.

Approved by Graduate Medical Education Committee (GMEC): 8/23/05

Revised & approved by GMEC: May 2012, November 2014

## RESIDENT/FACULTY WELLNESS POLICY

### Goal

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician; and, require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training. Altru FMR has the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

Residents and faculty members are at risk for physician distress and depression. The Residency Program, in partnership with the Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment model's constructive behaviors and prepares residents with the skills and attitudes needed to thrive throughout their careers.

### Policy

- Efforts to enhance the meaning that each physician find in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships.
- Attention to scheduling, work intensity, and work compression that impacts fellow well-being.
- Evaluating workplace safety data and addressing the safety of fellow and faculty members.
- Policies and programs that encourage optimal resident and faculty member well-being, and;
  - Fellows will be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.
- Attention to fellow and faculty member burnout, depression, and substance abuse. The program will educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Fellows and faculty members will be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, will:
  - encourage fellows and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence
  - provide access to appropriate tools for self-screening; and,
  - provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.
- There are circumstances in which residents/fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. The program will have policies and procedures in place that ensure coverage of patient care if a resident may be unable to perform their patient care responsibilities. These policies will be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.

## Procedure

- Essence of being a fellow/faculty member
  - Fellows and faculty will have scheduled time in clinic (refer to “Clinic Schedule Guidelines”)
  - Fellows will be allowed progressive autonomy (refer to “Resident Supervision Policy”)
- Scheduling and work intensity
  - Refer to Work Hour Policy
- Focus on quality and safety
  - Refer to Quality and Safety Policy
- Burnout, depression, and substance abuse
  - Fellows and faculty have access to the Employee Assistance Program (EAP) by phone, in person, or online 24 hours a day, 7 days a week 365 days a year allowing free, confidential support for depression, stress, anxiety, chemical dependency, physician burnout, relationship & parenting issues, legal & financial concerns, employee conflict, etc.
    - Phone: 1-800-383-1908
    - VITALWorkLife.com
      - Username: Altru
      - Password: Member
- Physician Wellness via AltruLink (<http://www.altrulink.org/physicians/physician-wellness/>)
  - Resources include the following:
    - Coaching and Support
      - The program is staffed by licensed social workers, psychologists, and peer coaches trained to provide support and consultation to other physicians/providers. Why a peer coach? It is no secret that providers often are reluctant to ask for help. However, providers will often consult physician/provider peer coaches when they are experiencing:
        - unusual levels of stress or anxiety;
        - sudden loss of temper or uncharacteristic outbursts;
        - negative feedback from peers, patients or staff;
        - concerns about substance abuse;
        - difficulty balancing the demands of family and practicing medicine.
      - Your peer coach can be a confidential and knowledgeable sounding board for a variety of work- and home-related issues.
      - Your Provider Wellness Resources benefit also includes unlimited access to online resources, including articles, downloadable audio files, interactive learning sessions, self-assessment tools and financial calculators.
      - To learn more, download a copy of our Physicians’ Coaching and Support fact sheet, contact us or call 877.731.3949
    - Concierge/WorkLife Assistant
      - In addition to the traditional counseling, and support for emotional issues, Provider Wellness Resources features virtual concierge services – the WorkLife Assistant. Concierge experts can assist you when you are at home or traveling. In fact, they can provide complete trip planning services. They also can:

- arrange for a house cleaner or schedule your car to be detailed;
- purchase tickets to an event (even those that are hard to get into) or find a romantic nightspot;
- find summer camps for your children or eldercare for a parent;
- find that perfect gift or send flowers;
- locate a rare bottle of wine or plan a retirement party.
- Etc.
- Consulting
- Physician Intervention
- Physician Wellness Resources
- Training and Education
- Sick and emergency leave
  - Refer to Sick and Emergency Leave Policy
- Medical appointments
  - Fellows who cannot schedule a medical appointment over the noon hour, or who have urgent health care needs, should contact the Program Coordinator with notification of time that will be missed for the medical appointment. The Program Coordinator will arrange for patient care coverage in the fellows' absence.
- Resident Wellness Committee
  - One faculty member and 1-2 resident representatives from each class-year
  - Budget \$5,000/academic year
  - At minimum, quarterly meetings
  - Plans wellness curricular activities for residents, fellows, and faculty
  - Arrange wellness didactic curriculum
  - Track workforce safety data with the assistance of the Program Coordinator

Approved by GMEC 5/23/17

Approved by faculty 6/16/17

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## RESIDENT/FELLOW FAIR PROCESS AND GRIEVANCE PROCEDURE

### Statement of Purpose

The role of a resident or fellow in the residency program at Altru Health System or the Altru Sports Medicine Fellowship, respectively, is educational in nature. A resident/fellow contract details a direct professional involvement with patients, other physicians and institutions, and reflects a role that is unique and sensitive. It is therefore acknowledged by Altru Health System and the resident/fellow that the following grievance and fair process rights shall be the sole and exclusive rights to which a resident/fellow is entitled.

The policies and procedures contained herein relate to the Altru Health System discipline of residents and fellows. Also, contained herein is the process by which a resident/fellow may grieve.

#### I. Policy on Discipline of Resident/Fellows

##### A. Altru Health System

1. Residents/fellows can be disciplined for both academic and non-academic reasons. Forms of discipline include, but are not limited to: verbal reprimand, written reprimand, remediation, probation, extension of training, suspension, and dismissal. Suspension and dismissal can give rise to a hearing.

#### **Grounds for such disciplinary actions include, but are not limited to:**

- a. Demonstrated incompetence in professional activities related to the fulfillment of assigned duties and responsibilities associated with the position;
- b. Demonstrated dishonesty in any dealing with Altru Health System or in professional activities related to the fulfillment of assigned duties and responsibilities associated with the position;
- c. Inability to satisfactorily perform functions essential to rendering proper medical care to patients and otherwise required of physicians providing direct patient care;
- d. Personal conduct that substantially impairs the individual's fulfillment of properly assigned duties and responsibilities;
- e. Substantial incapacity (physical or mental) to perform properly assigned duties;
- f. Failure to improve performance in an area identified in formal counseling or a written warning;
- g. Failure to satisfactorily complete probation;
- h. Conduct which violates professional and/or ethical standards;
- i. Failure to fulfill any term of the employment contract or violation of Altru Health System or affiliated training site policies;
- j. Violation of:

- 1) The rules of the Program in which the Resident/fellow is assigned;
  - 2) The rules of the institution to which the Resident/fellow is assigned; or
  - 3) The law.
- k. Inadequate medical knowledge, deficient application of medical knowledge to either patient care or research, deficient technical skills, or any other deficiency that adversely affects the Resident's/fellow's performance; or
- l. Disruptive behavior.
2. When problems arise concerning a Resident's/fellow's performance that may result in suspension or dismissal of the Resident by the Program Director, the following procedures shall be followed:
- a. Initial Investigation: The Program Director shall conduct an initial investigation. At the discretion of the Program Director, the resident/fellow may be placed on administrative leave during the initial investigation.
  - b. Informal Resolution: Unless the situation requires immediate action, the Program Director and the Resident/fellow shall meet to discuss the matter.
  - c. When an initial investigation has been conducted and no informal resolution has been achieved; the Program Director has the authority to:
    - 1) Suspend the Resident/fellow;
    - 2) Require remediation; or,
    - 3) Move to dismiss the Resident or Fellow.
  - d. Written Notice: Within forty-eight (48) hours of the decision by the Program Director to suspend, remediate, or move to dismiss the Resident/fellow, the Program Director shall deliver or mail a written notice of the decision to the Resident/fellow. If the decision is placed in the mail, it should be sent registered, return receipt.
  - e. Right to Hearing: The Resident/fellow is entitled to a hearing for disciplinary actions of suspension, remediation or action to dismiss by submitting a written request for review by a Hearing Panel to the Program Director within five (5) working days after receipt of notice of the Program Director's decision. The Program Director shall promptly forward the written request to the Designated Institutional Official (DIO) who will then convene the Hearing Panel and schedule a date and time for the hearing, which is to occur within ten (10) working days after receipt of the written request for a hearing by the DIO.
3. Hearing Panel
- a. The Hearing Panel shall consist of five (5) physicians defined as those who currently hold staff or resident privileges at Altru Health System. They shall be selected from at least four (4) physicians nominated by the Resident/fellow and at least four (4) physicians nominated by the Program Director. The Program Director and the resident/fellow shall each confirm the willingness and availability of their nominees to participate before submitting their names.

- 1) Two physicians, one of who may be a resident or fellow, selected by the (DIO) or designee from the physicians nominated by the aggrieved Resident/fellow. If the resident's/fellow's nominees prove to be unwilling, unable or ineligible to participate the DIO may appoint two other physicians of his or her own choosing.
  - 2) Two physicians selected by the DIO or designee from the physicians nominated by the Program Director. If the Program Director's nominees prove to be unwilling, unable or ineligible to participate the DIO may appoint two other physicians of his or her own choosing.
  - 3) A physician from a different department, who will act As Chair of the Hearing Panel, designated by the DIO.
- b. Convening of the Hearing Panel and the conduct of the hearing shall proceed according to the "Hearing Procedures for Resident/Fellow Grievances."
- c. Decision by Hearing Panel: The Hearing Panel will make a finding of facts and then choose from the following options in arriving at a decision:
- 1) Affirm the Program Director's decision;
  - 2) Reverse the Program Director's decision and reinstate the Resident/Fellow; or
  - 3) Reverse the Program Director's decision and reinstate the Resident/Fellow only after the Resident/Fellow has met certain, specified conditions precedent to reinstatement, which conditions shall include established time limitations for completion by the Resident/Fellow.

In considering any reinstatement, the Hearing Panel should refer to Section I.A.5. "Limitation on Reinstatement."

- e. Confidential Hearing Record: A confidential hearing record will be maintained in the Office of the Chair of the Graduate Medical Education Committee (GMEC) and will consist of:
- 1) A copy of the written notice sent to the Resident/fellow of the action taken;
  - 2) A written summary of the hearing together with all documentary and other evidence offered or admitted into evidence;
  - 3) Any other materials considered by the Hearing Panel; and
  - 4) The written decision of the Hearing Panel. The written decision of the Hearing Panel will also be kept as part of the Resident's/fellow's educational record.
4. Appeal to Designated Institutional Official:
- a. The Resident/fellow will have five (5) working days to submit an appeal in writing to the Designated Institutional Official. The appeal is to be filed using a form designated for the purpose.
  - b. An appeal to the DIO will trigger an automatic procedural review.
  - c. Within fifteen (15) working days after receiving the written appeal, the DIO shall issue a written decision based upon the confidential hearing record and the procedural review. All information relevant to the hearing process will be available to the Designated Institutional Official for review, if necessary. The Designated

Institutional Official may approve, reject, or modify the decision in question or may require the original hearing to be reconvened for the presentation of additional evidence and reconsideration of the decision. If the Designated Institutional Official requires the hearing to be reconvened, the reconsidered decision made by the Hearing Panel may again be reviewed by the Designated Institutional Official. If the Hearing Panel is not reconvened or if the Designated Institutional Official approves the Hearing Panel decision or modifies the Hearing Panel decision, the Designated Institutional Official's decision is final and unappealable.

5. Limitation on Reinstatement: Any decision, at any level of this appeal process, which includes a right to reinstatement must also include a specific timeline for completion of the conditions precedent to reinstatement and such reinstatement must comply with the applicable rules governing the residency program involved.
6. Determination of Deadlines and Definitions: "Working days" are defined as Monday through Friday, excluding holidays. If the person responsible for making a determination is out of the office, the counting of "working days" is suspended until the decision-maker returns to the office.

II. Procedures for Grievance Brought by a Resident/Fellow:

- A. Grievance Defined: A grievance is defined as a problem specific to the grieving Resident/Fellow regarding policies, procedures, personnel, interpersonal relationships, non-renewal or other contractual concerns. The items listed under section I.A.1. in this document, cannot be grieved under this section.
- B. Informal Resolution: A Resident/Fellow with a grievance shall discuss the problem with the Program Director. If the grievance involves the Program Director, the Resident/Fellow shall discuss the problem with the Associate Program Director. If the grievance involves the Program Director and the Associate Program Director, the Resident/Fellow shall discuss the problem with the DIO. If the problem occurs within a hospital or ambulatory care setting, the Resident/Fellow shall first discuss the problem with the on-site supervising staff member unless the grievance involves the on-site supervising staff member, following which the site supervisor will discuss it with the Program Director. If the grievance involves the on-site supervisor, the Resident/Fellow shall discuss it with the Program Director. The DIO shall be informed of all informal resolutions.
- C. Formal (Written) Grievance: If the problem is not resolved informally, the grievance shall be submitted in writing to the Program Director stating the specific basis for the grievance and the relief requested. The Program Director shall submit a written response to the Resident/Fellow within ten (10) working days after receipt of the written grievance.
- D. Review of Grievance Decision: If the Resident/Fellow is not satisfied with the response received, the grievance may be submitted in writing to the DIO with the Program Director's response attached for review and final resolution. The DIO or designee shall provide the Resident/Fellow and the Program Director with a written statement as to the final resolution of the grievance within ten (10) working days after receipt of the grievance. This decision is not appealable.
- E. Determination of Deadlines: "Working days" are defined as Monday through Friday, excluding holidays. If the person responsible for deciding is out of the office, the counting of "working days" is suspended until the decision-maker returns to the office.

This signature indicates I have read, understand, and agree to abide by this policy and its procedures.

\_\_\_\_\_  
Resident's/fellow's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
For the Contract Year

Approved by Graduate Medical Education Committee (GMEC): 8/23/05  
Revised & approved by GMEC: May 2012, November 2014, February 2015  
Approved by Faculty 2/6/19  
Approved by GMEC 2/26/19

## RESIDENT LEAVE POLICY

### Residency Training Requirements for Board Certification Eligibility:

All residents must have core clinical training that includes the breadth and depth of Family Medicine. The Program Director is required to attest to the resident's satisfactory performance and completion of the program requirements. The Program Director is expected to sign, on behalf of the program, that the resident has met all requirements for board eligibility. These include, but are not limited to:

1. Residents are required to spend their PGY-2 and PGY-3 training in the same residency program's teaching practice, in order to provide sustained continuity of care to their patient
2. Each year must include a minimum of 40 weeks of continuity clinic experience
3. Residents must provide a minimum of 1650 in-person patient encounters in the continuity practice site to be eligible for ABFM certification.
4. 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.

### Vacation

1. Residents shall receive three weeks (3 weeks or 21 calendar days = 15 weekdays + 6 weekend days) of paid vacation annually to be taken in periods of time mutually agreed upon by resident, training site, and Program Director. Vacation is non-cumulative from one year to the next.
2. Vacation requests should be submitted to the Chief Resident and the Residency Program Coordinator for approval. Residents wishing to take leave must have leave requests turned in at least six weeks for which leave is being requested. Residents with tardy leave requests may still take leave but must first **personally** arrange cover for call and clinic
3. Residents may take no more than seven consecutive days per month without special permission or no more than two days per two-week rotation
4. It is advised that you do not take vacation during the obstetrics or FPTS rotations. If resident requests a vacation leave during these rotations, the request must be submitted to the Program Director for review and final approval
5. Residents may obtain an extra vacation day by being on call during holidays as specified through Altru Policy. The Chief Resident will get an extra half day for being on chief call on a holiday.

### Meetings

Residents shall receive one week (7 calendar days = 5 weekdays + 2 weekend days) of paid leave for professional meetings, annually and non-cumulatively. ~~Leave taken under this section does not count towards the thirty (30) days of allowable leave in "Makeup for Extended Leave" as below.~~ Further details are found in "Educational Leave Policy".

### Sick Leave/Absences

1. Refer to Institutional Sick Leave Policy
2. Residents will be granted sick or emergency leave as needed. Before taking emergency leave or sick leave, the resident should contact the Chief Resident and the residency Program Coordinator

3. Residents will accumulate one day of sick leave per month of work for a maximum of 12 calendar days of paid sick leave per calendar year for personal and dependent illness. Sick leave is noncumulative from one year to the next.
4. Residents shall provide medical verification for absences due to illness when requested. Residents who use all allotted sick leave may not meet ACGME or certification board requirements. Refer to "Makeup for Extended Leave"

### **Additional Sick Leave**

~~Additional *unpaid* sick leave may be granted with written permission from the resident's program director. Additional sick leave shall not be credited as training time and will result in makeup requirements as described in "Makeup for Extended Leave."~~

### **Parental Leave Policy**

1. Please refer to institutional Parental Leave Policy
2. A parental leave that results in a total time away from the training program of more than 30 calendar days for all reasons will result a requirement to make up lost time. The resident may be subject to the provisions of "Makeup for Extended Leave."

### **Family Leave of Absence Policy:**

Family Leave provided under this policy is intended to be provided in the same circumstances specified in the federal Family and Medical Family Leave Act (FMLA), including:

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

### **Time Allowed for Family Leave of Absence Family Leave Within a Training Year:**

1. ABFM will allow up to 8 weeks for Family Leave in a given academic year. This leave is in addition to Vacation Leave allowed by the program. Eight weeks is defined as **42 working days or 60 calendar days**. Residents must **still achieve 40 weeks of continuity experience in each PGY year**, including any academic year in which they take Family Leave. Family Leave and Vacation Leave may be combined for up to 12 weeks away from the program in a given year to accommodate parental leave, personal medical leave, or care of immediate family. ABFM encourages programs to preserve at least one week of vacation outside of the Family Leave period for the resident to have for time off in that same year unrelated to their Family Leave.
2. Total Time Away Across Training: A resident may take up to a maximum of 20 weeks of leave over the three years of residency (104 working days or 149 calendar days). This includes Family Leave (up to 8 weeks total) and Vacation Leave (as allowed by the program). If either 12 weeks away from the program in a given year, and/or a maximum of 20 weeks total, is exceeded (e.g. second pregnancy, extended or recurrent personal or family leave) extension of the resident's training will be necessary to cover the duration of time that the individual was away from the program in excess of 20 weeks. Residency Directors must make appropriate curricular adjustments and notify ABFM of requested extensions through the RTM system, for approval by ABFM. Reports must include an explanation for the absence from training, the number of total days missed, and a plan for resuming training as basis for calculating a new graduation date.
3. Residents must still achieve 1650 continuity visits by the end of residency.
4. Additional Considerations:
  - ABFM will allow Family Leave to cross over two academic years. In this circumstance, the Program Director and sponsoring institution will be the ones to decide when the resident is advanced from one PGY-year to the next.

- Vacation time may be taken as part of approved Family Leave, or in addition to approved Family Leave. The ABFM's position is that all Vacation Leave should not be exhausted for the purposes of Family Leave. Vacation Leave is important for resident well-being and should not be sacrificed entirely during a period of Family Leave. Programs should preserve a minimum of one week of Vacation Leave in any year in which a resident takes Family Leave.

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

5 ABFM does not require approval of a resident's Family Leave if it is taken as outlined, and as long as the resident is on schedule to meet other training requirements. However, ABFM still requests that residencies report in RTM any Family Leave or other LOA, even when extension of training is not required, to allow for data tracking that supports ongoing evaluation of this policy change.

### Leave of Absence

1. Unpaid leave of absence may be granted for individual resident need at the discretion of the Program Director.
2. Any leave of absence or unpaid leave shall not be credited as training time and will result in makeup requirements as described in "Makeup for Extended Leave" "Residency Training Requirements for Board Certification Eligibility"

### Funeral Leave

1. Refer to institutional policy.
2. Funeral leave in this section counts towards the ~~thirty (30) days of allowable leave~~ **four weeks of Other Leave** in "Make-up for Extended Leave."

### Military Leave

1. Refer to institutional policy.
2. A resident may be given credit for certain military leave if this is arranged and approved by the Residency Program Director and faculty. This will have to meet any and all guidelines of the ACGME, ABFM, and Altru Family Medicine Residency regarding continuity care, off-site rotations and military leave. ~~Such leave cannot be longer than a 90-day period.~~

### Makeup for Extended Leave

The minimum amount of training time during the contract year is defined for some residencies by the Accreditation Council on Graduate Medical Education (ACGME) Program Requirements or by the requirements of relevant certification boards as ~~48 weeks or 11 months~~ **40 weeks (8 weeks of Family Leave and 4 weeks of Other Leave)**. ~~In the case where any such requirements relative to a particular Altru Family Medicine Residency program are not specific, the allowable combined total of Vacation Leave, Sick Leave, and any Additional Sick Leave taken during the contract year shall be 30 calendar days.~~ For combined leave totals that exceed this amount, residents shall be permitted to make up the excess amount or to have their program extended by an equivalent amount of time to meet the requirements of their residency program; however, for some programs, such an extension of program time may require the approval of the ACGME Residency Review Committee appropriate to that program **and be reported to the ABFM**. ~~For combined leave exceeding 30 calendar days, a review by the Residency Program Director shall be required.~~ If it is determined that the resident has not made sufficient progress in the program

due to the amount of training time missed ~~more than the thirty (30) allowable days as set out in this paragraph,~~ the resident may be required to make up training time.

Approved by Graduate Medical Education Committee (GMEC): 11/22/05

Revised & approved by GMEC: May 2012, November 2014

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

Approved by Faculty 6/12/20

## **RESIDENT RECRUITMENT, APPOINTMENT, ELIGIBILITY AND SELECTION POLICY**

All resident candidates must be graduates of LCME or AOACOCA accredited schools of medicine or have a valid ECFMG certificate and meet current North Dakota Board of Medical Examiners criteria for licensure. All potential candidates will be screened for possible interview by the program coordinator and forwarded to the program faculty for consideration. All candidates will be considered based on their academic achievements, communication skills, interpersonal skills, motivation, integrity, and in full accordance with all equal employment opportunity standards.

All interviewed candidates will meet with representative faculty and current residents during their interview. All candidates will receive a copy of a current contract, resident duty policy and resident leave policy. Upon completion of all interviews, candidates will be ranked by faculty and residents and the rank list submitted to the NRMP.

Upon learning of the match results, matched residents will be contacted and sent letters of appointment and resident due process agreement. Residents are expected to make application for and obtain a North Dakota resident training license prior to beginning training. Residents are given a copy of the Resident Handbook during orientation. All matched residents will be subject to a background check and Altru Health System Human Resources employee policies and procedures and Altru Hospital by-laws, rules and regulations, not specified otherwise by residency policy.

Approved by Graduate Medical Education Committee: 8/26/08

Reviewed: March 2012

Revised & approved by GMEC: November 2014

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## RESIDENCY SUPERVISION POLICY

The faculty is committed to supervision commensurate with resident competency and complexity of care while the educational curriculum and faculty and call schedules are designed to ensure such supervision. Progressive increase in resident responsibility with independence is provided individually based on expertise in the six ACGME core competencies with incorporation of the family medicine specific milestones and determined by multiple evaluation modalities. Notwithstanding, patient care complexity may always exceed resident capability and should be recognized.

Residents who have not satisfied the Program's requirements for advancement to indirect supervision (as defined by the ACGME and published at [altru.org/fmr](http://altru.org/fmr)) will not undertake any patient activity leading to change of status, acuity, or management, without the physical presence of an appropriately qualified physician. However, a resident will not interpret this in such fashion to curtail legitimate learning. All residents are encouraged to carry out activities necessary to strengthen history taking and physical examination skills, together with improving rapport with patients and their families, with whatever frequency the resident deems necessary. In the maturation of those skills, there is no substitute for patient contact.

### A. General Supervision Policy

- I. In each patient assignment, the resident will identify the practitioner ultimately responsible for the patient's care.
- II. That practitioner will be appropriately credentialed for his/her area of expertise.
- III. The resident will introduce himself/herself at the beginning of each patient encounter and inform the patient of his/her role in the healthcare team.

### B. Level of Supervision

#### II. Family Medicine Residency Clinic Supervision

##### a. Faculty Availability

- i. Faculty supervision is mandated whenever a resident is involved in patient care.
- ii. The minimum ratio of faculty to residents actively involved in patient care is 1:4.
- iii. Supervising faculty physicians are free from responsibilities that might prevent immediate availability.
- iv. Regardless of a resident's assigned degree of independence, the faculty physician may obtain further history or perform a focused physical examination if either determines additional evaluation is necessary.

b. PGY-1 residents or upper-level residents who are transferring into the Program will be under direct supervision. Direct observation will be utilized with patient module(s) in the simulation lab. Evaluation will be based upon the six core competencies mapped to appropriate milestones. In addition, direct observation will occur for 2 sports physicals and the first two office encounters. Evaluations will be reviewed by the Clinical Competency Committee to permit advancement to indirect supervision with direct supervision immediately available within an outpatient setting.

c. Residents will precept all Medicare patients.

d. Clinic procedures will have direct supervision until the resident is considered competent to perform the procedure with 'indirect supervision with direct supervision immediately available', because of faculty evaluation of skill and experience. Residents performing a procedure on a Medicare patient must be directly supervised.

#### III. Nursing Home Supervision

- a. A nursing home patient assigned to a resident will have an identifiable attending physician ultimately responsible for the patient's care though the resident is expected to function as an important member of patient's healthcare team.
- b. Residents will see assigned nursing home patients monthly with documentation in the electronic medical record which will be reviewed by the patient's attending physician.
- c. PGY-1 residents are assigned two nursing home patient and are not permitted to write orders without discussion with the patient's attending physician.
- d. PGY-2 and PGY-3 residents are assigned two nursing home patients and provide continuity of care as long as the patient remains in the nursing home. Such residents are permitted to write orders as their documented competency permits, though any major change in patient's status is required to be discussed with the attending physician.

IV. Hospital Supervision

- a. Specialty Rotations
  - i. Specialty rotations will be directly supervised by the physician preceptor or physician group (i.e., pediatricians for pediatrics) for the rotation.
- b. Family Medicine Teaching Service
  - i. Each patient on the teaching service will have an identifiable attending physician ultimately responsible for the patient's care.
  - ii. PGY-1 resident is directly supervised while involved in patient care by a family medicine physician or senior resident who has previously qualified to function in a supervisory role. (see stated requirements)
  - iii. Graded and progressive responsibility is encouraged and 'indirect supervision with direct supervision immediately available' is permitted for PGY-1 residents after thorough review of performance and evaluations at CCC meetings. Advancement will be documented in meeting minutes in addition to documentation within the resident file.
  - iv. PGY-1 residents may move to indirect supervision with direct supervision available after thorough review of performance and evaluations at CCC meetings. Advancement will be documented in meeting minutes in addition to documentation within the resident file.
  - v. PGY-3 residents serve as chief resident on the teaching service with responsibility for assisting in supervision of residents, medical students, educational opportunities, and management of service.
  - vi. Residents at all levels of training and independence are required to directly communicate with the attending physician any major change in patient's clinical status, transfer of care to a higher level of service (ICU, etc.) or initiating end-of-life orders.

V. Obstetrics

- a. Residents provide continuity of obstetrical care, including prenatal, antenatal and postnatal care, at the Family Medicine Residency Center.
  - i. All residents, regardless of level, require preceptor approval of an initial obstetrical visit, intended induction of labor, or any time a pregnancy is deemed to have deviated from normal.
  - ii. Preceptor approval is required at 28 and 36 weeks' gestation.

- iii. A resident is required to be present on the labor floor while the patient is in labor. A patient of the Family Medicine Residency Center will be supervised by the patient's attending physician but if the primary physician is a resident, then the attending physician will be the second preceptor on duty during the day or the family medicine department physician on call for labor and delivery after clinic hours. The minimum supervision required is defined below.
- b. Supervision of Labor and Delivery
  - i. All patients on the labor floor will have an easily identifiable attending physician, either a member of the OB/GYN department or a family physician with obstetrical privileges.
  - ii. Direct supervision for residents at all levels of training is required at the time of delivery, for the third stage of labor, as well as at the discretion of the attending physician depending on the resident's experience and/or complexity of care required to manage the labor.
  - iii. Circumstances requiring direct notification of the attending physician, include but not limited to: pregnancy related complications (i.e. pre-eclampsia, HELLP syndrome); non-reassuring maternal or fetal status; prior to initiating augmentation for labor dystocia; and postpartum hemorrhage
  - iv. In house supervision is available always for a PGY-1 resident by either the attending physician, OB fellow, or a senior resident. Senior residents are permitted to function in a supervisory role by successful completion of prior obstetrical rotations during the first year of training.

VI. Procedures

- a. Each procedure has a "Basic Skills Qualification" describing the procedure and an assessment form to verify procedure competency. "Basic Skills Qualifications" are available on E-Value. Prior to seeking BSQ certification, a resident should be confident in their skills. The "Basic Skills Qualification" is printed and given to the supervising physician, where after, the resident performs the procedure under direct observation of the supervising physician. The competency assessment is completed by the supervising physician with their signature and given back to the resident. The resident then returns the competency assessment to the Academic Coordinator.

Approved by Graduate Medical Education Committee (GMEC) 11/24/09

Revised 6/24/11

Revised 2/28/12; approved GMEC: May 2012, November 2014

Revised and approved at the Faculty Meeting 3/29/16

Revised and approved at the Faculty Meeting 7/12/16

Revised and approved at the Faculty Meeting 5/3/17

Approved by GMEC 5/23/17

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## TELEHEALTH POLICY

### Background:

TeleHealth is a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies. These include live video, mobile health (telephone visits), and remote patient monitoring. TeleHealth training is required for all Altru FMR residents who plan to perform direct live video provider-to-patient services via TeleHealth to ensure patient safety and patient satisfaction.

### Competency:

Altru FMR will confirm competency for all residents who wish to conduct TeleHealth visits. This includes any resident who will provide direct provider-patient care through interactive communication technology. Competency in TeleHealth reflects proficiency in:

1. Proper use of the TeleHealth equipment and technology
2. Adequate documentation of services provided
3. Effective communication techniques
4. Understanding appropriate application to clinical care
5. Delivery of services within the scope of practice

### Patient Visit Criteria for TeleHealth:

Patients that meet the following criteria are appropriate for TeleHealth:

1. Routine patients who prefers a TeleHealth visit
2. Those who are already quarantined but need routine or new visit care
3. Patient unable to come to clinic but requesting evaluation
4. Elderly patients with chronic illnesses
5. Immunocompromised patients such as those seen by transplant, oncology, or autoimmune disease providers

Visits that require the following are not appropriate for TeleHealth:

1. Required physical, in-person examination (abdominal, pulmonary, cardiac, etc.)
2. Recording of vital signs
3. Use of diagnostic equipment
4. Labs (Ex: nasal swabbing)
5. Imaging
6. Procedures as part of their care

### Session Structure and Precepting:

1. Video visits will be scheduled in Epic by entering the order "MyChart Video Visit" through an orders only patient encounter
2. Scheduled telephone encounters will be scheduled in Epic after communicating to staff that the patient meets the above criteria
3. TeleHealth visits appear in the provider's schedule like a regular office visit.
  - a. A camera icon appears in the video column when the patient is connected for a video visit.
  - b. To begin the video visit, log onto Epic on your device and select the MyChart Video Visit from your schedule. Click on "Telemed" at the bottom of the screen and select "Start Video Call" to connect to the video visit.
  - c. For telephone visits, the provider will need to click "Start the Visit" in the Precharting tab and call the patient to begin.
4. Sessions should be at least 20 minutes, but may be variable based on needs
5. General recommendations for the telehealth session
  - a. Prior to starting a telehealth visit
    1. Ensure a **calm and quiet** environment with good indirect lighting to conduct the visit

2. Verify patient identity by using **2 patient identifiers: Name and DOB**
  3. Provide your **name, your credentials, and information on who to contact if the connection is lost during the telehealth visit.** The best contact in this situation may be the provider's clinic phone number or call center number. If the patient becomes unstable during the visit, please advise them to contact 911 immediately.
  4. Receive and document **patient's verbal consent** to conduct the visit via telemedicine
- b. During visit
    1. Make sure you are visible and properly illuminated
    2. Try to maintain eye contact with the patient as much as possible (camera placement is key for this)
    3. Remain centered in the camera's field of view
    4. If necessary, to look away or if you are documenting something / reviewing the electronic medical record, be explicit and tell the patient
    5. Confirm any information that the patient discloses
    6. Receive verbal confirmation that the patient understands the information you are providing
    7. Precept the clinical case with supervising faculty (more details below on supervision)
  - c. Ending the visit
    1. Provide clear follow-up instructions (making appointments, treatment plans, prescriptions, etc.)
    2. If the patient has access to the patient portal, ask if they want instructions sent to their patient portal account
    3. Verify that they have no additional questions
  - d. Documentation
    1. Complete the note in EPIC consistent with an outpatient clinic encounter but document only physical exam findings that were visible during the visit (if applicable).
    2. Use the note template, **virtualvisitnote** and fill in the appropriate smartlists
6. Supervision:
- a. Direct Supervision:
    1. The supervising faculty is physically present in the room with the resident while they are conducting the TeleHealth visit.
    2. The resident may wish to present the case to the attending during the TeleHealth visit. If so, please explain to the patient the need to step away briefly from the visit.
    3. Faculty will complete competency checklist at the conclusion of the visit.
    4. If the resident is deemed competent, their level of supervision will move from direct supervision to indirect supervision with direct supervision available.
  - a. Indirect Supervision with Direct Supervision Available:
    1. Faculty will be available either at the site of care or through telecommunication access to precept TeleHealth patients
    2. It is the resident's digression to precept patients before, during, or after the encounter

#### References:

[https://www.aafp.org/journals/fpm/blogs/gettingpaid/entry/coronavirus\\_testing\\_telehealth.html?cmpid=em\\_FPM\\_2020\\_0318](https://www.aafp.org/journals/fpm/blogs/gettingpaid/entry/coronavirus_testing_telehealth.html?cmpid=em_FPM_2020_0318)

<https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>

[https://www.cchpca.org/sites/default/files/2020-01/Billing%20Guide%20for%20Telehealth%20Encounters\\_FINAL.pdf](https://www.cchpca.org/sites/default/files/2020-01/Billing%20Guide%20for%20Telehealth%20Encounters_FINAL.pdf)

Approved by Faculty 4/15/20

Approved by GMEC 4/18/20

## TIME OUT POLICY

Prior to starting a medical procedure, the medical team stops for a Time-Out. The Time-Out is a deliberate pause in activity involving clear communication and verbal confirmation. The Time-Out is one element of Universal Protocol, designed to ensure that the appropriate steps are taken to operations and invasive procedures.

### PROCEDURE

Time-Out is required for the following outpatient procedures

- Implanon placement and removal
- Endometrial biopsy
- Vasectomy
- Colposcopy
- Lumbar Puncture
- IUD insertion
- Incision and Drainage abscess
- Punch biopsy
- Circumcision

Time-Out steps:

1. Everything stops
2. Identify the patient using name and date of birth
3. Correct side and site marked as indicated if applicable.
4. Agreement on procedure to be done, as read from the informed consent document.
5. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.

Documentation: "Time out was performed. Correct patient was identified, and patient verified the procedure and correct site and side."

## TRANSITIONS OF CARE POLICY

### Family Practice Teaching Service (FPTS) and Obstetrics

#### Goal

Transitions of care refer to the movement of patients between health care practitioners, settings, and home as their condition and care needs change. Ineffective care transition processes lead to adverse events and higher hospital readmission rates and costs. Altru FMR carefully monitors transitions in care to improve effectiveness of the transitions which provide for the continuation of safe, quality care for patients in all settings.

#### Policy

- Altru will demonstrate effective standardization and oversight of transitions of care
- Time will be allocated for transitions in care
- Transitions of care will occur in-person with electronic/written support
- Transitions of care will be minimized to the extent possible given the context of duty-hour restrictions by the Accreditation Council for Graduate Medical Education (ACGME)

#### Procedure

- FPTS
  - Dedicated time for verbal and written (FPTS list) exchange of information at morning (8 am) or evening (5 pm) “sign-out rounds” on weekdays and 8 am on weekends
    - Prior to sign-out rounds, residents will have evaluated their patients and updated Epic
    - The FPTS list will be updated including, at minimum, the patient room number, MRUN, name, code status, attending physician, PCP, admission date, vital signs, and resident comment which will include all, of the following: hospital diagnosis, significant past medical history, diet, IVF, recent pertinent labs, and plan. All list updates will include anticipated follow-up required following the transition in care.
    - All patients on the FPTS list will be designated as “visit required” or “visit not required.” All patients designated as “visit required” will be seen by the day or night shift resident.
  - The chief resident will train and evaluate incoming residents in handoff expectations
  - All morning sign-out rounds will be monitored by the chief resident and attending physician for the FPTS
  - Evening sign-out rounds will be monitored by the chief resident and PGY-3 resident on-call. Periodically sign-out rounds will be monitored by core faculty
  - The formal policy for patient hand-off is formalized in Section 5 of the Family Practice Teaching Service (FPTS).
  - Documentation of mandatory hand-off for each patient assigned to the FPTS is maintained in the electronic medical record.
  - With the exception of emergent circumstances, transitions of care are strictly limited to conformance with the ACGME regulations and duty hours.
- Obstetrics
  - Dedicated time for verbal and written exchange of information at morning (6 am) or evening (6 pm) “sign-out rounds” on weekdays and weekends, unless resident is on a 24-hr shift where 6 pm sign-out will not occur

- The obstetrics list will be updated including room number, patient name, attending physician, gestational age, dilation, effacement, station, and resident comments. All postpartum care will be included in resident comment. Designation must be made as to the next time the patient will be evaluated.
- The obstetric fellows will train and evaluate incoming residents in handoff expectations
- With the exception of emergent circumstances, transitions of care are strictly limited to conformance with the ACGME regulations and duty hours.

Revised and approved at the Faculty Meeting 3/29/16  
Approved by GMEC 5/26/16

## **VENDOR POLICY**

### **Policy**

In accordance with guidelines set forth by the, acceptance of gifts from industry vendors is discouraged. Any gifts accepted by residents/fellows (trainees) should not be of substantial value. Accordingly, textbooks, modest meals and other gifts are appropriate only if they serve a genuine educational purpose. Acceptance of gifts should not influence prescribing practices or decision to purchase a device. Any gifts from patients accepted by trainees should not be of substantial value.

Approved by Faculty 2/6/19  
Approved by GMEC 2/26/19

## WORK HOUR POLICY

### General

The residency program is compliant with ACGME work hour policies. Compliance is monitored by the duty hours' log maintained in the electronic database at E-value.net. Any breach in duty hours requires written explanation from the resident on the duty hour entry. All breaches are reviewed immediately by the Program Director, Associate Program Director, and an Assistant Program Director. If there is question about a duty hour breach, the reviewing faculty member will have further discussion with the resident. In addition, hard copy of the work hours' log is reviewed by all faculty monthly.

### Fatigue and sleep deprivation

There is required attendance at a yearly presentation on fatigue and sleep deprivation by a sleep disorder specialist. Attendance at the sleep disorder clinic is also part of the required behavioral medicine rotation. The resident pool provides sufficient redundancy to allow call substitution and recovery time in the event of a fatigued or indisposed resident.

### Transfer of patient supervision

Errors of omission and commission during patient care "hand-offs" present a significant threat to patient safety. Adequate, protected, time is provided for the handover of care, twice daily, at the change of shifts. Patient status is updated, and outstanding studies and continuing therapies are reviewed, with emphasis on the critically ill, unstable, and those needing further evaluation.

### Accommodation and subsistence

Residents are provided with food service, a study area with electronic database connectivity, and a private sleeping area, the latter separated from patient care areas. If a resident becomes too fatigued to safely travel home, the resident may utilize the sleep area to rest until sufficient wakefulness is achieved to drive safely.

### Work Hour Regulations

Clinical and educational work periods for residents will not exceed 24 hours of continuous scheduled clinical assignments.

- Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. No new patient care responsibilities will be assumed.
  - In rare circumstances, after handing off all other responsibilities, a resident, on their initiative, may elect to remain or return to the clinical site to continue to provide care to a single severely ill or unstable patient, humanistic attention to the needs of a patient or family, or attend unique educational events.
- Such shifts will be followed by 14 hours free from assigned duties or responsibilities.
- **Residents** must have one 24-hour period free from assigned "in hospital" duties and responsibilities, and absent from the hospital, every seven days, averaged over a four-week period.
- **No resident** will work more than 80 hours per week averaged over a four-week period.
- **At home call** will not average more than every third night over a four-week period. Time spent working at home will count towards the total work week hours.
- Onerous activity resulting from such call will require relief from responsibilities.

• **All the foregoing is monitored through E-value.net and the timely entering of data is a resident professional responsibility.**

• Failure to record accurate duty hours through E-value within seven days will result in a verbal and email warning. An additional day of call will be assigned to the resident for each day that the resident fails to record duty hours beginning at 10 days of deficiency.

• Certain exceptions to the work hour regulations are recognized for infrequent and extenuating circumstances, such as continuity of care for a severely ill or unstable patient, academic importance of an event, continuity of care of an obstetrical patient, or humanistic attention to the needs of a patient or family.

• The decision to violate a work hour regulation is at the sole discretion of the resident.

• Care of all other patients will be handed over to the appropriate team once the resident is in violation of a work hour regulation.

• The resident must properly document in E-value the rationale for the work hour violation.

• The violation will be reviewed by an appointed faculty member, discussed with the resident, and appropriate faculty documentation in E-value is completed.

• The resident will also be provided a mandated rest period following the work hour violation, as appropriate for the type of violation

• Duty hours are reported by residents no less frequently than every 10 days. Duty hour reports are reviewed by three faculty members and the academic coordinator monthly. In addition, the chief resident is responsible for monitoring duty hours on a weekly basis. Residents who are at risk of averaging greater than an 80-hour work week over a four-week period have their work schedule modified to ensure compliance. The Program director is responsible for notifying the DIO of duty hour non-compliance, who provides action plan recommendations to ensure duty hour compliance

Approved by the Graduate Medical Education Committee 8/23/05

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Approved by GMEC 5/23/17

Approved by Faculty 2/6/19

Approved by GMEC 2/26/19

## OTHER

Residents are employees of Altru Health System. Residents are expected to abide by all Altru policies including, but not limited to, medical treatment of minors, subpoena procedures, and substance abuse. Residents may reference policies through Altru.org.