Jackson Hospital & Clinic
Family Medicine Residency Program
Residency Manual

2022 Academic Year

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POLICY: INTRODUCTION TO THE DEPARTMENT

Mission Statement

The mission of the Jackson Hospital is a not-for-profit organization committed to improving the health of all members of our community by providing superior, patient-centered, and cost-effect cate in a safe, compassionate environment.

Department of Family Medicine at the Sponsoring Institution is to contribute to the significant improvement of the quality and cost-effectiveness of health care in America, with a particular focus on rural and other underserved populations of Alabama. We strive to accomplish this through research, education, and a clinical practice, which focuses on the unique qualities of family medicine.

Family Medicine Training

The Department endeavors to increase the body of knowledge and to train learners in the discipline of Family Medicine. This discipline is the current expression of the true generalist tradition. This is uniquely defined by:

- **A method and structure of patient care characterized by continuing, comprehensive care of the undifferentiated patient.**
- **The context in which the basic medical sciences are applied to includes individual, family, and community where appropriate.**
- **A characteristic of this care is that it includes cooperation with other health care disciplines both within and outside of organized medicine.**

Departmental Objectives

- **We strive to maintain educational, research, and clinical programs that are of the highest standard as measured by internal review and external accrediting entities such as the Accreditation Council for Graduate Medical Education (ACGME), Liaison Committee on Medical Education (LCME), and pertinent patient care organizations.**
- **We will graduate six (6) family medicine residents per year with competency in family medicine knowledge, skills and understanding sufficient to respond to the health needs of the public.**
- **We will contribute to the sponsoring institution's objective to graduate competent medical students (on core clinical site rotations from respective medical schools) with the knowledge, skills, and attitudes specific to family medicine and an understanding and appreciation of the concept of family medicine in meeting the needs of the public.**
- **Residents and students who train with us will, upon matriculation, possess knowledge, attitudes, and skills to understand and provide medical services to the populations and communities that they serve.**
- **Through our scholarly activity, we will develop and disseminate new knowledge and answers to important questions, which will contribute to better patient care and to the academic discipline of family medicine as judged by peer review.**
- **We will participate in the education of the practicing family physicians in a continuing basis by participating in Continuing Medical Education (CME) and other forms of postgraduate instruction.**
- **In the process of providing health care for patients we will model high quality primary care using a family medicine model.**
- **We will use our resources wisely as shown by our ability to attract necessary funds, and provide and administer a budget, which enables us to meet our stated goals and objectives.**

- **We will secure, develop, and maintain faculty and staff sufficient to meet personal and developmental goals.**
- **We will strive to convince medical students of the value, both intrinsically and to society, and importance of practicing the intense, personal medicine characterized by primary care disciplines - especially family medicine.**
- **In our interactions with the broader medical community, we will work towards influencing the important policies of the sponsoring institution to reflect the departmental mission and to enable us to achieve the departmental goals and objectives.**

Policy: Clinical Competency Committee (CCC)

Current Chair: **Thomas Horton, M.D.**

Committee Members: **Paul Sheffield, MD; George Handey, MD; Mary Johnson, DO**

Purpose: To monitor resident performance and adherence to educational, program, and clinical responsibilities; to measure progression of resident performance and skill acquisition along the milestones with recommendations to the program director for advancement or learning plans for identified areas of needed improvement.

Policy: This policy defines the purpose and responsibilities for monitoring resident progression along the milestones.

This committee must review all resident evaluations of performance and assessment at least semi-annually; prepare and ensure reporting of Milestone Evaluations on each resident semi-annually to the ACGME; and advise the Program Director regarding resident progress, including promotion, remediation, and dismissal.

1. **Membership:**
    a. **The membership of the committee will be appointed by the Program Director and shall have at least three members of the program faculty**
        i. **Others eligible for appointment include the following:**
            1. **Non-physician members of the health care team**
        ii. **Other members that may attend CCC meetings and provide input include:**
            1. **Residency coordinators**
    b. **The committee Chair may either be appointed by the Program Director or elected from the membership**
2. **Purpose of the committee:**
    a. **The committee will be responsible for:**
        i. **Ensuring that each resident's performance is reviewed every 6 months**
        ii. **Monitoring the progress of each resident through review of evaluations and performance assessments, including assessment of the Milestones**
        iii. **Reviewing patient panel data (patient encounters as required by the Common Program Requirements for Family Medicine)**
        iv. **Recommending to the Program Director either resident promotion, remediation, or dismissal after comprehensive resident performance review**
        v. **Preparing Individualized Learning Plans for residents requiring remediation of a sub-competency or milestone as determined by individual programs**
        vi. **Preparing Milestone evaluations on each resident semi-annually**
        vii. **Ensuring the submission of Milestone evaluations for each resident semi-annually to the ACGME through the WebADS system prior to each deadline**
        viii. **Sending aggregate data from resident performance evaluations to the Program Evaluation Committee to include in the annual review process**
        ix. **Reviewing the progress of residents on probation, if any, and decide to lift or continue probation**
    b. **The CCC may make recommendations to the Program Director or designee regarding quality, number, frequency, and choice of evaluation tools to ensure adequate evaluation methods are available to measure performance and acquisition of the Milestones**

   c. **The CCC will identify evaluation methods or processes to address gaps in the assessment of resident performance along the Milestones to the Program Director or designee for implementation**
3. **All Milestone evaluations of resident performance compiled by the CCC will be maintained in their permanent files**
4. **Schedule:**
   a. **The CCC must meet at least semi-annually to provide aggregated performance data to the residents and the ACGME**
   b. **Ad hoc meetings may be called to address pressing resident issues that may include but are not limited to the following:**
      i. **Recommendation by the Program Director for any reason**
      ii. **Consistently low or unsatisfactory evaluation scores**
      iii. **Consistent lack of adherence to program requirements**
      iv. **A specific egregious incident for possible probation or dismissal**
5. **Due Process:**
   a. **Should a resident disagree with the recommendation of the CCC, the resident may address the clinical competency committee if requested**
   b. **The CCC shall follow the institutional Graduate Medical Education Grievance Policy and Due Process Procedure**

Policy: Program Evaluation Committee (PEC)

Scope: This policy applies to the Program Evaluation Committee in the JACKSON Family Medicine Residency Program.

Background

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

- **at least 2 members of the residency faculty**
- **There should also be at least one resident member**

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

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

Policy: PEC Membership

At JACKSON FMRP, the core committee structure includes:

- **All core physician faculty including the program director, and medical director.**
- **PhD Faculty**
- **Chief resident**
- **Ad hoc members on the PEC to include:**
  - **Non-physician/non-PhD faculty**
  - **Additional residents based on interest and need**

The Program Director will chair the PEC.

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

Approximately two months prior to the review date, the Program Director will:

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

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

- **Achievement of action plan improvement initiatives identified during the last annual program evaluation.**
- **Achievement of correction of citations and concerns from last ACGME program survey.**
- **Residency program goals and objectives.**
- **Faculty members' confidential written evaluations of the program.**
- **The Residents' annual confidential written evaluations of the program and faculty.**
- **Resident performance and outcome assessment, as evidenced by:**
  - **Aggregate data from general competency assessments**
  - **In-training examination performance**
  - **Case/procedure logs**
  - **Other items that are pertinent to the program/specialty.**
  - **Graduate performance, including performance on the certification examination and scope of practice,**
  - **Faculty development/education needs and effectiveness of faculty development activities during the past year**
  - **Comparative residency data collected from the Residency Performance Index (RPI)**
- **Additional meetings may be scheduled, as needed, to continue to review data, discuss concerns and potential improvement opportunities, and to make recommendations. Written minutes must be taken of all meetings.**
- **As a result of the information considered and subsequent discussion, the committee will prepare a written plan of action to document initiatives to improve performance in at least one or more of these areas:**
  - **Resident performance**
  - **Faculty development**
  - **Graduate performance**
  - **Program quality**

  - **Continued progress on the previous year's action plan**
- **The plan will delineate how those performance improvement initiatives will be measured and monitored.**
- **The final report and action plan will be reviewed and approved by the program's teaching faculty and documented in faculty meeting minutes.**

Policy: Annual Institutional Review (AIR)

Scope: This policy applies to the Annual Institutional Review in the JACKSON Family Medicine Residency Program.

Background

The Graduate Medical Education Committee (GMEC) must demonstrate effective oversight of the sponsored JACKSON Residency program through an Annual Institutional Review.

Purpose and Scope of Responsibility:

The Annual Institutional Review will include:

- **Results of the most recent institutional self-study visit to include [IR: 1.B.5.a). (1)] :**
  - **The action plan and outcomes to correct any citations from the most recent self-study visit.**
  - **The action plan and outcomes from any findings on the most recent AIR.**
  - **A review of the six areas of CLER (patient safety, quality improvement, transitions of care, supervision, duty hours/fatigue mitigation, professionalism) to formulate an annual plan to promote opportunities for improvement and faculty/resident engagement in CLER activities.**
  - **A review of the most recent CLER visit with the action plan to correct any recommendations from the visit and their outcomes.**
  - **A review of all Sponsoring Institution policies and procedures to ensure they are in substantial compliance with ACGME institutional requirements.**
- **Aggregate results of the annual ACGME resident and faculty survey to include [IR: 1.B.5.a). (2)]:**
  - **Institutional aggregate of the survey results to form action plan(s) to correct the areas of noncompliance or lower than average scores measured against national norms.**
  - **Individual program aggregate of survey results and comparison to national norms for each accredited program.**
  - **Comparison of current survey results to any internal surveys, program evaluations, or other institutional assessments, which support or do not align with the ACGME survey as a means of understanding and addressing "best practice" indicators as well as those areas need improvement.**
  - **Design of an action plan for areas deemed non-compliant, below national benchmarks, or changes in one standard deviation below prior survey results.**

- **Notification of ACGME-accredited programs' accreditation status and self-study visits [IR: 1.B.5.a). (3)]:**
  - **The action plan and outcomes to correct any citation(s) from the program's most recent self-study visit.**
  - **ADS data and/or GME scorecard data for each program i.e.**
    - **Board pass rate**
    - **Resident/faculty attrition**
    - **Procedural volume/case mix/patient mix**
    - **Faculty development**
    - **Faculty and resident scholarly activity**
    - **Milestones**
    - **Atmosphere for residents to raise concerns/issues; make inquiries**

- **ACGME cycle length ix. Match data**

  - **Program response to GMEC the domains of ACGME CLER Review.**

  - **Compliance with up to date, signed institutional agreements i.e., Affiliation Agreements and Program Letters of Agreement (PLA).**

  - **Results/outcome of each program's Annual Program Evaluation.**

Any item listed above that is found to be out of compliance will be an agenda item for each Graduate Medical Education Committee (GMEC) meeting to monitor progress toward resolution. The program director will present a report on behalf of their program with status of correcting deficiencies for documentation into the GMEC minutes. The DIO will provide a written Executive Summary of the Annual Institutional Review to the governing body.

POLICY: FAMILY MEDICINE CALL

Night Call

- **When scheduled for Family Medicine night call, residents are expected to be (by pager) available at 5:00 pm. The on-call resident is to communicate by 6:00 PM with a member of the in-patient team, usually the PGY-II regarding any problems on the service, expected admissions, and to report any other appropriate information or arrangements. The PGY- II (or PGY-I if the PGY-II is unavailable) will provide the on-call resident with a detailed checkout list. Call ends at the time of morning report the following morning. Weekend and holiday call runs from 8:00 a.m. to 8:00 a.m., also ending with morning report.**
- **PGY-II and PGY-III residents will stay in the hospital if there is an unstable patient, a patient in labor, a unit patient in the hospital and during the 1st 6 months of the year (July- January) if an intern is on call; otherwise, call may be taken from home if the resident lives within a reasonable distance (less than 10-minute drive) from the hospital.**
- **If there is any question regarding the need for in-hospital call, the attending on call should be consulted.**
- **Residents must attend morning report the day of call or on the Friday before a weekend call day. They must also attend the morning report after the end of call or the Monday after a weekend call.**
- **The first-call resident must keep a record of all call activities, including phone calls, ER visits, OB triage visits, deliveries, and admissions, and bring a copy to the FPC each morning after morning report.**
- **The attending on call should be notified of all admissions; any acute change of hospitalized patients or of any ER visits or phone calls that are not absolutely straightforward.**

Back-up

- **Back-up call may be called in for illness, when the primary call person cannot perform clinical duties, or when there are active patient management issues at multiple sites requiring the physicians to be present at the sites simultaneously. This should be discussed with on-call faculty. Back-up schedule will be posted along with the regular schedule.**
- **If a resident is required to come in for back-up call, the same duty hour rules will apply as previously stated in the above sections.**

POLICY: EDUCATIONAL PROGRAM

The residency exists to prepare physicians to practice in settings common to Alabama as well as prepare physicians for participation in academic medicine. The educational program is designed and will be maintained to achieve those educational goals.

- **An important goal of the residency program is to prepare graduates to take and pass the American Board of Family Medicine examination. We will maintain accreditation and ensure that our educational program contains elements required to facilitate this.**
- **Family Medicine faculty will develop the curricula and plans for all rotations and experiences. All common curricular elements will emphasize the range and scope of the practicing physicians. Opportunities for the resident to participate in the instruction of students and fellow residents will be developed. Other specialty faculty may be consulted for assistance during the development process, but the curriculum will ultimately be the responsibility of the faculty.**
- **All major dimensions of the curriculum will be structured educational experiences for which written goals and objectives, specific methodologies for teaching, and methods of evaluation exist. Family physicians will be utilized to the fullest extent as teachers consistent with their experience, training, and current competence.**
- **Rotation Evaluation: Residents are expected to offer feedback to the program director following each rotation. This will occur via the rotation evaluation form. The information will be regularly reviewed by the Program Director and the curriculum committee, as well as being shared with the appropriate departments at regular intervals.**
- **Curriculum revision will occur as a result of the following process: each major dimension of the curriculum will be the assigned responsibility of a family medicine faculty member. This faculty member will review all pertinent goals and objectives, teaching methodologies, and evaluation methods on an ongoing basis. Periodically, the curriculum will undergo a major revision. At this time, the information will be presented to the curriculum committee (consisting of all interested residents and faculty) and reviewed for content based on RRC requirements, the needs of the residents, and the feedback from the graduates. In addition, current learners' experiences will be reviewed. The results will be compiled, and curricular revisions will be brought to the residency GMEC for review and approval prior to implementation.**
- **Prior to the start of a rotation, residents will be directed to review the goals, objectives, anticipated teaching, and evaluation methods of the upcoming rotation. They will have an opportunity to offer verbal feedback at any time and written feedback at the end of the rotation via the residency coordinator.**

POLICY: EDUCATIONAL EXPERIENCE of the RESIDENT

- **In-patient family medicine service. This will be the residency program's inpatient activity to cover the breadth of the program's medical practice. The scope of this experience will be from newborn, pediatrics/adolescence, general adult medicine, to the special attributes of the elderly. The size of the service is expected to average twenty-five (25) patients, or around seven (7) patients per resident. Core family medicine faculty will oversee this component of the program's practice. Site support is directly from the sponsoring institution (JACKSON).**
- **Ambulatory activity in the Family Medicine Practice (FMP). This will be the residency program's ambulatory service for the program's practice. The scope will be from newborn to elderly. The patient encounter load at the FMP for each resident will exceed 1650 over 36 months. Core family medicine faculty will oversee this component of the program's practice. Site support is directly from the sponsoring institution (JACKSON).**
- **Long-term living facilities and home care. Residents will have regular monthly activity in the region's nursing homes as well as structured home visits. The scope will be the elderly and severely disabled. Core family medicine faculty will oversee this component of the program's practice. Site support is directly from the sponsoring institution (Jackson).**
- **Maternal care, prenatal, parturition, and postnatal. These elements will occur in the FMP, the preceptor's clinic, and the Jackson obstetrical suite. The program expects to provide clinical care to the level that satisfies the highest level of family medicine training, exceeding the ACGME expected numbers for total and continuity deliveries. Site support is directly from the sponsoring institution (Jackson) as well as the obstetrical department.**
- **Core specialty/sub-specialty rotation experiences (pediatrics, surgery, orthopedics/sports, psychiatry, radiology, ear-nose-throat, gastroenterology, cardiology, pulmonary, and gynecology). The coverage of these rotations will be from the highly supportive community physicians as appointed voluntary faculty in the respective specialties. The general curricular structure, with goals and objectives, will be set forth by the program director for each area. The program director and DIO will periodically assess the resources required to support and sustain this cohort of volunteer teaching site faculty.**

  The educational impact of each of these listed components is expected to achieve and exceed all desirable goals for the scope of family medicine practice as set forth by ACGME.

Graduated Levels of Responsibility:

As residents advance in their training program, they will be given progressive responsibility for care of patients. Residents are supervised by attending physicians and licensed independent practitioners in order for residents to assume progressively increasing levels of authority and responsibility, conditional independence, and the role of supervisor in patient care consistent with their level of education, ability, and experience.

The program should be organized in a way that promotes and allows residents to assume increasing levels of responsibility consistent with their individual progress in their training program. Each program director will delineate the levels of progressive responsibility for each year of residency training. The amount of supervision will vary with the clinical circumstances and the training level of the resident. Objective criteria used to assess a resident's aptitude to function independently in particular skill areas will be created and clearly described in the program's policy. When appropriate, the program will set specific expectations for non-supervised clinical activity. The program will communicate the defined levels of responsibility to each resident.

Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the resident. Senior residents or fellows will serve in a supervisory role of junior residents in recognition of their progress toward independence.

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

Program Requirements for Advancement

(See Appendix F)

Policy: Protocols Defining Common Circumstances Requiring Faculty Involvement

Purpose:
To provide minimal standards to guide residents with a set of clinical conditions that requires immediate attending notification.
Scope:
The following policy applies to all residents.
1. Escalation of Care:
Any urgent patient situation should be discussed immediately with the supervising attending. This includes:

- In case of patient death
- Any time there is unexpected deterioration in patient's medical condition
- Patient is in need of invasive operative procedures
- Instances where patient's code status is in question and faculty intervention is needed
- A patient is transferred to or from a more acute care setting (floor to ICU and vice versa)
- A patient's condition changes requiring Code Team activation
- Any other clinical concern whereby the intern or the resident feels uncertain of the appropriate clinical plan

2. Timeliness of Attending Notification:
It is expected that the resident will notify the attending as soon as possible after an incident has occurred. Notification of the attending should not delay the provision of appropriate and urgent care to the patient. If despite the best efforts, the resident cannot reach the assigned attending, then they should notify the program director, medical director of the service, or the chair of the department, for guidance.

3. Bed Side Procedures and Level of Training:
PGY 1 Resident:
Direct supervision by upper-level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity, this number can vary by training program.

PGY 2 and Higher Resident:
Direct supervision by peer upper-level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity, this number can vary by training program.

Policy:
Performance of Procedure:
1. It is the policy of Jackson Family Medicine Residency Program that all trainees performing a bedside procedure discuss the clinical appropriateness of the procedure with the senior resident or attending. PGY2 and higher GME trainees should discuss the clinical appropriateness of a bedside procedure with the attending as needed.

2. The attending physician is responsible for determining the appropriate level of supervision required for performing a bedside procedure, the appropriate indication for the procedures, discussion of risk-benefit with residents and patients (as necessary), assessing the risk of the procedure, determining the qualification of the resident performing the procedure and providing adequate support to the trainee performing the procedure.

3. It is expected that a resident shall inform the faculty member or upper-level resident when he/she does not feel capable of performing a bedside procedure.

4. The resident performing a procedure should make sure that there is adequate backup (such as senior resident, fellow, attending, interventional services, surgical services) before performing the procedure.

5. The resident should attempt the procedure no more than three times before stopping and re-evaluating the clinical situation and asking for a senior resident, fellow, attending, interventional service, or surgical service to take over the performance of the procedure.

6. The resident should call the senior resident, fellow or the attending if he/she has attempted the procedure three times unsuccessfully before attempting the procedure again.

7. The procedure should be aborted, and alternate plans discussed with the attending when the risk of the procedure including discomfort to the patient outweighs the benefit of repeated attempts beyond three.

8. In case of emergency, greater than three attempts can be made but should be justified with clear documentation of the need to do so in the procedure note.

POLICY: THE EVALUATION PROCESS

Resident performance will be evaluated as follows:

- **Each resident will be assigned a schedule prior to the start of the academic year. An initial evaluation of the clinical skills of all residents entering the program will be completed within the first three months and placed in the resident's QA folder. At the end of each month a written evaluation form will be expected from the resident's supervisor. The coordinator will send the evaluation and make a minimum of three attempts to have a completed form returned to the department. Should the evaluator not complete, for whatever reason, a verbal evaluation will be obtained by the program director.**
- **The attending of the day will complete a field note assessment following the end of the clinic session based on their assessment of performance as compared to the Goals and Objectives. These will be collected and aggregated prior to the meeting.**
- **Monthly, performance of each resident on discreet rotations will be assessed following completion of the assigned rotation. These will be placed in the resident's folder and reviewed.**
- **Quarterly, the performance of each resident will be evaluated in the GMEC based on all available information and a written assessment placed in the QA file. The resident is encouraged to review the summary with his or her advisor quarterly.**
- **Every 6 months an assessment of competence as indicated by the milestones and based on all available data is made by the Clinical Competency Committee and forwarded to the resident. The resident acknowledges receiving this information in the residency folder. The resident is required to develop a learning plan.**
- **Annually the resident is evaluated based on departmental criteria as previously outlined for fitness for promotion to the next level.**
- **If areas of deficiency are identified the following process occurs:**
    - **Informal notification occurs if the deficiency is minor, and the Committee feels that the resident can correct it without difficulty. This notification will occur either by the program director or the resident's advisor. The resident's progress will be monitored through the GMEC process.**
    - **If the deficiency is major (failure of a core rotation, lapse in judgment potentially resulting in unsafe patient care, repeated patient care errors) the resident will be called in for counseling by the program director or his designee immediately upon discovery. Following a face-to-face meeting, a remediation plan (Letter of Counseling) will be outlined, and a written copy will be placed in the resident's file. Mutually agreed upon benchmarks will be assigned. A faculty member will be assigned to monitor the resident's progress. Periodic reports will be given to the program director. Failure to achieve educational goals will result in further action.**
    - **If the deficiency is judged to be so severe that patient safety is of immediate concern, the resident will be removed from clinical duties until further action can be undertaken.**
    - **As residency is at its heart a training process, successful remediation will not be mentioned in the resident's final evaluation.**

Disciplinary Action

- **Residents will receive timely notice of the impending action, disclosure of the evidence on which the action is based, and an opportunity to respond. The resident's scores will be available for review and the resident will have a right and opportunity to challenge the accuracy of the record. Resident records are confidential and are available only to faculty and administration with a need to know, unless released by the resident, or otherwise governed by laws concerning confidentiality.**
- **Except in cases where patient care is compromised by continued employment, residents will be offered an opportunity for remediation as determined by the Program Director in association with the GMEC.**

- **Residents will be offered the following process prior to dismissal:**
  - **Meeting and Letter of Counseling - This will review all deficiencies and exceptions which apply, outline ways the resident can improve, and give residents an opportunity to respond and help determine any outside factors that may be affecting the situation. The faculty will review monthly all residents who have been given a letter of counseling.**
  - **Letter of Probation - This will state all deficiencies the individual has been counseled on and state that no improvement has occurred. It will state the period of probation, the expectations the resident is to meet, the assistance in meeting the expectations that will be offered, mechanism of evaluation that will be used, and the consequences if the expectations are not met. (It is understood that if the resident at any time after meeting the criteria of probation reverts to the pattern of behavior or deficiencies that provoked the probation, will immediately be placed on probation and will be at risk for dismissal.) The resident has a right of appeal as outlined in the Housestaff Manual.**
  - **Letter of Dismissal - This will state that the resident has refused or failed to meet the criteria outlined in the Letter of Probation.**

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

Evaluation of Faculty

Policy: All teaching faculty will be formally evaluated at least biannually. Our faculty also very much need and desire feedback on their performance. This is accomplished through semi-annual (June and January) basis on all FMP attendings, including part time faculty. The form is designed to evaluate teaching ability, clinical knowledge, attitudes, and communication skills. These evaluations are compiled by the Residency Office (program director and coordinator) and are strictly confidential. A composite evaluation will be reviewed by the program director and DIO, and the faculty member will be given feedback during his or her semi-annual review.

Evaluation of the Program

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

Evaluation of Patient Care

Patient care is evaluated through the QA process in both inpatient and outpatient settings. All residents are invited to participate through the Clinical Providers forum. Feedback is given to residents regarding the process and outcome of care that they took part in. The process of care is monitored over time with improvements in care documented. The residents, by the time they graduate, are required to investigate, evaluate, and improve at least one aspect of their patient care. During this exercise they must analyze practice experience and perform practice-based improvement activities using systematic methodology. The results are presented at the end of the third year to all residents.

Evaluation of the Graduates

The residency regularly obtains feedback on demographic and practice profiles, licensure and board certification, the graduates' perceptions of the relevancy of training to practice, suggestions for improving the training, and ideas for new areas of curriculum. We use a written survey after 1 year and every 5 years thereafter. The data from the evaluation of the graduates are presented at the Curriculum Committee and are used as part of our program's determination of the degree to which the program's stated goals are being met.

POLICY: EVALUATION OF RESIDENTS

Evaluation

Evaluation is an ongoing process, which is both formative and summative in nature. Formative evaluations are to be used to identify training needs, monitor progress, and document competence and mastery where appropriate. Evaluation will focus on the core competencies (patient care, medical knowledge, professionalism, interaction and communication skills, practice-based learning and improvement, and systems-based practice) as well as the competencies specific to family medicine. Techniques used in evaluations will include direct observation, targeted review, procedural, milestones, 360-degree evaluation, and case logs.

- **The Program Director will designate an advisor who is a Family Physician faculty member. Quarterly, the resident and advisor will meet briefly to identify progress, problems, other issues to include (but not limited to) review of the above evaluations, resident QA meetings and applicable test scores. This meeting will be documented in the resident's folder.**
- **Twice annually, the resident will be provided with written feedback on their performance in relation to the residency objectives as well as fulfilled milestone.**
- **Residents will be evaluated on their professional development:**
    1. **Residents must proceed toward Alabama medical licensure as outlined in this manual.**
    2. **Residents will provide necessary documentation regarding professional certifications to the coordinator.**
    3. **Residents will maintain a log of procedures using MedHub. This is reviewed on a biannual basis by their advisor to ascertain that it is up to date and that there are no deficiencies.**
    4. **Residents are required to comply with the Residency Policies and Procedures Handbook in its entirety, the Sponsoring Institution Drug Testing Policy.**
    5. **Residents will properly and completely log their duty hours using MedHub.**
    6. **Residents will stay up to date on all dictation and charting in each of the hospitals and in the FMP. Residents must sign off their dictations in MD Network.**

Evaluation Tools

- **At the completion of each year the program director with input from the Clinical Competency Committee (CCC) will assess performance and recommend to the GMEC a list of candidates for promotion to the next level.**
- **Prior to completion of the Family Medicine Residency Program, the program director provides a final evaluation and certification of competence. This evaluation includes a review of the resident's performance during the final period of training and verifies that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation is a part of the resident's permanent record that is maintained by the within the department as well as in the institution office of Graduate Medical Education.**

The following information is collected in a resident's file and should be reviewed by the resident's advisor with the resident at least semi-annually prior to the CCC meeting at which the resident is reviewed. The Program Director also reviews evaluations of resident's performance as they come in and initials these before they are placed in the resident's file. The information kept in the resident's file and is not to be removed from this department.

Resident Evaluation Form

The resident evaluation will be completed by the attending on all residents at the end of each rotation. The Residency Coordinator forwards this form to the appropriate service/department during the last week of each

month for completion by the appropriate attending. When the evaluation is received back from the appropriate service/department, it is reviewed by the Program Director. Should difficulties or problems surface, which require immediate consultation with the resident, he or she will be advised, and an appointment set for counseling. Normal procedure is for the evaluations to be placed in the resident's file maintained by the Residency Coordinator. They are reviewed with the resident during quarterly sessions with his or her faculty advisor. This process is accomplished using MedHub.

Evaluation Process: Milestones are used to track the resident's progress.

Outcome: The resident will be expected to meet milestones consistent with their level of training.

A failure will result in repeating a rotation. Elective time of up to 2 months may be used for remediation. When the remediation is complete that rotation will be judged as passed. Remediation of a rotation will not result in academic probation in and of itself. Upon successful completion the final record will not reflect the remediation.

Faculty Evaluation of Resident Clinical Performance in the Family Medicine Center

Evaluation Process: A semi-annual milestone evaluation will be done by FMP preceptor faculty.

Outcome: This compiled evaluation will be reviewed by the CCC

Policy: Program Specific Evaluation Tools

360 Evaluations (see Appendix A)

Field Notes (See Appendix B)

Field notes will be used as one element toward a formative evaluation process.

Chart Audit Evaluations

Periodic evaluations will be done by faculty in a group review leaning environment.
Outcome: Direct feedback will be given on an on-going basis.

In-Training Examination Scores

Annually, all residents complete the Family Medicine In-Training Exam. Should the resident desire a planned absence on the scheduled date of the exam; other arrangements must be made to complete the exam.

Evaluation Process: Scores will be distributed to the resident and discussed in the CCC meeting.

Outcome: Score are tracked over time. Residents function as their own control. Persistent deficiencies will result in more intensive educational efforts as deemed appropriate by the CCC.

Correspondence

As it becomes available, correspondence related to resident performance is maintained. These might include letter of commendation or complaints from rotation supervisors. This will also include documentation of incidents and corrective actions by the Program Director. These will be reviewed by the GMEC, and action will be taken as indicated.

Family Medicine Clinic Demographics

Quarterly, demographics of patients seen by individual residents are aggregated.
Evaluation Process: A comparison of the resident's data to his or her peers and other providers is made.
Outcome: The global assessment is tracked over time. Residents are compared to peers as well as function as their own control. A panel that is deficient in certain key areas will result in more intensive monitoring and other types of intervention as deemed appropriate by the GMEC.

Family Medicine Clinic Productivity

Quarterly, numbers of patients seen by individual residents are aggregated.
Evaluation Process: A comparison of the resident's data to his or her peers and other providers is made as well as comparison to RRC guidelines.
Outcome: The numbers of patient seen are tracked over time. Residents are compared to peers as well as function as their own control and are compared to a prototypical Family Medicine resident of comparable training. A resident who is unable to see sufficient patients in a timely manner will be subjected to more intensive monitoring and other types of intervention as deemed appropriate by the GMEC.

Resident Peer Evaluations

Quarterly, all residents complete an evaluation form for each of their peers. This process is accomplished using MedHub.
Evaluation Process: An assessment based on milestones is tracked, as well as comments.

Outcome: Compiled assessment is reviewed by the CCC. Annual Program Evaluation
Yearly, all residents and faculty complete an evaluation form for the overall residency program. This process is accomplished using MedHub.
Evaluation Process: An assessment based on Milestones is tracked, as well as comments.
Outcome: Compiled assessment is reviewed by the CCC.

Program Exit Evaluation

Yearly, all PGY Ill residents complete an evaluation form for the overall residency program and health system. This process is accomplished using MedHub.
Evaluation Process: An assessment based on milestones and competencies, as well as comments, are tracked.
Outcome: Residents are expected to reach a level of at least 'Competency' in all six general competencies to be eligible for graduation.

POLICY: Quality Improvement

- **The Program Director will ensure that all residents receive training and are involved in longitudinal quality improvement and patient safety projects each academic year.**
- **Residents are required to attend and participate in all activities aimed at expanding their knowledge and expertise in patient safety and quality improvement.**
- **Residents will attend and actively participate in weekly Quality Improvement meetings.**
- **Each resident will participate in a minimum of 2 scholarly activities (one of which must be centered on quality improvement). These scholarly activities should be published or presented in a local, regional or national venue.**
- **Each resident will demonstrate an understanding and adopt the values and components of the Patient Centered Medical Home.**

POLICY: PATIENT SAFETY

Culture of patient safety will be promoted and assured through:

- **Active participation by faculty and residents in the hospital safety committee.**
- **A structures relationship with hospital interdisciplinary teams that will include pharmacy, case management, and nursing.**

Safety education and reporting:

- **The program will utilize Jackson Hospital's interactive programs on safety.**
- **Instruction on monitoring and reporting techniques for adverse events.**

Successful delivery of quality primary care services depends on a thorough understanding and adherence to the following principles:

- **Prevention of patient injury is the responsibility of each provider who practices in the department.**
- **Policies and procedures to minimize the possibility of patient injury are essential parts of the patient safety initiative.**
- **The administrative and medical staff leaders are responsible for putting in place policies and procedures to ensure the safe delivery of healthcare.**

It is the responsibility of all residents and faculty to:

- **Know and follow the rules and procedures applicable to their patient care and non-patient care duties. In addition to strict adherence to these rules, each individual is responsible for using sound judgment and for being aware of potential hazards to patients before taking action.**
- **Conduct their duties in such a way as to avoid harm to patients.**
- **Promptly report events or situations of actual or potential patient harm.**
- **Actively participate in hospital as well as clinic committees tasked with oversight of patient safety measures.**
- **Adhere to both the transition of care and duty hour restriction policies related to relieving residents that suffer from fatigue.**

POLICY: PROFESSIONALISM

Residents are responsible for demonstrating and abiding by the following professionalism principles and guidelines.

Residents must develop habits of conduct that are perceived by patients and peers as signs of trust. Every resident must demonstrate sensitivity, compassion, integrity, respect, professionalism, and maintain patient confidentiality and privacy. A patient's dignity and respect must always be maintained. Under all circumstances, response to patient needs shall supersede self-interest.

A medical professional consistently transmits respect for patients by his/her performance, behavior, attitude and appearance. Commitment to carrying out professional responsibilities and an adherence to ethical principles are reflected in the following expected behaviors:

- **Respect patient privacy and confidentiality.**
- **Respect patient self-autonomy and the right of a patient and a family to be involved in care decisions.**
- **Respect the sanctity of the healing relationship.**
- **Respect individual patient concerns and perceptions.**
- **Respect the systems in place to improve quality and safety of patient care.**
- **Respect for peers and co-workers.**
- **Respect for cultural diversity in the workplace.**

POLICY: PERSONAL WEB SITES, BLOGS, AND SOCIAL MEDIA

Residents may use personal web sites and web logs (blogs) during their personal (non-work) time. If a resident chooses to identify himself or herself as a Jackson resident on a personal web site, blog, or other social media, he or she must adhere to the following:

- **That the views expressed are solely of the resident's, and are not necessarily those of the Facility**
- **That patient confidential information under HIPAA or other laws is not disclosed or identifiable**

Unacceptable behavior by Jackson Residents through such technology includes, but is not limited to, the following:

- **Behavior that promotes or produces an unlawful end**
- **Action that promotes an act of violence or harm**
- **Action that meets judicial standards of harassment, defamation, and obscenity**
- **Action that is counterproductive to the mission of Jackson or any of its affiliates**

Policy: Well-Being

The well-being of residents at Jackson FM residency program is of utmost importance. Psychological, emotional, and physical health of our physicians-in-training are nurtured in order to provide the very best care to our patients as well as develop a life-long habit of self-care for our young professionals.

To promote the best in this direction, the program provides:

- **Enhancing the meaning and experience of being a physician.**
- **Attention to schedules and work intensity.**
- **Monitoring workplace safety parameters.**
- **Ample opportunities to fulfill personal healthcare needs (appointments, etc.).**
- **Structured education for faculty and residents toward burnout, depression, and substance abuse.**
- **Structured training in recognition of these problems in colleagues.**
- **Access to appropriate tools for self-screening.**
- **Access to the mental health system.**
- **Policies and procedures in place to assure seamless coverage of patients in the event of a physician gap.**

POLICY: FATIGUE MITIGATION

Residents and faculty will receive training on the detrimental effects of fatigue

Policies will remain in place to prevent work weeks of greater than 80 hours, no continuous duty of greater than 24 hours with an additional 4 for continuity and education, and an average of 1 out of every 7 days completely free of clinical duties.

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

Information regarding the effects of fatigue will be prominently posted.

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

If necessary, fatigued residents or physicians may rest in call rooms available at the hospital prior to leaving or transportation to their home may be provided.

Policy: Clinical Responsibility, Teamwork, and Transitions of Care

Transition of Care

It is essential for patient safety and resident education that effective transitions in care occur. Residents must remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient such as an acutely ill or laboring patient. When this happens, a notation is made in the duty hour log with the justification. In addition, the resident must:

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

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

POLICY: LICENSURE PROCEDURE

PGYI

Your program does not allow you to independently write controlled substance prescriptions outside of the Jackson Hospital Family Medicine Residency Program.

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

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

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

PGYII

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

US Medical Graduates -
Schedule USMLE Step 3 as soon as possible after completing your PGY1 year and request your Unrestricted License Application Packet from the Board at the same time.

If USMLE Step 3 IS taken and a passing score give to the program coordinator by defined time (it takes approximately 6 weeks to obtain results): You must send your application packet to the Board in October (See Appendix E). This will allow two months for the Board to receive all of the information to present your application at the December meeting.

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

You must renew your Limited License. Complete Renewal of Limited Certificate of Qualification and mail it with a $15 check to the Alabama Board of Medical Examiners in October. Upon approval by the Board, you should receive a Limited License Renewal Application that must be completed and returned to the Board with a licensing fee of $300. You will also receive an application for an Alabama Controlled Substance Certificate. This must be completed and returned to the Board with a check for $150.00.

When you receive your Alabama Controlled Substance Certificate you should apply for your Federal DEA. Fee $551.00 - 3 years.

Passing USMLE Step 3 after October- you will have already applied for a renewal of your Certificate of Qualification and Limited License. However, as soon as you receive your scores for the USMLE Step 3 you need to proceed with application for your Unrestricted License (See Appendix E) NOTE: This is why it is important to take Step 3 as soon as you become eligible in hopes of avoiding paying double fees for licensure.

PGY Ill

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

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

WHEN APPLYING FOR YOUR FEDERAL DEA YOU MAY WANT TO TRY FILING AS A FEE EXEMPT STATE EMPLOYEE.

APPENDIX A
Unrestricted License
To' request a licensure application package, please send the following by mail to

PO Box 946
Montgomery AL 36101-0946

Include:
$20.00 check or money order payable to: Alabama Board of Medical Examiners

- **your FULL name**
- **your mailing address**
- **name and date of your original licensure exam (i.e., NBME, FLEX, USMLE, NBOME, LMCC)**
- **date of (re)certification by ABMS/AOA specialty board if applicable whether you will be applying by taking USMLE Step 3**

After receiving your packet -
Complete the application packet and return it to the Board with your $175.00 check for Certificate of Qualification and a $65.00 check for criminal background check. You will need to request your USMLE scores from the Federation including a $65.00 check.

After receiving Certificate of Qualification, you will receive a license application and an Alabama Controlled Substance Certificate (ACSC) application. Both should be completed and returned to the Board with a check for $75.00 for your license and a check for $150.00 for your ACSC.

***NOTE: The above requirements are based on Alabama state law and requirements of the Alabama State Board of Medical Examiners in order to practice medicine in the state of Alabama.**

POLICY: PATIENT CARE IN THE FAMILY MEDICINE CLINIC (FMP)

Patient care begins at 8:30 am Monday through Friday unless otherwise noted on the schedule. On the rare occasions where you will be unavoidably late, please call and let someone know. Clinic starts at 9:30 on the second Tuesday of the month due to a nursing meeting.

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

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

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

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

You are given a schedule that is appropriate for a community family physician, and you should be able to see your patients in the time allotted. If you are unable on a routine basis to accomplish this, you should seek out consultation from other faculty and staff to assist you.

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

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

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

- **All patients must have their medical records completed with permanent problems, past medical, family, and social history, and allergies listed. It is required that today's problem list be completed with each visit.**
- **All patients should have health maintenance issues addressed at every visit.**
- **You are expected to assign the proper ICD-10 and CPT codes for the visit. These codes should cover any labs and x-rays ordered.**

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

Documentation will be done on a given encounter on the date of encounter if at all possible or no later than 24 hours. The medical director grants exceptions for unusual circumstances.

Duties of the Attending Physician

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

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

There must be one attending for every four residents.

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

When a resident presents with a patient to present the attending must focus on the resident's issues.

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

First year residents will be required to sign out 100% of their patients. 2nd year residents will sign out a minimum of 50% of their patients. 3rd year residents will be required to have a minimum of 25% of their patients reviewed by an attending physician. The attending physician will countersign all encounter notes.

You will be asked to provide written feedback on a daily basis on all the residents in the office for that session and quarterly basis on every resident. Please be forthright and honest.

For billing purposes, those patients with Medicare and certain other insurances must be signed out to you at the time of encounter. You must use the format provided and document the key portions of the history, physical, and

decision-making in your hand or ensure the resident documents your participation within the body of their dictation.

POLICY: CHIEF RESIDENT

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

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

ELIGIBILITY:
Candidates for Chief Resident must:

- **Be a second-year resident in good standing**
- **Have demonstrated exceptional leadership, communication, and organizational skills**

SELECTION OF CHIEF RESIDENTS:

- **Residents and faculty are asked to nominate two people for chief resident. Residents may self-nominate or may request not to be considered.**
- **The two residents with the most nominations will be presented to the GMEC for the selection and approval of one.**

KEY AREAS OF RESPONSIBILTY:

Academic Responsibility

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

Administrative Responsibility

- **Reads, fully understands, and follows the Resident Policy and Procedure Manual.**
- **Address any/all concerns that exist for the on-call and backup call resident.**
- **Ensure residents are meeting deadlines. Especially, learning modules for electronic medical records and ACGME resident survey.**
- **Keeps current with MedHub updates and is responsible for ongoing training of MedHub for all residents as needed.**
- **Participates in Residency Recruitment Fairs.**
- **Participates in the Clinical Management Team.**
- **Present graduation honors.**
- **Assists in scheduling/organizing graduation.**
- **In concert with the Residency Coordinator, ensure that scheduled and requests for leave are optimized.**

- **Represent the residents by attending faculty and QA meetings. Communicate pertinent information and issues to residents in a timely manner.**
- **Work with the Residency Coordinator and the faculty in curriculum development and revisions.**
- **Act as liaison between faculty and residents.**
- **Work as a mediator for resident, faculty, staff and/or patient conflicts.**
- **Organize resident retreats.**
- **In concert with the Residency Coordinator, ensure that scheduled professional leave is optimized.**
- **Participate in the recruiting and interview process.**
- **Conduct monthly residents' meetings. Document and distribute minutes (resident only portion) to all residents. Assign another resident for these tasks if both Chiefs will be absent.**
- **Works with the residency staff to update the policy and procedure manual. As well as, assisting up-dates to rotation details and locations.**
- **Work closely with the residency coordinator and the program director to identify and resolve residency problems.**
- **Assists residents in adapting their learning experienced as possible on an individual basis to accomplish their individual learning plans.**
- **Assist as needed with the rotation schedule for the up-coming academic year.**
- **Encourage academic growth through example and formal instruction.**
- **Maintain discretion and confidentiality with regard to faculty meeting agendas, business matters and other issues unless expressly released for this requirement by the program director for a specific circumstance.**
- **Act as a resource for program director and meet with program director a minimum of once a month.**
- **Create call and backup schedule for the next academic year (and training the in coming Chiefs).**
- **Collect yearly voluntary resident dues (currently $25) to be utilized for resident initiatives and projects.**
- **Schedule and organize (with assistance from residency coordinator) requests for physicals. (Payment helps with cost of annual retreat.)**
- **Annually update the intern rotation expectation manual in collaboration with PGY II residents.**
- **Performs other tasks as assigned on an ongoing basis.**

Clinical Responsibility

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

TRAINING RESOURCES

- **Chief Resident Leadership Development Program sponsored by the American Academy of Family Physicians**
- **Out-going Chief Residents**

REPORTING RELATIONSHIPS

- **Reports to the Residency Program Director**
- **Can be rescinded for inadequate performance (including academic performance).**

BENEFITS

- **Attend Chief Resident conference**
- **Attend annual AAFP Scientific Assembly**
- **Hands-on leadership experience**

- **Recognition by faculty and fellow residents**
- **Added value to curriculum vitae**

Family Medicine Residency Yearly Planning Calendar

July	August	September	October
• Remind PGY IIs to Sit for Step III before December • Update Program Website	• Order ABFM In-Training Exam • Prepare for Interviews • Check interview dates with Hotel	• ERAS opens in early September • Book Interviews • Arrange Pre-Interview Functions • Remind residents and rotations of ITE • Residency Fairs	• Book interviews • In-Training Exam (last week) • Make Rotation Schedule for Upcoming Year
November	**December**	**January**	**February**
• Interviews • 2nd & 3rd Year Residents' Renew Alabama License & ACSC • 1st Years Renew Limited License	• Interviews • Schedule Rank Meeting	• Interviews • NRMP Quota Change Deadline • Make Rotation Schedule for upcoming year	• Rank Meeting • NRMP Rank Order List Due
March	**April**	**May**	**June**
• NRMP Match Week • Order Diplomas • Begin work on Call Schedules • Select Chief Residents • Plan Graduation Banquet	• Orientation Committee • Annual Program Eval • Policy and Procedure Manual Updated • Get Paperwork Done for Incoming Residents • Complete Orientation Schedule • Hold New Chiefs/Old Chiefs Meeting • Plan Graduation • ACGME Survey • Make arrangements for Alabama Academy Meeting	• Order Plaques for Graduation • First Year Residents Should Schedule USMLE Step 3 or Equivalent • Graduation Banquet held end of May	• NPI Numbers for Incoming Residents • Graduation • AAFP Census Deadline • Final Evaluation for Graduates • Alabama Academy Meeting • Orientation

Residency Eligibility

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

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

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

B. Occasionally a PGY II position will become available. At that time, we will solicit applications for this (these) position(s) utilizing methods such as the Jackson "Find A Resident". Applicants must meet one of the following qualifications in order to be eligible for appointment at the PGY II level:

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

Selection

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

POLICY: ANNUAL REAPPOINTMENT

Procedure for Review

Annual reappointment of the postgraduate is the responsibility of the program director. It is based on evidence of progressive scholarship and professional growth of the postgraduate as demonstrated by his or her ability to assume graded and increasing responsibility for patient care. If it is deemed necessary by the program director to suspend or terminate the postgraduate's training, the grievances and decision will be discussed with the postgraduate. The final decision of termination shall be communicated in a letter, which contains a statement that the postgraduate has the right to appeal the final decision.

Appeal

The postgraduate has the right to appeal a decision reached by the program director. The appeal must be made within thirty (30) calendar days of notification of the decision. Should this occur, the postgraduate is granted an opportunity to appear before the GMEC. The postgraduate cannot be represented by legal counsel in the appeal hearing. The procedure available to the postgraduate is outlined in the Housestaff Manual. The decision reached by the GMEC represents the highest level of due process available within the Jackson.

Records

The Program Director and Institution are expected to keep appropriate records. That portion of the records which describes any act affecting performance is to be placed in the postgraduate's permanent record. A copy of the minutes of each committee meeting, in which pertains to the case is made available, upon request, to the postgraduate involved in the appeal. Verbatim records of an appeal hearing will be kept on file.

Policy: Family Medicine In-Patient Service

- **The attending physician is professionally, legally and ethically responsible for all patients admitted to the Family Medicine Service.**
- **A complete H&P, patient orders, daily progress notes, and the discharge summary are the responsibility of the upper-level residents on the Family Medicine Service.**
- **The PGY-1 resident is responsible for the day-to-day management of all patients, but under direct supervision of an upper-level resident and/or attending faculty.**
- **It is the responsibility of the upper-level resident to assist with patient admissions, write a resident admission note, assure that all patients are seen prior to morning report, and supervise and teach the PGY-l's and acting interns.**
- **It is expected that faculty and residents from the Family Medicine Center will follow their own patients who are hospitalized on the Family Medicine Service whenever possible. The residents on the service are responsible for notifying each patient's continuity physician of the admission. Each physician with a patient in the hospital should round on their patient prior to morning report and attend morning report to participate in the discussion of his/her patient unless they are unable to participate for valid reasons. Those reasons to not participate include when participation would place the resident in a duty hours' violation, or the resident is working at such a physical distance as to make it impractical. In these cases, the care team contacts the resident daily and the primary physician's management input is solicited in this manner. The primary physician is always included in discharge planning. The continuity physician may choose to manage the patient without the ward team. If this physician is a resident, the ward team must be informed of the patient's condition and anticipated problems at checkout.**
- **Before initiating therapy on all new admissions, the on-call upper-level resident will review appropriate patient data with the hospital attending or the on-call faculty to confirm the diagnosis and management plan. This review should also take place before any significant modification in therapy, before a consultation is obtained, or prior to a patient's discharge.**
- **"Acting interns" (senior medical students) will function as PGY-1 residents on the Family Medicine Service.**
- **Working and attending rounds will be made seven (7) days per week.**
- **Working rounds will be made by residents prior to morning report and attending rounds.**
- **Morning report begins at 7:00 a.m. daily in the private dining room of the cafeteria in Jackson Hospital. Residents and attendings are expected to be punctual.**
- **On weekends, a similar procedure will be followed with checkout rounds conducted both mornings. Weekend on-call residents should be present for morning report on Mondays. Generally, weekend rounds begin at 7:00 a.m. with the group meeting in the Jackson private dining room, unless otherwise designated by the attending on call.**
- **Consultations, as appropriate, will be requested as required on all admissions to "intensive care units". Newborns and pediatric patients needing intensive care will be referred to the Pediatrics Department.**
- **An admission of a Family Medicine patient to labor and delivery requires immediate notification of the attending faculty. Attending faculty will notify the collaborating OB physician, examine patient on admission, record findings, and supervise labor and delivery as appropriate in conjunction with the collaborating OB physician.**
- **At the time of discharge, as well as at key points during the hospitalization, the attending resident on the service will call referring physicians with a verbal summary of the patient's progress.**
- **The housestaff responsible for the patient's care will dictate discharge summaries on the day of discharge.**
- **Copies of the discharge summary will be sent to the referring physician, the FPC (when indicated), and to the attending physician.**
- **Patients from the family medicine in-patient service "referred" or "transferred" to another service will be seen daily by the referring resident as appropriate in order to maintain continuity.**

- **Transfer of patient care will occur on a daily basis by 6:00 p.m. It is the responsibility of the on call resident to contact the Family Medicine Service resident.**
- **Patients will be admitted only after approval of the PGY-2 or PGY-3 resident following consultation with the attending faculty.**
- **Patients admitted from the Family Medicine Center will be discussed with the Family Medicine Service resident. Patients will be admitted from the Family Medicine Center by the resident seeing them only after consultation with an attending. Routine admissions (non-emergent) should be scheduled for the morning except under special initial orders (lab, x-ray, etc.) or unless requested otherwise by the in-patient team. A resident and attending admission note should be sent (may be brief, if appropriate) and pertinent office records should also be sent. The physician at the Family Medicine Center admitting the patient is responsible for notifying the admitting office. A phone call transmitting DOB, insurance or 3rd party coverage, previous admissions, old records request and initial labs requested, will facilitate more rapid processing of both routine and emergency admissions. The patient should be admitted directly when feasible.**
- **Patients to be seen in the Emergency Room for evaluation should be instructed to identify themselves as Family Medicine patients. The emergency room is not to be used as a facility for routine admission work-up, but may be utilized if it is unclear whether a patient should be admitted and in emergency evaluation when the patient's condition may necessitate a critical care unit (e.g., "call in" with severe chest pain) or other rapid intervention. These are not to be pre-admitted patients.**
- **The physician who sends a patient to the ER will notify the resident on call or on the Family Medicine Service. It is then the responsibility of the physician who will see the patient to notify the ER triage desk.**
- **PGY-1 residents will be directly supervised by PGY-2 or 3 residents and an attending on all activities in the ER. Attending notification should take place promptly in the instance of critically ill patients, invasive procedures, and diagnostic or management difficulties. The attending will be present for such procedures as appropriate.**
- **The attending physicians and residents who are taking call for the weekend should attend morning report on Friday and Monday whenever possible.**
- **Maintenance of billing sheets and records of attending services are the responsibility of attending faculty.**

Policy Regarding Care of Complex and Critically Ill Patients

- **A physician (attending or resident) from our practice at least twice daily will chart on patients in critical care units (defined as L&D, and the step-down units).**
- **The team will start rounds with the least stable patients.**
- **A physician will be available in house when patients are unstable.**
- **When consultation is necessary the consultant will be personally called, and all pertinent material will be available for the consultant to review.**
- **The patient care team shall be well versed in the indications, contraindications, techniques for insertion and removal, complications, and management of the following invasive access and monitoring techniques: arterial line, central venous catheter insertion, artificial ventilation. Simulation training and certification may be required.**
- **Consultants are called as soon as practical when the patient requires an intervention available only through them such as bronchoscopy, cardiac catheterization, etc.**
- **Consultants will be called when patients fail to respond as expected to therapeutic maneuvers or require aggressive, immediate intervention to avoid death or permanent disability.**
- **Consultants will be called when the patient's condition falls outside the realm of diseases usually managed by family physicians. Examples would include (but not be limited to) management of critically ill children under 12 or management of the surgical intensive care patient.**
- **Consultants will be asked specific management questions regarding the patient's care.**
- **Consultant recommendations will be monitored and followed as appropriate.**

- **When disagreement occurs between the primary care team and the consultant, the attending Family Medicine physician and the attending consultant will speak directly.**
- **Patients will have care transferred when the care requires continuous monitoring with in-house physician coverage, particularly at Jackson hospital. Examples would include children under 12 in respiratory failure.**
- **Patient care will be transferred when their condition requires continuous monitoring and feedback from specialists and intensive family physician involvement would be redundant. Examples of this would include patient following invasive cardiac intervention, surgery, etc.**
- **As we place a premium on continuity, we will continue to round on these patients, monitor their progress, and offer assistance in any way.**
- **The patient's family shall be notified at least every other day of the patient's condition, more frequently if circumstances dictate.**
- **The patient's community physician shall be notified weekly of the patient's condition, more frequently if circumstances dictate.**
- **The Family Medicine continuity physician will be notified of their patient's admission on the day of admission, if possible; also as soon as possible, regarding acute changes in their patient's status.**
- **When a decision is made to transfer the patient, it shall be done as expediently as possible.**

POLICY: Conference Attendance

Purpose of Conferences

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

Goals of Conferences

The resident should attend as many conferences as not precluded by clinical responsibilities. Attendance requirements for each rotation are set based on reasonable expectations for attendance during each rotation. These requirements include conferences missed as a consequence of vacation.

Objectives of Conferences

Objective 1: The rotations will be notified of the conference schedules and of the requirements for attendance.

- **Rotations where 100% attendance has not been historically possible have been identified and exceptions are made for these rotations.**
- **Being involved in direct clinical patient care is an accepted excuse for missing conference.**

Objective 2: Missed conferences for non-patient care reasons should be minimized.

Objective 3: Make-up opportunities will be made available.

- **Residents will have post call time to run any errands.**
- **If lunch is not provided, the resident should make some provision for food that allows attendance of conference.**
- **Curriculum committee and other committee meetings will be available as make up meetings.**
- **Residents who have failed to attend the minimum number of conferences by the middle of the third year will be offered the following make-up opportunities.**
  - **For those residents who neither meet the requirements nor participate in the make-up, their graduation certificates will be held until they negotiate and satisfactorily complete a remedial action as negotiated with a committee of the department faculty as a whole.**

Objective 4: The conference curriculum is expected to be covered by the resident regardless of physical presence. Conferences will be posted on the web site and the learner should review the content matter missed as time permits.

Objective 5: The percentage of conferences attended must equal or exceed the number in the table below:

Year Level	Required
PGY I	65%
PGY II	75%
PGY III	85%

GENERAL CONFERENCE CURRICULAR REQUIREMENTS

See Appendix C

POLICY: RESIDENT ADMINISTRATIVE RESPONSIBILITIES BY YEAR

PGYI

- **Complete health work and provide paperwork necessary to obtain hospital employment.**
- **Find out about all schedules, clinic, rotation, and call prior to scheduled rotations.**
- **Appear for duties promptly and dressed appropriately.**
- **Request vacation time from appropriate rotations and MedHub in timely manner.**
- **Upkeep of paperwork and charts at Jackson Hospital, and FMRP.**
- **Cover call of the clinic & hospital.**
- **Recruiting.**
- **Obtain Alabama Limited License, Alabama Controlled Substance and DEA**
- **Begin process of securing a date for USMLE Step Ill**
- **Chart procedures in MedHub.**
- **Meet with advisor on a quarterly basis.**
- **Provide any and all necessary duties to ensure smooth operation of program, clinic, call and hospital service.**
- **Complete all evaluations in a timely manner.**
- **Check departmental email every weekday.**
- **Attend or complete makeup for all conferences.**
- **Maintain duty hours in MedHub.**

PGY II

- **Complete USMLE Step Ill within the first six months of eligibility.**
- **Obtain Alabama License, DEA License and Controlled Substance License within 6 months of eligibility.**
- **Provide copies of all licensure information to residency office.**
- **Request vacation time from appropriate rotations and MedHub in timely manner.**
- **Upkeep of paperwork and charts at Jackson Hospital and the FMP.**
- **Find out about all schedules, clinic, rotation and call.**
- **Appear for duties promptly and dressed appropriately.**
- **Resident's cover calls for both the clinic & hospitals.**
- **Recruiting.**
- **Chart all procedures in MedHub.**
- **Meet with advisor on a quarterly basis.**
- **Complete all evaluations in a timely manner.**
- **Check departmental email every weekday.**
- **Attend or complete makeup for all conferences.**
- **Maintain duty hours in MedHub.**
- **Provide any and all necessary duties to ensure smooth operation of program, clinic, call and hospital service.**

PGY Ill

- **Secure rotations for elective months.**
- **Keep current Alabama License, DEA License and Controlled Substance License.**
- **Provide copies of all licensure information to residency office.**
- **Request vacation time from appropriate rotations and MedHub in timely manner.**
- **Upkeep of paperwork and charts at Jackson Hospital, and FMP.**
- **Find out about all schedules, clinic, rotation and call.**
- **Appear for duties promptly and dressed appropriately.**

- **Resident’s cover calls for both the clinic & hospital.**
- **Recruiting.**
- **Chart all procedures in MedHub.**
- **Meet with advisor on a quarterly basis.**
- **Complete all evaluations in a timely manner.**
- **Check departmental email every weekday.**
- **Attend or complete makeup for all conferences.**
- **Maintain duty hours in MedHub.**
- **Perform any and all necessary duties to ensure smooth operation of program, clinic, call, and hospital service.**
- **Complete all paperwork necessary prior to graduation including: licensure in other states, credentialing for hospital privileges, and insurance companies.**
- **Coordinator available to assist but ultimately resident's responsibility.**

Accomplishment of these responsibilities will be monitored on a monthly basis and will be reported to the housestaff. Failure to perform these duties satisfactorily may result in probation, unpaid leave and extension of the program and will result in adverse action on the summative evaluation.

Graduates Administrative Responsibility

Keep program advised of current address, submit information regarding practice profile when queried, provide information regarding licensure and board certification, and respond to requests regarding training experience and recommendations for improvement of training.

POLICY: RESIDENT ROTATION SCHEDULES

- **The Program Director or his/her designee is responsible for the rotation schedules of Family Medicine residents.**
- **Whenever possible, individual requests will be considered. However, program requirements and overall schedule balance will receive priority.**
- **The requirements of the American Board of Family Medicine will be followed.**
- **The Program Director is responsible for scheduling the days and times that residents will be in the Family Medicine Center for patient care. The yellow schedule is the default schedule after the final schedule for the month is published. It is the responsibility of the resident EACH MONTH to confirm his/her schedule. Patient care times once posted cannot be changed without written approval of the Program Director (pink sheet) via MedHub.**
- **Patient care in the Family Medicine Center is a longitudinal rotation, which occurs over a three-year period. A premium is placed on availability, continuity, and comprehensive care. Performance in this arena will be subject to continuous oversight.**

POLICY: AVAILABILITY AND WORK HOURS FOR FAMILY MEDICINE RESIDENTS

The Work Environment

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

Definition of Duty Hours

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

Absolute Limitation on Duty Hours

- **Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Rotations are arranged so that compliance is not a problem.**
- **Residents are provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. Rotations are arranged so that compliance is not a problem.**
- **Adequate time for rest and personal activities is provided. The resident's rotation is designed such that there should be a 10-hour time period, but must have an 8- hour time period, provided between all daily duty periods and 14-hour time period after in-house call.**
- **PGY I residents are limited to an absolute 16 hours per duty period.**
- **PGY II residents are limited to 24 hours on continuous duty, and up to 4 hours afterwards for stabilization and transferring of patient care - but not to include care of a new patient - and educational activities.**

- **PGY Ill residents have the same guidelines as PGY II residents; however, as senior residents, duty hours may be extended on occasion for the stabilization of a critically ill patient or the care of a laboring patient.**
- **For those rotations that are not under the control of the department, duty hours are established by rotation and are listed in the Goals and Objectives for the rotation. If the resident finds him or herself in a position where a potential violation may occur, he or she must report the situation at the time of discovery to the immediate supervisor for correction. Should the situation persist, the resident must then contact the program director who will facilitate compliance.**
- **Residents are responsible for their patients, both on the Family Medicine hospital service and patients they have seen in the office, on a continuous, ongoing basis regardless of work hour status. Family Medicine personnel (residents, students, etc.) should complete their day's work prior to leaving for the day. It is not the responsibility of the on-call resident to "clean up" after the other residents. It is the responsibility of the resident to make sure that all "loose ends" have been tied up or that an effective and adequate hand-off has been made to the coverage team. Repeated instances of unanticipated problems will result in remediation.**

Education Regarding Duty Hours
Residents and faculty will receive training on the detrimental effects of fatigue. Policies will remain in place to prevent work weeks of greater than 80 hours, no continuous duty of greater than 16 hours for PGY I residents or greater than 24 hours with an additional 4 for continuity and education for PGY II and Ill residents, and an average of 1 out of every 7 days completely free of clinical duties. We will encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. Information regarding the effects of fatigue will be prominently posted. Any resident or physician found to be suffering the ill effects of fatigue will be excused from his or her clinical duties and an effort will be made to prevent recurrence. If a resident or physician is excused from his or her clinical duties, available residents, as listed in MedHub, will be assigned to ensure continuity of care. If necessary, fatigued residents or physicians may rest in call rooms available at the hospital prior to leaving for home or a taxi service may be called.

Duty Hours Documentation

All residents must maintain an accurate log of duty hours in MedHub and must be completed for the previous month by last day of the month and delinquent on the 5th of the next month. This is analyzed twice a month for compliance. Non-compliance can lead to a suspension from the program (including having to come before the GMEC), extension of residency and a negative statement on the summative evaluation.

POLICY: ABSENCE

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

- **Director of current rotation,**
- **Senior resident or fellow of current rotation, if applicable, and**
- **Residency Coordinator (currently Mary Bradley) as records must be kept of sick and personal days taken.**

An UNEXPLAINED or UNEXCUSED absence from your assigned work area is a serious offense. The first time this happens, you will be given a written warning. The second occurrence will result in termination from the program. It is the resident's responsibility to check the clinic schedule. The clinic schedule overrides any other schedule. The

resident should check the schedule prior to the start of the month and any questions should be handled ahead of time (contact Mary Bradley, Program Coordinator). Not checking your schedule will NOT be an EXCUSED absence. All sick and personal leave must be appropriately documented in MedHub.

POLICY: VACATION

Upon employment and with each anniversary, each resident is granted twenty (20) days of paid vacation leave per year. Vacation leave cannot be taken prior to its accrual, nor can it be carried over to subsequent years. There is not terminal pay for unused vacation leave.

The following departmental vacation policies also apply:

- **Vacation requests are made several months prior to the beginning of the academic year for scheduling purposes and changes are only made for extreme circumstances. Requests receive priority in relationship to the dates submitted. No changes will be entertained once the clinic schedule is out for the month in question (3 months in advance).**
- **Vacation must be requested for only five (5) weekdays. As a courtesy, you will not be scheduled for call on one of the weekends around this block of time. Please indicate the weekend that you wish to be off. Please note that residents do not get paid holidays. If a holiday falls during the vacation week, it is taken as a day of vacation.**
- **Vacation may only be requested for five (5) days from any given month or service.**
- **NO vacation will be approved during the last two weeks of June of the PGY Ill year for the day of the In-Training exam or during the annual resident retreat.**
- **Special requests or exceptions to the above should be directed to the Program Director.**

Meetings, Leave, etc. Scheduling Policy

All other requests for scheduled absence must be requested and approved through MedHub, prior to the first (1st) day of the month, at least 90 days (3 months) prior to the first of the month in which you are requesting time off. Example: CME time desired for June 15-20, should be requested no later than March 1.

Requests must be sent by email.

POLICY: LEAVE OF ABSENCE

Housestaff Leave

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

Sick Leave

Upon employment and with each anniversary, each resident is granted twelve (12) days paid sick leave per 12-month year. Sick leave does not accrue and is not cumulative.
There is no remuneration for unused sick days. Sick leave may be used when a resident is: unable to perform work duties because of illness or injury; a member of the household that has been quarantined because of the presence of a contagious disease; or required to care for a seriously ill member of the immediate family (not to exceed 3 days). The sponsoring institution reserves the right to have a resident examined by a physician of its choice where abuse of sick leave is suspected. Abuse of sick leave benefits is grounds for disciplinary action.

Family and Medical Leave

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

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

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

Military Leave, Administrative Leave, on the Job Injury

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

Professional Meetings/Continuing Education

At the program director's discretion, residents will or will not be charged vacation for attending professional and continuing education meetings as designated representatives of their department.

ACGME Guidelines

Per ACGME and ABMS Policies, six weeks of paid leave will be offered to all residents/fellows for medical, parental and caregiver leave, with the right to take such leave on the very first day of the program. Any total absence exceeding ACGME guidelines may require an extension of training time to complete the program.

POLICY: DEPARTMENTAL MOONLIGHTING POLICY

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

Documentation & Requirements

- **Permission to moonlight may be granted by the Program Director following a written request of a resident. Residents requesting permission to moonlight must have an unrestricted license, individual professional liability insurance, and must be a resident in good standing. Permission status will be reviewed quarterly at the residents QA meeting. The Chief Resident will maintain a roster as to the site, frequency, and value of the experience. The Program Director may withdraw this permission at his or her discretion or at the suggestion of the GMEC.**
- **Total work hours (duty and moonlighting hours) are limited to 80 hours per week, averaged over a four-week period of time. There are no exceptions to this rule.**
- **It is not detrimental to the educational, research, and patient care activities of the resident or the residency program, as determined by the Program Director.**
- **It does not interfere with the personal and family life of the resident as determined by the Program Director.**
- **It has an educational value.**
- **It provides services to medically underserved areas of patients.**
- **It enhanced community good will.**
- **It incurs no legal liability or risk to the Sponsoring Institution or the Department of Family Medicine. You must carry your own professional liability insurance for moonlighting purposes.**

POLICY: PHARMACEUTICAL INDUSTRY RELATIONS

Principles

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

Faculty

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

Educational Conferences and Activities

Faculty are forbidden from accepting honoraria directly from pharmaceutical companies that might affect resident education. Faculty may serve as consultants to pharmaceutical or proprietary companies for clearly defined professional services.

Faculty and residents will conduct or participate in pharmaceutical company-sponsored research only if the research: is scientifically valid, would-be justifiable research even if company funding were not available, results are not subject to censorship and the sponsoring company is publicly identified. The residency will accept and use pharmaceutical or other proprietary companies' financial support of residency education activities for the following activities:

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

Gifts

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

- **Not to directly solicit or receive personal gifts from pharmaceutical companies.**
- **Not to allow pharmaceutical representatives to conduct contests, drawings, raffles, or other activities that lead to personal gifts for residents or faculty.**
- **Not to display gifts or other promotional materials directed to the physician and that advertise brand names for pharmaceutical products in patient care or waiting room areas.**

Residents and faculty may receive competitive national awards and scholarships funded by pharmaceutical companies if all control of recipient selection rests with an independent professional organization (e.g., AAFP, STFM).

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

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

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

Samples
The program accepts medication coupons that are given to patients. It is the policy of Jackson Hospital & Clinic to neither store nor distribute samples.

Literature
To help promote high quality patient education, patient education materials provided by pharmaceutical and other proprietary companies, will be reviewed by appropriate faculty, residents and/or office staff before distribution to patients. We will select patient education materials that are accurate, that are written at appropriate patient readability levels, and that present balanced and objective information.

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

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

POLICY: SPECIAL CERTIFICATION

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

We will provide access to special certification programs at various times throughout the three-year training program. We will provide funding for certain of these which will vary depending on funding sources. We will provide time away from rotations to allow housestaff to remain current should they so desire. These programs are considered part of the curriculum and do not count against the 5 allowable professional development days.

Program	Jackson FM's Responsibility	Resident's Responsibility
BLS	Will allow time off for certification and recertification pending the needs of the practice	Must be certified as soon as possible upon entering training. Recertification will be reimbursed through Jackson Housestaff Office.
ACLS	Will allow time off for certification and recertification pending the needs of the practice	Must be certified as soon as possible upon entering training. Recertification will be reimbursed through Jackson Housestaff Office.
PALS	Will allow time off for certification and recertification pending the needs of the practice	Can request certification paid through Jackson Housestaff Office.
NRP	Will allow time off for certification and recertification pending the needs of the practice.	Responsible for finances of course. Jackson FM may offer reimbursement if funding is available.
ATLS	Will allow time off for certification and recertification pending the needs of the practice	Responsible for finances of course. Jackson FM may offer reimbursement if funding is available.
ALSO	Will allow time off for certification and recertification pending the needs of the practice	Responsible for finances of course. Jackson FM may offer reimbursement if funding is available.

POLICY: RESIDENCY FACULTY-ASSIGNMENT, RESPONSIBILITIES, EVALUATION

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

Program Director

There will be a single program director responsible for the residency. The program director at this time is Thomas Horton, M.D. The RRC will be notified promptly in writing upon the decision to make a change by the current program director. The director will be scheduled such that at least 60% of his or her time is available for education, supervision, or administration of the residency program.

QUALIFICATIONS for the PROGRAM DIRECTOR

The following are the requirements for any person named to the position of program director (either permanent or acting) at the Sponsoring Institution Residency Program.

- **Academic and professional qualification: the director must be capable of administering the program in an effective manner; must be actively involved in the care of patients. Prior to assuming this position, the program director must have had a minimum of 5 years full-time professional activity in family medicine and must have had a minimum of 2 years' experience as a core faculty member teaching in a family medicine residency.**
- **Licensure: the director must be licensed to practice medicine in the State of Alabama.**
- **Certification requirements: the director must be currently certified by the American Board of Family Medicine.**
- **Medical staff appointment: the director must hold an appointment in good standing to the medical staff of the Jackson prior to having clinical duties within the Jackson Healthcare system.**

RESPONSIBILITIES of the PROGRAM DIRECTOR

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

- **Written educational goals.**
- **Selection of residents.**
- **Selection and supervision of teaching staff and other program personnel.**
- **Supervision of residents.**
- **Resident evaluations.**
- **Discipline.**
- **Resident well-being and provision of back-up support.**
- **Provide each resident with quarterly feedback of performance.**
- **Ensure compliance with grievance and due process as outlined in the Housestaff Manual.**
- **Provide verification of residency education upon request.**

- **Implement policies and procedures consistent with the institutional and program requirements for duty hours and work environment including moonlighting and distribution, monitoring and mitigating excess service demands.**
- **Compliance with institutional requirements.**
- **Compliance with ACGME requirements.**
- **Provision of accurate information to appropriate governing bodies...**
- **Notification of major programmatic change.**

Program Coordinator

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

- **Make arrangements for graduation banquet and picnic.**
- **Make orientation schedule.**
- **Schedule Welcome Aboard and other resident gatherings.**
- **Complete forms sent by accreditation agencies.**
- **Order and proctor In-training exam.**
- **Compile agenda for Curriculum Committee.**
- **Faculty evaluations – create, compile, and report.**
- **Update and post rotation information.**
- **Manage departmental pagers.**
- **Distribute resident info to rotations.**
- **Complete conference schedule - arrange topics.**
- **Create and send resident evaluations.**
- **Create and send rotation evaluations.**
- **Attend QA, Curriculum Committee, CCC, PEC and Resident Meetings and take minutes.**
- **Publish and distribute call schedule.**
- **Maintain resident's vacation, personal, sick and CME days.**
- **Assist in maintenance of residency web site.**
- **Maintain conference attendance and make-ups.**
- **Coordinate the creation, revision, and posting of rotation goals and objectives.**
- **Assist Program Director in all aspects of residency administration.**
- **Coordinate resident/advisor meeting process and documentation.**
- **Create and send Practice Management evaluations to be completed by nursing staff.**
- **Answer and direct all questions relating to residency program.**
- **Review ERAS applications.**
- **Oversee incoming and outgoing resident mail and messages.**
- **Create and send faculty evaluation of residents in FMP.**
- **Function as a liaison between residents and administration.**
- **Assist residents and graduates with facilitation of paperwork to acquire and maintain licensure and credentials.**
- **Attend necessary meetings to further the development of residency program.**
- **Supervise residency secretary.**
- **Troubleshoot residency.**

Family Physician Faculty

The program will maintain a core family physician faculty with the following attributes: All physicians who are core faculty members will excel at teaching. These faculty members will individually have expertise as family physicians but also the faculty collectively will maintain expertise in skills important to the training program. These skills include, but not limited to:

- **Dermatology.**
- **Geriatrics.**
- **Behavioral medicine.**
- **Nutrition.**
- **The use of medications and their interaction.**

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

General Rules for Residents and Faculty Members at Jackson Family Medicine

- **PROFESSIONALISM - Our faculty physicians are expected to be exemplary physicians and educators, and function as emissaries for our profession to the medical school, community, and our profession as a whole. They are expected to demonstrate exceptional knowledge through maintaining Board certification and meeting the requirements for Academy membership as well as through demonstrated knowledge of recent medical literature and participation in CME. They are expected to be good corporate citizens through participation in committees at the local, state, and national level. They are offered the opportunity to participate in scholarly inquiry and should be skeptical consumers of medical information.**
- **CONFIDENTIALITY - We are bound by an oath to maintain patient confidentiality. This means that you will not discuss patient information except with colleagues or office staff and then only in a manner that respects the patient's right to confidentiality.**
- **AVAILABILITY - You are expected to be always available for questions regarding patient care issues by pager during the work week and when on call.**
- **PHYSICIAN DRESS & APPEARANCE - Hair should be neat, clean, and of a natural human color. Hair should be styled off the face and out of the eyes. Shoulder length hair must be secured, away from the face, to avoid interference with patients and the resident's work. Avoid scarves or ribbons (unless culturally appropriate). Beards/mustaches must be neatly trimmed. Keep jewelry at a minimum (represents potential for cross-infection). The following are permitted: a watch, up to four rings, small earrings, academic pin/s, badges, or insignias which represents an award, modest bracelet/s, and necklace chains. Appropriate holiday pin during the holiday is suitable. Clothing should be clean, professionally styled and in good repair. Women should wear skirts of medium or knee length, or tailored slacks. Men should wear tailored slacks and a dress shirt that is tucked in. All Residents should wear a clean, white, coat over their clothing. Shoes must be closed toe and comfortable, clean and in good repair. Shoes should be worn with socks when appropriate. Fingernails should be clean and extend no further than one quarter inch in length from fingertips. Nail polish is appropriate for women. Artificial nails are not permitted in clinical areas. These are to be worn in specified patient care areas only or as required by your program or as defined by Jackson. They are property of the hospital and are not to be defaced, altered, or removed from the hospital premises. If a scrub suit must be worn outside clinical areas, it must be clean and then covered with a clean, white lab coat. Should a scrub suit be worn outside of a surgical suite, the scrub suit must be removed and replaced with a clean set upon re-entering the surgical clean operation area. Shoe covers, masks, hair covers, and beard covers must be removed before leaving the clinical area. Stained or soiled scrub suits must be changed as soon as possible (source of contamination). The following items are specifically prohibited in any hospital or clinical facility/location: blue jeans (except when**

permissible by hospital administration), regardless of color, or pants of a blue jean style; shorts, open-toed, high-heeled or canvas shoes (this is to prevent blood or needles from penetrating the fabric); midriff tops, tee shirts, halters, translucent or transparent tops, shirts or tops with plunging necklines, tank tops or sweatshirts; buttons or large pins that could interfere with work functions, transmit disease or be grabbed by a patient; visible body tattoos or visible body piercings, other than one in each ear. The program director or hospital administration may at any time prohibit a Resident from any location based on appropriate and professional dress code and standards.

- **Patient care begins at 8:30 AM & 1:30 PM Monday through Friday unless otherwise noted on the schedule. On the rare occasions where you will be unavoidably late, please call and let someone know.**
- **The morning patient care session ends when the last morning patient is seen. When a provider is done with their schedule, they may leave the premises once they have ascertained that there are no more unscheduled patients to be "worked-in" with them. Before leaving it is a courtesy for residents to notify the clinic attending to see if he or she is aware of anything else that might need attention.**
- **Faculty members are encouraged to attend conferences as residents are required to unless they have a scheduling conflict. He or she may have to make arrangements for lunch prior to the beginning of conference. Not being able to get away for lunch is not an acceptable excuse for missing conference. The conferences are some Mondays, Tuesday, Wednesday, Thursday, and Friday at 12:30 pm.**
- **Patient care in the afternoon begins at 1:30. If you will be delayed, you are expected to call and let the staff know what the situation is to allow rescheduling of your patients if necessary.**
- **The evening patient care session ends when the last patient is seen. When a provider is done with their schedule, he or she may leave the premises once he or she have ascertained that there are no more unscheduled patients to be "worked-in" with them. Before leaving it is a courtesy for the resident to notify the clinic attending to see if he or she is aware of anything else that might need attention.**
- **The provider is given a schedule that is appropriate for a community family physician or his or her training year and should be able to see the patients in the time allotted. If the provider is unable on a routine basis to accomplish this, he or she should seek out consultation from other faculty and staff to assist him or her.**
- **The providers are expected to build a continuity practice. Because of the nature of academic duties this is difficult to do at times. To compensate for lack of immediate availability, he or she should make an effort to check frequently for messages, return phone calls promptly, and be available for your patients. The physician's nurse will assist in doing this. The manager of clinical operations is the contact person should problems arise.**
- **Some patients are not strongly attached to a physician. The resident or faculty member seeing the patient is expected to take responsibility for the patient for the duration of their illness care and if they are suffering from a chronic illness may elect to take over their care. All paperwork regarding these patients will be directed to the last provider to see the patient. The faculty member may choose to assign these patients to a resident.**
- **Some patients have seen one provider exclusively and may be seeing another provider because their provider is not available. It is important to maintain the continuity relationship of the patients. When seeing a patient for an acute problem and they wish to return to their provider, all labs and paperwork should be directed to the patient's PCP.**
- **All patients must have their medical records completed with permanent problems, past medical, family, and social history, and allergies listed.**
- **All patients should have health maintenance issues addressed at every**
- **visit whenever possible.**
- **The provider is expected to assign the proper ICD-10 and CPT codes for the visit. These codes should cover any labs and x-rays ordered.**
- **All tests and specialty consultations should be well thought out prior to making the arrangements. This includes a working knowledge of the patient's condition and the documentation of the reason for test or the**

referral on the day the patient is seen. The referral is not completed until ALL information necessary to make the referral is given to the referral clerks.

- **Documentation should be done at the time of an encounter and must be completed within 24 hours of the encounter if unusual circumstances prevent the documentation from being done immediately. All notes will be done in the EMR.**

Position	Name	Email	Phone Number
Designated Institutional Official (DIO)	Dr. Thomas Cobb	Thomas.Cobb@jackson.org	(334)293-8780
Chief Marketing Officer	Joe Riley, Interim		
Chief Quality Officer	Gina Anderson	Gina.Anderson@jackson.org	(334)293-8617
Nursing Supervisor/ Chief of Nursing	Jan Hill	Jan.Hill@jackson.org	(334)324-6370
Program Director	Dr. Thomas Horton	Thomas.Horton@jackson.org	(334)293-8122
Associate Program Director	Dr. Paul Sheffield		
Program Coordinator	Mary Bradley	Mary.Bradley@jackson.org	(334)293-4008
Chief Resident			
Institutional Review Board Contact	Robin Pate	Robin.Pate@jackson.org	(334)293-8802
Patient Safety and Quality Improvement Contact	Gina Anderson	Gina.Anderson@jackson.org	(334)293-8617
System Quality Representative			
Electronic Residency Application Service (ERAS) Contact			
National Residency Matching Program (NRMP) Contact			
Resident Management System (RMS) Contact			

Curriculum Block Diagram

(See Appendix D)

CURRICULUM

The complete set of curricula for core rotations and currently available electives are included here *(See Appendix E).*

APPENDIX

Appendix A Program Specific Evaluation Tools

Appendix B Field Notes

Appendix C - Noon Conference Grid

Appendix D Curriculum Block Diagram

Appendix E Program Curriculum

Appendix F Licensure Application Forms

Appendix G Program Requirements for Advancement

Appendix A Program Specific Evaluation Tools

Jackson Hospital & Clinic Family Medicine Residency Program will use competency-based milestones. The program plans to implement these as structured through MedHub. The back-up paper system included here follows the basic structure that is anticipated electronically in MedHub.

The following evaluation tools are included:

1. Rotational milestones/competencies
2. Annual Clinic Nurse Evaluation
3. Patient evaluation form for the 360
4. A compiled hypothetical 360 radar graph

Jackson Family Medicine Residency Dates: ________________

Resident: ___________________ PGY: ___ Rotation: ____ Preceptor: ________________

Mark an X in the box on the right next to the description that best fits the resident.

PATIENT CARE	
Rehearsed communication with patients and families. Gathers information according to a list and sometimes fails to gather all pertinent info. Diagnosis and treatment are according to textbooks and show no real complexity of thought or consideration of the patient as a whole. No procedural experience. No knowledge of preventive care guidelines and rare consideration of the need for prevention.	
Caring & respectful, although sometimes awkward in difficult situations. Gathers medical information according to a list of what is needed. Diagnosis and treatment are sometimes incomplete and show simple concrete thinking followed by early closure. Needs experience in procedures. Occasionally considers counseling, education, and preventive care.	
Respectful, comfortable, and compassionate with patients as a general rule. Gathers essential information to guide decision making. Diagnosis and treatment are according to accepted guidelines and show some degree of intuition. Able to perform essential procedures unassisted. Remembers counseling and preventive care and abides by accepted guidelines.	
Sets patients and families at ease with their communication and compassion. Gathers all information needed to work through a differential diagnosis and takes the whole person into account as they make insightful decisions about diagnosis and treatment. Is capable of teaching the basics of essential procedures. Counsels' patients about their illness in an effective way and always strives to practice prevention according to the standards.	
Is a role model of communication, counseling, and compassion. Effortlessly gathers all information for decision making including what is needed to rule out rarer diagnoses in a differential. Diagnosis and treatment are according to the latest evidence and show complexity of thought, insight into the whole person, and medical intuition. Able to teach the finer points of procedures to those already experienced. Guides preventive care according to the latest guidelines and emerging medical evidence.	
MEDICAL KNOWLEDGE	
Understands basic physiology and pathology and can sometimes apply these in the clinical context.	
Analyzes situations based on knowledge of basic sciences.	
Applies basic sciences, clinical experience, and recent evidence in analyzing clinical scenarios.	
Is able to teach the science behind diagnoses and treatments. Consistently analyzes and investigates subtleties in clinical situations.	
Is involved in shaping the understanding of certain disease processes through clinical investigations. Is able to argue the finer points of the basic sciences in their application to these processes	
PRACTICE-BASED LEARNING & IMPROVEMENT	
Systematically reads textbooks to advance knowledge. Can perform an adequate self-evaluation on command. Is usually able to apply new information to clinical care. Attempts to use experience in guiding clinical decisions.	
Reads texts to investigate clinical questions. Assesses past experience and textbook knowledge to look for ways to establish practice patterns.	
Uses both texts and the up-to-date medical literature to further medical knowledge. Is in a stage of beginning to refine personal clinical pathways by using both evidence and experience. Has some experience with online medical literature reviews.	
Regularly analyzes and critiques the medical literature based on a proficient understanding of pathophysiology, statistics and epidemiology, and other current available evidence. Practice habits are set by an ongoing review of evidence and constant adjustment. Frequently and easily reviews the latest evidence online.	
Is capable of reviewing the online and offline medical literature and making public recommendations with regards to changing practice guidelines. Has a vast clinical experience that can be drawn from in evaluating and applying the latest evidence. Teaches or encourages other physicians to practice evidence-based medicine.	
INTERPERSONAL & COMMUNICATION SKILLS	
Acts as an adjunct to the real doctor patient relationship which is between the preceptor and patient. Listens but frequently fails to see the importance of it and spends more time demonstrating knowledge to patients. Patients frequently need further clarification and or feel that	

they weren't completely understood. As a member of a team, is basically there to follow direct commands. Understands feedback and but is occasionally defensive or feels misunderstood.	
Takes more responsibility as the sole member of the physician side of the patient-doctor relationship. Listens well and rarely needs clarification by an attending to help the patients understand what they need to know. Acts as a contributor to the medical team, but is not involved in directing and only occasionally initiates actions. Receives feedback and frequently acts on it.	
Is seen by the patients and other physicians as the patients' sole care provider. There is trust built through good listening skills and the physician is able to adequately communicate the essential information to patients that is needed for proper patient care. Is able to act independently in directing non-physician staff. Receives criticism well and looks for ways to use it for personal improvement. Criticism given is constructive.	
Has relationships with patients that are marked by trust, understanding, and mutual respect. Listens to patients in a way that engenders these attributes, and communicates to them about both medical and social issues in a way that is sensitive and clear. Assumes the role of leader of a medical team easily and gives and receives criticism with colleagues in a way that benefits both of them.	
Has markedly above average relationships with patients who sometimes make appointments for just a listening ear. Listens well and still manages to be timely. Communicates plans of care, solutions to complex problems, and advice for lifestyle and situational changes such that patients understand, act on them, and feel understood. Is frequently requested to be a member of medical teams and to assume leadership roles in various institutions and associations.	
PROFESSIONALISM/ETHICS	
Is occasionally late, needs to work on appearance, and has many lessons to learn about professional behavior in the workplace and in patient interaction. Knows that ethics is an issue but has difficulty articulating a personal code of ethics generally or in relation to specific issues. Needs to develop a sense of responsibility to patients, to the profession and to himself with regards to excellence and ethics.	
Is usually on time and responsive to paging. Can articulate the general principles of medical ethics but is still forming a personal code of ethics and a proper understanding of the principles that underlie the ethics of the profession. Has a growing sense of need to practice medicine excellently and ethically.	
Is timely, professional in appearance, and positive in attitude, and can separate personal and professional behavior. Acts on an awareness of basic cultural differences. Has a firm understanding of the basics of fundamental medical ethical principles and of one's own code of ethics and the presuppositions that underlie them. Feels a deep responsibility to adhere to excellence and to this code of ethics for the sake of the patient and for the profession in general.	
Timeliness and professional appearance are a way of life. Is marked by appropriate behavior in professional and public life. Can teach ethics to younger colleagues and those in training and can help guide them in their personal ethical formation. Not only feels a personal responsibility to ethics and excellence, but lives and practices in such a way that engenders this in others.	
Teaches by example and precept issues of timeliness, professional appearance and behavior. Can lead discussion on the difficult ethical questions without endangering the foundational principles that guide our ethical code, and pushes those in the community to ask these important questions. Demands ethical and excellent practice, both personally and with colleagues, in a way that has a positive effect on the medically community as a whole. Is the epitome of "the good doctor".	
SYSTEMS-BASED PRACTICE	
Is unaware of issues of cost. Orders all studies recommended by a medical text without insight into why. Does not know when referral is appropriate and certainly cannot help patients navigate the complex medical system in which we practice.	
To meet expectations, tries to be judicious with ordering tests and labs and has some insight into the relevance or irrelevance of tests. Referrals are more appropriate and are based on learning from previous trial and error. Cannot offer much with regards to helping patients through the medical system, but has learned who can and uses that resource.	
Has a basic understanding of cost control in ordering tests and studies. Doesn't order tests that will not change plan of care. Refers appropriately and manages patients alone appropriately. Can help patients navigate issues of the medical system by having several good resource persons they can go to as well as being aware of issues such as drug formulary and medical necessity.	

Can help with guiding and educating young physicians in issues of cost control and appropriate referral patterns. Is a desirable referral source for consultants which is marked by referrals that the consultants feel is necessary and timely. Is a resource for patients and sometimes other physicians in working through the complexities of our medical system with regards to both third-party payers and the uninsured.	
Is capable of being part of decision-making teams that are directed toward cost control in various settings. Is always appropriate in testing and referrals and frequently can help even experienced physicians save the system/patients money by adjusting practice patterns. Is an excellent resource for other physicians who are trying to maximize their use of the system to help both the insured and the uninsured.	

OVERALL ASSESSMENT OF THE RESIDENT (Circle one)

Stage of Learning:	Novice /	Adv Beg /	Competency /	Proficiency /	Mastery
Appropriate level of training for stage:	3RD YEAR Med Stdnt	1ST YEAR Resident	2ND YEAR Resident	Practicing Physician	Some may never attain this

Comments:

____

____

____

______________________ ________ ______________________ ________

Preceptor signature Date Resident signature Date

ANNUAL CLINIC NURSE EVALUATION Resident: __________

Mark an X in the box on the right next to the description that best fits the resident.

PATIENT CARE	
Rehearsed communication with patients and families. Gathers information according to a list and sometimes fails to gather all pertinent info. Diagnosis and treatment are according to textbooks and show no real complexity of thought or consideration of the patient as a whole. No procedural experience. No knowledge of preventive care guidelines and rare consideration of the need for prevention.	
Caring & respectful, although sometimes awkward in difficult situations. Gathers medical information according to a list of what is needed. Diagnosis and treatment are sometimes incomplete and show simple concrete thinking followed by early closure. Needs experience in procedures. Occasionally considers counseling, education, and preventive care.	
Respectful, comfortable, and compassionate with patients as a general rule. Gathers essential information to guide decision making. Diagnosis and treatment are according to accepted guidelines and show some degree of intuition. Able to perform essential procedures unassisted. Remembers counseling and preventive care and abides by accepted guidelines.	
Sets patients and families at ease with their communication and compassion. Gathers all information needed to work through a differential diagnosis and takes the whole person into account as they make insightful decisions about diagnosis and treatment. Is capable of teaching the basics of essential procedures. Counsels' patients about their illness in an effective way and always strives to practice prevention according to the standards.	
Is a role model of communication, counseling, and compassion. Effortlessly gathers all information for decision making including what is needed to rule out rarer diagnoses in a differential. Diagnosis and treatment are according to the latest evidence and show complexity of thought, insight into the whole person, and medical intuition. Able to teach the finer points of procedures to those already experienced. Guides preventive care according to the latest guidelines and emerging medical evidence.	
MEDICAL KNOWLEDGE	
Understands basic physiology and pathology and can sometimes apply these in the clinical context.	
Analyzes situations based on knowledge of basic sciences.	
Applies basic sciences, clinical experience, and recent evidence in analyzing clinical scenarios.	
Is able to teach the science behind diagnoses and treatments. Consistently analyzes and investigates subtleties in clinical situations.	
Is involved in shaping the understanding of certain disease processes through clinical investigations. Is able to argue the finer points of the basic sciences in their application to these processes.	
PRACTICE-BASED LEARNING & IMPROVEMENT	
Systematically reads textbooks to advance knowledge. Can perform an adequate self-evaluation on command. Is usually able to apply new information to clinical care. Attempts to use experience in guiding clinical decisions.	
Reads texts to investigate clinical questions. Assesses past experience and textbook knowledge to look for ways to establish practice patterns.	
Uses both texts and the up-to-date medical literature to further medical knowledge. Is in a stage of beginning to refine personal clinical pathways by using both evidence and experience. Has some experience with online medical literature reviews.	
Regularly analyzes and critiques the medical literature based on a proficient understanding of pathophysiology, statistics and epidemiology, and other current available evidence. Practice habits are set by an ongoing review of evidence and constant adjustment. Frequently and easily reviews the latest evidence online.	
Is capable of reviewing the online and offline medical literature and making public recommendations with regards to changing practice guidelines. Has a vast clinical experience that can be drawn from in evaluating and applying the latest evidence. Teaches or encourages other physicians to practice evidence-based medicine.	
INTERPERSONAL & COMMUNICATION SKILLS	

Acts as an adjunct to the real doctor patient relationship which is between the preceptor and patient. Listens but frequently fails to see the importance of it and spends more time demonstrating knowledge to patients. Patients frequently need further clarification and or feel that they weren't completely understood. As a member of a team, is basically there to follow direct commands. Understands feedback and but is occasionally defensive or feels misunderstood.	
Takes more responsibility as the sole member of the physician side of the patient-doctor relationship. Listens well and rarely needs clarification by an attending to help the patients understand what they need to know. Acts as a contributor to the medical team, but is not involved in directing and only occasionally initiates actions. Receives feedback and frequently acts on it.	
Is seen by the patients and other physicians as the patient's sole care provider. There is trust built through good listening skills and the physician is able to adequately communicate the essential information to patients that is needed for proper patient care. Is able to act independently in directing non-physician staff. Receives criticism well and looks for ways to use it for personal improvement. Criticism given is constructive.	
Has relationships with patients that are marked by trust, understanding, and mutual respect. Listens to patients in a way that engenders these attributes, and communicates to them about both medical and social issues in a way that is sensitive and clear. Assumes the role of leader of a medical team easily and gives and receives criticism with colleagues in a way that benefits both of them.	
Has markedly above average relationships with patients who sometimes make appointments for just a listening ear. Listens well and still manages to be timely. Communicates plans of care, solutions to complex problems, and advice for lifestyle and situational changes such that patients understand, act on them, and feel understood. Is frequently requested to be a member of medical teams and to assume leadership roles in various institutions and associations.	
PROFESSIONALISM/ETHICS	
Is occasionally late, needs to work on appearance, and has many lessons to learn about professional behavior in the workplace and in patient interaction. Knows that ethics is an issue but has difficulty articulating a personal code of ethics generally or in relation to specific issues. Needs to develop a sense of responsibility to patients, to the profession and to himself with regards to excellence and ethics.	
Is usually on time and responsive to paging. Can articulate the general principles of medical ethics but is still forming a personal code of ethics and a proper understanding of the principles that underlie the ethics of the profession. Has a growing sense of need to practice medicine excellently and ethically.	
Is timely, professional in appearance, and positive in attitude, and can separate personal and professional behavior. Acts on an awareness of basic cultural differences. Has a firm understanding of the basics of fundamental medical ethical principles and of one's own code of ethics and the presuppositions that underlie them. Feels a deep responsibility to adhere to excellence and to this code of ethics for the sake of the patient and for the profession in general.	
Timeliness and professional appearance are a way of life. Is marked by appropriate behavior in professional and public life. Can teach ethics to younger colleagues and those in training and can help guide them in their personal ethical formation. Not only feels a personal responsibility to ethics and excellence, but lives and practices in such a way that engenders this in others.	
Teaches by example and precept issues of timeliness, professional appearance and behavior. Can lead discussion on the difficult ethical questions without endangering the foundational principles that guide our ethical code, and pushes those in the community to ask these important questions. Demands ethical and excellent practice, both personally and with colleagues, in a way that has a positive effect on the medically community as a whole. Is the epitome of "the good doctor".	
SYSTEMS-BASED PRACTICE	
Is unaware of issues of cost. Orders all studies recommended by a medical text without insight into why. Does not know when referral is appropriate and certainly cannot help patients navigate the complex medical system in which we practice.	
To meet expectations, tries to be judicious with ordering tests and labs and has some insight into the relevance or irrelevance of tests. Referrals are more appropriate and are based on learning from previous trial and error. Cannot offer much with regards to helping patients through the medical system, but has learned who can and uses that resource.	

Has a basic understanding of cost control in ordering tests and studies. Doesn't order tests that will not change plan of care. Refers appropriately and manages patients alone appropriately. Can help patients navigate issues of the medical system by having several good resource persons they can go to as well as being aware of issues such as drug formulary and medical necessity.	
Can help with guiding and educating young physicians in issues of cost control and appropriate referral patterns. Is a desirable referral source for consultants which is marked by referrals that the consultants feel is necessary and timely. Is a resource for patients and sometimes other physicians in working through the complexities of our medical system with regards to both third-party payers and the uninsured.	
Is capable of being part of decision-making teams that are directed toward cost control in various settings. Is always appropriate in testing and referrals and frequently can help even experienced physicians save the system/patients money by adjusting practice patterns. Is an excellent resource for other physicians who are trying to maximize their use of the system to help both the insured and the uninsured.	

OVERALL ASSESSMENT OF THE RESIDENT (Circle one)

Stage of Learning:	Novice /	Adv Beg /	Competency /	Proficiency /	Mastery
Appropriate level of training for stage:	3RD YEAR Med Stdnt	1ST YEAR Resident	2ND YEAR Resident	Practicing Physician	Some may never attain this

Jackson Family Medicine Residency Program

Evaluator: ________________________

Date: ________________

Jackson Family Medicine Residency
360º Performance Evaluation by PATIENT / Date: __________

No	Yes	Don't

Resident: Dr. ________________

Patient's name_____________________

Nurse's initials ______

The resident's nurse is to ask the patient the following questions:

- **Feel free to reword the question if that will help the patient understand.**
- **An answer of 1 is a DEFINITE NO**
- **An answer of 5 is a DEFINITE YES**
- **Use your judgment, if the patient is not emphatic about their answer, circle 2, 3, or 4**

PATIENT CARE	**NO**				**YES**	**DON'T KNOW**
Will you continue to see this doctor?	1	2	3	4	5	#
Did your doctor listen to you?	1	2	3	4	5	#
Did the doctor give you the opportunity to ask questions?	1	2	3	4	5	#
INTERPERSONAL & COMMUNICATION SKILLS						
Did the doctor greet you and introduce himself?	1	2	3	4	5	#
Was the doctor caring and compassionate?	1	2	3	4	5	#
Did the doctor include you in decisions & choices about your care?	1	2	3	4	5	#
Were the doctor's explanations & recommendations clear & easy to understand?	1	2	3	4	5	#
PROFESSIONALISM/ETHICS						
Did the doctor have a neat, clean, well-groomed appearance?	1	2	3	4	5	#
Did the doctor treat you with courtesy & respect?	1	2	3	4	5	#

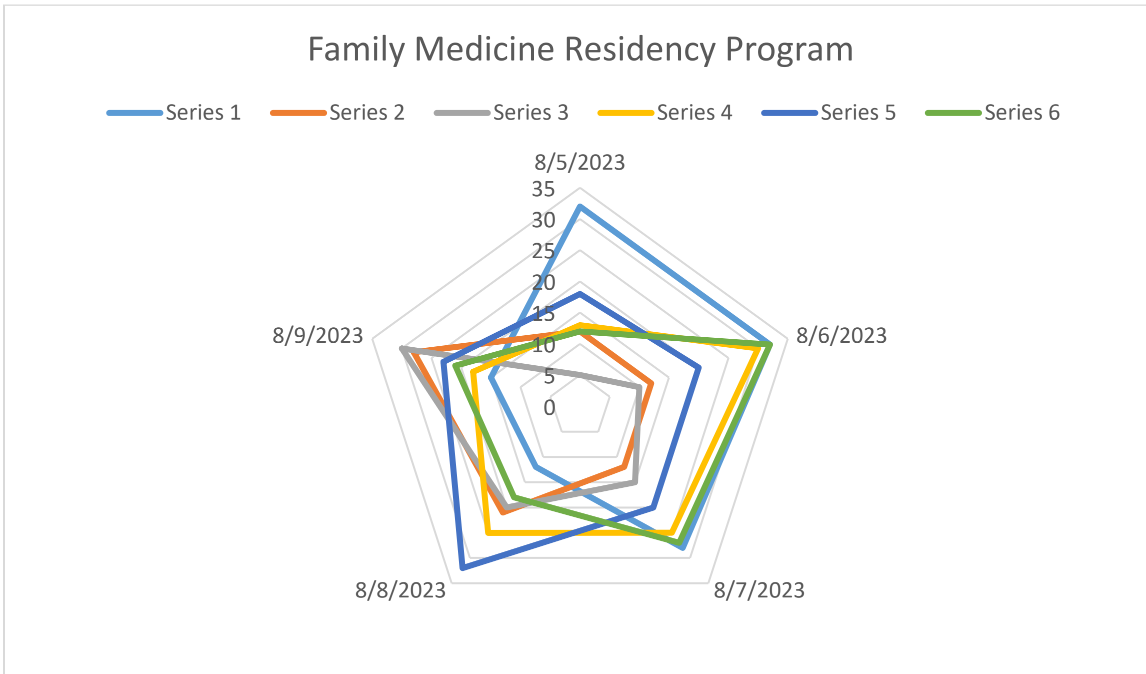
Positive & negative comments are helpful if they add to the personal development of the physician

____

____

A Compiled Hypothetical 360-radar graph

(This is an example of the 360-radar graph)



Appendix B Field Notes

The Role of the Field Notes

- Field notes are used to provide the supervisor and the resident a focus for recording observed performance.
- They are used to confirm for the resident what he/she did well.
- They are used to identify areas requiring improvement and to help the resident find ways to achieve this.
- Resident Field Notes are initiated by the resident allows the resident to reflect on practice and to promote self-assessment skills.
- Resident Field Notes are a safe venue for constructive feedback.
- Residents are encouraged to acknowledge the things that they do not know so they can improve their level of competency.
- Faculty Field Notes are initiated by supervising faculty and are used to document performance and progress in the resident's learning portfolio.
- Collectively, field notes provide a method of "multiple sampling" of performance over time by different observers, which leads to more reliable assessment.
- Collectively, field notes should show overall progress, not perfection.

When to Use Field Notes

Field notes can be used to provide feedback following direct observation of a resident encounter with a patient; patient's family member(s); other health care team members; colleagues and others.
Field notes can also be based on the resident's case presentation of a patient and discussion around differential diagnosis, approach to management; investigations, interventions and/or follow-up.

Field notes can also be used to capture other activities as a resident. These can include:
- Filling out a form for a patient
- Interacting with any allied health professional in person or on the telephone
- Writing a referral letter
- Giving a presentation at your clinic

They can be based on anything the resident or supervisor feels is important to get feedback on.

Frequency of Field Notes

Ideally field notes should be completed on a daily basis.
At a minimum, there should be two (2) Resident Field Notes and two (2) Faculty Field Notes completed each week during family medicine block time.

Content of Field Notes

Field notes should be short (only in the space provided)
They are a narrative-rich, specific, and meaningful, descriptive comment on what was observed and what the supervisor and resident discussed.

Where appropriate the field notes should also include:

IDENTIFYING DATA
- Add the resident and supervisor's names, and the date
- Indicate the setting: outpatient, inpatient, emergency room, patient's home, personal care home

DESCRIPTION OF THE ACTIVITY

1. Provide a short description of the interaction (age of patient, gender)
2. Identify the domain of clinical care:
    a. Maternal care
    b. Care of children and adolescents
    c. Care of adults
    d. Care of elderly
    e. Palliative Care
    f. Care of First Nation, Inuit, Métis
    g. Care of vulnerable and underserved populations
    h. Behavioral medicine
3. Identify the competency from the list of 99 core topics or, if not listed, identify the phase(s) of clinical encounter observed:
    a. Hypothesis generation (or early differential diagnosis)
    b. History (gather the appropriate information)
    c. Physical examination (gather the appropriate information)
    d. Investigation (gather the appropriate information)
    e. Diagnosis (interpret information)
    f. Management
    g. Referral
    h. Follow-up
    i. Complete encounter

NARRATIVE COMMENT

Use this space to provide focused feedback based on what the resident has done well (his or her strengths), should consider doing differently in the future (areas that would benefit from development or attention).
Use language that is descriptive, specific, and constructive.

ASSESSMENT PARAMATERS

Select the appropriate assessment parameter.
.

Overall performance

Assess the overall level of performance on the task completed.

Action Plan

Select interventions to address any gaps identified

Form to Use

Appendix C - Noon Conference Grid

(Insert latest conference grid here)

Appendix D Curriculum Block Diagram

Jackson Hospital and Clinic Family Medicine Residency
Block Schedule 2023

PGY-1 Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Rotation	Orient./ Night Float 1	Night Float 2	FM Inpt Service 1	FM Inpt Service 2	OB 1	OB 2	Behav. Med	Cardio-logy	General Surgery	Pulmon/ ICU	ER 1	Radiology/ Elective*	Rural Health (Peds, Sports, Industrial) 1
Site	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1 FMP 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1 FMP 1
% Outpatient	10%	10%	10%	10%	20%	20%	60%	50%	50%	20%	100%	50-100%	100%
% Research	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

PGY-2 Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Rotation	FM Inpt Service 3	FM Inpt Service 4	Night Float 3	Night Float 4	Pulmon./ICU/Elective*	Urology/Elective*	ER 2	Inf. Disease	Rural Health (Peds, Sports, Industrial) 2	OP Clin/ Com Med	Rural Health (Peds, Sports, Industrial) 3	Ortho	Vacation/ Elective*
Site	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	
% Outpatient	10%	10%	10%	10%	20%	40%	100%	40%	20%	100%	100%	80%	
% Research	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	

PGY-3 Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Rotation	FM Inpt Service 5	FM Inpt Service 6	Night Float 5	Night Float 6	Rural Health (Peds, Sports, Industrial) 4	OP Clin/ Pop Health	Geriatrics	Prac.Man/ Board Review	Sports Medicine	ENT	GYN/ Women's Health	Vacation/ Elective*	Vacation/ Elective*
Site	Hosp 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1	FMP 1	Hosp 1 FMP 1	Hosp 1	Hosp 1	Hosp 1	Hosp 1		
% Outpatient	10%	10%	10%	10%	100%	100%	75%	100%	100%	90%	100%		
% Research	0%	0%	0%	0%	0%	5%	0%	5%	0%	0%	0%		

* Electives may include Neurology, Endocrinology, Nutrition, Wellness, Industrial Medicine, Dermatology, Hospice/Palliative Care,

Electives may include Neurology, Endocrinology, Nutrition, Wellness, Industrial Medicine, Dermatology, Hospice/Palliative Care, Addiction Medicine, Allergy/Immunology, Wound Care, Urology, Plastic/Cosmetic Surgery, Rural Health, Research, Pharmacology, additional exposure to existing rotation content, and others as approved by the program director.

Vacation in PGY-1 year may be taken in any rotation other than hospital service, float call, or anesthesia/ICU blocks with prior program director approval.

A collaboration with Bullock County Hospital and its related clinics provides longitudinal experience in pediatrics, sports medicine, and industrial medicine under the supervision of our FP faculty and preceptors

Other longitudinal components include nursing home care and home visits, as well as on-going practice management, geriatrics, wellness, research, and community medicine. Additional experiential subject matter deemed beneficial may also be incorporated over the course of the three-year residency

Appendix E Program Curriculum

(Insert program curriculum here)

Appendix F Licensure Application Forms

(Items/forms to follow)

Appendix G Program Requirements for Advancement

PROGRAM ENTRY - Completion of USMLE II (or equivalent), IMG- ECFMG is required.

PGY 1

- Completion of ACLS certification by the end of third month of PGY I.
- November In-Service Examination score of 20 z score or less will result in being placed on academic notice.
- JACKSON Family Medicine strongly encourages interns to take Step III by the end of their first year. This will allow for a retake if necessary (www.fsmb.org).
- Noon conference attendance 80% or greater per month.
- Maintenance of all hospital and office charts on a timely basis.
- Must successfully complete each rotation. Any marginal performances will be evaluated for the possibility of repeating that particular rotation.
- Demonstrate ability to see two patients or more per hour.
- Completion of ALSO & PALS by the end of PGY 1
- Documentation of 220 patient encounters, benchmark for PGY 1.
- The program expects enrollment of more than 8 continuity OB patients.
- Completion of PGY 1 Evidence Based Medicine Project.
- Completion of at least 10 hours of Sports Medicine
- Documentation of observed patient encounter
- All CERT requirements met
- Progress reviewed by Program Director, and contract renewed if resident is in good standing.
- Achieve 'Advanced Beginner' level for all competency-based milestones
- Recommended completion of EKG interpretation testing

To obtain Step III instructions and application: www.fsmb.org

PGY 2

- Successful completion of USMLE Step III before the end of the eighteenth month of residency (12 months of PGY I, extended six months to retake if needed).
- November In-Service Examination score of 20 z score or less will result in being placed on academic notice.
- Noon conference attendance 80% or greater per month.
- Timely completion of all hospital and office charts.
- Demonstrate ability to see at least three patients per hour.
- The program expects enrollment of more than 20 continuity OB patients (8 in PGY1 and 12 in PGY2), resulting in more than 10 continuity deliveries.
- Non-continuity deliveries should exceed 35 by the end of PGY 2.
- Documentation of 850 patient encounter, benchmark for PGY 2.
- Completion of PGY 2 Evidence Based Medicine Project.
- Approval of QA Project by mid-year PGY 2
- Documentation of at least 20 hours of sports medicine
- Documentation of taped and reviewed patient encounter
- All CERT requirements met
- Progress reviewed by Program Director, and contract renewed if resident is in good standing.
- Achieve 'Competency" level for most competency-based milestones
- Mandatory completion of EKG interpretation testing

PGY 3

- November In-Service Examination score of 20 z score or less will result in being placed on academic notice.
- Noon conference attendance 60% or greater per month.
- Timely completion of all hospital and office charts.
- Demonstrate ability to see at least four patients per hour.
- Documentation of at least 1650 patient encounters by graduation.
- Documentation of direct experience with at least 15 critically ill in-patients

- Documentation of at least 40 deliveries, of which 30 are vaginal.
- Documentation of at least 10 continuity deliveries.
- Documentation of at least 2 home visits, at least one being for an older adult continuity patient.
- Documentation of at least 2 continuity nursing home patients.
- Competence in the program's list of required procedures.
- Completion of PGY 3 Evidence Based Medicine Project.
- Completion of QA Project
- Documentation of 30 hours of sports medicine
- Documentation of observed difficult patient encounter
- All CERT requirements met
- Achieve 'Proficiency" level for most competency-based milestones

GRADUATING RESIDENT'S CHECKLIST

Turn in forwarding address and keys to Business Administrator.
Complete hospital charts
Complete all tasks in EMR
All rotation evaluations returned and signed
Any keycards to Business Administrator

Foreign Medical Graduates

- For international graduates, Alabama law does not recognize the completion of USMLE until completion of three years of postgraduate training. However, Step III may be completed under the jurisdiction of certain other states.
- All residents should take and pass USMLE III before the end of their 18-month of residency. Although for international graduates, Alabama does not offer Step III for FMG until residency is completed, there are several states that allow one to sit for the examination, but do not require application for license.