FLORIDA HOSPITAL EAST ORLANDO

OSTEOPATHIC FAMILY MEDICINE and FM / NMM RESIDENCY

PROGRAM MANUAL

2009-2010

Department of Medical Education
July 2009

The following pages contain information, rules and regulations pertaining to your residency. It is important that all residents review these pages along with the GME Manual and ask any questions they may have. Failure to read and understand the information contained within this manual does not excuse the resident from adherence and possible disciplinary action.

There have been policy changes implemented for 2009-2010, so each resident should carefully review the entire manual.

Review each rotation section prior to the start of the rotation.

NOTE: Policies and Procedures within this manual are subject to change and are superseded by Florida Hospital Policies and Procedures as well as FH GME Manual.

TABLE OF CONTENTS

Manual Acknowledgment 6
The Osteopathic Oath 7
From the Director of Medical Education 8
Family Medicine and FM/NMM Residency ProgramS 9
Introduction to Residency 9
Program Description 9
Mission Statement 9
Goals and Means 10
General Goals of the Program 10
Orientation 11
Orientation Program 11
Facilities 11
ACOFP Resident Requirements 12
Longitudinal Rotations 13
Family Medicine RESIDENCY- OGME-1 13
Block rotations: 13
Longitudinal Rotations 13
General Information and Regulations 14
FHEO Medical Education Staff 14
FHEO Faculty/Proctors 15
alumni surveys 16
Annual Program Review 16
Annual Resident evaluation of the program 17
Annual resident evaluation by the program director 17
Board Scores 17
Cafeteria 17
Call guidelines and responsibilities 17
Call and Clinic Switches 17
CALL/CLINIC SWITCH FORM 19
Certifications 20
Chief Residents 20
Citizenship Policy 21
Continuing Medical Education 21
Continuing Medical Education Requirements for Licensure 21
Confidentiality and Medical Records 22
Contract Extensions & Obligations 22
Curriculum 22
Criteria for Advancement/Promotion of Residents in Family Medicine 24
Diagram of Criteria for Advancement/Promotion of Residents in Family Medicine and FM/NMM 25
Department Meetings 27
Didactic Programs 27
Morning Report – Internal Medicine 27
Attendance Policy- 27
Disaster Plan (Hurricane) 28
Initial Preparations 28
Notification of Disaster (Hurricane) Warning 28
Disciplinary Policy / Remediation 29
Dismissal Policy 29
Dress Code 29
Elective Rotations 29
Evaluations 29
Resident Evaluations: 30
Faculty Evaluations: 30

Confidentiality: *30*
Expenses 30
FM/NMM Residency Program........ 30
RESIDENT ELIGIBILITY CRITERIA FOR THE FM/NMM RESIDENCY *30*
RESIDENT SELECTION POLICY AND PROCEDURES *31*
RESIDENT ROTATIONS FM/NMM OGME-2 through OGME-4........ *32*
EXPECTATIONS FOR FM/NMM RESIDENTS *33*
OMM Rotation *34*
Graduation ceremony 35
Holidays 35
Hospital Quarters 35
Housing 35
Impaired Physician Policy........ 36
Inservice Examination ACOFP and AAO (for FM/NMM Residents) 36
Institutional Core Competency Plan (ICCP) 36
Learning Center........ 40
Leave 40
Leave/Sick *40*
Leave/Time-Off Requests *41*
Rotations Leave/CME Time Allowed........ 41
TIME-OFF REQUEST FORM 43
Library........ 44
Licensing 44
Logs........ 44
OGME-1 Log Requirements........ *44*
Resident Log Requirements........ *44*
Mandatory Procedural Competence (Required Procedures) *45*
Mentoring........ 45
Moonlighting........ 46
Residents *46*
MOONLIGHTING APPROVAL FORM........ *48*
Hours Worked Form *49*
Residency and Moonlighting........ *49*
Parking 50
Patient Care 50
History and Physicals (H&P's) *50*
Documentation *50*
Resident Responsibilities 50
FHCE Admissions........ 51
Practice Groups 51
Professional Memberships 52
remediation process........ 52
Resident Remediation Action Plan 54
Action Initiated: Step 1: ____Departmental Academic Remediation (Initial) *54*
I. Areas of weakness and/or concern 54
Patient Care 54
Professionalism 54
Follow-up 55
Verification 55
Outcome of Remediation Plan 56
Research and Scholarly Activity Requirement 56
Residency Orientation 58
Resident Association 58
Resident Selection Policy and Procedures 58

Resident Eligibility Criteria For Osteopathic FM Residency 58
Resident Selection Policy And Procedures 59
Rotation Documentation 60
Procedure Logs 60
Evaluations 60
Impairment: 61
Supervision of Residents 61
Outpatient Activities 62
Inpatient Activities 62
Tumor Board 63
Winter Park Initial Orientation 65

MANUAL ACKNOWLEDGMENT

I, ___________________________________ acknowledge that I have
Print Name

received a copy of the 2009 Resident Information Manual and Florida Hospital GME Manual on ____________,

Date

and acknowledge I have read and understood the contents, including the Osteopathic Oath.

____
Signature of Resident

____
Date

NOTE: This signed acknowledgment is due in Medical Education by the end of Orientation.

THE OSTEOPATHIC OATH

American Osteopathic Association

I do hereby affirm my loyalty to the profession I am about to enter. I will be mindful always of my great responsibility to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend who will guard their secrets with scrupulous honor and fidelity, to perform faithfully my professional duties, to employ only those recognized methods of treatment consistent with good judgment and with my skill and ability, keeping in mind always nature's laws and the body's inherent capacity for recovery.

I will be ever vigilant in aiding in the general welfare of the community, sustaining its laws and institutions, not engaging in those practices which will in any way bring shame or discredit upon myself or my profession. I will give no drugs for deadly purposes to any person, though it may be asked of me.

I will endeavor to work in accord with my colleagues in a spirit of progressive cooperation and never by word or by act cast imputations upon them or their rightful practices.

I will look with respect and esteem upon all those who have taught me my art. To my college I will be loyal and strive always for its best interests and for the interests of the students who will come after me. I will be ever alert to further the application of basic biologic truths to the healing arts and to develop the principles of osteopathy, which were first enunciated by Andrew Taylor Still.

FROM THE DIRECTOR OF MEDICAL EDUCATION

Like Dr. Andrew Taylor Still, the founders of Florida Hospital believed physical healing by itself is not enough. They believed, as we do today, that a person's physical health is closely linked with his/her spiritual, emotional and mental well-being; and they sought to provide a place where each of these aspects of the whole person could find both healing and nurture.

Today, more than 105 years later, Florida Hospital is committed to these same goals, and to provide excellent medical care through state-of-the-art serviced, equipment and training.

As a result, the Family Medicine Residency Program at Florida Hospital East Orlando offers the opportunity to provide high quality, comprehensive medical care for the whole person.

We believe our Family Medicine Residency Program, as well as our Externship program, is among the finest available.

This manual will acquaint you with the Family Medicine Residency Program. It is important that all Family Medicine Residents review these pages and ask the Department of Medical Education Staff, or myself, any questions you may have.

Joseph D. Allgeier, DO, FACOFP
Director of Medical Education, Osteopathic Programs
Director Family Medicine Residency Program
Florida Hospital East Orlando

FAMILY MEDICINE AND FM/NMM RESIDENCY PROGRAMS

Introduction to Residency

The osteopathic profession has long been recognized as a source of primary care physicians. In recent years there developed an increased demand for physicians trained in comprehensive ambulatory medical care for urban and rural areas. An osteopathic family practitioner is equipped with a broad base of medical knowledge and skills including the ability to relate to patients, families, and community. The Family Medicine physician functions within a medical team to ensure effective and efficient patient care. They recognize the importance of behavioral medicine and commit to addressing these components. The family physician contributes expertise to community needs such as home care, drug/alcohol abuse, family planning, community medicine, and other health oriented activities. Peer review organizations, state welfare, Medicare, medical insurance and managed care are thoroughly understood. The Florida Hospital East Orlando Residency programs provide experiences in all these areas to develop competency in the residents.

Program Description

Our program allows flexibility to address and satisfy each resident's educational needs and practice preferences. Residents care for patients a minimum of thirty (30) percent of their time in the continuity of care clinic. Full and part time Family Medicine proctors supervise these experiences. Additional block ambulatory care training occurs in rural and urban offices. Other rotations in specialty and subspecialty areas provide needed knowledge and skills. Required rotations include Emergency Medicine, Surgery, Colorectal Surgery, Internal Medicine, Obstetrics/Gynecology, Osteopathic Manipulative Medicine, ENT, Behavioral Medicine, Gastroenterology, Pulmonology, Office Management, Pharmacology, Cardiology, Urology, Orthopedics, Dermatology, Geriatrics, Community Medicine, Practice Management and Pediatrics. Additional specific requirements are mandated for the FM/NMM residents. Additional inpatient/outpatient training may be desired or needed. Elective rotations are chosen from Cardiology, Chemical Dependency, Infectious Diseases, Nephrology, Neurology, Orthopedics, Ophthalmology, Osteopathic Manipulative Medicine, Otorhinolaryngology, Plastic and Reconstructive Surgery, Public Health, Pulmonary Medicine, Rheumatology, and Allergy. The program's responsibilities require mature, well motivated, self disciplined residents with a clear vision of their future goals. Residents assume responsibility for their education. Ambulatory patient care as opposed to hospital medicine is the program's emphasis. The program equips residents to practice "solo" or with a group. Residents have the opportunity to spend time in a variety of Family Medicine settings. Continuity of care includes following the patients in the clinic for three years and in FHEO when they are hospitalized from the Residency clinic. Inpatient care typically considered internal medicine plays a major role in our Family Medicine training. These experiences with complex critically ill patients provide residents exposure to acute episodes, relapses of chronic diseases and end stages of disease processes routinely seen in the outpatient setting. The didactic program consists of informal discussions, morning reports, Jeopardy, Journal Clubs, and the formal programs at FHEO. Funds and time for CME courses are available, subject to approval by the FM program director and/or DME.

Mission Statement

The Family Medicine Residency is operated by Florida Hospital, a not-for-profit health care institution, to further its mission "To extend the healing ministry of Christ".

In the furtherance of this mission, the Residency is dedicated to the development and maintenance of a training program of the highest quality whose mission is "To extend the healing ministry of Christ by preparing compassionate and competent Family Physicians".

In its striving for excellence, the Residency Program is committed to serving the community, the sponsoring institution, the faculty, staff and resident physicians.

Goals and Means

Motto: Healing Hearts, Healing Hands

In conjunction with the Residency's mission statement, more specific goals and objectives are:

I. TRAINING

Goal: Develop family physicians that excel in their medical knowledge, clinical practice, and professionalism.

Objectives:

a. Prepare residents to fulfill requirements for certification by the American Osteopathic Association, the American College of Osteopathic Family Physicians, and the American Academy of Osteopathy.
b. Train residents to a level of confidence to evaluate the health needs of patients in the context of comprehensive care and to seek appropriate consultation for patients.
c. Promote a responsibility for health care that continues throughout the patient's life and includes health maintenance and preventive medicine.
d. Develop and encourage a holistic perception of patients as biological, social, and spiritual beings.
e. Provide instruction regarding practice management skills.
f. Develop a philosophy, attitude and method for long term learning skills and to maintain them throughout the resident's professional career.
g. Develop competency in Family Medicine/FM/NMM knowledge and diagnostic and procedural skills.

II. ENVIRONMENT

Goal: To provide an environment conducive to education, good patient care, and research.

Objectives:

a. Maintain a model Family Medicine practice in a realistic setting.
b. Encourage learning through the use of computers, research, and technology.
c. Encourage academic excellence within the Residency, faculty, and medical staff of Florida Hospital.

General Goals of the Program

The Family Medicine Residency Program and FM/NMM Residency provides the basic Residency requirements for certification by the American Osteopathic Association (AOA), the American College of Osteopathic Family Physicians (ACOFP), and the American Academy of Osteopathy (AAO). The programs comply with the standards and requirements of the AOA, ACOFP, and AAO. The Family Medicine Residencies are designed to improve proficiency in the knowledge and art of diagnosis, treatment, and practicing in an ambulatory setting.

Goals are:

1. Recognize the concept of providing quality comprehensive medical care.
2. Awareness of community needs and their effect on individual and public health problems.
3. Recognize psychosocial aspects of Family Medicine.
4. Be familiar with financial, legal, and business areas of practice.
5. Be aware of requirements and procedures of hospital, professional, third party payers, and government involvement with medical practice.
6. Understand the relationship of biological, psychological, sociological and spiritual components of health and illness in the ambulatory setting.
7. Improve diagnostic skills.
8. Understand interdisciplinary team approach to maintenance and delivery of health care.
9. Integrate osteopathic principles in diagnosis and treatment of patients.
10. Understand skills necessary to be a competent clinician, teacher and clinical researcher.
11. Recognize the needs and methods of continuing medical education throughout the professional life.
12. Understand the indications and methods of Family Medicine procedures.

Orientation

The orientation program is conducted prior to the first week of the Residency for all new physician trainees to Florida Hospital. The resident will be introduced to administration officials, the Family Health Center East, and various patient care disciplines. The hospital's rules and regulations, benefits, human resources policies, advanced directives information, health sciences (library) services, risk management procedures, and health information management (medical records) systems will be explained.

The orientation process exposes the resident to the culture and functions of the Florida Hospital System, Florida Hospital East Orlando and the FHEO Family Medicine Residency functions.

Orientation Program

- ACLS/PALS certification (if needed)
- Introduction to Hospital Administration; DME
- General Overview of Residency
- Florida Hospital in Perspective
- Medical Library
- Lab Coats
- Residency Success
- Pastoral Services
- Benefits Presentation
- Safety & Security
- Infection Control
- SHARE Presentation
- HIPAA
- Research
- Clinical Performance Improvement
- Human Resources Processing/Employee Physicals
- Case Management
- PICC Team
- Nursing Administration
- Palliative Care
- Health Information Management
- Team Building
- Physician Support Services
- Family Health Center East
- Assessment Exam
- Manual Review
- New Innovations
- Coding/Billing
- Chief Resident Orientation
- Whole Person Care
- SHARE
- Risk Management
- National Patient Safety Goals

Attendance is required at the Graduation / Awards Banquet

Facilities

Florida Hospital East Orlando (FHEO) is a 235-bed acute care communityl hospital in Orlando, Florida. Family Health Center East (FHCE) contains Family Medicine, OMM, Geriatrics, and Pediatric clinics and is located next to the hospital in the Medical Office Building. The clinic has thirty (30) examination rooms with the capability for special procedures, laboratory, and minor

surgery. Other experiences are at rural and urban practice sites in the Orlando area. Florida Hospital Orlando is the program's OB/GYN training site and Florida Hospital Winter Park Memorial Hospital is the program's newborn / neonatal care training site.

A virtual library through Florida Hospital is available on the Internet at www.floridahospitalmd.org. The medical data resource, Clinical Resource @ Ovid and UpToDate is provided to each resident through the Internet.

The Florida Hospital Health Sciences Library, located at Florida Hospital Orlando (601 E. Rollins Street in the basement beside the Barker Conference rooms), contains 1200 books and maintains subscriptions to over 130 Journals. Through Florida Hospital's library and interlibrary loans, access to any published literature available in the United States is possible. Computer searches of published literature by topic or author are available. Internet access for medical research is provided.

ACOFP RESIDENT REQUIREMENTS

All residents are required to maintain AOA, ACOFP, Florida Society of ACOFP, FOMA and AAO memberships (AAO memberships apply to FM/NMM residents).

All residents must attend a minimum of one national ACOFP Scientific Seminar during OGME-2 / OGME-3. This requirement can be met by the resident attending either the ACOFP Spring Scientific Seminar or the AOA / ACOFP Fall Scientific Seminar. If they attend the Fall AOA Meeting the resident must register as an ACOFP member for the Fall Meeting to count towards this requirement.

Each residency year a *"Resident Annual Report"* and a *"Program Director's Annual Report"* must be submitted within thirty (30) days following the end of the resident year to the ACOFP and AAO (for FM/NMM residents).

All residents are required to write and submit a scientific paper approved by the program director to the ACOFP and AAO (for FM/NMM residents) before or with the final "*Resident Annual Report"*. (See *Scientific Clinical Investigation Papers* section for further information.)

All residents must have successfully completed COMLEX Part III in order to be advanced to OGME-3.

Minimum requirements for Block rotations:

A. **Internal medicine**: Twenty-four (24) weeks or six (6) months in Internal Medicine with a minimum of twelve (12) weeks or three (3) months in general internal medicine and four (4) weeks or one (1) month in critical care. During OGME-1 year there must be at least eight (8) weeks of general internal medicine experiences. Four (4) weeks or one (1) month may be spent on in-house general medicine.

B. **Surgery**: Twenty (20) weeks or five (5) months in Surgery, with four (4) weeks of general surgery training in OGME-1. Pre and post operative diagnosis and management will be stressed.

C. **Obstetrics and Gynecology**: Twelve (12) weeks or three (3) months in OB/GYN with a minimum of one (1) month of maternity care. Four (4) weeks must be completed during OGME-1. The gynecologic portion should include both ambulatory and in-hospital patient care.

D. **Pediatrics**: Sixteen (16) weeks or four (4) months in Pediatrics. Four (4) weeks shall be completed during OGME-1. The training must include neonatal medicine, as well as the care of the ambulatory or hospitalized patient between 2 and 16 years of age.

E. **Emergency Medicine**: Eight (8) weeks or two (2) months in Emergency Medicine with a minimum of one (1) month during OGME-1. One (1) month of Urgent Care Medicine during OGME-3

F. **Elective**: Minimum of twenty (20) weeks and a maximum of twenty-eight (28) weeks of supervised electives with at least four (4) weeks during OGME-1, eight (8) weeks during OGME-2, and eight (8) weeks during OGME-3. All electives must be approved by the Director of Medical Education (DME) and the Program Director of the Family Medicine Residency Program.

Longitudinal Rotations

Guidelines: This type of training allows for continuity of care, which is a hallmark of Family Medicine.

Family Medicine Continuity of Care: The OGME-1 resident will spend one-half (1/2) day per week for the entire year in the ambulatory care clinic. OGME-2 and OGME-3 residents will spend three (3) half days per week. There must be a minimum of three hundred twelve (312) half days during the final twenty-four (24) months of the residency.

FAMILY MEDICINE RESIDENCY- OGME-1

Under this rotation schedule, each OGME-1 must complete the following educational rotations and activities. These rotations will be scheduled as thirteen (13) four (4) week rotations.

Block rotations:

Guidelines: This schedule allows for intense training within the one-year period.

A. **Internal medicine**: The OGME-1 spends twenty (20) weeks or five (5) months in internal medicine with a minimum of twelve (12) weeks or three (3) months in general internal medicine and four (4) weeks or one (1) month in critical care. Four (4) weeks or one (1) month may be spent on in-house general medicine. The preferred rotation is assignment to individual internists, rather than to a floor. Each OGME-1 should maintain an adequate patient load.

B. **Surgery**: The OGME-1 spends twelve (12) weeks or three (3) months in surgery, with a minimum of seventy (70) percent of the time being dedicated to pre and postoperative management of surgical diseases.

C. **Obstetrics and Gynecology**: The OGME-1 will spend six (6) weeks or one and one-half (1 1/2) months in obstetrics and gynecology, with a minimum of twenty-five (25) percent of the time being dedicated to prenatal care and fifty (50) percent of the time being dedicated to gynecology.

D. **Pediatrics**: The OGME-1 will spend eight (8) weeks or two (2) months in pediatrics, with a minimum of twenty-five (25) percent of the time being dedicated to the neonatal nursery and fifty (50) percent of the time being dedicated to care of the ambulatory or hospitalized patient between two (2) and sixteen (16) years of age.

E. **Emergency Medicine**: The OGME-1 will spend four (4) weeks or one (1) month in the emergency room, treating patients under direct supervision.

F. **Elective**: The OGME-1 will spend four (4) weeks or one (1) month in an elective approved by the Director of Medical Education (DME) and the Program Director of the Family Medicine Residency Program.

Longitudinal Rotations

Guidelines: This type of training allows for continuity of care, which is a hallmark of Family Medicine.
Family Medicine Continuity of Care: The OGME-1 will spend one-half (1/2) day per week for the entire year in the ambulatory care clinic. The patients seen during these experiences will be followed into the residency.
Geriatrics: All OGME-1 residents may be assigned nursing home patients at Sunbelt Nursing Home to follow longitudinally during the OGME-1 year of training. Refer to Geriatrics section. Both of these processes are to improve the patients' continuity of care and the training experience.

GENERAL INFORMATION AND REGULATIONS

FHEO Medical Education Staff

Department of Medical Education (ME)
Florida Hospital East Orlando
Medical Office Building (MOB)
7975 Lake Underhill Road, Suite 210
Orlando, Florida 32822
Phone: (407) 303-8683
Fax: (407) 303-8659

Director of Medical Education for Osteopathic Programs – Joseph D. Allgeier, DO, FACOFP
Family Medicine Program Director – Joseph D. Allgeier, DO, FACOFP
FM / Neuromusculoskeletal Medicine Integrated Program Director – Wm. Thomas Crow, DO, FAAO
Gynecology Oncology Fellowship Program Director – Neil Finkler, MD
Director of Podiatric Services – Gerald Bornstein, DPM
Director of Podiatric Externship Program – Howard Finkelstein, DPM
Medical Education Staff:
Becky Morgan, Residency Coordinator
Jennifer Paolicelli, Med Ed Specialist

Family Health Center East (FHCE) - 407-303-6830

Medical Director –	Lyn Johnson, DO (Associate Director)
Family Medicine –	Joseph Allgeier, DO
	Thomas Crow, DO
	Margarita Delgado, DO
	Lyn Johnson, DO
	Maria Gonzalez, MD
	Brian Browning, DO
Internal Medicine –	Theodore Lee, MD (Associate Director)
	Edward Yee, MD
Obstetrics/Gynecology –	Stanley Angus, MD
	Scott Boone, MD
	Mark Crider, MD
	D. Ashley Hill, MD
	Fred Hoover, MD
	Kristen Jackson, MD
	Georgine Lamvu, MD
	Christopher Walker, MD
Pediatrics –	Pallavi Deliwala, MD (Associate Director)
	Sonia Rico, MD
Pharmacotherapeutics –	Shannon Miller, Pharm D.
Podiatry –	Gerald (Jay) Bornstein, DPM
	Joseph Conte, DPM
	Vincent Milione, DPM
Behavioral Medicine –	Timothy Spruill, MA, Ed.D.
	Walter Vyhmeister, Ph.D.
Geriatrics –	Maria Gonzalez, MD
OMM –	Thomas Crow, DO
	Brian Browning, DO
Practice Manager –	Desiree Rivera
Office Manager –	Melissa Marcano
Department Secretary –	Elizabeth Estrada

Pediatric Clinic Proctors –
Family Health Center East

Pallavi Deliwala, MD
Sonia P. Rico, MD

Florida Hospital East Orlando Inpatient Services –

Full Time: Joseph Allgeier, DO (Family Medicine)
Thomas Crow, DO (Family Medicine / NMM)
Margarita Delgado, DO (Family Medicine)
Lyn Johnson, DO (Family Medicine)
Theodore Lee, MD (Internal Medicine)
Edward Yee, MD (Internal Medicine)
Brian Browning, DO (FM/NMM)
Maria Gonzalez, MD (Geriatrics)

FHEO Faculty/Proctors

ANESTHESIOLOGY	OMM
Grant, Tim DO	Brown, Juanita DO
Sullivan, George DO	Downing, Jeffrey, DO
Tao, David DO	Hoffman, Kent DO
BEHAVIORAL MEDICINE	Ramey, Kenneth DO
Spruill, Timothy MA, Ed.D.	Browning, Brian DO
CARDIOLOGY	Samano, Greg II DO
Ali, Syed MD	Schamberger, Robert DO
Harris, Glenn MD	Thomas, Brett DO
Kelly, Brian DO	**OPHTHALMOLOGY**
Sickinger, Barton DO	Susi, Richard DO
Okerokee, Chika MD	**ORTHOPEDICS**
DERMATOLOGY	Billings, Joseph DO
Yungmann, Martin DO	McFadden, Sean DO
Spohr, Kevin DO	**OTORHINOLOARYNGOLOGY**
EMERGENCY MEDICINE	Bibliowicz, Michael DO
Mitchell Maulfair, DO	Harrington, Dale DO
Jose Rubero, MD	Weizeneggar, Lisa MD
Marc Santambrosio, DO	Rabaja, David DO
Regan Schwartz, MD	**PATHOLOGY**
Joseph Zarlengo, MD	Sullivan, Laura MD
FAMILY MEDICINE	**PEDIATRICS**
Allgeier, Joseph DO	Deliwala, Pavalli MD
Johnson, Lyn DO	Mandani, Sadiq MD
Browning, Brian DO	Ahmad, Aneesa MD
Hoffman, Kent DO	Rico, Sonia P. MD
Mercado, Carlos, MD	**PHARMACOTHERAPEUTICS**
Downing, Jeffrey DO	Shannon Miller, Pharm D.
Rocker, Jeffry DO	**PODIATRY**
Silverman, William DO	Bazata, John DPM
Smith, Neal MD	Blum, Jonathan DPM
Delgado, Margarita DO	Bornstein, Gerald (Jay) DPM
Schamberger, Robert DO	Childs, Douglas DPM
GASTROENTEROLOGY	Duggan, Robert DPM
Moore, Keith DO	Estrada, Robert DPM
Aniq Shaikh MD	Fann, Thomas DPM
Shultz, Robert DO	Finkelstein, Howard DPM
GERIATRICS	Funk, Joseph DPM
Gonzalez, Maria MD	Hoover, Robert DPM
INTERNAL MEDICINE	Hoover, Robert II DPM
Attermann, Steven DO	Krauklis, Robert DPM
Barroso, Luis DO (Pulmonology)	McNamara, Victor DPM

Yee, Edward MD	Milione, Vincent DPM
Law, Robert DO	Pascarella, Eugene DPM
Lee, Theodore MD	Sanchez-Robles, Luis DPM
INFECTIOUS DISEASE	Saranita, Anthony DPM
Sniffen, Jason DO	Talbert, Todd DPM
NEPHROLOGY	Wagner, Curtis DPM
Williams, Mark MD	Wiernik, Daniel DPM
OBSTETRICS/GYNECOLOGY	**PSYCHIATRY**
Finkler, Neil MD (GYN ONC)	Roberts, Paul DO
Hill, D. Ashley, MD (OB GYN)	Allen, Luis MD
Holloway, Robert, MD (GYN ONC)	**RADIOLOGY**
Hoover, Fred MD (OB GYN)	Giuliano, Concetta DO
Lense, Jorge MD (OB GYN)	Giuliano, Vincenzo MD
Sipprell, Thomas DO (OB GYN)	**SURGERY**
Walker, Christopher MD (OB GYN)	Bennett, Joseph DO
Bigsby, Glenn DO (GYN ONC)	
Hamm, Jennifer MD (OB BYN)	McDonald, Malcolm DO
	Baig, Ajmal MD
	Modesto, Victor MD
	UROLOGY
	Albers II, Arthur DO Dobkin, Stephen MD

ALUMNI SURVEYS

All graduating residents will be required to complete a program survey as part of the exit procedures. In addition, alumni who are one year and five years out of residency will be asked to complete a program survey. The purpose of this survey is to obtain information regarding strengths and weaknesses of the program. The feedback from these surveys will be presented at the Medical Education Committee meeting.

ANNUAL PROGRAM REVIEW

In accordance with AOA and ACOFP requirements:

The educational effectiveness of a program must be evaluated at least annually in a systematic manner. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution (the internal review), and the residents' confidential written evaluations of faculty, rotations, and the program. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting (maintained by the program).
The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.
Each program will be required to present an annual report to the GMEC regarding the effectiveness of the program. The report should include the following:

- list of those involved in the annual review
- progress in correcting AOA citations/concerns and recommendations from the most recent GMEC internal review of the program
- quality improvement activities involving residents
- list identifying residents on department and hospital committees
- research and scholarly activity of faculty and residents

- resident supervision
- duty hours compliance
- other required resident policies
  - o selection
  - o evaluation
  - o promotion
  - o dismissal
- program affiliation agreements with participating institutions
- review of educational goals and objectives
- core competencies – how they are taught and evaluated

ANNUAL RESIDENT EVALUATION OF THE PROGRAM

In May of each academic year, each resident will be required to complete a program evaluation form. The form is meant to assess program strengths and weaknesses, and to provide suggestions to enhance the education process. The feedback from this annual survey will be presented to the medical education committee at the annual program evaluation meeting.

ANNUAL RESIDENT EVALUATION BY THE PROGRAM DIRECTOR

As per AOA and ACOFP basic standards, the Program Director will meet with and evaluate each resident at the end of the academic year. The purpose of this meeting is to ensure educational goals are being met, and the resident is ready to progress to the next academic year. This is in conjunction with the quarterly evaluation process.

BOARD SCORES

All residents must provide the Medical Education (ME) office with a copy of Parts I, II, and III of the board scores, a final certified medical school transcript, letter confirming graduation, and Osteopathic Medical School Diploma. (OGME-1 residents shall provide a copy of a final medical school transcript, letter confirming graduation and Part III board scores as soon as they are available.) If an OGME-1 resident fails to pass the Part III board s/he will provide Medical Education a copy of the scores and set an appointment to meet with the DME as soon as possible.

Residents entering the Family Medicine Residency or FM/NMM Residency Program (OGME-2 or 3) must have successfully completed the boards and have or be eligible for a full Florida License. The ME office will be provided with a copy of your Part III scores, current Florida Physician license, and DEA when available.

CAFETERIA

See GME manual for information.

CALL GUIDELINES AND RESPONSIBILITIES

Call and Clinic Switches

When a resident finds it necessary to switch call or clinic responsibilities, the following procedure is to be followed.

1. Arrange the switch with a fellow resident.

2. Complete a “Clinic/Call Switch” form explaining the switch and have the covering resident sign. Requests for changes in call and clinic schedules shall be made in advance by submitting the “Clinic/Call Switch” form to the Medical Director at least forty-five days for call and clinic schedule changes. No switching is to be done without approval by the Medical Director.

3. Rotation preceptors and covering residents must be informed and reminded of the change in coverage.

4. Consider and address the impact on clinic operations and patient care. The Clinic Medical Director, Practice Manager and DME must approve all clinic changes.

5. It is the resident’s responsibility to follow up and confirm approval.

ALL CHANGES MUST HAVE FORTY-FIVE (45) DAY PRIOR APPROVAL FOR CALL AND CLINIC COVERAGE CHANGES FROM THE DME!

CALL/CLINIC SWITCH FORM

NAME: ________________________________ **CURRENT DATE**: ________________________

Instructions:

- To switch a clinic day, indicate what day you were originally scheduled for, and what day you are requesting to switch to. Also, please indicate if you are switching with another resident.
- Requests for clinic switches are to be turned in forty-five (45) days in advance.
- If you are requesting to switch a call day with another resident, please complete the "Call Day Switch" section. If you are covering call but not switching with anyone, please complete the "Call Day Coverage" section.
- Requests for call switches are to be turned in at least forty-five (45) days in advance.
- It is your responsibility to notify Medical Education and your attendings.
- The resident must forward their EPIC inbaskets to another resident for coverage.
- **No request is approved without the signature of the DME**.

CLINIC DAY SWITCH:

Original Clinic Day Scheduled: __________________ Clinic Day Requested: _______________

Reason for Request: ____

Are you switching with another resident? ☐ YES ☐ NO

Resident providing coverage: ____

CALL DAY SWITCH:

Original Call Day Scheduled: ____________________ New Call Day: ______________________

Resident providing coverage: ____

Do you have clinic the following day? ☐ YES ☐ NO

NAME OF ATTENDING(S)/ ROTATION: ____

CALL DAY COVERAGE:

Call Day Scheduled: ____

Do you have clinic the following day? ☐ YES ☐ NO

NAME OF ATTENDING(S)/ ROTATION: ____________________________________

Resident Signature: ____

FOR ME OFFICE USE ONLY

Submitted to FHCE (Date): ________________________________ Initials: _________

____
Aida Rodriguez
FHCE Department Secretary

____
Desiree Rivera
Practice Manager

Number of clinic days scheduled: _________

Number of clinic patients scheduled: _________

APPROVED **YES** ☐ **NO** ☐

____
LYN JOHNSON, DO
FHCE MEDICAL DIRECTOR

____
DATE

____
JOSEPH ALLGEIER, DO
DIRECTOR OF MEDICAL EDUCATION

____
DATE

CERTIFICATIONS

See GME manual for information.

CHIEF RESIDENTS

In April of each year, two chief residents are appointed by the DME for the upcoming academic year. They will serve from July 1 until June 30 of the following year. The following criteria will be considered:

- OGME-3 or OGME-4 resident in good academic standing (must have successfully completed COMLEX III, have a Florida medical license and DEA number)
- Demonstrates teaching skills and interest
- Demonstrates leadership and rapport with fellow residents and faculty
- Demonstrates a positive attitude towards the residency program

The DME will take into consideration the rank lists of the residents and faculty. The residents and faculty will submit their rank list of all residents interested in serving as a chief resident to the DME. Graduating residents are not eligible to vote. The DME will evaluate the candidates, interview them, and select the new chief residents.

A representative from the FM/NMM program will be selected in April of each year. They will serve from July 1 until June 30 of the following year. This individual may also serve as one of the chief residents.

A representative for the OGME-2 class will be selected by the class in April of each year and will serve from July 1 until June 30 of the following year. The OGME-2 representative serves as part of the Medical Education Committee quarterly. They work with the Chiefs and DME on communication, resident input and decision making. The OGME-1 chief will be selected by the OGME-1 class in July each year and will serve until June 30 of the following year.

GOALS

- To facilitate the educational experience of the residents and medical students
- To be a liaison between the residents, faculty, and medical education administration
- To be a resource for problem solving

RESPONSIBILITIES

- Advise the DME on issues of importance to the residency
- Attendance at the following committee meetings:
    - Quarterly MEC meetings
    - FP department meetings
    - Invited to attend monthly FHCE business meetings
    - Encouraged to attend monthly Research Committee meetings
    - Meet with Office Manager and Medical Director on a regular basis RE: FHCE issues.
    - Attendance at faculty retreats
    - Be creative in developing teaching strategies
    - Manage any daytime scheduling conflicts for resident coverage which may arise.
- Oversee residency scheduling
- Attend Family Practice Department Credentials Committee and the Family Practice Department meeting each month.
- Meet with the DME on a monthly basis
- Participate in intern orientation each year
- Assist with resident and faculty interviews
- Assist with attendance and sign-in at lectures
- Assist with audio-visual set up at lectures
- Partner with the Chief Residents at FHO FM Residency to plan / prepare for Annual Primary Care Update Conference
- Other responsibilities which may be added

The following responsibilities will be divided up between the two chiefs equally in a manner agreed upon between them:

- Supervise scheduled review courses
- Participate in intern orientation
- Input into Curriculum Development
- Attendance at monthly Curriculum Committee meetings
- Develop the resident night, weekend, and holiday call schedules
- Coordinate and oversee Thursday afternoon Medical Student lectures
- Other responsibilities which may be added

COMPENSATION

The two chief residents will receive a monthly stipend during the period of their appointment.

CITIZENSHIP POLICY

See GME manual for information.

CONTINUING MEDICAL EDUCATION

OGME-1 residents receive no CME days. The DME will use part or all of the funds (OGME-1 $500) for electronic Medical Library software and/or hardware (PDAs), if the resident does not have comparable resources acceptable to the DME.

OGME-2 Residents are permitted to take five (5) days of paid leave for CME time. The DME will use some of these funds for electronic Medical Library software and/or hardware, if the resident does not have comparable resources acceptable to the DME. Expenses related to CME will be reimbursed up to $800.00 after the proper receipts are provided to the Medical Education Office. (Refer to Expense Reimbursement Regulations.)

OGME-3 and OGME-4 Residents are permitted to take five (5) days of paid leave for CME time. Expenses related to CME will be reimbursed up to $1300.00 after the proper receipts are provided to the Medical Education Office. (Refer to Expense Reimbursement Regulations.)

CME time is to be requested in writing on a "*Time Off*" form and approved by the program director forty-five (45) calendar days in advance. CME time is for the expressed purpose of obtaining CME credits. A copy of the program brochure showing the program content and CME credits must be attached to your CME request.

CME funds may be applied to approved medical reference texts or other educational materials with the approval of the DME. CME time and money will not be allowed to accrue from OGME 1 to OGME 2 to OGME 3 to OGME-4 and will not be paid out at the end of the contract.

No CME time will be allowed during core rotations or rotations that explicty state "No personal leave is allowed during this rotation." (Please see Part II of this manual for more information.) (*exception*: ACOFP Boards).

No CME time is permitted during the last two weeks of a resident's contract period of the normal academic year.

For the clinic, CME time for Holiday periods must be worked out by the residents to ensure no more than half the residents scheduled for any half day are gone, and approved by the DME. Anticipated CME requests for the next contract period should be turned in to the office of Medical Education by May 1 to facilitate the scheduling of core rotations for the next contract period.

Continuing Medical Education Requirements for Licensure

AOA CME requirements are met by being a resident. HOWEVER, the Florida Department of Health Board of Osteopathic Medicine requirements must be met by each resident to obtain and retain a physician's license. **This is extremely important for all graduating residents.** It is the responsibility of the resident to meet state law, which reads:

CONTINUING MEDICAL EDUCATION (CME):
A total of 40 hours of CME, 20 of which must be AOA category 1A or 1B. Included in the 40 hours, there are 7 MANDATORY hours required for Florida relicensure. These 7 hours CANNOT be taken by correspondence. They must be LIVE, PARTICIPATORY credits for the following courses:

- 1 of the 40 hours must be on the topic of **Risk Management**, either AOA or AMA approved-this must be an attendance-type course (live, participatory, attended courses).
- 1 of the 40 hours must be on the topic of **HIV/AIDS** and contain current information on Florida law, either AOA or AMA approved (live, participatory, attended courses.)
- 1 of the 40 hours must be on the topic of **Domestic Violence** (live, participatory, attended courses.)
- 1 of the 40 hours must be on the topic of **Florida Laws and Rules** (live, participatory, attended courses.)
- 1 of the 40 hours must be on the topic of **Managed Care** (live, participatory, attended courses.)
- 2 of the 40 hours must be on the topic of **Prevention of Medical Errors** (live, participatory, attended courses.)
- **End-of-Life Care** may be substituted for **HIV/AIDS or Domestic Violence** if the licensee completed an approved HIV/AIDS or Domestic Violence course in the immediately preceding biennium.

The Board generally accepts CME that is approved for credit by either the American Osteopathic Association or the American Medical Association.

All credit hours must be earned within the biennium for which they are claimed.

CONFIDENTIALITY AND MEDICAL RECORDS

See GME manual for information.

CONTRACT EXTENSIONS & OBLIGATIONS

See GME manual for information

CURRICULUM

The following grid is a listing of program curricula along with the designated faculty coordinators. Please see Curriculum Manual for more specific information on goals and objectives as well as the integration of the core competencies.

Rotation	Written Curriculum (Y/N)	Competencies Incorporated (Y/N)	Date Curriculum last updated	Rotation Coordinator	Number of Preceptors
Administrative Resident	Y	Y	7/1/06	Lyn Johnson, DO	6
Behavioral Medicine	Y	Y	7/1/06	Timothy Spruill, EdD	2
Cardiology I/Critical Care	Y	Y	12/15/06	Theodore Lee, MD	4
Colorectal Surgery	N	N	N/A	Joseph Allgeier, DO	1
Dermatology	Y	N	8/18/05	Joseph Allgeier, DO	1
EM/Radiology I	Y	Y	7/1/06	Margarita Delgado, DO	varies

Emergency Medicine	Y	Y	7/1/06	Margarita Delgado, DO	varies
ENT	Y	N	8/18/05	Margarita Delgado, DO	3
FM/Continuity Clinic	Y	Y	7/1/06	Lyn Johnson, DO	6
FMRS	Y	Y	7/1/06	Theodore Lee, MD	7
FP/OMM	Y	Y	1/1/07	Thomas Crow, DO	varies
Geriatrics	Y	Y	12/15/06	Maria Gonzalez, MD	varies
GI	Y	Y	12/15/06	Theodore Lee, MD	2
Gynecology I	Y	Y	7/1/06	Joseph Allgeier, DO	1
Gynecology III	Y	Y	7/1/06	Joseph Allgeier, DO	2
Gynecology/Oncology I	Y	N	8/18/05	Joseph Allgeier, DO	3
Management/Radiology	Y	N	8/18/05	Joseph Allgeier, DO	2
Neurology	Y	Y	12/15/06	Joseph Allgeier, DO	1
Nights	Y	Y	7/1/06	Theodore Lee, MD	2
NMM II	Y	Y	1/1/07	Thomas Crow, DO	varies
NMM/ENT	N	N	N/A	Thomas Crow, DO	varies
NMM/Gynecology	Y	Y	1/1/07	Thomas Crow, DO	varies
NMM/Obstetrics	Y	Y	1/1/07	Thomas Crow, DO	varies
NMM/Orthopedics	Y	Y	1/1/07	Thomas Crow, DO	varies
NMM/Radiology	N	N	N/A	Thomas Crow, DO	2
NMM/Rampil	Y	Y	8/18/05	Thomas Crow, DO	1
NMM/Rheumatology	Y	Y	1/1/07	Thomas Crow, DO	varies
Obstetrics	Y	Y	7/1/06	Joseph Allgeier, DO	varies
OMM I	Y	Y	8/18/05	Thomas Crow, DO	2
Orthopedics	Y	Y	12/15/06	Joseph Allgeier, DO	1
Pediatrics	Y	Y	7/1/06	Pallavi Deliwala, MD	4
Pharmacy	Y	N	8/18/05	Shannon Miller, PharmD	1
Pulmonology/CC	Y	Y	12/15/06	Theodore Lee, MD	1
Surgery	Y	Y	7/1/06	Joseph Allgeier, DO	4
Surgery Elective	Y	Y	7/1/06	Joseph Allgeier, DO	varies
Urology	Y	N	8/18/05	Joseph Allgeier, DO	2

CRITERIA FOR ADVANCEMENT/PROMOTION OF RESIDENTS IN FAMILY MEDICINE

The decision whether to promote and graduate a resident shall be determined by the Program Director and/or DME with the recommendations of the faculty and the Medical Education Committee.

The methods of evaluation shall consist of direct observation, indirect observation through videomonitoring, rotation evaluations, and correspondence between departments and written examinations (Part III of Boards, In-Service Examination, and Board Certification Examination). Residents will participate in all aspects of the curriculum, evaluations of education experiences and faculty. It is expected that residents will complete all resident administrative responsibilities including logs, licensure, and other required paperwork in a timely fashion.

Criteria for advancement shall be based on the seven (7) core competencies. Residents are required to be judged as competent for advancement to each level.

Competencies:

I. **Osteopathic Principles Application –** Demonstrate knowledge and application of the Osteopathic Principles to patient care in the inpatient and ambulatory settings.

II. **Patient Care** – caring and respectful behavior, interviewing, informed decision making, develop and carry out patient management plans, counsel and educate patients and families, performance of procedures (routing physical exam and medical procedures), preventive health services, work within a team.

III. **Medical Knowledge** – investigatory and analytic thinking, knowledge and application of basic sciences.

IV. **Practice Based Leaning and Improvement** – analyze own practice for needed improvements, use of evidence from scientific studies, application of research and statistical methods, use of information technology, facilitate learning of others.

V. **Interpersonal and Communication Skills** – creation of therapeutic relationship with patients, listening skills.

VI. **Professionalism** – respectful, altruistic, ethically sound practice, sensitive to cultural, age, gender, disability issues.

VII. **Systems-Based Practice** – understand interaction of their practices with the larger system, knowledge of practice and delivery system, practice cost-effective care, advocate for patients within the health care system.

Criteria:

1. **Clinical competence** – fund of knowledge, clinical performance rotation evaluation, clinical judgment, knowledge of limitations, doctor-patient relationship. OGME-1 must have successfully passed Part III National Boards and be licensed, or in the process of applying with a license expected, to be advanced to OGME-2.

2. **Professional Attitude/Behavior** – working relationship with others, acceptance of responsibility, punctuality and reliability. All residents, at every level, are expected to teach and supervise.

3. **Technical Skills and Procedures** – procedural competence and experiences, documentation (medical record), completeness and timeliness, all evaluations, (rotation, preceptor and resident) documented and reviewed quarterly.

4. **Impairment Prevention** – absence of impaired function due to mental or emotional illness, personality disorder, substance abuse and other adjustment disorders.

Three promotion steps require criteria and competency evaluation: OGME-1 to OGME-2, OGME-2 to OGME-3, and OGME-3 to graduation (OGME-3 to OGME-4 and OGME-4 to graduation for FM/NMM residents). Competencies shall be documented. Additionally, the resident must be judged competent to supervise others (residents and students), and to act with progressive independence. In the OGME-3 or OGME-4 to graduation step, the resident must be judged competent to act independently and meet all the requirements of the ACOFP.

Diagram of Criteria for Advancement/Promotion of Residents in Family Medicine and FM/NMM

OGME-1 ⟶ OGME-2 ⟶ OGME-3 ⟶ GRADUATION/OGME-4 ⟶ GRADUATION

CRITERIA FOR EVALUATION

1. Clinical competence
   - **I. Osteopathic Principle Application**
     - A. Demonstrate knowledge of the Osteopathic Principles
     - B. Apply the Osteopathic Principles in patient care in both inpatient and ambulatory settings.
   - **II. Patient Care**
     - A. Caring and respectful behavior
     - B. Interviewing
     - C. Informed decision making
     - D. Developing and carrying out patient management plans
     - E. Counseling and educating patients and families
     - F. Performance of procedures
       - a. Routine physical exam
       - b. Medical procedures
     - G. Preventive health services
     - H. Working within a team
   - **III. Medical Knowledge**
     - A. Investigatory and analytic thinking
     - B. Knowledge and application of basic sciences
   - **IV. Practice Based Learning and Improvement**
     - A. Analyzing own practice for needed improvements
     - B. Use of evidence from scientific studies
     - C. Applying research and statistical methods
     - D. Using information technology
     - E. Facilitating learning of others
   - **V. Interpersonal and Communication Skills**
     - A. Creating of therapeutic relationship with patients
     - B. Listening skills
   - **VI. Professionalism**
     - A. Respectful, altruistic
     - B. Ethically sound practice
     - C. Sensitive to cultural, age, gender, disability issues
   - **VII. Systems-Based Practice**
     - A. Understanding interaction of their practices with the larger system
     - B. Knowledge of practice and delivery system
     - C. Practicing cost-effective care
     - D. Advocating for patients within the health care system
2. Professional Attitude/Behavior
3. Technical Skills and Procedures
4. Impairment Prevention

ADVANCEMENT SPECIFICS

OGME-1 to OGME-2	OGME-2 to OGME-3	OGME-3 to Graduation or OGME-4	OGME-4 to Graduation
1. Acceptable progress in criteria 2. Able to supervise OGME-1's and students 3. Able to act with limited independence	1. Acceptable progress in criteria 2. Able to supervise/teach students and residents 3. Increased independence	1. Competence in criteria 2. Able to act independently	1. Mastery of competence in criteria 2. Able to act and teach independently

I have read, understand, and agree to follow this criteria for advancement and graduation.

____
PLEASE PRINT Resident Name

____
Resident Signature Date __________________

NOTE: This signed acknowledgment is due in Medical Education by the end of July.

DEPARTMENT MEETINGS

Residents are required to attend the Internal Medicine, Pediatrics and Obstetrics/Gynecology specialty department meetings of the rotation they are currently assigned which are held at Florida Hospital East Orlando (or Winter Park Memorial Hospital). Any absence from these meetings must be cleared by the DME in advance. When you received notification of a meeting, mark it on your calendar. It is your responsibility to show up at the appointed place and time.

All Family Medicine and FM/NMM residents are required to attend all FM department meetings at FHEO. The meeting is the third Tuesday of the month on a quarterly basis. The OGME-2 or OGME-3 FM resident assigned to the Administrative Resident rotation may be asked to present a FM case at the meeting unless notified there will be another educational program. A typed summary and bibliography of the case being presented must be distributed by the resident at the beginning of the meeting and turned in to Medical Education. You may request a copy of the meeting schedule from the Department of Medical Education.

OGME-1 residents are assigned to provide a case report at section meetings. Residents may be assigned to provide a case report at other department meetings. You will be notified of your assignment in July. You must submit a typed summary and bibliography of the case being presented to the ME office.

A resident representative will be appointed annually to sit on the Division Leadership Committee as well as the Patient Care Council (PCC).

DIDACTIC PROGRAMS

The didactic program is held every Wednesday afternoon from 12:30 PM – 5:00 PM in the 3rd Floor Conference Room in the hospital. This is a required program for all students and residents. Only "post-call" residents and residents on approved Personal Time Off are excused from attending these conferences.

Lectures will cover various aspects of outpatient and inpatient medicine and other aspects of medical practice in today's health care arena. This will include Family Medicine, Internal Medicine, Pediatrics, Surgery, Ortho / Sports Medicine, OB/GYN, OMM, Practice Management / Legal Medicine, Behavioral Medicine, Dermatology, Pharmacology, Procedural Workshops, Personal Finance, Billing and Coding, EBM and other areas of need and interest.

In the instance that the Wednesday afternoon didactic program is cancelled or not scheduled, then it is expected that all residents resume their normal rotation requirements.

Morning Report – Internal Medicine

Morning report will be held in conjunction with the Wednesday didactic program. The FMRS resident "on-call" will be responsible for conducting morning report. The "night" OGME-1 resident will report to the house-staff any cases and significant floor calls encountered during the previous shift. The residents will discuss one or two admissions in detail by copying the admission orders, labs, and EKG's. Radiographs will be reviewed by the group and discussed. The presenter must be prepared to develop a differential diagnosis. (NOTE: all radiographs are to be returned at the end of the morning report and all orders, labs, etc. are to be shredded.)

The FMRS resident will present admissions to FMRS. The OGME-1 resident or resident who participated with the admission will present the case and the senior FMRS resident will supervise the presentation in cooperation with the attending (s) present.

Attendance Policy-

All residents are expected to **attend 100%** of the Wednesday PM didactic conferences, unless the have a valid excuse (see below).

The Resident is expected to **attend lectures, arrive on time and remain for the entirety of the lecture in order to be counted in attendance**, unless on an authorized leave of absence from the program. There will be excused absences for post-call, illness, vacation days, or other as approved by DME.

An official sign-in sheet is to be completed and signed by all of those in attendance. Residents who sign in prior to lecture and do not attend will be assigned extra call as determined by the DME. The chief resident is responsible for ensuring that the sign-in sheet is returned to the Medical Education office.

Medical Education Office may request an explanation for absences. Absences will be addressed by the DME.

Medical Education maintains the monthly lecture attendance by the sign-in sheets. These are the official calendars submitted at year-end to the ACOFP with other resident records. If a sign-in sheet is not available, the residents should use a blank sheet of paper, include date, time, subject, speaker, and print and sign their names. Notify the Medical Education department as soon as possible afterwards. Residents cannot sign in for one another, and cannot sign in after the sign-in sheet has been picked up.

Attendance is reviewed quarterly in Medical Education and addressed during the mentoring feedback sessions.

The DME may assign appropriate punitive measures for failure to attend lectures. This includes warnings, additional call, suspension without pay, dismissal or other actions deemed appropriate, including the loss of moonlighting privileges.

DISASTER PLAN (HURRICANE)

At the issue of a Hurricane **WATCH** by State and/or local governments for Brevard, Volusia, Seminole, or Orange counties, faculty, residents, students, and staff will follow *initial preparations* guidelines.

At the issue of a Hurricane **WARNING** by State and/or local governments for Brevard, Volusia, Seminole, or Orange counties, faculty, residents, and students will activate for first 24 hour shift including overnight at the hospital in anticipation or preparation for the disaster. This is to ensure coverage in the event roads are not passable after the initial stages of the disaster. The second team will report to the hospital at 7:00 am the next day or as soon as physically possible to travel on the roads to relieve the first team that stayed overnight at the hospital. (See attached Team Assignments.) All Team Members should contact Medical Education to advise of status, location, and current phone numbers.

Initial Preparations

At the issue of a Hurricane Watch, Team 1 of the Practice Management groups should begin emergency preparations. Check pagers and have a fresh battery. Externs are to come to Medical Education and provide current phone number.

Podiatry residents are to prepare in the same manner as Family Medicine residents.

Notification of Disaster (Hurricane) Warning

Teams will be activated. Normal rotations will be suspended until recovery is complete at a time determined by the DME.

All residents are to:
1. Report to the command center.
2. Support resident service areas if needed and available.
3. Keep attendings, Chiefs, and Command Center appraised of location and availability.
4. Both teams may be called in initially and the shifts worked out according to workload demands.

Teams will thereafter go to twelve-hour shifts with a twelve-hour recovery shift, or other shifts as assigned, before returning to normal rotations. Normal dress code regulations will be suspended for the duration of the emergency. Scrubs may be worn.

Clinics and Medical Education office will be closed at the discretion of the Clinic Director and DME. Notification will be given to employees as to possible responsibilities by one of these individuals. Clinic Manager with hospital Nursing Managers will coordinate clinic nursing staff usage.

All faculty, residents, externs, and other personnel are to wear name badges at all times while in the hospital. If name badge is missing, employee is to go to the command center check-in and be arm banded.

Faculty will release employees after discussion with the DME and not without Command Center notification and agreement. All employees will be available when in the hospital to provide whatever services Command Center may need. All employees are to

be present at assigned location. Failure to appear will result in a review and possible disciplinary action up to and including termination.

Employees may bring immediate family members with them when they report to work. All family members are to bring three-day kits and bedding. Each person is to check in and be arm banded before taking them to their assigned location. Pets are not allowed.

All activities are to be coordinated with the Command Center.

AFTER THE DISASTER (HURRICANE)
The DME will meet with the Command Staff for debriefing. Disaster (Hurricane) Report will be provided to Administration.

COMMAND CENTER
The Command Center will begin functioning at the determination of the Hospital Administrator and will be located in the Emergency Department Conference Room. The DME or DME representative will attend all scheduled Command Center meetings prior to, during, and after disaster to assist with coordination.

PHONE NUMBERS
Special Needs Patients (Orange County) 836-7115
Medical Education FHEO 303-8683
Command Center Extensions at FHEO
6842, 6843, 6844, 6845, 6846, 6847, 6848, 6849, 6850, 6851
Cell phone number: 342-8232

DISCIPLINARY POLICY / REMEDIATION

See GME manual for more information.

DISMISSAL POLICY

See GME manual for more information.

DRESS CODE

See GME manual for more information.

ELECTIVE ROTATIONS

Each resident will be assigned elective rotations. Specifics of the elective rotations must be approved by the DME no less than thirty (30) days in advance. Failing to submit a request in a timely manner may result in your elective being assigned. The *Resident Elective* form should be completed by the preceptor's office and returned to the Medical Education Office for approval. The resident needs the approval form signed by the DME prior to the beginning of the rotation. All preceptors must be on Florida Hospital medical staff and have a signed Off-Site Affiliation Agreement contract with the FHEO Medical Education Office. The following is a list of available Elective Rotations:

EVALUATIONS

Resident Evaluations:

Residents will be evaluated by the faculty/preceptor at the end of each rotation and feedback will be given. Evaluations are based upon the seven core competencies established by the AOA:

1. Osteopathic Principles and OMT
2. Medical Knowledge
3. Patient Care
4. Interpersonal and Communication Skills
5. Professionalism
6. Practice-Based Learning and Improvement
7. Systems-Based Practice

The faculty/preceptor will meet with the resident approximately mid way through the rotation to give feedback on his or her performance and to address any specific deficiencies. Evaluations will be reviewed on a quarterly basis by the faculty and Program Director during the Medical Education Committee meeting. The Mentor and/or Program Director will meet with the resident at least quarterly to review performance. Any necessary remediation or counseling will be determined by the Program Director and when indicated, individuals may be placed on probation or suspended. Evaluations will be kept on file in the resident's personnel file and will be accessible to the resident through the Medical Education office.

Additionally, residents will be evaluated by means of a 360-degree approach which will include evaluations by peers, nurses, ancillary staff, and patients. The results of these evaluations will also be discussed with the resident during quarterly mentor meetings.

Faculty Evaluations:

Residents will perform anonymous evaluations of the program, rotations, and faculty on an on-going basis. The results of these evaluations will be reviewed by the Program Director and appropriate feedback will be given to individual faculty members. Furthermore, evaluations of the rotations will be used by the Curriculum Committee to revise and alter the educational content of the program and its rotations.

Confidentiality:

All evaluations, counseling and probationary actions involving a resident will be kept in a confidential fashion. Under no circumstances will such actions be discussed in a public forum. Additionally, all evaluation of faculty by residents will be treated as confidential by the Program Director.

EXPENSES

See GME manual for more information.

FM/NMM RESIDENCY PROGRAM

RESIDENT ELIGIBILITY CRITERIA FOR THE FM/NMM RESIDENCY

Florida Hospital East Orlando will comply with all of the requirements for the basic standards for training. All OGME-1 residents considered for application for FM/NMM Residency training will meet the requirements of the basic standards for residency training in the program and have:

1. Graduated from an AOA Accredited College of Osteopathic Medicine.

2. Completed the ERAS application process.

3. Successfully passed COMLEX I and COMLEX II board exams.

4. Acceptable explanation of break in education (if necessary).

5. Commitment to Family Medicine and Neuromusculoskeletal Medicine .

Reasons for Ineligibility:

- Applicant does not demonstrate sufficient commitment to the specialty of Family Medicine. and Neuromusculoskeletal Medicine
- Applicant did not present favorable impression to faculty and/or resident physicians during elective time spent at Florida Hospital
- Quality of interaction during preliminary contact with staff suggests incompatibility with the Mission and Values of Florida Hospital
- Quality of personal statement, including no obvious commitment to Family Medicine and Neuromusculoskeletal Medicine
- Limited verbal and written English skills, including the inability to write clearly and legibly.

Non-eligible candidates will not be offered an interview or accepted into Florida Hospital Graduate Medical Education residencies.

RESIDENT SELECTION POLICY AND PROCEDURES

1. Applicant must meet all eligibility requirements. The requirement for successful completion of the COMLEX II board exam may be waived by the DME / Program Director as frequently the results are not available at the time of application.

2. Information regarding our programs and a letter with information about the program is sent to the applicant or seen on the website.

3. When the application is complete, the file will be downloaded from ERAS and a checklist is started for the applicant.

4. If the applicant is interested in Family Medicine and Neuromusculoskeletal Medicine then an interview is granted. The applicant is contacted by letter, telephone, or e-mail and instructed to contact the Medical Education office to arrange an interview time.

5. The interview process is conducted as follows:
   a. The applicant is advised to report to the Medical Education office at 8:00 AM
   b. The DME / Program Director, Behavioral Scientist, selective faculty and current residents will interview the applicant. Applicants may tour the FHCE and FHEO and meet other faculty and residents.

6. Each interviewer completes an evaluation form which includes four areas:
   a. Professional direction
   b. Personal characteristics and interpersonal communication skills
   c. Clinical competence
   d. Overall potential as a resident in our program

   The scores are calculated and summarized (Interview Score)

7. The files are reviewed and screened by the DME and Residency Coordinator.
   The following criteria are utilized:
   a. Personal statement
   b. Transcript score
   c. Dean's Letter
   d. COMLEX scores
   e. Letters of Recommendation

The scores are calculated and summarized (Screening Score)

8. An overall score is calculated for each applicant based on 40% of the Interview Score and 60% of the Screening Score.

9. The files are reviewed by the residents at the monthly resident meeting and a rank list is created.

10. All applicants who have been interviewed will be reviewed for ranking by the selection committee (all faculty, chief intern and chief residents) in mid-late December. The overall applicant score as well as the resident rank list will be taken into account.

11. The DME / Program Director will contact applicants to follow-up and answer any additional questions. The final rank list is at the discretion of the DME / Program Director and is confidential.

12. The rank list will be submitted to the National Residency Match Program by the DME / Program Director.

13. Applicants that have matched will be contacted and contracts will be sent within 10 working days of the match results.

RESIDENT ROTATIONS FM/NMM OGME-2 through OGME-4

OGME-2

- ADMINSTRATIVE RESIDENT (4 weeks)
- BEHAVIORAL MED (2 weeks)
- EMERGENCY MEDICINE (4 weeks)
- FMRS (4 weeks)
- GERIATRICS (4 weeks)
- GYNECOLOGY (4 weeks)
- PEDIATRICS (4 weeks)
- RADIOLOGY/MANAGEMENT (4 weeks)
- PHARMACOLOGY (2 weeks)
- SURGERY – COLORECTAL (4 weeks
- NMM SPECIALIST (4 weeks)
- NMM GYN (4 weeks)
- NMM ORTHOPEDICS (4 weeks)
- NMM PM&R (4 weeks)

OGME-3

- ADMINSTRATIVE RESIDENT (4 weeks)
- BEHAVIORAL MED (2 weeks)
- EMERGENCY MEDICINE (4 weeks)
- FMRS (4 weeks)
- GERIATRICS (4 weeks)
- GI (2 weeks)
- GYN ONCOLOGY (4 weeks)
- GYNECOLOGY (4 weeks)
- PEDIATRICS (4 weeks)
- ELECTIVE (4 weeks)
- NMM PEDS (4 weeks)
- NMM RADIOLOGY (4 weeks)
- NMM RHEUMATOLOGY (4 weeks)
- NMM ENT (2 weeks)
- NMM ELECTIVE (2 weeks)

OGME-4

- Administrative Resident (2 weeks)
- Dermatology (4 weeks)
- ELECTIVE 1 (4 weeks)
- ELECTIVE 2 (4 weeks)
- ELECTIVE 3 (2 weeks)
- FMRS (4 weeks)
- GYN -STD CLINIC (2 weeks)
- PEDIATRICS (4 weeks)
- PEDS SELECTIVE (2 weeks)
- RESEARCH (2 weeks)
- SURGERY – UROLOGY (4 weeks)
- NMM PEDS (4 weeks)
- NMM SPECIALIST (4 weeks)
- NMM Neurology/NEUROSURGEON (4 weeks)
- NMM ELECTIVE (4 weeks)
- NMM ELECTIVE (2 weeks)

EXPECTATIONS FOR FM/NMM RESIDENTS

RESEARCH REQUIREMENT

You are required to complete a research project for the NMM residency as well as one for the FM requirement. You can use data collected for one study to do both, i.e. looking at antibiotic choices and effectiveness in community acquired pneumonia as well as the effect on length of stay of OMT in patients with Community Acquired Pneumonia.

DIDATICS

During the week, on Thursday afternoons there is NMM didactics. You are expected to read the articles prior to the didactic session. You are expected to write one question per article or chapter or section that you have read. It must be e-mailed to Dr. Crow (THOMAS.CROW.DO@FLHOSP.ORG) preferably the same week that the readings are done, but no later than the last day of the month. For each week of questions are not submitted on time, you will be required to present another lecture for the FM noon lecture assigned by Dr. Allgeier at his discretion.

LECTURE REQUIREMENTS

During OGME 2 you will be assigned 1 lecture a year on an NMM subject agreed to by the FM/NMM program director
During OGME 3 you will be assigned 2 lectures a year on an NMM subject agreed to by the FM/NMM program director
During OGME 4 you will be assigned 3 lectures a year on an NMM subject agreed to by the FM/NMM program director

CLINICS

You will be assigned one afternoon a week for OMM clinic and two FM clinics. During your Administrative Resident time, you will have two NMM clinics during that week.

PATIENTS PER CLINIC

OGME 2 – During the first four months you will see a minimum of 4 patients per clinic. (During this time you are expected to present the patient to an attending prior to initiation of treatment and then have an attending recheck your work post-treatment.) After four months you will be titrated to 6 patients per clinic

OGME 3 & 4 – You will be expected to see between 6 and 8 patients per clinic.

CONSULT SERVICE

While on an NMM rotation you will be required to participate in the NMM consult service at the hospital. This fulfills your hospital service requirement which states that you must have a minimum of 100 consults over your three years. There are certain rotations that we prefer you to go to the other service because of the educational experiences being offered. That you will need to discuss with the hospital NMM attending.
Consults are to be completed in 24 hours. You will dictate the consult. However, on Thursdays you will handwrite all notes. The notes will include the reasons or goals for the treatment.
Follow up noted can be either hand written or use of the approved form is acceptable except on Thursdays when the notes will be all handwritten

At the present time we do not have call for the NMM service on Saturdays. Therefore, any consult called in by 5pm Friday must be completed on Friday and not held until Sunday. However, if an attending physician requests a consult that day i.e. Saturday, then you will need to notify the OMM attending on call and meet them there to do the consult. (This happens rarely, but has occurred in the past.)

Call will be shared between the intern and residents on call including the NMM residents. The Chief Resident will create a master schedule for the year. Any changes for on call have to be cleared on the appropriate change form in the Department of Medical Education. If you fail to show up for your scheduled call, then you will be assigned additional hospital call at the end of the year.
BEEPER- during the day the intern or one of the residents will carry the pager. At night and on weekends the FMRS resident/intern on call can be given the beeper with a list of present patients.

ANNUAL CONVOCATION

You are required each year to attend the annual convocation and take the inservice exam there. The residency will cover your hotel and travel expenses outside of your CME allowance.. You will share a room with a,member of the same sex. If you choose to bring a spoiuse or significant other, the room expense is yours alone. The choice of the hotel where you will stay is up to the Program Director. At certain cities the residents and attendings will stay at an alternate location and the residency will provide adequate transportation between the two sites.

OMM Rotation

ASSIGNMENTS

Daily Rounds begin at 1:15 p.m. Meet in the physician's dining room.
Didactic Sessions: Thursday afternoons in 3rd fl. Conference Room 1 or 2
⇒ Get Calendar of assignments from Dr: Crow
⇒ Sign out books or make copies to complete the reading assignments.
Write a multiple question from each reading; include page number, answer & reference book. The question must have 5 distractors to choose from. You CANNOT use ALL OF ABOVE, NONE OF THE ABOVE. The stem CANNOT use EXCEPT or WHICH ONE IS FALSE. The questions must have only one right answer.

Interns/Residents must carry OMM beeper at all times during the workweek. On Fridays at 5:00PM hand off beeper to FMRS resident, discuss the patient list and inform the resident of any NMM resident rounding for that weekend. Students are not allowed to carry the beeper. (Weekend OMM rounds will be supervised by Dr. Crow/ Dr. Rampil or another D.O. attending.)

On Monday at 7:00AM pick up beeper and list from FMRS resident.

Residents will go to the community physician's office in the mornings on the day that he/she is not assigned to the Family Health Center. Interns will get assignments from Dr. Browning or Dr Crow. If you choose NOT show up at your assigned physician's office, you will fail the rotation, and be required to make it on your own time after the completion of the residency program.

Format for completing Consults for OMM: Give copy to Wanda
Call Dr. Crow to discuss the case PRIOR to treating
In-patient consultations must be completed within 24 hours from the initial call
There are pre-printed consult forms available in the mail boxes in the physician's dining room

OMT/Rampil/Allgeier/Crow

Assessment: 1) Reason for hospitalization/OMM consult
2) Somatic dysfunction (anatomic regions) head, cervical, thoracic, ribs, lumbar, sacral, visceral, pelvis, other (write out no abbreviations)
3) Other contributing medical conditions

Plan: 1) Medical Management as per attending
2) OMT X ____ regions (count the total of SD above)
3) Other suggestions

CC: Reason for hospitalization &/or reason for OMM consultation
HPI: PSHx:
PMHx: SOCHx: ALL:
PE: must include: vitals

Neuro exam	PT/INR
musculoskeletal	Platelet Count
osteopathic exam	Exam pertinent for Dx

Write out relevant somatic dysfunctions (i.e. OAESlRr, restricted respiratory diaphragm, 1st rib restricted in inhalation, LLQ fascial strain with tissue congestion.)

Please write a statement describing the goals of Osteopathic treatment.

Illeus example: Treatment goals are to stimulate bowel peristalsis by balancing the autonomics, decrease somatic dysfunction, decrease tissue congestion to increase healing time, increase lymphatic drainage.

Pneumonia example: Treatment goals are to increase sputum expectoration. Decrease somatic dysfunction. Decrease work of breathing to increase overall O2 availability. Balance autonomics. Decrease sympathetic input to the lungs by breaking the visceral-somatic reflex, this will thin sputum consistency.

Contact number: Dr. Crow
Cell: 610 304 1676
Office: ext 1019
Pager: 3750

If Dr. Crow is not available then contact Dr. Browning.

GRADUATION CEREMONY

See GME manual for more information.

HOLIDAYS

See GME manual for more information.

HOSPITAL QUARTERS

The resident on-call quarters are located in the hospital on the third floor. Accommodations for spouses, friend(s), or children of residents are not provided. Staff and students are not to lounge in these quarters.

Do not leave personal items in the quarters, except in assigned locker, as the quarters remain unlocked. If the quarters need beds made or cleaned, have the switchboard operators page Environmental Services. Please be neat at all times.

HOUSING

Florida Hospital does not provide housing for residents. All residents must reside within thirty (30) minutes driving time of the hospital (this is a thirty minutes drive while obeying posted speed limits and during heavy traffic drive time).

IMPAIRED PHYSICIAN POLICY

See GME manual for more information.

INSERVICE EXAMINATION ACOFP AND AAO (FOR FM/NMM RESIDENTS)

Residents will be required to take the inservice examination each year. These exams are to assist in comparing the educational accomplishments and progress of residents and the program. After the results have been returned, the Program Director will meet personally with each resident to go over the results. Residents who have scored below the 50th percentile, will be given a remediation plan to assist with their education in the areas demonstrated as weak.

INSTITUTIONAL CORE COMPETENCY PLAN (ICCP)

Introduction
The Florida Hospital Institutional Core Competency Plan (ICCP) is a guide for continuous improvement in teaching and in evaluating competency-based curriculum and medical education. The curriculum is based on the seven core competencies defined by the American Osteopathic Association (AOA). Florida Hospital is to committed to ensuring professional competence, which is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served.
The administrative officers of Florida Hospital firmly support the Director of Medical Education (DME) and the faculty in their commitment to excellent and quality graduate medical education programs to ensure the consistent care for our patients in the community.

DME Responsibility
The designated ICCP institutional official at Florida Hospital is the Director of Medical Education for osteopathic programs, Joseph Allgeier, DO. As DME, Dr. Allgeier is responsible for drafting the ICCP and presenting it to the Medical Education Committee (MEC).

MEC Responsibility
The Medical Education Committee of Florida Hospital is responsible for approving the ICCP and monitoring the plan's implementation and performance.

Program Directors/Faculty Responsibility
The Internship Director, the Directors and Associate Directors of each Residency Program and the Program Faculty are responsible for implementation of the ICCP.

Support Staff
The DME, Residency Coordinator, and medical education office staff will collect, review and input information for the annual report and plan update.

Program Participation
The Family Medicine Residency, and Family Medicine/Neuromusculoskeletal Medicine Residency Programs will participate in the development and integration of the ICCP for Florida Hospital.

Resources
Florida Hospital and the Osteopathic Foundation of East Orlando will provide the needed resources to support the development and monitoring of the ICCP. Periodic review of resource needs will occur and if additional resources are required, they will be incorporated into the budget.

Osteopathic Postdoctoral Training Institution (OPTI)

Florida Hospital will work in conjunction with the Consortium for Excellence in Medical Education (CEME) to develop and implement assessment tools necessary to measure the seven core competencies.

Effectiveness
Effectiveness and progress will be monitored in the following manner. The DME will monitor monthly evaluations, procedure and case logs, faculty evaluations, lecture attendance, mentoring feedback forms, and other methods as deemed appropriate. Program directors will monitor trainee evaluations, faculty evaluations, in-service exam scores and day-to-day progress of trainees. Quarterly progress reports will be presented to the medical education committee by the DME. The annual report given to the Medical Education committee will be forwarded to the OPTI.

Teaching Methods

Osteopathic Philosophy and OMM
Teaching:
- Inpatient Credentialing
- Weekly Didactic Sessions
- Monthly Distance Learning
- OMT Clinics
- Computer Modules

Medical Knowledge
Teaching:
- Morning Report
- Weekly Didactic Programs
- Journal Club
- Family Practice Workshops
- Tumor Board
- Board Review

Patient Care
Teaching:
- Morning Report
- Weekly Didactic Programs
- Family Practice and Procedural Workshops
- Bedside teaching rounds
- Procedural Credentialing
- Procedural Models
- Strategy Sessions (Counseling)
- Tumor Board

Interpersonal and Communication Skills
Teaching:
- Bedside and Outpatient teaching and modeling
- Videos / Movies
- Workshops
- Medical Spanish classes
- Whole Person Care conference

Professionalism
Teaching:
- End of Life Care Training (EPEC)
- Role Modeling
- Practice Management
- Cultural Diversity Training

Practice-Based Learning and Improvement
Teaching:

- Use of “virtual library” in real time patient care
- QA / PI data
- Practice Management rotation and conferences
- Billing and Coding workshops
- Journal Clubs
- EBM workshops
- Use of EBM order sets

Systems-Based Practice
Teaching:
- Practice management rotation and conferences
- Multidisciplinary rounds
- Community Health Center and AHEC rotations
- Community service involvement (e.g. Shepherd’s Hope)
- Home visits
- Group visits

Evaluation

Osteopathic Philosophy and OMM
Evaluation:
- Inpatient Credentialing
- Computer Modules
- Videomonitoring
- OSCE
- Monthly Service Evaluation

Medical Knowledge
Evaluation:
- In-service Exams
- Core Medical Knowledge Exams
- Post-lecture Quizzes/PRS
- COMLEX III
- OSCE
- Monthly Service Evaluation

Patient Care
Evaluation:
- Videomonitoring
- OSCE
- 360 Degree Evaluation
- Record Review
- Procedural Models
- Procedure and Case Logs
- Monthly Service Evaluation

Interpersonal and Communication Skills
Evaluation:
- Videomonitoring
- OSCE
- 360 Degree Evaluation
- Patient Surveys
- Monthly Service Evaluation

Professionalism
Evaluation:

- Videomonitoring
- OSCE
- 360 Degree Evaluation
- Patient Surveys
- Portfolios
- Monthly Service Evaluation

Practice-Based Learning and Improvement
Evaluation:

- AOA CAP program
- QA /PI reports
- Videomonitoring
- OSCE
- 360 Degree Evaluation
- Portfolios
- Monthly Service Evaluation

Systems-Based Practice
Evaluation:

- Videomonitoring
- OSCE
- 360 Degree Evaluation
- Portfolios
- Monthly Service Evaluation

Outcomes

Each trainee will develop skills to professionally and competently care for patients in a variety of clinical settings.

Each trainee will be expected to score ≥ 55th percentile on in-service exams.

Each trainee will develop academic skills to successfully pass certification boards (COMLEX III, AOBFP, AAO) within the first year.

Remediation Plan
Trainees not meeting an acceptable level of achievement on core competency evaluations will be required to complete an academic remediation plan. The remediation process is outlined in the residency manual and will be developed in conjunction with the program director and DME.

Tracking Methods Used

Florida Hospital Core Competency Evaluation Measures and Methodologies									
	Inservice Exam	360 Degree Evaluation	Checklist	OSCE	Monthly Evaluation	Procedure/ Case Logs	Portfolios	Written Exam	Video-monitoring
OP - OMM	●			●	●	●		●	●
Medical Knowledge	●		●	●	●	●		●	
Patient Care		●	●	●	●	●			●

Interpersonal Comm Skills		●		●	●				●
Professionalism		●		●	●		●		●
Practice Based Learning & Impr		●		●	●		●		●
Systems Based Practice		●		●	●		●		●

LEARNING CENTER

A learning center is available for residents' use on the third floor of Florida Hospital East Orlando. The learning center provides three computers with an available printer. A reference library is also available for resident use.

LEAVE

See GME manual for more information.

Leave/Sick

The resident contract allows up to twenty personal days of leave annually with pay. Each resident will have a personal medical record kept in the Family Health Center East.

If a resident becomes ill during a rotation shift, s/he should follow the procedure below as soon as the illness requires them to leave their shift. The team senior partner should notify appropriate people as outlined below within thirty minutes of notification.

PROCEDURE:

1. If you need to call in sick or to report that you cannot work your regular scheduled work hours, you must page **one hour before your regular scheduled work time.**
2. **All attendance/covereage calls are to go through the FHCE Practice Manager.**
   Desiree Rivera
   Home: 352-227-4125
   Cell: 352-348-3165
   Pager: 407-303-5599 (211)
3. If they are unavailable, you may page or call the below:
   Joseph Allgeier, DO
   Cell: 407-579-4218
   Pager: 407-303-5599 (3731)

Unexcused absences will be dealt with at the discretion of the DME and may include, but are not limited to, two extra days added to the end of the contract for each unexcused absence, additional call or other assignments. Lecture attendance will not be excused. Excessive unexcused absences may result in additional disciplinary action at the discretion of the DME. All absences are unexcused until approved by the DME.

Practice Management Group Senior Partner of ill resident:

- ✓ Call PRIOR to 8:00 am

- ❖ Medical Education (407-303-8683) to advise which team member will see assigned patients if ill resident is on Clinic, Pediatrics, or OB/GYN.

  Team members on FMRS, Pediatrics, or OB/GYN may <u>NOT</u> be called off rotations to cover for ill resident(s).

- ✓ Problems should be reported to Medical Education immediately.

Whenever a resident feels slightly ill but wishes to continue working, s/he must report to Medical Education within a reasonable time. The resident and nurses should be alert to any signs of illness displayed by one another so that the Medical Director can arrange an appropriate evaluation. The resident who is ill must contact the Senior Team Partner to take care of or arrange care for his/her hospitalized and clinic patients, call, and clinic responsibilities.

Upon return to work after absences of three (3) days or more, or in circumstances where the potential of contagion or risk exists, employees may be required to provide to Medical Education (or Employee Clinic) a physician's statement which documents the validity of, or need for, time away from work.

Where there is a question of contagious illness, an employee may be referred to the FHCE Clinic or Employee Clinic to determine fitness to return to work.

Leave/Time-Off Requests

To request time off for personal or CME leave, the resident must complete and submit a *Time-Off Form* for **<u>ALL</u>** days off – regardless of type, reason, event, or holiday and submit to Medical Education. No time-off requests are permitted during the last two weeks of a resident's contract period of the normal academic year.

Time-off requests are considered individually by the DME and must have his/her approval. Do not assume your request has been granted. An approval or disapproval will be forwarded to the resident in his/her mailbox.

- Requests for Leave are to be turned in at least forty-five (45) calendar days in advance.
- It is the responsibility of the resident to notify Medical Education.
- It is the responsibility of the resident to provide coverage for shifts when assignments have already been given by the DME.
- No request is approved without the signatures of the DME <u>and</u> Clinic management.
- Verify days available with Medical Education **prior** to completing a *Time-Off Form*.
- CME, mission trip, Residency retreat, and granted days for Boards are not assumed; you must follow normal procedure and complete a *Time-Off Form*.
- Actual days of Boards are granted days. Any days before or after (including travel days), CME, and/or leave days must be approved by the DME.
- Resident is responsible for follow-up and confirmation of approval.
- Resident may not take leave or CME during core rotations as noted in the rotation schedules and sections of the manual.
- Planned leave/time off must be taken on specific rotations (see below).
- OGME-1 Residents may not take more than five (5) personal days at one time, and cannot use more than fifteen (15) of their personal days as vacation.

Leave without pay is allowed based on an as needed evaluation in cases of extended illness or serious personal problems. Request must be made no less than thirty days in advance. Leave without pay will extend the resident contract for the length of the leave and may jeopardize the resident's standing in accordance with regulations established by the AOA/ACOFP/AAO and the residency program.

Rotations Leave/CME Time Allowed

OGME-3

- Dermatology
- Elective III
- Elective IV
- Emergency Medicine
- GI
- Gynecology III

- Gynecology/Oncology I
- OMM III*
- Urology

OGME-2
- Elective II
- Emergency Medicine
- ENT
- GI
- OMM*
- Surgery Elective

OGME-1
- Cardiology
- Elective I
- Emergency Med/Radiology I
- Gynecology I
- OMM*
- Orthopedics
- Pharmacy
- Pulmonology/CC

For rotations that are two weeks in length, leave for more than one (1) week will not be allowed.
**Time off will only be allowed if there is adequate coverage.*

TIME-OFF REQUEST FORM

NAME: ____ **CURRENT DATE**: ____________________

- Requests for leave are to be turned in at least forty-five (45) days in advance.
- It is the responsibility of the resident to notify Medical Education.
- The resident must provide coverage for shifts when assignments have already been given by the DME.
- The resident must forward their EPIC in basket to another resident for coverage.
- No request is approved without the signature of the DME (signature of Clinic is required first).

REQUESTED DAY(S) OFF: ____

REASON FOR REQUEST:

☐ CME (please attach a copy of information on the convention/seminar you are attending)

☐ PERSONAL

NUMBER OF ACTUAL LEAVE DAYS REQUESTED: ____

NUMBER OF LEAVE DAYS REMAINING FOR CONTRACT YEAR **EXCLUDING** THIS REQUEST: ___________

NAME OF ROTATION AND/OR ATTENDING(S): ____

APPROVED BY ATTENDING(S) YES ☐ NO ☐ N/A ☐

____

SIGNATURE OF ATTENDING

____

SIGNATURE OF REQUESTING RESIDENT

EPIC Inbasket coverage provided by: ____

EPIC "Out of Contact" completed YES ____ NO ____

FOR ME OFFICE USE ONLY

Leave Days Remaining Verified? YES ____ NO ____ Rotation Verified? YES ____ NO ____

Submitted to FHCE (Date): ___________________________ Initials: ________

____

Aida Hernandez
FHCE Department Secretary

____

Desiree Rivera
Practice Manager

Number of clinic days scheduled: ________

Number of clinic patients scheduled: ________

APPROVED **YES** ☐ **NO** ☐

____ ______________________

LYN JOHNSON, DO
FHCE MEDICAL DIRECTOR

DATE

____ ______________________

JOSEPH ALLGEIER, DO
DIRECTOR OF MEDICAL EDUCATION

DATE

LIBRARY

See GME manual for more information.

LICENSING

See GME manual for more information.

LOGS

Residents are required to maintain complete and accurate patient and/or procedure logs. Logs need to be completed on New Innovations within ten (10) days of the completion of the rotation. All procedures completed during rotation period are to be recorded. This includes Clinic and moonlighting experiences.

OGME-1 Log Requirements

At the end of each service, each OGME-1 resident is required to keep a log of activity performed during that service. Logs should be maintained daily. Logs are to be completed within **TEN (10) days** of the completion of the rotation. When entering logs into New Innovations, OGME-1 residents are to document who supervised the procedure under "comments." For preceptors who are not on New Innovations, the mentor must be selected as the preceptor. The preceptor/mentor will review and confirm logs.

Logs will be available for review and chart audit during OGME-1 program inspections. Logs are not only a requirement of the training institution and the AOA, but should be accurately maintained for requesting future privileges as well as potential requirements of hospitals or liability insurance carriers to verify areas and levels of training. While DMEs are to maintain logs for three years, it is recommended that OGME-1 residents maintain copies of logs for their personal records. (Copies are not kept by the AOA). OGME-1 residents must complete logs on all patient contacts and activities.

Logs will consist of the following:

1. Name of service and dates.
2. Case participation (by medical record number and diagnosis), history and physical examinations performed, level of participation, record of osteopathic manipulative treatment.
3. Surgery attended (by case number, operation, and level of participation).
4. Special procedures (such as endotracheal intubations, cutdowns, liver biopsies, cardiac resuscitations, lumber punctures, and thoracentesis).
5. Lectures, clinical pathological conferences, and clinical conferences attended and presented.
6. Reading performed (list books, journal, title of article or scope of reading).
7. Autopsies attended.
8. Obstetrical assists (by case number and type of delivery).
9. Mark patients which OMM was applied.

Resident Log Requirements

GENERAL PRINCIPLES FOR PROCEDURE LOGS

Hospital medical staff and multi-disciplinary group employers are increasingly requiring itemization of all procedural skills acquired in Residency training. Documentation will be vital to your future. With this in mind, each resident is required to document all procedures completed (i.e. paps, pelvics, sutures, castings, etc.). With this information, the resident who graduates and seeks privileges to perform a given procedure should have sufficient information to locate and review actual records, contact a physician who is well acquainted with his/her competence and provide Residency faculty with some indication of his/her clinical background in performing the procedure.

Immediately after any procedure, the following information should be recorded. Many residents find that stamping a paper with the patient's nameplate identity card is helpful. Ideally, the following information should be recorded:

a. Patient's name, age, and MRI # — Needed to locate records

b.	Date & location performed	Needed to locate records
c.	Procedure	
d.	Preceptor	Specify if primary surgeon or first assist, etc., i.e. someone who can verify your procedure. Not all procedures will necessarily be supervised after certification is achieved.
e.	Comments	Indications, complication, diagnoses, etc.
f.	Level of Participation	

Mandatory Procedural Competence (Required Procedures)

1. Incision and drainage of abscess
2. Biopsy of skin
3. Excision of subcutaneous lesions
4. Cryosurgery of skin
5. Curretage of skin lesion
6. Laceration repair
7. Injection of shoulder joint
8. Injection / aspiration of knee joint
9. Injection of sacroiliac joint
10. Endometrial biopsy
11. Office microscopy
12. Casting
13. EKG interpretation
14. Office spirometry
15. Toenail removal
16. Defibrillation
17. Removal of cerumen from ear canal
18. Insertion of urethral catheter
19. Endotracheal intubation

Optional Procedures

1. Vasectomy
2. Central line placement
3. Vaginal delivery
4. Episiotomy repair
5. Flexible sigmoidoscopy
6. Colonoscopy
7. Lumbar puncture
8. IUD insertion
9. Breast cyst aspiration
10. Epistaxis management
11. Trigger point injection
12. Allergy testing
13. Neonatal circumcision
14. Colposcopy with biopsy

MENTORING

The purpose of mentoring is to provide each resident with an experienced role model to personally assist them in their professional development. The mentor's role is not to formally evaluate, but to serve as a guide to "learning the ropes" to become a top quality physician. The contents of the interaction will remain **confidential**.

1. The Coordinator of the mentoring process will:
   - Periodically contact individual residents to assure appropriate interactions with their mentors and/or mentees and troubleshoot mentoring problems.
   - Periodically contact faculty members to assure appropriate interactions with their mentees and troubleshoot mentoring problems.
2. Mentoring "matches" will be updated in July of each year.
3. Mentors are expected to meet every other month with each of their mentees during the assigned "mentoring week".
   - At the initial meeting, expectations will be discussed and clarified
   - Meetings may not conflict with scheduled lectures, rounds or rotation responsibilities
   - Possible meeting times include:
     - 12:00-1:00 PM (Lunch)
     - during the mentor's Administrative Time (when the resident's rotation responsibilities allow)
     - after hours as agreed upon by both the mentor and the mentee
4. Mentors are expected to give feedback on overall performance, lecture attendance, outstanding charts or records, progress in their scholarly activity requirements, rotation paperwork and inservice exam results.

MOONLIGHTING

Residents

Residents may be granted permission to participate in moonlighting activities with the approval of the DME. Moonlighting is an earned privilege and must be maintained by the Resident even after being granted. Moonlighting activities may not interfere with the Residents' educational program or rotations. The Resident will be expected to complete all rotation and Residency requirements. The Resident must maintain active FHCE credentialing and keep medical records for inpatients and outpatients current to be allowed to moonlight. The DME may revoke or suspend privileges. Any professional clinical activity (moonlighting) performed outside of the official residency program may only be conducted with the permission of the program administration (DME/Program Director). A written request by the resident must be approved or disapproved by the Program Director and DME and be filed in the institution's resident file. All approved hours are included in the total allowed work hours under AOA policy and are monitored by the institution's graduate medical education committee. This policy must be published in the institution's housestaff manual. Failure to report and receive approval by the program may be grounds for terminating a resident's contract.

The faculty of the Residency are not required to provide any urgent consultation or medical support to the resident at a moonlighting site. The site employer must provide any appropriate consultation and supervision.

A record of all moonlighting activity shall be turned into the DME for review and approval in advance. Residents found moonlighting without current DME approval will face disciplinary action as determined by the DME. A monthly report of moonlighting hours worked during the previous month will be submitted to the DME by the tenth business day of the next month.

Resident qualifications to moonlight must include the following:

a. Licensure and DEA by the State of Florida.
b. Certification in ACLS, PALS, NRP.
c. Satisfactory completion of all rotations with no pending remedial requirements.
d. Be in good standing, not on probation, and have all charts and paperwork current.
e. Approval in writing from DME.
f. Adequate outside malpractice insurance must be maintained. A copy of the insurance policy is to be given to Medical Education at the time of submission for approval.
g. Meet all educational standards as established within the program.

Resident restrictions to moonlighting:

a. Work no more than twenty (20) hours a week.
b. Not to work a shift later than twelve (12) o'clock midnight preceding a working day.
c. Do not moonlight while on call.
d. Moonlighting may not interfere with any Residency functions, i.e. moonlighting is not allowed between the hours of 7 AM – 5 PM Monday through Friday.
e. If FH moonlighting structure is established these responsibilities will be required to be covered before outside moonlighting will be approved by the DME.

f. Average weekly program hours worked plus the moonlighting hours worked must not exceed the AOA's allowed eighty (80) hours.

In summary, it is our intention that moonlighting will enhance the Residents' medical knowledge, clinical judgment and educational experience and assist him/her financially during their Residency training. It must be understood that moonlighting is a **privilege** and if ever the Resident's educational and Residency responsibilities are compromised, the Resident's moonlighting privileges will be altered or terminated. Persistent poor performance in the Residency will result in termination of moonlighting privileges.

Failure to attend mandatory meetings or other program requirements may result in loss of moonlighting privileges.

The Resident must receive advanced approval for EACH moonlighting site where s/he intends to work.

OGME-1 Residents are not permitted to participate in moonlighting activities.

MOONLIGHTING APPROVAL FORM

DEPARTMENT OF MEDICAL EDUCATION

PLEASE PRINT

Resident Name:____

Date: ____________________

Number of moonlighting locations: ________________

Employment:

- Address:____
- Phone number:____________________________________
- FAX number: ____________________________________
- Contact person: __________________________________
- Physician: ______________________________________
- Type of work: ___________________________________

OFFICE HOURS:		EXPECTED MOONLIGHTING HOURS:	
Monday	__________	Monday	__________
Tuesday	__________	Tuesday	__________
Wednesday	__________	Wednesday	__________
Thursday	__________	Thursday	__________
Friday	__________	Friday	__________
Saturday	__________	Saturday	__________
Sunday	__________	Sunday	__________

FOR MEDICAL EDUCATION USE ONLY

Copy of Current Malpractice Certificate Attached: YES ☐ NO ☐

DME APPROVAL: YES ☐ NO ☐

________________________ __________
DME SIGNATURE DATE

Moonlighting
Revoked:____
____

Reinstated:____

________________________ __________
DME SIGNATURE TO REINSTATE DATE

Hours Worked Form
Residency and Moonlighting

Resident: ________________________________ Date: ______________

MONTH: ______________________

RESIDENCY HOURS:		MOONLIGHTING HOURS:	
Monday	___________	Monday	___________
Tuesday	___________	Tuesday	___________
Wednesday	___________	Wednesday	___________
Thursday	___________	Thursday	___________
Friday	___________	Friday	___________
Saturday	___________	Saturday	___________
Sunday	___________	Sunday	___________
Monday	___________	Monday	___________
Tuesday	___________	Tuesday	___________
Wednesday	___________	Wednesday	___________
Thursday	___________	Thursday	___________
Friday	___________	Friday	___________
Saturday	___________	Saturday	___________
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Friday	___________	Friday	___________
Saturday	___________	Saturday	___________
Sunday	___________	Sunday	___________
Monday	___________	Monday	___________
Tuesday	___________	Tuesday	___________
Wednesday	___________	Wednesday	___________
Thursday	___________	Thursday	___________
Friday	___________	Friday	___________
Saturday	___________	Saturday	___________
Sunday	___________	Sunday	___________

Total Residency Hours: _______

Total Moonlighting Hours: _______

PARKING

Employee parking is restricted to certain areas. Park behind the building (hospital and MOB) in unmarked spaces.

Do Not Park in the Emergency Department parking lot, Pastoral care, or front parking lot of the Hospital or MOB.

Parking in areas designated for patient/visitor parking could result in having your car towed.

RESIDENTS:
Residents may park in the Doctors Parking lot on the west side of the hospital. Residents will need their employee badge to access the gate. OGME-1 residents may NOT park in the Doctors' Parking lot at any time.

PATIENT CARE

History and Physicals (H&P's)

H&P's are due on all inpatients within 24 hours of admission. FMRS H&P's are to be completed legibly by hand on the H&P **AND** Osteopathic Structural Forms (both are required to be a complete H&P). Surgery patients must have an H&P on the chart prior to surgery. The history, physical, and structural examination forms must be comprehensive. Residents should verify compliance to JCAHO, AOA and FH guidelines. Admission notes must be written by the admitting resident assigned to the patient covering the key points, thought processes and care plan. A note should be dictated with the H&P and Osteopathic Structural forms discussing these same items.

Only approved FH Abbreviations are to be used during dictation and in the chart.

An Osteopathic examination is required on all H&P's by the AOA and as part of your osteopathic training. Use the Osteopathic Structural Form.

You may do an interim H&P on patients who have been admitted within 30 days with the same or related chief complaint IF a complete H&P was done with the most recent prior admission. The interim H&P must consist of cc, HxCC, PMHx, PSHx, medications, allergies, and PE. The rest of the OGME-1 H&P should read "as per previous admission. Please see old chart."

All patients admitted to the hospital must be told that a breast, pelvic/pap and rectal examination are part of the physical examination. If the patient refuses this part of the exam, it must be documented on the chart and the H&P as "Patient refused the ______ for the following reason ______." Obviously, ICU and PCU patients confined to bed cannot have the most complete physical exam, but breast, biannual pelvic, and rectal exams can be performed on patients confined to bed rest. If items on the H&P are deferred, they must be completed as soon as possible. In addition, the patient must be told to follow up with their family doctor or a specialist.

The Medical Education Department will assign H&P's to be done on all FMRS and staff faculty admissions that are not done by the following morning of admission. H&P's are to be assigned in a fair and equitable manner. Whenever possible, H&P's will be assigned by service.

Documentation

All entries on the patient chart must include the date, time, and legible signature to comply with AOA and The Joint Commision requirements. Do not scribble out errors in progress notes and orders. Draw one line through the error. Then, sign, time and date the lined out error, then write the correct note or order. The attending physician who is currently covering the case will be indicated as the doctor the resident is ordering or noting for the chart.

Resident Responsibilities

Daily progress notes, in the SOAP format, will be written legibly by residents on assigned patients.

If the admitting diagnosis is apparently in conflict with the physical findings and summary, the resident must immediately discuss the case with the attending physician.

The attending staff shall be constantly advised by residents of the progress of patients and promptly notify them of any significant changes or emergencies which may occur.

The resident must immediately notify the attending if a patient dies, is transferred to ICU/PCU, or is placed on the “critical” list.

Residents shall respond when called concerning a FMRS, or other assigned patient. The resident must document all patient contacts and orders. Residents shall respond to calls from the floor if the attending or physician responsible for patient care is Residency Faculty or Attendings. Other patient calls will be referred to the attending unless the information provided is determined to be a life-threatening emergency. In those situations, the residents will evaluate the patient, provide emergent care, if determined as necessary, and communicate if possible with the attending or consultant on the case.

FHCE Admissions

(also see Specifics of Resident Rotations – FHCE section)

FHCE patients will be admitted by the Attending Clinic resident with consultation and approval of the Clinic supervisor. Orders and admitting information will be submitted by the clinic resident. This resident will write the admitting note and daily progress notes. The daily care will be provided by the FMRS resident and service in conjunction with the admitting clinic resident. The patient will be discharged to the admitting resident. FHCE resident will follow the patients and document their involvement with daily progress notes.

FHCE patients admitted from the ED will be followed by the FMRS service resident and FHCE FM resident. The patient’s FHCE resident will be notified and expected to follow the patient until discharged back to the clinic. This includes daily progress notes.

PRACTICE GROUPS

In an attempt to foster continuity of care as well as to create a clinic experience that more closely approximates that of a typical group practice, the residents have been divided into 8 practice groups of 3 or 4 residents each. The groups are identified by the first 8 letters of the alphabet (A-H). Each team consists of one OGME3, one OGME2 and one OGME1. Those teams with 4 members will include one OGME4 member.

In order to foster heterogeneity among teams so as to increase their versatility, all teams must have at least one member of each gender. In addition, Spanish speaking residents will be limited to one/team and every effort will be made to evenly distribute NMM residents between the teams.

In order to enhance continuity, when a patients’ primary physician is not available, they will automatically be scheduled with one of the other team members. That team member will then communicate with the primary physician concerning any important matters resulting from the visit so as to keep them informed.

During the transition at the end of each clinical year, the patients who have been the primary responsibility of a particular outgoing OGME3/4 will remain with the same team, with most being divided among the incumbent practice group members and some being assigned to the new OGME1. With each incoming class, a lottery method will be used to determine the order by which OGME1s will be added to each group. Each resident is encouraged to think of their practice group as a partnership. As with all partnerships, communication is essential to effective teamwork.

Team A ***Delgado***	**Team B** ***Allgeier***	**Team C** ***Crow***	**Team D** ***Johnson***	**Team E** ***Crow***	**Team F** ***Browning***	**Team G** ***Allgeier***	**Team H** ***Gonzalez***
M. Winfrey	Duvall	Smith-Gonzalez	Mason	Roop	Timoshkin	K. Winfrey	Watters
Selvaraju	Sloan	Seals	Weaver	Marcelo	Hartman	Mangiaracina	Smith
Tabor	VanderBiezen	Bensusan	Bengaard	Gallas	Spagnolo-Hye	Mele	Sieb
		Margaitis		Thompson			

PROFESSIONAL MEMBERSHIPS

All residents must remain members in good standing of the American Osteopathic Association (AOA), Florida Osteopathic Medical Association (FOMA), Florida Society American College of Osteopathic Family Physicians (FSACOFP), and the American College of Osteopathic Family Physicians (ACOFP). FM/NMM Residents have the added requirement of remaining members in good standing of the American Academy of Osteopathy (AAO). All expenses for these requirements will be paid by Florida Hospital East Orlando or reimbursed to the resident.

REMEDIATION PROCESS

Resident Academic Remediation and Institutional Probation Process

I. POLICY

When there are sufficient deficits in a resident's performance it is required that all program directors and chairs utilize the resident academic remediation and/or institutional probation process.

Academic Remediation is considered a structured formative process designed to assess, document and supportively correct factors that negatively impact resident performance. Such factors may include, but are not limited to:

- Below average clinical knowledge and skills deficits
- Performance deficits related to anxiety in test-taking, morning reports, teaching rounds, conferences, etc
- Work/life balance issues – i.e. family concerns, work stress
- Cultural adjustments
- Interpersonal and communications skills deficits
- Professionalism
- Work environment factors
- Personal coping deficits

Institutional probation - Probation is not to be confused with remediation. Probation is a separate and resultant action when 1) an academic remediation process at the departmental level has not been successful and continuation of the resident in the training program is in jeopardy; or 2) an action or behavioral event has occurred, such as, a serious lack of professionalism; endangerment to the well-being of patients or co-workers; a disregard for medical protocol; an illegal action; any other serious and/or willful infraction of hospital policies, procedures and corporate compliance requirements for residents and all employees. In certain cases, placing a resident on institutional probation may result in an adverse action.

This policy should not conflict with, nor replace, the hospital's Adverse Action Policy for residents as stated in the hospital's contract with the Committee on Intern and Residents (CIR).

II. PROCEDURE – Academic Remediation

At the first signs of a performance problem it is the responsibility of the program director to meet with the resident and to identify specific issues and/or behaviors that affect performance. It is beneficial both diagnostically and for intervention to frame performance deficits within the AOA required competencies. If these issues cannot be resolved, it is the program director's responsibility to activate the remediation process by taking the following steps.

1. Academic remediation should be initiated at the first signs of deficiency in a resident's academic performance.

    a. Initiating the remediation process requires that the program director or chair must document a resident remediation plan that is focused on specific academic issues. Use the AOA Competencies to designate the required behavioral criteria to be met in the remediation process.
    b. A remediation period typically lasts 60 to 90 days, depending on the level of remediation required for performance improvement.
    c. During the remediation period, the program director and other faculty must closely supervise, frequently evaluate, and document the progress of the resident in the deficient areas noted in the remediation plan.
    d. The resident must receive frequent feedback on performance improvement.

2. The program director must draft the remediation plan and consult with Academic Affairs or Medical Education before meeting with the resident. (See attached remediation form.)

3. The program director must meet with the resident to explain the reason(s) for academic remediation, evidence for it, and the corrective interventions planned.

4. During the remediation period program directors must meet with the resident periodically (once a week is recommended) to facilitate and review progress toward objectives documented in the initial planning stage of remediation (see 1-a).

5. After the remediation period is completed the program director must meet with the resident to formally discuss:

    a. Whether or not academic performance issues have been resolved satisfactorily
    b. If the remediation period will continue
    c. Or if the resident is being placed on probation and that continuation in, or reappointment to, the residency program is in jeopardy.

6. Institutional probation may be initiated at any time for any of the situations described in Section I of this policy that remain unresolved. Such a situation may result in: 1) extended remediation; or 2) dismissal from the program; 3) initiation of the resident adverse action policy.

III. RESPONSIBILITIES

The program director and chairs are responsible for disseminating and implementing the remediation policy and process and establishing/coordinating learning objectives with the department of Academic Affairs or Medical Education. The head of Academic Affairs, DIO, (or delegate) will also provide consultation and monitor the process.

Attachment

Resident Remediation Action Plan

Please read these guidelines before completing this form:

Academic remediation is considered a formative process to assess and correct a variety of situations and problems that are affecting resident performance. These include 1) below average clinical knowledge and skills deficits; 2) poor performance due to anxiety related perhaps to tests, morning reports, teaching rounds, conferences, etc; 3) the work/life balance; 4) cultural adjustments; 5) interpersonal and communication issues; 6) family concerns; 7) work environment factors; and 8) coping deficits.

Institutional probation is a resultant action when 1) an academic remediation process at the departmental level has not been successful and continuation of the resident in the training program is in jeopardy; or 2) an action or behavioral event has occurred, such as, a serious lack of professionalism; an endangerment to the well-being of patients or co-workers; a disregard for medical protocol; an illegal action; any other serious infraction of hospital policies, procedures and corporate compliance requirements for residents and all employees. In certain cases, placing a resident on institutional probation may result in an adverse action.

Action Initiated: Step 1: ____Departmental Academic Remediation (Initial)
Step 2:_____Departmental Academic Remediation (Extended)

Resident:	Department:
Program Director/Faculty Advisor:	Today's Date: Remediation Period: _____Months Extended Period: _____Months

I. Areas of weakness and/or concern	Remediation Plan
Patient Care	
Medical Knowledge	
Practice-Based learning and Improvement	
Interpersonal and Communication Skills	
Professionalism	
Systems-Based Practice	

II. Evaluation - The following interventions will be used to determine if improvement has been achieved in all areas of weakness and/or difficulty. (Please check the appropriate boxes and specify the names of the individuals who will provide evaluations).	
( ) Examinations	
( ) Direct observation	
( ) Evaluation report(s) by attending faculty	
( ) Evaluation report by Chief Resident(s)	
( ) Reports by other staff	
( ) Other ( ) Referral for Professional Development	

Follow-up

The next meeting between the resident and advisor will be on _________________________________.
(Date)

Verification

I have reviewed and discussed the contents of this document.

Resident Comments:
____
____
____

Signatures:

Resident____Date__________________

Program Director____Date__________________

Advisor____Date__________________

Academic Affairs____Date__________________

Outcome of Remediation Plan

____ Successful Completion of Remediation Plan

____ Step 3: Place on Institutional Probation (Refer to Academic Affairs)

Plan: ____

____

____

Officer of Medical Education

____________________________________ Date ______________________

RESEARCH AND SCHOLARLY ACTIVITY REQUIREMENT

AOA / ACOFP: The AOA / ACOFP guidelines state that the program must provide opportunity for residents to participate in research or scholarly activities.

The residents will be required to participate in the following:

1) QI Projects
   → 1 QI Project/ year/ Practice Group
2) Patient Orientated Evidence that Matters (POEMS)
   → OGME-1 = 2 (1 in Emergency Medicine; 1 in Pharmacology)
   → OGME-2 = 2 (1 in Emergency Medicine; 1 in Behavioral Med)
   → OGME-3 = 3 (1 in Emergency Medicine; 1 in Behavioral Med; 1 in Geriatrics)
   Note: POEMS must be completed within 30 days of the end of the assigned rotation and a copy is to be given to the Research Coordinator and the Program Director. If not completed, then the Program Director may issue additional call.
3) Scholarly projects
   Conduct research project (elective time given) - investigator initiated, *or*
   → Present a case report, a poster or an oral presentation at a regional or national conference, *or*
   → Write a case report submitted for publication in peer review journal, *or*
   → Prepare literature review article submitted for publication in peer review journal
4) IRB certifications (NIH, Research HIPAA & CV)
   → OGME-1 will complete this requirement following EPIC training or within the first 3 months of residency.

I. QI projects

Resident involvement in quality improvement projects results in healthcare excellence with reduction in risk and cost. As frontline physicians, residents can recognize when problems in quality, safety, and efficiency occur.

QI projects are important to resident education:

a) Fulfills AOA /ACOFP criteria for practice-based learning and improvement competency
b) Allows residents to become active participants in our residency practice – improving healthcare, delivery and outcomes
c) Increased awareness in methods for performance improvement leading to increased re-imbursement (P4P)
d) To learn the skills required for future re-licensure requirements

Quality improvement projects are not intended to be "generalizable" to outside practices, or to be published. IRB approval is not needed.

Pre-requisite knowledge for faculty:

1) Strategies to recognize clinical management issues
2) Skills to assess the issue
3) Knowledge of how to implement a practice change
4) Skills to analyze the project impact

Resident Goals:

1) Understanding quality improvement in the clinical setting from the stakeholder's perspective.
2) Identify a clinical management issue
3) Analyze the issue
4) Research the current guidelines/evidence for standard practice or alternative practice
5) Develop a plan to improve patient care
6) Implement the project
7) Analyze the impact of change
8) Project presentation

II. Patient Oriented Evidence that Matters (POEMS)

Residents will learn the skills to answer questions which occur in everyday practice via efficient, evidence-based methods. Through explicit review of selected resources, they will learn to quickly review literature for strengths, weaknesses and take-home messages. They will integrate this information and develop a bottom-line answer to their clinical question.

POEMS are important to resident education:

a. Fulfills AOA / ACOFP criteria for critical review of the literature
b. Enables the resident to answer Clinical questions at the point of care
c. Improves the resident's ability to provide EBM care

Pre-requisite knowledge for faculty:

1) Knowledge of resources to rapidly retrieve the evidence
2) Skills to appraise the evidence
3) Knowledge of the POEMS format

Resident Goals:

1. Identify clinical questions which occur in regular practice
2. Efficiently search and find resources to answer clinical questions
3. Rapidly retrieve (& appraise as necessary) evidence
4. Gain awareness of some of the available resources (& use more than 1-2)
5. Enhance the skills and comfort in presentation.

III. Scholarly projects

Scholarly activity is important to resident education:

a. Fulfills AOA / ACOFP requirements for opportunities for research in principles of research design, performance, and analysis and encourage research participation.
b. Fulfills AOA / ACOFP recommendations that faculty must demonstrate broad involvement in scholarly activity.

Scholarly project options

1) Conduct research project (elective time given) - investigator initiated
Project leaders – Crow, Allgeier, Spruill, Lukman

2) Present a case report, a poster or an oral presentation at a regional or national conference
Project leaders – individual mentors

3) Write a case report submitted for publication in peer review journal
Project leaders – individual mentors

4) Prepare literature review article submitted for publication in peer review journal
Project leaders – individual mentors

Pre-requisite knowledge for faculty:

a. Overview of scholarly activity: what is it, how can we incorporate it into our current load and where can we present, submit, etc
b. Learn all of the components of preparing a manuscript, case study, or review article for a peer-reviewed journal.
c. Key concepts and basic rules of good grammar
d. Writing in the "active voice"

Resident Goals:

a. Develop skills that encompass the ability to: perform literature searches using MEDLINE and other resources
b. Ability to critically evaluate research articles
c. Utilize evidence-based medical information resources
d. Interpret and apply clinical decision rules; and appropriately apply evidence in clinical decision-making

RESIDENCY ORIENTATION

In July of each academic year, a Residency Orientation will be performed for all OGME-2, OGME-3, and OGME-4 residents. New policies for the academic year will be introduced, and pertinent procedures will be reviewed.

The orientation will cover important policies and procedures for the Department of Medial Education, including but not limited to:
Evaluations
Research and Scholarly activity
Clinic and call schedules
CME / Expense reimbursement
Moonlighting policy
Electives
Duty hours
Clinic policies

At this time, residents will be given a manual acknowledgement form which must be completed and returned to the Department of Medical Education for their files.

RESIDENT ASSOCIATION

See GME manual for more information.

RESIDENT SELECTION POLICY AND PROCEDURES

Resident Eligibility Criteria For Osteopathic FM Residency

Florida Hospital East Orlando will comply with all of the requirements for the basic standards for training. All OGME-1 residents considered for application for FM Residency training will meet the requirements of the basic standards for residency training in the program and have:

1. Graduated from an AOA Accredited College of Osteopathic Medicine.

2. Completed the ERAS application process.

3. Successfully passed COMLEX I and COMLEX II board exams.

4. Acceptable explanation of break in education (if necessary).

5. Commitment to Family Medicine.

Reasons for Ineligibility:

A. Applicant does not demonstrate sufficient commitment to the specialty of Family Medicine.
B. Applicant did not present favorable impression to faculty and/or resident physicians during elective time spent at Florida Hospital
C. Quality of interaction during preliminary contact with staff suggests incompatibility with the Mission and Values of Florida Hospital
D. Quality of personal statement, including no obvious commitment to Family Medicine
E. Limited verbal and written English skills, including the inability to write clearly and legibly.

Non-eligible candidates will not be offered an interview or accepted into Florida Hospital Graduate Medical Education residencies.

Resident Selection Policy And Procedures

1. Applicant must meet all eligibility requirements. The requirement for successful completion of the COMLEX II board exam may be waived by the DME / Program Director as frequently the results are not available at the time of application.

2. Information regarding our programs and a letter with information about the program is sent to the applicant or seen on the website.

3. When the application is complete, the file will be downloaded from ERAS and a checklist is started for the applicant.

4. If the applicant is interested in Family Medicine then an interview is granted. The applicant is contacted by letter, telephone, or e-mail and instructed to contact the Medical Education office to arrange an interview time.

5. The interview process is conducted as follows:
    a. The applicant is advised to report to the Medical Education office at 8:00 AM
    b. The DME / Program Director, Behavioral Scientist, selective faculty and current residents will interview the applicant. Applicants may tour the FHCE and FHEO and meet other faculty and residents.

6. Each interviewer completes an evaluation form which includes four areas:
    a. Professional direction
    b. Personal characteristics and interpersonal communication skills
    c. Clinical competence
    d. Overall potential as a resident in our program

    The scores are calculated and summarized (Interview Score)

7. The files are reviewed and screened by the DME and Residency Coordinator.
    The following criteria are utilized:
    a. Personal statement
    b. Transcript score
    c. Dean's Letter
    d. COMLEX scores
    e. Letters of Recommendation

    The scores are calculated and summarized (Screening Score)

8. An overall score is calculated for each applicant based on 40% of the Interview Score and 60% of the Screening Score.

9. The files are reviewed by the residents at the monthly resident meeting and a rank list is created.

10. All applicants who have been interviewed will be reviewed for ranking by the selection committee (all faculty, chief intern and chief residents) in mid-late December. The overall applicant score as well as the resident rank list will be taken into account.

11. The DME / Program Director will contact applicants to follow-up and answer any additional questions. The final rank list is at the discretion of the DME / Program Director and is confidential.

12. The rank list will be submitted to the National Residency Match Program by the DME / Program Director.

13. Applicants that have matched will be contacted and contracts will be sent within 10 working days of the match results.

ROTATION DOCUMENTATION

By the end of each rotation, the resident must complete an attending evaluation form and a resident rotation evaluation form. These forms are available in the Medical Education Office. All evaluations, patient logs, procedure logs, and summaries are to be completed and submitted to Medical Education no later than ten (10) working days after the end of each rotation.

Procedure Logs

Resident procedure logs or OGME-1 patient logs must also be completed. The ACOFP does not accept "no procedure" rotation logs. Procedures performed in the Clinic and/or during moonlighting should be included on procedure logs for that rotation period.

Evaluations

Documentation required within 10 working days of completion of rotation:

	OGME-2/OGME-3	OGME-1
Logs of all patient encounters		✓
Logs of all procedures	✓	✓
Typed Summary of rotation		
Evaluation of Rotation	✓	✓
Evaluation of resident by Attending	✓	✓

All evaluations, patient logs, procedure logs, and summaries are to be completed **no later than ten (10) working days after the end of each rotation**. Failure to complete evaluations on time may result in disciplinary actions. Evaluations of rotation by the resident are to be completed electronically in New Innovations.

Calendars will be maintained by Medical Education on each resident noting all lectures attended from the lecture sign-in sheet.

STRESS, FATIGUE AND IMPAIRMENT

The Program Director and faculty realize that residency training is a time of high stress. They will make every effort to monitor residents on their rotations for signs of stress, fatigue, or impairment. The resident can assist on his/her own behalf by adhering to duty-hour mandates and by communicating problems with his/her preceptor, faculty advisor, or the Program Director. Signs and symptoms of fatigue, stress, or impairment include some of the following:

1. Recent changes in behavior, including irritability, mood swings, inappropriate behavior, a breakdown in logical thought, trembling, slurred speech
2. Irresponsibility, such as failure to respond to calls, late arrivals at rounds or call, rounding at irregular times, neglect of patients, incomplete charting, unexplained absences
3. Inaccurate or inappropriate orders or prescriptions

4. Insistence on personally administering patients' analgesics or other mood-altering medications rather than allowing nursing staff to carry out orders
5. Poor concentration or poor memory, such as failure to remember facts about individual patients
6. Depression
7. Evidence of use or possession of alcohol or other drugs while on duty; intoxication at social events
8. Anger, denial, or defensiveness when approached about an issue
9. Unkempt appearance and/or poor hygiene
10. Complaints by staff or patients
11. Unexplained accidents or injuries to self
12. Noticeable dependency on alcohol or drugs to relieve stress
13. Isolation from friends and peers
14. Financial or legal problems
15. Loss of interest in professional activities or social/community affairs

In situations of stress, fatigue, or impairment, the faculty or resident may approach the Program Director or the Program Director may call a meeting with the resident. The problem will be discussed, and the Program Director will make recommendations for resolving the problem. Such recommendations may include use of services within Florida Hospital such as the Employee Assistance Program, Employee Health Services, or referral to a counselor or psychiatrist. For further information, please refer to the GMEC policy on Impairment found in the Graduate Medical Education Policy Manual.

Impairment:

Florida Hospital, along with the medical staff and graduate medical education is committed to providing safe, effective, timely, and respectful medical care while fostering an environment that promotes practitioner health. We affirm that substance use disorders and other behavioral health disorders are treatable illnesses and after treatment, practitioners can return to the safe and effective practice of medicine with appropriate monitoring. Please refer to the GMEC Policy Manual for specific policy on impairment.

SUPERVISION OF RESIDENTS

Purpose: The purpose of this section is to safeguard patient care and enhance graduate medical education by setting standards for supervision of residents.

Supervision Privileges: Florida licensed physicians credentialed through Florida Hospital Medical Staff and with appropriate clinical privileges must supervise all residents in their patient care responsibilities. Supervising physicians are either FP Residency faculty, voluntary faculty with signed agreements or attendings who request and/or accept the responsibility for supervising residents. This section does not prohibit non-supervising physicians from writing orders and shall not deny or limit non-supervising physicians privileges.

The Medical Education Committee of Florida Hospital East Orlando (FHEO) will have the responsibility for periodic or DME requested review of the safety and quality of patient care provided by the residents and their related educational and supervisory needs.

Internship is defined as *"supervised care of patients in a hospital…with continued instruction …by the hospital staff…under the supervision of the attending staff, he (the OGME-1) is given progressively increasing responsibility to the end that he acquires confidence in his own clinical judgment"* by the Florida Administrative Code (Code B 64B8-6.003 {2001}). Residency is a continuation and extension of this process with the caveat that residents may, if licensed, legally practice independent of the residency and supervision.

Neither residents nor interns are credentialed at Florida Hospital to have medical staff privileges. Therefore, all resident activities within Florida Hospital must be supervised by an attending who is licensed in the state of Florida and credentialed at Florida Hospital in the care and/or procedures to be performed by the resident. The "supervising" physician may be a Family Practice Residency faculty, the admitting physician or any physician on Florida Hospital's medical staff. The residents do not require direct supervision except in surgery. Direct supervision does not have to be provided at all times.

Residents are responsible for their own decisions and actions without reference to the so-called "supervising" physician. Residents should provide only medical care procedures for which they are qualified by training or experience, even if they are

under the supervision of a credentialed attending physician. Therefore, even residents who are not under direct supervision (i.e. under "indirect supervision") are expected to seek the counsel and advice of their supervising physician before proceeding in an area with which the resident has no training or experience.

In turn, supervising physicians will accept as their responsibility the education and monitoring of residents who seek their advice and direction. In particular, the assigned faculty member for a resident, or the contracted attending physicians who serve as on-call faculty, shall be available to address concerns and questions of residents and shall directly supervise them.

Outpatient Activities

In the Family Health Center East, faculty members will be assigned to supervise (chief) interns/residents who are seeing and caring for scheduled outpatients. The ratio of faculty to interns/residents must be less than or equal to 1:4. Faculty must not be seeing their own patients during the same time period that they are supervising the interns/residents.

Specific supervision policies for each level of training are described in Part II of this manual.

Inpatient Activities

Descriptions of inpatient duties and on-call responsibilities for interns/residents on all inpatient services are included in Part II of this manual.

All inpatient intern/resident activities are supervised by an attending physician who has been granted privileges by the Medical Staff to perform the specific procedure or duty they are supervising. The supervising physician will be one of the faculty, Family Practice, internal Medicine, Pediatrics or OB/GYN or a licensed independent physician specialist who has agreed to supervise the intern/resident for those specific circumstances.

The actual procedures, level of training of intern/resident and severity of illness of the patient will be used to determine if the supervising physician will be physically present at the time of service. If the supervising physician is not physically present,t hey must be available on short notice by telephone and be willing/able to make themselves physically present in a reasonable amount of time.

Interns/residents may write admitting orders and subsequent orders for the care of the patient. These orders in combination with all pertinent information regarding the patient's specific case must be communicated with the attending physician within a reasonable amount of time based on the urgency, or severity of the patient's condition. The entry of orders into a patient chart does not preclude the attending or licensed dependent practitioner involved in the care of that patient from entering orders on their own.

The Florida Hospital Residency Services accept many patients for care provided directly by the specific Residency Service. These patients are under the care of the residents of the program who are under the supervision of the faculty attending physicians and the contracted attending physicians. Residents may provide services and review tests on behalf of the Residency Services for any Residency Service patient treated in a hospital or clinic setting.

Ordinarily, residents will not act as physicians for patients of the hospital or clinic who are not part of a Residency Service ("non-Residency Service patients").

The resident should not involve themselves with the care of non-residency service patients except at the specific request of a non-faculty attending physician who has the credentials to provide the required care and who accepts the responsibility for supervising the resident. In non-emergency situations residents may assist the attending physician or that physician's partner or covering physician if the resident's duties to residency service patients allow. Otherwise, non-residency service patients will not be seen by residents. In an emergency situation for a non-residency service patient, when residents are unable to contact the attending physician, the resident shall attempt to contact a supervising physician in this order: (a) the patient's attending physician or that physician's partner or covering physician, (b) a consultant on the case, (c) the on-call faculty physician for Family Medicine Residency Service (FMRS), (d) other faculty physicians, (e) the on-call resident.

Efforts to contact one or more of the attendings and potential supervisors must be continued during and after the emergency activities. The attending and on-call faculty member should be notified if any care or procedures were carried out in advance of

conversations with a “supervising” physician. All conversations, efforts to contact supervising physicians, and actions supporting the above process must be documented in a timely manner in the patient’s chart.

Progress notes and orders shall be written before the resident leaves the hospital for each patient contact which includes the date, time, name of the supervising physician contacted and resident signature. All physician attendings and supervising attendings shall be notified ASAP. The supervising physician must countersign all orders and notes written by the residents of FHEO.

TUMOR BOARD

1. Tumor Board is held monthly during the Wednesday didactic program. OGME-2 residents will be assigned a Tumor Board month at the beginning of the academic year. This is a requirement per the AOA.

2. All residents are required to attend this program. Residents that are not in attendance will be responsible for the information and will need to complete an assignment per Dr. Lee.

3. If the OGME-2 resident does not present on their assigned day because of lack of preparation or planning then they will be assigned a future date to present as well as given an extra night of call.

   The procedure is outlined below:

4. Contact Dr. Theodore Lee for ideas on a case to present.

5. The OGME-2 resident is expected to research updated information regarding the patient’s diagnosis and treatment as well as have an article available on the topic.

6. Complete a Power Point presentation and review it with Dr. Theodore Lee.

7. The following evaluation form will be completed for all Tumor Board presentations and will be maintained in the OGME-2 resident’s file.

TUMOR BOARD PRESENTATION EVALUATIONS

DATE:____________________

PRESENTER:

TUMOR TYPE:

1 = lowest 5 = highest

PRESENTATION FORMAT: 1 2 3 4 5

PRESENTATION DYNAMICS: 1 2 3 4 5
(leadership, level of interest, etc.)

INTERACTION FROM
HOUSESTAFF/ATTENDINGS: 1 2 3 4 5

DISCUSSION:

TIME USED:

SUMMARY:

OVERALL RATING: 1 2 3 4 5

WINTER PARK INITIAL ORIENTATION

The Administration and employees welcome you to Winter Park Memorial Hospital. We are excited about your working here and wanted to provide information to orient you. You may receive a personal tour if you contact Barbara Davis, Director of Medical Staff Services, at 407-646-7681. Do not hesitate to call anytime for assistance.

DOCTOR'S PARKING
The main Doctor's Parking Lot, which is locked, is located off Lakemont Avenue with the entrance gate just south of the Emergency Room. Access cards are provided to the Medical Education Office. Several "Emergency" parking spaces are available on the Edinburgh side of the hospital. Do not park there if you are to be in the hospital for an extended period of time.

DOCTOR'S ENTRANCE
The Doctor's Entrance is located just off the Doctor's Parking Lot. It is open during the day, but locked in the evening. When locked, enter 1985 on the keypad.

DOCTOR'S LOUNGE
The Doctor's Lounge (Physician Education Center) is located on the South Corridor, just inside the Physician's Entrance. This is locked in the evening and can be opened by Code 1985, or using your parking card. Breakfast and lunch are served in the Lounge and sandwiches, drinks and other snacks are available at all times.

CAFETERIA
The hospital cafeteria is located in the Basement of the hospital and is open during the following hours:
7:00 a.m. - 10:00 a.m. - Breakfast
11:00 a.m. - 2:00 p.m. - Lunch
4:30 p.m. - 6:30 p.m. - Dinner

MEDICAL RECORDS
The medical records access numbers for Florida Hospital are the same for Winter Park Memorial Hospital. Medical Records is located across the hall from the Doctor's Lounge. The computer system is the Florida Hospital computer system and any passwords or access numbers are the same. There is a computer in the Doctor's Lounge with Internet access.

LABOR & DELIVERY, GYN, NURSERY, PEDIATRICS
These units are located on the East side (Edinburgh Avenue) of the hospital on the Third Floor. Unit specific orientations will be provided to you by the directors of these areas. For questions prior to these orientations, or at other times, please call Karen Purnell-Wells, Director of Women & Childrens' Services, at 407-646-7425.

SLEEPING ARRANGEMENTS
There are three separate sleep rooms located in Labor & Delivery next to the operating rooms. The first room is labeled "Anesthesia Sleep Room". The other two (2) are reserved for Obstetricians and you may use either of these two rooms as needed.

MEDICAL STAFF OFFICE
Medical Staff Services office is located on the South Corridor of the hospital and is open days, Monday through Friday. Call here if you have additional questions or need assistance.