Florida Hospital Family Medicine Residency Manual

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Note The content of a manual does not constitute nor should it be construed as a promise of employment or as a contract between Florida Hospital Family Medicine Residency and any of its Residents.

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Welcome

On behalf of your faculty, staff and fellow residents, we welcome you to FHFMR and wish you every success here.

We believe that each resident is here to finally complete their formal education and be trained to be the best family physician they can be. Not only do you have the opportunity to develop and fine tune your skills and knowledge but you also have the chance to contribute directly to FHFMR's growth and success. We hope you will take pride in being a member of our team. This Manual was developed to describe some of the expectations we have of our residents and to outline the policies, programs, and benefits available to you. Please **familiarize** yourself with the contents of this resident manual as soon as possible, for it will answer many questions about employment and training with FHFMR.

We hope that your experience here will be challenging, enjoyable, and rewarding.

Sincerely,

Kris D. Gray, MD, Program Director

Jennifer Keehbauch, MD, Associate Director

Alexander Fishberg, MD, Medical Director FHC

Sophia Lucey, Program Coordinator

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1 Mission

The Family Medicine Residency is operated by Florida Hospital, a not-for-profit health care institution, in support of its mission, "To Extend the Healing Ministry of Christ."

To further 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."**

While striving for excellence, the Residency Program is committed to serving the community, Florida Hospital, the faculty, staff and resident physicians. It is also focusing its efforts on training residents to be family physicians prepared for the future. This includes an emphasis on **"patient-centered"** care, both in and out of the hospital, in tertiary as well as community hospitals and even in the neighborhood and workplace. With an emphasis on comprehensive care through the maintenance of health, prevention of illness, prompt and directed treatment of acute problems as well as management of chronic disease, our residents will be trained to provide true continuity of care, in an **"evidence-based"** manner, to their patients over the entire lifespan.

In concert with Florida Hospital, the family medicine residency provides whole-person care with utilizing the eight principles of ultimate health described in the **"CREATION"** model. These principles of—**Choice, Rest, Environment, Activity, Trust, Interpersonal relationships, Outlook and Nutrition**—will be the basis of our focus on lifestyle, health maintenance and prevention.

1.1 Goals and Means

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

- **Training**
  - **Goal:** Develop family physicians that excel in medical knowledge, psychomotor skills and behavioral skills.
  - **Means:**
    - Prepare residents to fulfill the requirements for certification by the American Board of Family Medicine.
    - Train residents to evaluate the preventive, health maintenance needs of patients and treat the entirety of acute and chronic diseases in the context of the patient's psychosocial and spiritual environment, to provide competent care, and to seek consultation for patients when appropriate.
    - Promote an understanding of mutual responsibility through collaboration between the physician and patient, for health care that continues throughout the patient's life that includes health maintenance and preventive medicine.
    - Develop and encourage the practice of whole-person care, perceiving patients as biological, social, emotional, and spiritual beings.
    - Provide instruction regarding practice management skills.

- **Environment**
  - **Goal:** To provide an environment supportive of personal and professional growth and conducive to high quality education, efficient patient care, and research.

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- **Means:**
  - Maintain a family medicine practice in a realistic setting demonstrating the standards of the "Patient-Centered Medical Home."
  - Encourage learning through the use of computers, research, and electronic library facilities.
  - Encourage academic excellence within the medical staff of Florida Hospital.

- ## Community

  - **Goal:** To improve the health status of the community.
  - **Means:**
    - Provide comprehensive and continuing health services through the Family Health Center as well as in various other settings within the community.
    - Educate the community about the comprehensive care that family physicians provide.
    - Provide care to the community in an efficient and cost-effective manner.
    - Extend care to patients not adequately served by other community resources.
    - Extend care to the underserved within the community.

- ## Institution and State

  - **Goal:** To provide constituent organizations with a source of well-trained family physicians.
  - **Means:**
    - Provide Florida Hospital, Adventist Health System and the State of Florida with an excellent and sufficient source of family physicians.
    - Provide physician services to Florida Hospital concordant with the house officer's responsibilities and education.
    - Be an example of continued quality improvement and excellence within the medical staff.

- ## Resident Recruitment

  - **Goal:** To recruit and train physicians who will likely practice in Florida. (Eligibility and Selection criteria and recruiting/interviewing processes included in Section 2.1
  - **Means:**
    - Provide organized recruitment teams who will focus on in-state medical schools and affiliates (Florida State University, University of Central Florida, University of Florida, University of South Florida, University of Miami and Loma Linda University)
    - Provide an unbiased selection of resident physicians. Discrimination based upon race, creed, color, sex, age or disability is prohibited.

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1.2 History

Florida Hospital was established in 1908 in a two-story, 20 bed wooden building on the shore of Lake Estelle. It has grown to a 7 campus hospital system in Orlando with over 2000 beds, over 2000 medical staff of all specialties and a tertiary medical facility of unmatched quality.

The Family Medicine Residency began as an internship in the 1960's and became an accredited Family Medicine residency program in 1973. We have maintained full accreditation for all those years and have grown to a program of 43 residents and 3 fellows. Having been the only residency at our campus for 34 years, we established a solid reputation for quality education in primary care at Florida Hospital. In 2007 a General Surgery residency program joined us and is building into a strong training program for surgeons within the context of "whole person care" as modeled by the family medicine program.

1.3 Changes in Policy

This manual supersedes all previous employee manuals and memos.

While every effort is made to keep the contents of this document current, FHFMR reserves the right to modify, suspend, or terminate any of the policies, procedures, and/or benefits described in the manual with or without prior notice to employees.

2 RESIDENT DEFINITION AND STATUS

A "resident" of FHFMR is a person who, having satisfied all eligibility criteria, has mutually selected/been selected to train in the family medicine allopathic residency program. He/she is hired on an annual contract basis and renewed each year for a three year period with an option to add a fourth year for fellowship if the resident chooses to apply for that position AND is selected by the fellowship program to do so. Residents are paid on a salary basis according to their contract. The salary is reviewed and adjusted annually based on market trends for similar residency positions, cost-of-living allowances and budgetary issues. However, all residents of a particular PGY status are paid the same salary and given the same benefits. These are NOT adjusted either up or down based on merit or for any disciplinary purposes.

2.1 Resident Eligibility and Selection

- All applicants must submit applications through ERAS.

- **LCME (Liaison Committee of Medical Education) graduate:**
  - Successfully passed USMLE I and USMLE II CK and CS (United States Medical Licensing Examination)
    - Transcript directly from the FSMB (Federation of State Medical Boards)
  - Doctor of Medicine diploma without reservations
  - Acceptable explanation of any break in education (if necessary)
  - Proof of citizenship or eligible visa status as required by Florida Hospital Human Resources
  - Fluency in spoken and written English

- **DO (Doctor of Osteopathy) graduate (eligibility considered only in consultation with the Osteopathic Residency Program Director):**
  - Successfully passed COMLEX appropriate boards
    - Transcript directly from the NBOME (National Board of Osteopathic Medical Examiners)
  - Doctor of Osteopathy diploma without reservations
  - It is the expectation that residents fulfill the requirements of the osteopathic internship year (required by the Florida Board of Medicine and the American Osteopathic Association). This may be completed through time spent at the DO residency program or CMEs, please see American Osteopathic Association site for more information.
  - Acceptable explanation of any break in education (if necessary)
  - Proof of citizenship or eligible visa status as required by Florida Hospital Human Resources
  - Fluency in spoken and written English

- **International Graduate:**
  - Successfully passed USMLE I and USMLE II (CK and CS)
    - Transcript directly from the FSMB (Federation of State Medical Boards)

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  - Doctor of Medicine diploma, or equivalent, without reservations
  - Translation of degree in English (if necessary)
  - Current ECFMG (Educational Commission for Foreign Medical Graduates) certification
    - Transcript directly from the ECFMG
  - Successfully completed a transitional year of internship/residency in an ACGME accredited residency program with a letter from the residency program director (this requirement **may** be waived if the applicant attended a medical school that provides all clinical years of training in the US. All other eligibility requirements apply)
  - Proof of citizenship or eligible visa status as required by Florida Hospital Human Resources
  - Acceptable explanation of any break in education (if necessary)
  - Fluency in spoken and written English

- **Reasons for Ineligibility:**
  - Applicant does not meet all the eligibility requirements
  - Applicant does not demonstrate sufficient commitment to the specialty of Family Medicine—
    - No advanced-level FM electives during medical school
    - No letters of recommendation from FM faculty/physicians
  - Applicant's personal statement does not reflect appropriate temperament or understanding of the family physician role in healthcare
  - Applicant did not present favorable impression to faculty and/or resident physicians during elective time spent at Florida Hospital
  - Applicant's affect during preliminary interactions with staff suggests incompatibility with the Mission and Values of Florida Hospital
  - Applicant not able or willing to arrange a personal interview at Florida Hospital
  - Medical Board exams (USMLE or COMLEX) not passed or more than two attempts were made to pass before being successful

- **Selection Policy:**
  - All applications must be made through ERAS.
  - Once an applicant is determined to have met the eligibility criteria, the program director may invite them for an interview.
  - Interviews are set up from November 1 through January 31 and preference is given to scheduling interviews on Monday through Wednesday and Friday. There is a maximum of four applicants per interview day.
  - Applicants generally meet with a resident for dinner the evening before the interview if their travel plans allow.
  - Interviews are set up starting at 8:00 am and include behavioral medicine faculty, clinical faculty, program director, chief resident, upper level resident and intern.
  - Following interviews, preliminary rankings are made by both faculty and residents using four categories: Blue (Top 16), Green (high, medium or low), Yellow and Red. These

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are based on interview scores, acceptable board scores, appropriate personal statement and letters of recommendation. They are not final rankings.

- At the end of the interview season and prior to the deadline to submit the match list, a meeting will be scheduled with all available faculty, chief residents and resident recruitment committee leaders. At that meeting the proposed rank list is developed.
- Once reviewed again by the program director, the list is entered into the NRMP Rank Order list on the internet and certified prior to the deadline. The rank order list is confidential.
- Match results are determined by NRMP in mid-March and the program director is notified of the number of the program slots that filled in the match.
- If all slots did not fill in the match, the “scramble plan” is implemented. Available applicants that did not match submit their applications through ERAS to programs that did not fill. Those applications are reviewed to determine if eligibility criteria are met. The application is then reviewed for merit including acceptable board scores, appropriate personal statement and letters of recommendation. A call is then placed to the applicant and a group interview is done on speaker phone. Once an adequate number of applicants are interviewed, the program director, program coordinator and all available faculty and resident leaders discuss the applicants. A decision is then made to offer a position to the necessary number of applicants to fill the unfilled slots. The chosen applicants are then contacted again by phone and offered the position. If they accept, a verbal agreement is made followed by a letter of intent that is sent out from the program director.
- The names of the applicants selected through the match are posted via the NRMP website during the Wednesday following the scramble date. This list is kept confidential by the program director and program coordinator until the following day when the names of all new residents are announced at the noon conference. No contact with the matched applicants is made until after 1 pm on the day of the official announcement.
- Matched new residents are contacted by the program director to confirm the match agreement.
- Letter of Intent, contract, schedule request forms and other required documents are prepared and sent to the matched applicants within two weeks. The required documents include this Resident Manual, GME Manual and listing of American Board of Family Medicine requirements.
- Orientation schedules, dates and requirements are sent to the new residents as soon as available.

2.2 Resident Promotion Criteria

The authority whether to promote a resident shall be determined by the Program Director, based on the Criteria for advancement with the advice of the faculty of the Department.

The method of evaluation shall consist of direct observation of the resident as well as indirect observation through video-monitoring, rotation evaluations, and correspondence between departments and written examinations (USMLE, INTRAINING EXAMINATIONS). It is expected that residents will participate in all aspects of the curriculum, as well as in the periodic evaluation of educational experiences and instructors. It is further expected that residents will complete all administrative responsibilities of a resident, including licensure, credentialing, etc. in a timely fashion.

The criteria for advancement shall be based on ACGME's six core competencies, all of which need to be evaluated as competent for the appropriate level of advancement. These parameters are:

1. Medical Knowledge
2. Patient Care
3. Practice-Based Learning and Improvement
4. Professionalism
5. Interpersonal and Communication
6. Systems-based Practice

See http://www.acgme.org/acWebsite/downloads/RRC_progReq/120pr07012007.pdf for more details.

In addition to the evaluation parameters listed above, the resident must have medical records that are thorough, comprehensive and completed in a timely manner. All evaluations (rotation requirements, preceptor and resident evaluation) must be documented prior to the resident semi annual evaluation.

There are three steps that shall be evaluated: the PGY1 to PGY2, the PGY2 to PGY3, and PGY3 to graduation. At each level, acceptable progress in the six competencies will need to be documented. Additionally, the PGY2 and PGY3 resident must be judged competent to supervise others (PGY-1s and students), and to act with limited independence. Before graduation, the resident must be judged competent to act independently.

Promotion criteria will also be based on the requirements for certification by the American Board of Family Medicine and Accreditation Council of Graduate Medical Education.

Access to Information Related to Eligibility for Specialty Board Examination:

1. ACGME Common Requirements for Residency Training (http://www.acgme.org/acWebsite/home/home.asp).
2. ACGME Institutional Requirements for Residency Training (http://www.acgme.org/acWebsite/home/home.asp).
3. Program Requirements for Residency Education in Family Medicine (http://www.acgme.org/acWebsite/home/home.asp).
4. American Board of Family Medicine Requirements for Certification (https://www.theabfm.org/).
5. The Florida Hospital Graduate Medical Education Manual and Family Medicine Residency Manual (http://www.new-innov.com/Login/Login.aspx).

In addition, the following are the requirements for resident promotion:

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- **PGY1-PGY2**
  - USMLE III completed and passed
  - At least 5 ICU patients logged into New Innovations
  - Medical Records up to date—
    - Inpatient <30 days
    - Outpatient <48 hrs
  - Satisfactory completion of rotations Blocks 1-13 (post tests, assignments and evaluations)
  - PGY1 research requirements complete
  - In-Training exam scores above 75th percentile for PGY year or Education Planning Committee (EPC) Individual Education Plan (IEP) requirements complete.

- **PGY2-PGY3**
  - Licensure application complete (IMGs have until mid-PGY3)
  - Medical Records up to date—
    - Inpatient <30 days
    - Outpatient <48 hrs
  - At least 3 continuity OB patients delivered and logged into New Innovations
  - At least 1 Home visit on a continuity patient done and logged into New Innovations
  - At least 10 ICU patients logged into New Innovations
  - PGY2 research requirements complete
  - Satisfactory completion of rotations Blocks 1-13 (post-tests, assignments and evaluations)
  - In-Training Exam scores above 75th percentile for PGY year or Education Planning Committee (EPC) Individual Education Plan (IEP) requirements complete.

- **Graduation**
  - Application for ABFM Board Certification Exam completed and test date scheduled
  - Medical Records up to date
  - Satisfactory completion of rotations Blocks 1-13 (all post-tests, assignments and evaluations)
  - Completed Research/Scholarly activity project presented
  - Procedures logged into New Innovations
  - At least 10 continuity OB patients delivered and logged into New Innovations
  - At least 5 Home visits including at least 1 continuity patient done and logged into New Innovations
  - At least 15 ICU patients logged into New Innovations
  - All minimum numbers of required procedures completed and logged for OB, Surgery, GYN, FM, EM, Ortho, Sports Medicine
  - Exit interviews and survey completed

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3 EMPLOYMENT POLICIES (for Hours of Operation and Contact Information for Human Resources—click here: http://insite.floridahospital.org/hronline/locations/orlando.html)

Note: Residents are not considered regular employees since they are intentionally hired for a limited three-year period. Residents also do not accrue PDO, are not automatically entitled to bonuses and are not eligible for matching or employer contributions to the retirement fund. Benefits for residents are listed in the Resident Employment Agreement and may differ from what is listed in the Employee Handbook for Florida Hospital.

3.1 Florida Hospital Policies

Please refer to the Florida Hospital Employee Handbook
http://private.floridahospital.org/fhpp/fh_pp.nsf/WTOC?OpenView&Start=1&Count=2000&CollapseView

3.2 New Employee Orientation

New residents are expected to arrive one week prior to the week that includes July 1 for an orientation week. The orientation week will be considered "paid" time even though the employment contract start date will be July 1.

Residents are also expected to be certified in ACLS, PALS and NRP. If the resident is not already certified, they are to arrive two weeks prior to July 1 in order to participate in the certification classes for ACLS, PALS and NRP.

3.3 Personnel Records and Administration

Personnel records and documentation of residency experience are kept by the Program Coordinator. These include some or all of the following documents:

- ERAS application and associated documents
- Medical school diplomas and other documentation of educational experience
- Resident Employment Agreement
- Certifications (ACLS, PALS, NRP)
- Licensure applications and verification
- Mandatory education (CARE Facts, etc.)
- Malpractice insurance application and documentation
- Evaluation forms for all rotations as well as other evaluation forms not for specific rotations
- Portfolio including scholarly activity, presentations, accolades, awards, etc.
- Letters of Recommendation
- In-Training Exam scores/reports
- Education Planning Committee Education Plans (if applicable)

Personal medical records, if any, will be kept in the EMR of the Family Health Center and are confidential.

3.4 Change of Personal Data

Any change in an employee's name, address, telephone number, marital status, dependents, or insurance beneficiaries, or a change in the number of tax withholding exemptions, needs to be reported in writing without delay to the Program Coordinator.

3.5 Safety

The safety and health of employees is a priority. FHFMR makes every effort to comply with all federal and state workplace safety requirements.

Each employee is expected to obey safety rules and exercise caution and common sense in all work activities.

If your or your supervisor feels that you are too fatigued to drive home safely, arrangements will be made to ensure your safety. Please inform your attending, supervisor, Medical or Program Director if you find yourself in this scenario.

3.6 Building Security

Florida Hospital has its own Security department and officers. Parking lots are patrolled on a regular basis and security cameras are strategically placed in many areas.

If any resident would like a security escort when going to their car in the parking lot or if traveling over to the Behavioral Health building, they can call security at extension **1916** (or if there is an **emergency** extension **1515**)

3.7 Personal Property

Florida Hospital Volunteer Services department maintains a property management system that efficiently tracks lost and found property reports. Persons seeking information about lost or found property in the Family Health Center, may do so by contacting the Office Manager at **tie line 844-303-2855**. For items lost in the hospital, call **tie line 831-303-1772**. Florida Hospital assumes no risk for any loss or damage to personal property and recommends that all employees have personal insurance policies covering the loss of personal property left in the Family Health Center or in the hospital.

3.8 Health-related Issues

Residents who become aware of any health-related issue should notify their advisor and current preceptor/attending physician of health status as soon as possible (please see details in **Section 3.15**)

3.9 Resident Requiring Medical Attention

Any resident who is ill and will be unable to attend their normal work hours will contact the appropriate person as soon as they are aware of their inability to work. They should contact the ADULT FAMILY MEDICINE FACULTY ATTENDING ON-CALL between 5:00 PM and 7:00 AM including weekends/holidays. From 7:00 AM till 5:00 PM please contact the Medical Director of the Family Health Center or his/her designee. The Adult Family Medicine attending will contact

the Medical Director or his designee at 7:00 AM on the morning after call with the names of those physicians who are ill. When calling in sick, you MUST talk with a person. It is NOT appropriate to leave messages regarding this matter on any voice mail or answering machine. Page the person you are to notify.

Residents should also personally contact the peers and/or Senior with whom they are working that block as well as the Administrative Chief Resident to arrange for coverage of their responsibilities including call coverage if necessary.

Any resident, staff or faculty member who becomes ill during regular FHC working hours should contact the Medical Director of the FHC or his/her designee.

Any resident, who is sick for 2 or more days in a row, is requested to come and be seen in the Family Health Center on the second day unless otherwise directed by the Medical Director, Program Director or an Associate Director.

Residents should report all work-related injuries and accidents, including “needle-sticks,” immediately to their advisor and current preceptor/attending physician, and then follow the steps as listed in the Florida Hospital Blood borne pathogen policy.

3.10 Visitors in the Workplace

For safety, insurance, and other business considerations, only authorized visitors are allowed in the workplace. When making arrangements for visitors, employees should request that visitors enter through the main reception area and sign in and sign out at the front desk.

3.11 Weather-related and Emergency-related Closings

At times, emergencies such as severe weather, fires, or power failures can disrupt company operations. In such instances, Executive Staff will decide on the closure and Human Resources will provide the official notification to the employees. Disaster Plan details are listed in the

GME Manual

4 STANDARDS OF CONDUCT

4.1 General Guidelines

All residents are urged to become familiar with Florida Hospital Family Medicine Residency and Graduate Medical Education rules and standards of conduct and are expected to follow these rules and standards faithfully in doing their own jobs.

4.2 Attendance and Punctuality

FHFMR expects residents to be ready to work at the beginning of assigned daily work hours, and to reasonably complete their assignments by the end of assigned work hours.

4.3 Work Schedule

Office hours scheduling is in “half-day” blocks, the AM block is 8AM till Noon, and the PM block is 1 to 5:00 PM. PGY1 residents are scheduled for 1-5 half-days per week, PGY2 residents for a minimum of 2-5 half-days per week and PGY3 residents for 3-5 half-days per week.

Residents are expected to be present and ON TIME to see patients whenever they are scheduled. The schedule is generally published 3 months in advance, and entered into New Innovations. Residents are responsible for checking this schedule and knowing when they should be present. If there are any conflicts with other duties which were not noticed by those responsible for scheduling, the resident should notify the scheduling coordinator and/or the medical director of the FHC at least 4 weeks in advance of the date. Failure to do this will result in the resident being expected to be present for the scheduled office hours, and arrange for coverage of any other duties themselves.

4.4 Absence and Lateness

From time to time it may be necessary for a resident to be late or absent from work. FHFMR is aware that emergencies, illnesses, or pressing personal business that cannot be scheduled outside work hours may arise. It is the responsibility of all residents to contact all affected parties if they will be absent or late.

4.5 Unscheduled Absence

Absence from work for even one day without notifying FHC Medical Director, Program Director, advisor or preceptor may be considered a voluntary resignation. If this is to occur, the resident will be required to present the situation at the Associate Directors’ meeting.

4.6 Harassment Policy

Please refer to the Florida Hospital Employee Handbook. Policy #800.242

4.7 Sexual Harassment Policy

Please refer to the Graduate Medical Education Manual. GME Manual

4.8 Confidential Information and Nondisclosure

It is our legal responsibility to maintain confidentiality according to the Health Insurance Portability and Accountability Act (HIPAA). This includes information either written or electronically maintained. HIPAA uses the phrase Protected Health Information (PHI) which goes beyond the traditional medical record. It now includes medical and demographic information such as Social Security Number, Patient Name, Address, phone Number, Birth Date, or anything that could individually identify the patient.

Every reasonable effort must be made to disclose or use a minimum amount of information necessary to do our jobs. Clinicians may review the entire record of patients they are caring for and share information freely with other clinicians caring for the patient.

We must take every precaution to protect patient information such as:

- Page patients in a way that does not reveal the reason for their visit or medical treatment
- Do not leave medical or treatment information on answering machines
- Do not leave unattended medical/billing records where they could be readily seen by visitors
- Close doors when possible
- Draw curtains and speak as softly as possible
- Pay attention to conversations in the hallways, elevators, cafeteria where patients or visitors may be present
- Dispose of patient information properly in the hospital and the Family Medicine Residency by placing it in a shredding box located in the Family Health Center or in Florida Hospital
- Do not share your computer passwords and do not write them down and leave them where someone can access them
- Log off when leaving a workstation
- Never send PHI outside the Florida Hospital system via e-mail

There are many statutes governing the release of information to patients and others. If you receive a written or verbal request from patients or others to release information, refer these to the appropriate department, Family Medicine Residency Health Information staff or Florida Hospital Health Information staff. Refer any billing concerns to the appropriate billing department, Family Medicine Residency or FH Patient Financial Services.

Should the patient request that you not share their information with a spouse, family member, or another individual, you may assure them that we follow the policy of releasing only to the patient with the exception of parents of pediatric patients and guardians of incompetent patients.

4.9 Professionalism

A. Teaching Methods

i. Role Modeling:

- Faculty must act professionally at all times.
- Develop a list of professional behaviors (specific and measurable).

- Give permission to point out unprofessional behavior in ourselves.
- Develop a “culture of professionalism” in the residency.
- Observe appropriate boundaries between faculty and residents.

ii. Observation/Feedback

- Reward professional behavior.
- Correct unprofessional behavior.
- Set clear expectations (See list at the end of this document.).
- Feedback should be direct, timely, specific, and private.
- Feedback should be instructive and not demeaning.
- Feedback should be documented when appropriate.

iii. Formal Teaching:

- Should include all three years.
- Send list of behaviors/expectations to students who apply for residency positions.
- Discuss list and culture of professionalism during orientation.
- Use vignettes during PGY-2 and PGY-3 for small group or one-on-one discussion.
- Advisor/advisee one-on-one sessions to discuss vignettes during PGY-1.
- Vignettes from ACGME toolbox
- Vignettes from Loma Linda
- Vignettes we develop based on our own needs

B. Rotations
  i. PGY-1: advisor meetings to review the ACGME vignettes, Medicine Rotations.
  ii. PGY-2, PGY-3: advisor meetings to review FMI, FMO, Medicine Rotations.
  iii. Role modeling and observation/feedback occur in all settings at all times.

C. Marker Behaviors

- Honest and trustworthy
- Adheres to established ethical standards
- Recognizes, admits to and corrects errors
- Maintains patient confidentiality
- Punctual
- Performs assigned duties in a timely manner
- Reliably follows through on assigned tasks
- Completes charts in a timely manner
- Dresses appropriately
- Communicates appropriately with other members of the health care team
- Respectful of others
- Demonstrates care, empathy, and compassion
- Sensitivity to cultural differences
- Exhibits teamwork
- Accepts criticism and suggestions with a positive attitude
- Does not engage in substance abuse
- Provides leadership when asked to do so
- Responds promptly to emergencies and pages
- Demonstrates responsibility for patient care

D. Methods of Evaluation—based on observation and documentation of specific behaviors

  i. Observed behavior, professional and unprofessional.

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ii. Willingness to correct unprofessional behavior once it has been identified.
iii. Adherence to the formal curriculum described in 4.9 A iii above.
iv. 360 degree evaluation, including peer evaluation.

4.10 Dress Code

Please see the Graduate Education Manual. GME Manual

The following additions have been made:

- Scrubs are not appropriate for wear while seeing patients in the FHC.
- “Casual Friday” means that on Friday physicians may wear residency team shirts instead of the usual professional attire. ONLY residency team shirts are allowed on Fridays and are not to be worn when seeing patients or making rounds in the hospital.

4.11 Use of Internet

Residents are responsible for using the Internet in a manner that is ethical and lawful. Use of the Internet must solely be for educational and patient care purposes.

4.12 Alcohol and Substance Abuse

It is the policy of Florida Hospital that the workplace be free of illicit drugs and alcoholic beverages, and free of their use. GME Manual

4.13 Grievance Procedure

Please see the Graduate Education Manual. GME Manual

Disciplinary Policy

Please see the Graduate Education Manual. GME Manual

Dismissal Procedures

Please see the Graduate Education Manual. GME Manual

Exit Interview

At the completion of residency training, the graduating PGY3 residents as a group meet with the Behavioral Medicine Faculty for an “Exit Interview”. They also participate in filling an anonymous survey about the program. This exercise provides them an opportunity to give feedback about their experiences in the program plus making suggestions for improvement. During the last month of the PGY3 year, each of the graduating residents will meet with his/her advisor and the program director for a final “semi-annual” evaluation. Likewise, each has the opportunity to give feedback on the program.

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5 COMPENSATION POLICIES

5.1 Salary

It is Florida Hospital's desire to pay all Residents wages or salaries that are competitive with other residency programs in the marketplace. Compensation will vary based on PGY level and other responsibilities such as Chief Resident duties.

5.2 Payroll and Paydays

Residents are paid every two weeks on or by the Friday following the end of the pay period. Paychecks may be deposited directly in the resident's bank account if they so choose. That may be arranged during the orientation period or at any time thereafter.

5.3 Evaluation of Progress and Performance

The purpose of residency is to help a medical resident develop into a compassionate and competent physician. Accordingly, the program and its faculty regularly and thoroughly assess and evaluate how the resident is progressing toward that goal. The faculty "coach" and directs the resident on methods of improvement. When an area of weakness or deficiency is identified, an Individualized Education Plan (IEP) is developed for that resident through The Education Planning Committee (EPC) which serves the primary function of helping residents succeed in meeting the goal. The advisor, program director, and/or other faculty member often participate in this process.

See section 8 "Evaluation" for further details

6 BENEFITS

6.1 Health Insurance

Please see the Graduate Education Manual. GME Manual

6.2 Dental Insurance

Please see the Graduate Education Manual. GME Manual

Life Insurance

Please see the Graduate Education Manual. GME Manual

Continuing Education Allowance (CME)

Please see the Graduate Education Manual. GME Manual

6.3 Licensing and DEA

Please see the Graduate Education Manual GME Manual

Hospital Meals

Please see the Graduate Education Manual. GME Manual.

6.4 Parking

Please see the Graduate Education Manual. GME Manual

6.5 Payroll

Please see the Graduate Education Manual. GME Manual

6.6 Optical/Dental Reimbursement

Please see the Graduate Education Manual. GME Manual

6.7 Uniform Jackets

Please see the Graduate Education Manual. GME Manual

6.8 Professional Memberships

Please see the Graduate Education Manual. GME Manual

6.9 Book Allowance

Please see the Graduate Education Manual GME Manual.

6.10 Moving Expenses

Please see the Graduate Education Manual GME Manual.

6.11 Counseling Support

Please see the Graduate Education Manual. GME Manual

6.12 Expense Report Regulations and Process

Please see the Graduate Education Manual GME Manual

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7 TIME-AWAY BENEFITS

The Florida Hospital Family Medicine Residency Time Away Policy is based upon the ACGME policy regarding continuity of care. This policy states:

"Residents should develop and maintain a continuing physician-patient relationship with an undifferentiated panel of patients and their families throughout the 3-year period. The program must be structured to ensure that residents maintain such continuity at least throughout their second and third years of training. This continuity may be interrupted for a maximum of 1 month in the first year of training. During the last 2 years of training the resident may not be absent longer than 2 months in each year, and these 2 two-month periods may not be consecutive. After the first interruption, the residents must return to provide continuity care for their patient panels for at least 2 months before interrupting continuity again."

Time away from the residency program for educational purposes, such as workshops or continuing medical education (CME) activities, and leaves of absence are not counted in the general limitation on absences.

7.1 Holiday Call Schedule

For National Holidays, see Graduate Medical Education manual. GME Manual

The residency program honors the following holidays each year:

Holidays

Thanksgiving	July 4
Christmas	Memorial Day
New Year's Day	Labor Day

The call schedule will be arranged such that each resident will work on each of these some time during years PGY1-PGY3. In general, no resident shall be assigned the same holiday twice, with the exception of Christmas or New Year's Day.

The Administrative Chief Resident will be responsible for creating an equitable call schedule. As circumstances dictate, he/she may at times require residents to cover additional holiday calls to ensure patient care. The Chief Resident will publish in advance a schedule of upcoming holidays stating which residents will cover which duties on which days.

Compensation Days: When residents work during holidays honored by the residency program, they receive compensation days as follows:

- One (1) compensation day for working a holiday except for Christmas or New Years.

7.2 Personal Time

Resident time-off is all considered "Personal Time" rather than "vacation" or "sick" time.

Each resident is entitled to at least 10 working days per year for Personal Time but no more than 20 working days per year. These days may not be carried over to the following year and there is no monetary reimbursement for unused Personal Time.

If a resident is entitled to Compensation Days, for working a holiday, as described in section 7.1, these days may be used as additional personal days. Residents are responsible for keeping

track of the number of vacation and or compensation days he/she has remaining. A record will also be maintained by the Medical Director, but he/she will not be responsible for notifying the residents of their allotment.

In some cases, vacation days may be pre-empted (a half-day at a time up to 5 days) to complete delinquent medical records, at the discretion of the program director or faculty member assigned to oversee medical records completion. Serious delinquency to complete charting, rotation scheduling, and rotation evaluation may also result in time away not being approved.

Personal time may not be carried over from one year to the next. The Medical Director has the authority, in rare instances, to allow a small amount of personal time to be carried forward, provided it was not taken in the allotted year due to forces beyond the control of the resident. In this situation, all decisions of the Medical Director are final.

A resident may not reduce the total time required for residency (36 calendar months) by forgoing personal time off.

7.3 Vacation/ Time Away Rules

a) The number of Personal Days provided for PGY 1-3 is 20 working days per year.

b) Requests for vacation/time away must be available at least 3 blocks before requested time to properly handle patient needs.

c) Residents must have their rotations chosen at least 60 days after resident lottery to allow the schedule to continue 90 days out. We plan to publish the call/pager and FHC office schedule on the last day of the block, so as to keep 3 blocks in advance, at all times. (Thus block 6 will be published on the last day of block 2 so as to have blocks 4, 5, and 6 out during block 3. Block 7 will be published on the last day of block 3, block 8 on the last day of block 4, etc...)

d) A time away request will not be considered if the resident has not confirmed his/her rotation for that month. For PGY-2 and 3 residents, no time away will be approved until all electives have been chosen and approved up to the point when time away is requested.

e) A request is approved when it has the signature of the Medical Director and has been stamped “Approved” in the upper right hand corner.

f) Time away request must be submitted before that block’s schedule is published; otherwise you will need to have someone cover your office time in order for your time away request to be approved. If the request is for less than 3 blocks, then it will be considered only for emergency reasons, even with coverage. THIS WORKS OUT AS FOLLOWS:
   - If your request is for time in which the call/pager schedule has not yet been published, your time can be canceled as appropriate.
   - If your request is for less than 3 blocks in advance, it will only be considered for emergent or urgent reasons, and where possible should have coverage.

g) The Family Health Center (FHC) should be a **high priority** for all residents. Other schedules should be adjusted to ensure that FHC obligations are met. Patients should be rescheduled on an emergency basis only.

h) DME has developed a longitudinal calendar that will reflect upcoming activities such as PALS, ACLS, Mission trips, etc…

i) A maximum of 4 residents may be gone from any given team at any given time. A time away request may be denied if too many are already gone from a particular team.

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j) There must be at least 3 residents on the Family Medicine Outpatient (FMO) block for a time away request to be granted while on FMO rotation.

k) For core rotations, the family medicine faculty coordinator must approve a time away request **before** the request is considered by the Medical Director.

l) Emergency time away is at the discretion of the Program and Medical Director. This includes, but is not limited to: death in the family, significant illness in the family, personal illness or death, and obligations that could not reasonably be known in advance.

m) Only 1 month of time away (elective away, vacation, sick leave, etc.) is allowed at any one time, unless otherwise approved by the Medical director. A resident may not link a month of elective away with any vacation time or holiday time, to extend the period beyond two months.

n) There must be an intervening period of at least 2 months separating any 2 vacation months or other time away segments of more than 2 weeks.

o) A resident may not link June and July vacation times together. No two vacation periods may be concurrent (e.g., last month of PGY-2 and first month of PGY-3 year in sequence).

p) Vacation may not be taken during core rotations.

q) According to ACGME and ABFM, PGY-3 residents may not take time away during the final month of residency. Time away will not be granted during the month of June. Please plan accordingly. The last day or your residency responsibilities will be June 30.

r) Vacations during PGY-1 year are linked to the surgery rotations and are pre-determined by the rotation track schedule.

7.4 Requesting Elective Time Away

This refers to unique educational experiences available to second and third year residents which require the resident's absence from the FHC. This especially refers to geographic relocation for rotations. In general, residents are discouraged from using away rotations when similar rotations are available locally.

Leaves of absence from the residency, for academic rotations, exclusive of one month vacation/sick time, may interrupt continuity of patient care for a maximum of two (2) months in each of the PGY-2 and PGY-3 years of training. These types of leave of absence will not affect the length of the residency. Remote site training must comply with the ACGME "Special Requirements" and will not be affected by any leave of absence taken by a resident.

The resident may not be absent from the FHC for more than two months in PGY-2 and PGY-3, including elective away, vacation time, and sick time. The two months may NOT be consecutive. Elective time away must be submitted to the Medical Director for approval.

Before time away can be approved, a resident must be in good academic standing, based on clinical performance evaluations. In general an away elective will not be approved for residents on EPC. Forms are available to the faculty and preceptors, and if a resident is delinquent on finishing rotation requirements, that faculty/preceptor can fill out this form and send a copy to the Medical Director. Time away will not be approved until the Medical Director has received the time away form and has been notified that the delinquency has been completed.

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Charting, rotation scheduling and rotation evaluations must also be kept up to date. Serious delinquency of these will also result in time away not being approved.

7.5 Time-away Policies for Family Health Center (see section 7.3g)

7.6 Calling In Sick

See Section 3.15

7.7 Sick Leave

Please see the Graduate Education Manual GME Manual

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7.8 Conference/CME Days Off

The following number of days for conference is available PGY 1-3:

- *days for PGY-1
- 5 days for PGY-2
- 5 days for PGY-3

*(at the director's discretion)

Conference rules include:

- CME leave is not cumulative to the next year.
- First year residents are restricted to in-state conferences.
- Conferences must be accredited by the AMA or AAFP, and there must be at least four (4) hours of CME per conference day.
- The conference brochure must be submitted with the Time Away request form.
- Conference days must be approved by the Medical Director.

Please also see the Graduate Education Manual. GME Manual

Mission Trips

The Family Medicine Residency program encourages residents to participate in a mission trip at least once during their training program. There is an allowance in the budget for a certain amount of resident and faculty time to be away on a mission trip and this time is given on a first-come, first-served basis to qualified residents that have not yet participated in a mission trip. If a resident is part of one of these trips, their time is considered part of their training and therefore is not considered "time-off." However, residents that desire to go on mission trips a second or third time may have to use their own Personal Time to do so. Priority will be given to residents who have not yet gone on a mission trip. However, this policy does not prevent a resident from going on multiple mission trips if other residents decline. Expenses of the trip may or may not be the responsibility of the resident depending on the trip and availability of funding from other sources.

Mission trips are considered "Away Electives". They are limited to the one month away time, including vacations etc…in PGY-2 and PGY-3 years. PGY-1 residents are ineligible for mission trips. Mission trips are subject to all of the above time away policies. In addition, the resident needs to have the time away request signed by their faculty advisor and the associate director prior to submitting the request to the Medical Director.

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Residents must be considered in good standing in all areas free from any academic concerns or weaknesses. All inpatient and outpatient charts must be completed before leaving on a mission trip. Failure to do this will result in being ineligible for any future mission trips.

7.9 Family and Medical Leave/ Leaves of Absence

Leaves of absence (LOA) for illness or FMLA exceeding personal time may result in extension of your residency. Such LOA may not exceed three (3) months. LOA time must be made up before the resident advances to the next training level and the time will be added to the projected date of completion of the required 36 moths of training. A resident will be permitted to take vacation time immediately prior to or subsequent to a LOA.

In cases where a resident is granted a LOA by the program, or is away because of illness or injury, the Program Director must promptly inform the Board in writing of the date of departure and the expected return date. The resident may not return to the program at a level beyond that which was attained at the time of departure.

Leaves of absence in excess of three months are a violation of the continuity of care requirement. The Board may require the resident to complete additional continuity of patient care time beyond that which is expected to complete training requirements, in order to be eligible for application for certification.

Please also see the Graduate Education Manual GME Manual

Extended Sick Leave

Please see the Graduate Education Manual GME Manual

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7.10 Maternity Leave

Please see the Graduate Education Manual. GME Manual

7.11 Paternity Leave

Please see the Graduate Education Manual. GME Manual

7.12 Adoption Leave

Please see the Graduate Education Manual. GME Manual

Funeral Leave

Please see the Graduate Education Manual. GME Manual

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8 EVALUATION

8.1 Introduction

Residency training is a learning experience and as such must be thoroughly evaluated to determine satisfactory progress of the resident/learner through the process. This implies that every resident has areas that MUST be improved upon in order to qualify for board certification and to be considered ready to provide the highest quality patient care.

Florida Hospital Family Medicine Residency has developed a number of evaluation tools to assist the faculty and resident in assessing the progress of each resident as well as the effectiveness of the curriculum and the program as a whole in achieving this goal. Some of these will be self-evaluations by the resident, faculty evaluation of the resident on each block experience, resident evaluation of the block experience, resident evaluation of his/her peers, nursing staff evaluation of the resident, patient assessment of the resident and faculty assessment of overall resident performance done on a periodic basis.

The following is a description of each of the tools used currently.

Please note that evaluations of faculty or other residents are confidential and are reviewed only by your Program Director, Advisor and EPC (if deemed necessary). You are able to review your evaluations by meeting with the Program Director.

8.2 Evaluation Tools

1. Resident's Semi-Annual Evaluation.

a. Make sure all block rotation Evaluations (Preceptor of Resident, Resident of Rotation and Resident of Preceptor), have been submitted.

b. Update Procedure List on New innovations for insertion in your permanent residency file.

c. NOTE: The following will be reviewed and recommendations will be made:

- Evaluations, including preceptor comments, post test information and procedure lists.
- Review of evaluations listed above as well as Evaluations regarding Resident of Resident Peer, Staff of Resident (360°), and Patient Assessment of Resident Care
- In-Training Exam Scores
- Conference Attendance (minimum attendance 75%)
- Moonlighting activities
- Chart Completion (both inpatient and outpatient)
- Attendance of Critical Care and ALSO courses
- Status of Provider Cards (ACLS, PALS and NRP, etc.)
- Personal study plan (CORE Content Review, etc.)
- Event Cards, Confidential evaluations
- TB test status
- Focused Chiefing Items
  - Chart documentation
  - Time Management / Scheduling Issues
  - Interview Technique / Video Monitoring (Clinical and Behavioral)
  - Pharmacy Review (Medication Indications, Refills, Side Effects)
  - Billing / CPT Coding Issues

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- Clinical Assessment Skills
- Overall impression & comments

2. Policy for Evaluation of Faculty and Preceptors by Residents. At the completion of each rotation, an evaluation form will be completed by the resident. These evaluations are confidential and anonymous. Annually, the residents will be assigned an evaluation form through New Innovations to evaluate every faculty member for their teaching skills. If they have not had enough contact with any individual faculty member to adequately assess their skills, there is a box to indicate such.

3. Evaluation of Rotations by Residents. These evaluations will occur after each rotation is completed. Each resident will be given an evaluation form to be completed at the end of their block. These forms will be on New Innovations or are available at the DME receptionist's desk. They are to fill the forms out and return them to DME. They will be responsible for these forms at their Semi-Annual Evaluation.

8.3 Education Planning Committee

Mission:
The Florida Hospital Family Medicine Residency is designed to enable residents to achieve competency in the areas of: medical knowledge, patient care, professionalism, practice-based learning, communication and systems-based practice. These competencies are defined by the ACGME to ensure that residency training produces competent, compassionate, board-certified Family Physicians.

Purpose:
The purpose of the Education Planning Committee is to assist residents in meeting the requirements towards attaining the competencies set by ACGME. It aims to tailor the educational plans that meet the individual needs of residents who required the assistance of EPC, thus enabling them to successfully complete residency training in preparation for board certification.

Goals:

- Evaluate the areas of core competency that the residents to attain.
- Identify core competency areas in need of improvement and further development
- Outline an educational plan for achieving success in satisfactorily meeting identified core competencies
- Monitor and re-evaluate for achievement of goals and milestones during specified time frame

EPC committee members

- Chairperson: Must have at least one year of experience with the EPC committee
- Chief resident
- Behavioral medicine faculty
- Faculty members from medicine, obstetrics, family medicine, and pediatrics

Management of Residents Referred to EPC

IDENTIFICATION
There are four ways to identify residents as needing further evaluation through the EPC:

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- Executive faculty committee refers a resident for review
- Resident scores below the 25th percentile on the in-training examination
- Resident does not pass a block rotation
- Self-referral

NOTIFICATION
- EPC chairperson sends written notification to the resident and advisor of the resident's referral to EPC

REVIEW
1) EPC chairperson assigns a committee member to review the residents previous performance in medical school and the residency to date
2) Assigned EPC member and advisor discuss possible secondary causes with the resident

DEVELOPMENT OF REMEDIATION PLAN OR LETTER OF RELEASE
1) An in-depth evaluation is performed to determine need for remediation or release from EPC
    a. Letter of release is written if the EPC determines no further need for review
    b. Plan for method of remediation and evaluation is designed and approved by the committee
2) A learning contract is written by the committee and signed by the EPC chair.
3) The learning contract is approved and signed by the Program Director
4) The learning contract is presented to the resident and signed by resident and advisor

MONITOR
- The EPC committee monitors the resident for task completion and milestones reached in the outlined time-frame.

REASSESSMENT
1) The EPC reviews the resident after completion of remediation plan for determination of release, continued remediation or progressive action.
2) Letter sent to resident on status with EPC

Methods of evaluation
- Direct Observation
- Videotape/Audiotape
- Chart Review
- Activity Log
- Written Examination (In-training exam)
- Case Presentation
- Oral Examination
- Self-assessment
- Mini- CEX (Clinical Evaluation Exercise)
- Case Practicum (full H& P)
- 360 evaluations
- Block evaluations

Methods of remediation
- Challenger Program
- Physician support services
- Behavioral medicine coaching
- Mandatory attendance at various conferences
- AAFP board review questions
- Mentoring/role modeling by advisors
- Test taking courses
- Referral to other professionals for evaluation

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- Self-review of video-tape performance

Consequences for not complying with remediation plan:

1) Delay of completing required tasks by **30 days** – 2 additional calls per month until tasks completed
2) Delay of completing required tasks by **60 days** - Mandatory month of in-training review with delay of promotion to next residency year until tasks completed
3) Delay of completing required tasks by **90 days** – successive disciplinary actions to possibly include the following:
   a) repeat rotation
   b) retention to current year of residency
   c) dismissal from residency program

Attachment 1: In-Training Exam Policy

IN-TRAINING SCORES

75-100%ile
Earns 75 points for their jeopardy team
Qualifies for moonlighting, away rotations, and mission trips
Remediation: none required

50-75%ile
Earns 50 points for their jeopardy team
Qualifies for moonlighting, away rotations, and mission trips
Remediation:
1. Correct and return in-training missed questions for review with advisor within 30 days
2. Requested attendance at all in-training reviews

25-50%ile
Remediation:
1. Correct and return in-training missed questions for review with Advisor within 30 days
2. Mandatory attendance at all in-training reviews
3. Answer 100 board questions or alternative site agreed upon with advisor, and return them to Advisor within 60 days

≤ 25%ile
Referral to Educational Planning Committee (EPC) for evaluation of medical knowledge
Remediation:
1. Correct and return in-training missed questions for review with Advisor within 30 days
2. Mandatory attendance at all in-training reviews
3. Answer 100 board questions and return them to advisor within 60 days
4. Complete a full mock in-training and return it to your Advisor by 90 days

Consequences for not complying with In-training remediation plan:

1) Delay of completing required tasks by **30 days** – 2 additional call per month until tasks completed
2) Delay of completing required tasks by **60 days** - Mandatory month of in-training review with delay of promotion to next residency year until tasks completed

Note: Top scoring resident in each class receives 100 jeopardy points.

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Attachment 2: *Policy for residents with low in-training scores wishing to participate in extracurricular activities*

Residents must score 50th percentile or better on their in-training exam. If the resident scores less than the 50th percentile on their in-training exam, they must obtain a letter of support from their advisor recommending the specific extracurricular activity. This letter must address the remediation plan and how the resident's fund of knowledge will be expanded during this activity. Letters should be sent to the program director for final approval.

Extracurricular activities include:

a) Moonlighting
b) Mission trips
c) Leadership positions
d) Away rotations

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9 DOCUMENTATION OF EXPERIENCE

9.1 Procedure Logging

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. All procedures are to be documented in the New Innovations website. 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 entered on line:

a. **Patient's name, Age and Account/Medical Record Number** (needed to locate records)

b. **Date & Location Performed** (needed to locate records)

c. **Procedure** Specify if primary surgeon or first assist, etc.

d. **Preceptor** Someone who can verify your procedure. Not all procedures will necessarily be supervised after certification is achieved.

e. **Comments** Indications, complications, diagnoses, etc.

On the New Innovations website will be a list of procedures which should be documented with a corresponding number of supervised procedures to be done before certification is possible. Please note that you will not receive credit for a procedure, unless it is documented. This includes home visits and continuity OB deliveries and behavioral counseling consults.

**OB continuity deliveries* *consist of deliveries in which you are participating (directly or supervising) and have had at least one documented prior prenatal care visit. Prenatal care visits can be outpatient (clinic) or inpatient. If visits were inpatient, please document when and where you saw the patient. (I.e. Pt seen 12/8-12/29/2009 in PHRU and delivered 12/29/2009.)*

9.2 Rotational Experience Logging

Following is a List of Required Procedures to be logged in New Innovations as stated in section 9.1. (Many of these are specifically required by certain rotations—the number in the column to the right is the number arbitrarily set as a credentialing target)

Procedure	Target
Admission/Management - ICU	15
Anesthesia-Local/Digital	5
Bladder catheterization - female adult	3
Bladder catheterization - male adult	3
C-section	20
Casting of simple fracture	5
Cerumen removal	3
Cervical biopsy	5
Circumcision	10

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Colposcopy	30
EKG performance/interpretation	5
Endometrial biopsy	5
Endotracheal intubation	5
Episiotomy/repair (2nd degree)	10
Episiotomy/repair (3rd degree)	10
Examination-Ankle	5
Examination-Knee	5
Examination-Shoulder	5
Home visit	5
I&D	3
Induction/Augmentation of Labor	5
Internal fetal monitor placement	5
Intrauterine Pressure Catheter Placement	10
IUD Insertion	3
Joint injection/Aspiration	5
Laceration repair (multiple layers)	5
Lumbar puncture - adult	3
Lumbar puncture - peds	5
OB-Continuity Delivery (Vag. or C/S)	10
Paracentesis	3
Pelvic exam / pap smear	10
Reduction of shoulder dislocation	5
Skin biopsy	5
Splinting of sprains & non-displaced fractures	5
Sports Physical-Pre-participation	10
Sterile speculum exam/eval for ROM	5
Surgery - first assist	10
Thoracentesis	5
Tympanometry	2
Vaginal delivery	30

9.3 Moonlighting Policy

Moonlighting is a privilege extended to licensed residents to enhance their educational experience and to assist them financially during their training. The following stipulations are to be met to achieve the objectives and maintain moonlighting privileges:

1. All moonlighting sites must be pre-approved by the Program Director. Once a site is approved, it can be added to the list and will remain approved until deleted from that list. In order for a new moonlighting site to be approved, it must be submitted to the Program Director with objectives, times of moonlighting and documentation of insurance coverage.

2. The RA President is responsible for maintaining a roster of approved sites. This active file of moonlighting opportunities will be maintained in the RA President's office and updated as necessary.

3. The RA President will report directly to the Director of the Residency to assure compliance with policy objectives.

4. The RA President and Program Director should review the moonlighting activities on a

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regular basis with its members and with input from the various residents' experiences.

5. The resident must send a letter to the site's employer requesting locum tenens, along with a copy of the Moonlighting Policy. The latter must be signed and returned acknowledging receipt of our guidelines. This will coordinated by the RA President and Program Director.

6. The resident must fill out the moonlighting application, which can be obtained from the RA president, and have it approved by the Program Director prior to moonlighting.

7. Moonlighting activities must not interfere with Residency work and night call. Therefore, moonlighting should not commence prior to 5:30 p.m. on weekdays.

8. Moonlighting on weekdays is limited to a maximum of 20 hours per block for senior residents on core inpatient rotations (Medicine, Pediatrics, Obstetrics and Family Medicine Service).

9. Moonlighting activities are limited to a maximum of 50 hours per block. The resident must maintain a total average of 80 hours, or less, worked per week over the 4 week block period.

10. No moonlighting is permitted during the intern year.

11. Malpractice insurance coverage by the employer must be documented. Residents must understand that each future employer will require documentation of all past malpractice insurers, so it behooves each resident to have a copy of their malpractice insurance policy for each employer and check that the employer provides "tail coverage".

12. The faculty of the Residency will not provide any urgent consultation or medical support to the resident at a moonlighting site. The site employer must provide any appropriate consultation and supervision. However, faculty on call is available for phone discussions for teaching purposes.

13. A record of ALL moonlighting activity should be turned into the RA President and Program Director for review. Also, a copy of this record should be entered into the resident's file as part of the bi-annual evaluation.

14. Resident qualifications to moonlight must include the following:

- **a.** Licensure by the State of Florida;
- **b.** Certification in ACLS, PALS and Neonatal Resuscitation Program (NRP);
- **c.** Satisfactory completion of all rotations with no pending requirements; and
- **d.** Be in good standing and not on probation and score 50th percentile or greater on the In-Training exam. Any score less than 50th percentile will require a letter from the resident’s advisor approving their participation in moonlighting. This letter must also be approved by the Education Planning Committee and the Program Director. A copy of this letter must be placed in the resident’s permanent file.

In summary, it is our intention that moonlighting will enhance the residents’ medical knowledge, clinical judgment and educational experience and assist them financially during their Residency training. It must be understood that moonlighting is a privilege and if ever the resident's education and Residency responsibilities are compromised, the resident's moonlighting

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privileges will be altered. Persistent poor performance at the Residency or non-adherence to its policies will result in termination of moonlighting privileges.

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10 CONFERENCES

1. Expected Attendance - at least 75% of total offered. Residents must sign-in prior to 12:30 to have a valid attendance.

2. Procedure followed for Attendance < 75%

   a. Attendance Reviewed Quarterly

      i. If <75% (first time), a warning issued. Record will be reviewed monthly

      ii. If <50% (first time), one extra call/month will be assigned. Record will be reviewed monthly

   b. Subsequent Monthly Reviews

      i. If <75%, one extra call/month assigned.

      ii. If <50%, two extra calls/month assigned, and monthly reviews will be continued.

3. Outline of Responsibilities

   a. Resident Advisors Responsibilities

      i. Be provided with the attendance record.

      ii. Review deficiencies with resident and determine existence of potential excuses.

      iii. Notify the chief resident if resident is subject to "extra call" assignment.

11 DUTY HOURS (http://www.fhgme.com/gmemanual.pdf)

A resident's work schedule will vary widely dependent on the PGY level, the rotation the resident is on and the unique patient care needs at the time. However, there are very specific Duty Hour restrictions we must comply with as a residency program. Specifically:

- A limit of 80 hours per week, averaged over a four-week period
- A resident must have one day in seven free from all educational and clinical responsibilities, averaged over a four-week period
- At least 10 hours rest time between all daily duty periods and after in-house call
- When a resident is on duty for 24 consecutive hours he/she may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, to conduct outpatient clinics or to maintain continuity of medical and surgical care.
- For description of full duty hours regulations, see http://www.acgme.org/acWebsite/dutyHours/dh_Lang703.pdf

12 INPATIENT RESPONSIBILITIES

Residents on core services will be given handouts describing responsibilities for PGY 1-3 years. Please see these handouts for full details. As these policies will likely change more

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frequently than this manual is updated, maintaining such guidelines here would be impractical.

12.1 CALL RESPONSIBILITIES

The call schedule will be made 3 blocks in advance. Preferences for call on/off must be submitted to the Medical Director 3 blocks in advance.

R1 call duties extend from 7 am - 7 am on Saturdays and Sundays. On Monday through Friday nights a night float system is in place. Night float interns on Med/Peds are scheduled from 5:30 pm –7am. Medicine interns are expected to stay at the end of the shift until 7 am for Morning Report.

R2/R3 night call duties extend from 5:30 pm - 7 am on Fridays, and from 7 am - 7 am on Saturdays. Sunday there is a “short-call” that runs from 7 am –5:30 pm at which time the senior night float resident begins their shift. Senior night float on Medicine and OB runs from 5:30 pm – 7 am Sunday night through Thursday night. The medicine senior on night float is expected to stay at the end of the shift until 7 am for Morning Report.

The following Call Beepers are designed as "Code Beepers": 3316 - Medicine Intern Call, 3320 - Senior Medicine Call. These beepers must be worn at all times by on-call medicine residents and kept "charged" and functional. 1833 – FMI/GIT Call. 5511 – OB Intern Call and 4724 – OB Senior Call. 2661 – Pediatric Intern Call and 1662 – Pediatric Senior Call.

REMEMBER--***Medicine/Pediatrics***: Faculty MD available from home at any hour for resident questions. Attending will come into hospital if needed. ***OB Attending***: In house at all times.

12.1-1 ORGANIZATION OF PGY-1 CALL SCHEDULE

Call rotates among all PGY-1 residents on internal medicine and pediatrics. Each intern does one week of night float per block rotation in medicine and pediatrics. Weekends are covered as regular call by the interns not on night float. OB call rotates among all PGY-1 residents on obstetrics. With changing residency circumstances, residents from Surgery or Emergency Room (ER), or other rotations may be at times placed in the OB call schedule. Average call will be every third or fourth day.

Medicine call responsibilities will include the following:

i. Initial, supervised work-up of all medicine and pediatric admissions.

ii. Response to all Code Blue pages, when holding the Medicine Call pager.

iii. Response to in-house nursing calls. However, resident are not responsible for pronouncement of death except when personally involved in code situations.

iv. Due to the OB patient population, intern duties are somewhat different on OB call. They are as follows:

- Work-up of FMR and CHC OB admissions, for women with an 24 weeks >EGA >34 weeks
- Management of labor and the delivery
- Assistance at C-sections, if senior unavailable

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- Response to nurses concerning postpartum patients
- Evaluation of patients in L&D Exam Room
- Attendance at newborn resuscitations whenever possible

v. Other duties that may be assigned by the senior admitting resident

PGY-1 Surgery and Emergency Medicine Call

Each surgery/EM intern takes OB Intern call for one night per week on average. The resident is expected to respond to calls on surgical patients at the direction of the surgery attending physician during the day, Monday through Friday.

12.1-2 ORGANIZATION OF SENIOR (PGY-2/3) CALL SCHEDULE

General Principles

i. In general, PGY-3 calls will be less frequent than PGY-2 calls. The schedule will be arranged so that R3 residents will take 1/3 of all senior calls, and PGY-2 residents cover the remaining 2/3. All categories will be split in this manner.

ii. The medicine senior residents will alternate weekends to round.

iv. All other senior residents will participate in the call schedule providing coverage for the rest of the senior medicine, peds and OB call.

v. Seniors should call attending on all admissions. No senior should hesitate to call an attending, regardless of time of day, if any questions regarding patient care arise.

vi. PGY-2 seniors will take 2 weeks of OB night float and 2 weeks of medicine night float. PGY-3 seniors will also take 4 weeks of night float, but this will be distributed between OB, Pediatrics and Medicine depending on the preference of the resident and service needs.

Senior Call

Responsibilities shall include the following:

i. Supervise admission work-ups by PGY-1 and manage ER evaluations.

ii. Write notes on all admissions and co-sign admission orders on weekends and for ICU admissions.

iii. Ensure all transfers are accepted by attending on-call, prior to transfer. Please do not accept transfers yourself, but direct calls to the attending on call.

iv. Supervise activities of the Call Team so that responsibilities are equitably shared in the interest of good patient care and resident education.

v. Medicine seniors may call in the backup resident (Pediatric Senior) when overburdened to ensure that responsibilities are met in a timely manner.

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vi. Pediatric seniors will respond to and document all FHC phone calls as well as respond to call regarding restraints. (See section 12.2 for more information regarding Restraints).

vii. OB seniors will cover high risk FMR OB admissions (24 weeks < gestational age <34 weeks) and calls regarding high risk OB patients in addition to supervising the OB interns. It is imperative that all patient information is discussed with the OB attending.

Night Float:

Night float begins at 5:30 p.m. Please be prompt in getting the pagers from the day residents. Specific night float expectations will be discussed on each core rotation.

12.1-3 EMERGENCY ROOM ISSUES

A large portion of a residents call time will be spent in the emergency room (ER). The following issues are important to remember:

- When documenting ER evaluations, residents should remember that the ER sheet is a legal document and incomplete or illegible records may prove embarrassing at a later time. Carefully document telephone consultations with the attending physician as well as discharge and follow-up instructions. "Progress note" pages may be used if additional space is needed.

- Pediatric patients that come to the ER for any reason will be seen by the ER physician and, if admission is needed, the Pediatric resident/attending is called.

- Florida Living Center and Mayflower patients requiring ER evaluation will initially be seen by the ER physician. If they need admission, the appropriate Senior will be notified and the patient will be admitted to the Family Medicine Service if followed in the nursing home by a FMR resident or attending.

- The following ER follow-up issues should be kept in mind:

a. Patients seen by the ER physician needing prompt follow-up in the FHC will be given a “referral” by the ER secretary. This will include a phone number to call and what to tell the FHC secretary, allowing them to be worked into the schedule. Ensuring that patients call before arriving will avoid confusion.

In addition, patients should be made aware that the physician who cared for them in the ER may not be available to follow them in the FHC and that care may be provided by another physician. Other referrals to the FHC will be given appointments as our schedule allows.

b. FHC patients will need an appointment with their primary care resident after evaluation in ER.

c. Cigna/CentraCare (or other outside managed care plans) patients will need appointments with their respective physicians.

Residents need to state the attending's name whenever dictating hospital history and physicals and clinical summaries (i.e., "This is John Doe, M.D., dictating. The attending physician is John

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Fleming, M.D."). We are unable to bill without the attending's name.

12.1-4 CROSS COVERAGE OF RESIDENCY PATIENTS.

To improve the cross coverage of mutual patients (East Orlando Residency and Florida Hospital Family Medicine Residency patients), please keep the following points in mind:

When residency patients from either program present to outpatient departments of either facility for diagnostic studies (radiology, laboratory, Women's Medicine, etc.) and they require emergent treatment, these patients should be directed to the Emergency Room for evaluation by the ER physician. If hospitalization is required, the patient may be transferred to their primary care physician if stable or admitted to the resident service in the facility to which they presented.

12.2 POLICY FOR BEEPER COVERAGE FOR MEDICINE SERVICE

1. All calls for admissions through the ED, whether for IM or FM are called to pager # 3320. The resident carrying that pager is responsible to contact the proper resident to notify them of the admission.

2. After 1pm on Saturday and Sunday, the resident carrying pager #3320, whether it is an IM or FM resident is responsible for all admissions. The FMI/GIT admissions during that time will be transferred to the FMI/GIT team the following morning. Following the 5:30pm transfer to the night float teams, every night, the night float residents are responsible for all admissions with FMI/GIT admissions admitted to those services (directly on Sunday through Thursday night and transferred the next morning if Saturday or Sunday night) and the Medicine admissions admitted to the proper Medicine team.

3. The FM resident rounding Saturday and/or Sunday morning, holding pager #1833 during that time, will be responsible for FMI/GIT admissions. If they are completely done with all their work before 1pm, they do NOT have to remain in the hospital but MUST return for an admission if needed and MUST return to turn over the pager at 1:00pm. During these set hours, if an IM resident is holding pager #3320, they will page #1833 notifying them of any FMI/GIT admissions.

4. Residents from both programs will be educated on the paging protocols and phone system, so that calls from nursing staff are returned consistently and in a timely manner.

BEEPER AND PHONE SYSTEM TIPS

- If calling a Medical Plaza extension from the hospital – dial 844 – then 7 digit extension
- If calling a hospital extension from the Medical Plaza – dial 831 – then 7 digit extension
- The 7 digit extensions start with either 110 or 303. If you are paged with a 4 digit extension only, try adding either 110 or 303 when returning the page
- Beepers with 4 digits: dial 87 then follow prompting, making sure to include the full 7 digit extension and tie line if appropriate
- Beepers with 4 digits offsite: dial 407-303-5599 then follow prompting
- Beepers with 7 digits: dial 91 – 407 and dial as local number
- Local calls: dial 91 – 407 and number
- Long distance calls: dial 90 – 1 and rest of number starting with area code

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12.3 RESTRAINT POLICY

Psychiatry Department Behavioral Restraints through Family Medicine Resident Call Coverage

Pediatric Senior Resident (beeper 1662) is assigned to manage behavioral restraints for psychiatry department after hours, weekends, and holidays. If the pediatric senior cannot initiate restraints in the required timeframe, the Med senior should assist, followed by the OB senior if the Med senior is unable to assist.

Responsibilities:

a. Initiate order for restraint after competent nursing assessment

b. Face to Face evaluation within 1 hour

c. Documentation:
Need for restraint: violent/aggressive behavior
Vital signs – RR
Cognitive evaluation – alert, responsive, agitated
Skin integrity/circulation – No injuries, neurovascularly intact
Restraint – restraint positioned correctly and intact

d. Continuation of Restraint Order - verbal
At four hours if age ≥ 18
At two hours if age 9–17
At 1 hour if age <9

e. Re-evaluation of patient in restraint – Face to Face
At 8 hours if ≥ 18
At 4 hours if < 18

f. Re-order restraint if patient fails trial out of restraint – verbal

g. Whose on First for Restraints?

Pediatric Senior—Beeper 1662

Emergency Back-up—FMI senior 1833

13 OUTPATIENT RESPONSIBILITIES

The FHC must be the center of the education for the Family Medicine resident, as it represents the overwhelming majority of where family medicine doctors spend their professional time.

13.1 Chiefing and Video Monitoring

Each resident is assigned to a chief on the chiefing schedule and is expected to chief their patients with that faculty member. If the chief assigned is busy, it is not acceptable to utilize another chiefing faculty unless that faculty has less than four residents assigned to them during that half day.

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All resident charts must be co-signed by faculty. When the residents attempt to close their charts in EPICare, a screen will pop up asking the resident to designate a co-signer. The co-signer will be the chief assigned to the resident for that half-day. A list of the faculty responsible for co-signature will be posted in the chiefing rooms on the respective sides. If there are any questions regarding who should co-sign your chart, please ask the nurse coordinator on your side.

All residents will be video monitored at some point during their residency either by the clinical attending faculty or the behavioral medicine attending faculty. Most of the time the resident will be informed in advance of any monitoring, but the faculty maintains the right to monitor without notice.

13.2 Resident Duties

PGY-1 Resident Duties: PGY-1 residents begin the year with a maximum of 4 patients in the half-day, and end the year with a maximum of 8 patients in a half-day. They are expected to present EVERY patient to their attending for the day. During the first 6 months of their residency, the attending must see every Medicare patient. After the first six months, the attending need only see the Medicare patients who will be charged a level 4 or 5. PGY1 residents are encouraged to discuss billing and charting with the attending.

PGY-2 Resident Duties: PGY-2 residents must chief all OB, Medicare, Medicaid and Medipass patients with the attending, as well as any patients they have questions about. The attending needs to see any Medicare patient who will be charged a level 4 or 5. PGY2 residents are encouraged to take an active role in choice of billing code, and are expected to be competent with charting on our current EMR.

PGY-3 Resident Duties: PGY3 residents must chief all OB, Medicare, Medicaid and Medipass patients with the attending, as well as any patients they have questions about. The attending needs to see any Medicare patient who will be charged a level 4 or 5. PGY3 residents are expected to be competent with charting on our current EMR as well as choice of billing code. PGY3 residents are encouraged to practice as independently as possible, although immediate supervision is always available.

13.3 Charting

The Family Health Center uses an electronic medical record (EMR). Residents are encouraged to learn to chart concurrently with patient care. Ordering labs, x-rays and medications during the visit is a must, and charting the note during the visit aids in efficiency. Charts are expected to be completed within 48 hours of the visit and any charts still “open” after this will be considered “Delinquent”. Failure to complete the charts within 48 hours will result in loss of one-half day vacation time in order to complete the records. For purposes of this policy, only working days are counted.

In addition to the note for the day, the following parts of the chart need to be kept up to date:

- Medication List
- Problem List
- Histories
- Appropriate Diagnoses
- Appropriate Charges
- Physician’s “in basket” which is the area where patient messages, staff messages, refill

requests, lab results and notation of overdue results
- Pain Management

Florida Hospital Family Medicine Residency Guidelines for the prescribing of controlled medications

1. Carefully evaluate the patient's complaint which may require controlled medications: *(Strong recommendation, low-quality evidence)*
   a. A complete history of the problem and assessment of the impact of the problem on the patient including:
      - History of present illness including past evaluations and treatments
      - Psychiatric history including current psychiatric evaluation
      - History of substance abuse and treatment
      - History of controlled medication use including type and dosing of previous medications, reactions, and reasons for success or failure of medications
      - Co morbid conditions (e.g. depression)
      - Complete medication list
      - Pertinent physical exam

   b. Obtain old records regarding the diagnosis for which controlled medications are required.
   c. Order appropriate diagnostic tests.
   d. Arrange referrals as indicated.
   e. Determine a working diagnosis which is as specific as possible. Avoid general terms such as headache or back pain. Enter it on the problem list.

2. If considering starting opioid therapy, use the DIRE screening tool to assess potential efficacy as well as harm. *(Strong recommendation, low quality evidence)*

3. Establish an overall treatment plan with appropriate goals and objectives. Goals should include the reduction, not necessarily elimination, of symptoms, and increase in patient function. *(Weak recommendation, low-quality evidence)*

4. Remember to use all available treatment modalities including:
   (Strong recommendation, moderate quality evidence)
   - Physical therapy
   - Occupational therapy
   - Exercise program, weight loss
   - Acupuncture
   - Manipulative techniques
   - Psychotherapy
   - TENS unit
   - Injections

5. Treat depression and/or anxiety as indicated. *(Strong recommendation, moderate quality evidence)*

6. Consider "adjuvant" medications: *(Strong recommendation, low quality evidence)*
   - tricyclic antidepressants
   - SSRI's
   - duloxetine (Cymbalta)
   - carbamazapine (Tegretol)
   - gabapentin (Neurontin)
   - lamotrigine (Lamictal)
   - pregabalin (Lyrica)

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7. You are not obligated to prescribe controlled substances. Just because a new patient was previously treated with controlled medications does not mean that it is the best treatment for this patient. The Florida board of Medical Examiners states:

- The Boards consider "prescribing, ordering, administering, or dispensing controlled substances for pain to be for a **legitimate medical purpose if based on accepted scientific knowledge** of the treatment of pain or if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal laws."
- The Boards "will judge the validity of prescribing based on the physician's treatment of the patient and on **available documentation**, rather than on the quantity and chronicity of prescribing."

8. Using Medications for chronic non-malignant pain:
(Strong recommendation, low quality evidence)
    i. Use frequency of pain to determine type of medication to employ. Significant pain > 4 days per week may require long-acting pain medications.
    ii. Recognize the toxicities of non-narcotic pain medications.

Non-controlled pain Medications	Potential side-effects
NSAIDs:	❖ 0.2% end-stage renal disease per year ❖ 2-4% duodenal or gastric ulceration per year ❖ Block effects of diuretics, ACE-inhibitors, β-blockers ❖ May cause Hypertension or edema ❖ Among the elderly, the chronic use of NSAIDs is not recommended.
Acetaminophen	❖ Hepatotoxicity

    iii. In general, use short-acting narcotic pain medications only for intermittent pain that is not relieved by non-narcotic medicines.
    iv. Consider long-acting opiates when the patient has a clear pain diagnosis, constant pain, pain associated with significant disability.
    v. Have a plan for common side effects (e.g. constipation)

9. All patients on chronic opioid therapy should sign a pain contract. *(Weak recommendation, low quality evidence)*

10. Periodic random urine drug screens should be performed on all patients on chronic opioid therapy. *(Strong recommendation, low quality evidence for patients who are at high risk for abuse of medications)*

11. Follow-up visits should include subjective as well as objective measures of the effectiveness of the controlled medication. These measures may include: *(Strong recommendation, low quality evidence)*
    - objective pain scale
    - activities of daily living
    - social function
    - occupational function
    - etc.

12. The COMM screening tool should be used at follow-up to help identify patients who may be misusing their opioid medications. *(strong recommendation, low quality evidence)*

13. Chronic opioid therapy may be tapered and discontinued for several reasons: *(strong recommendation, low quality evidence)*

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- Satisfactory analgesia has not been obtained
- Underlying pain has improved as a result of surgery or other interventions
- Patient prefers not to continue therapy
- Patient experiences intolerable adverse effects
- Patient engages in aberrant drug related behavior or drug abuse

Florida Hospital Family Medicine Residency Controlled Medication Policy

- Any prescription for a controlled medication will be reviewed by an attending physician at the time of the patient's visit.

- All patients requesting chronic pain medications (in general, three consecutive months) must have a documented history (per medical records) of a medical condition requiring controlled substances. No chronic pain medications will be prescribed to new patients until medical records have been obtained.

- All patients who are prescribed chronic pain medications will sign a controlled substance contract. All pain contracts must be renewed annually. These are found in the letter section of the EPIC chart.

- The problem list will be updated to include the diagnosis of chronic pain (338.29), list the condition requiring narcotics, and dates of pain contract and last urine drug screen.

- Unannounced urine drug testing will be performed at the time of contract signature, and at least twice in any twelve month period.

- Controlled medications will not be prescribed after office hours or on weekends. In general, controlled medications should not be prescribed over the telephone. This may require monthly visits for most patients. If they cannot see their PCP, they should see someone from their team.

- All patients should be given prescriptions for enough medication to last until their next scheduled visit to avoid call-ins for medication. In general, controlled medications will not be refilled early.

- Follow-up visits for patients on controlled medications must be done on a monthly basis unless approved by an attending and noted in the problem list of patient's appropriateness for less frequent visits.

- Combined use of benzodiazepines with chronic pain medications may only be prescribed in conjunction with a psychiatrist. In general, benzodiazepines will not be prescribed by FM residents for chronic use with narcotics.

- All violations of the controlled substance contract must be discussed with an attending physician and is grounds for patient dismissal. These patient names should be forwarded to the practice manager for review.

Test Follow-up: ALL labs, x-rays and other orders require follow-up to assure that a physician reviews the results. Physicians are expected to review their in-basket (EPIC and DME) at least daily, review results, and then do appropriate follow-up on each one. Orders with no results, after an appropriate period of time, will come to the physician's in-basket as an "overdue result". The physician should review these and notify the patient, by phone or letter as appropriate, to have the test done. Communication with patients post visit is a priority, not only for test follow-up, but in such things as reviewing patient messages frequently (at least daily as a minimum) and responding appropriately.

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Health Maintenance: Health maintenance or "preventive medicine" is one of the few items that has good evidence that it reduces mortality. Thus, we have an "every patient, every time" approach to preventive care, rather than doing it once a year. We use the mnemonic: ADDWITHGOD to help everyone remember what to do. (the description is noted elsewhere)

13.4 Team Continuity

The FHC has 4 teams—Blue, Green, Yellow and Red. Each team is divided into four sub-teams consisting of a resident from each PGY level. In order to maximize continuity of care and teamwork, it is strongly recommended that when a patient cannot see their assigned resident, they see physicians on the same sub-team first and if that is not possible then one of the same color team physicians.

13.5 Home Visit Policy

It is expected that all residents will make at least five (5) home visits by the end of the third year. Home visits are to be chiefed with the Resident Advisor or other appropriate faculty member.

Purpose: To promote and document the Home Visit experience family medicine resident physicians.

Frequency: At least one scheduled during the PGY2 Geriatric Inpatient/FMI rotations and the remainder scheduled during the PGY3 and Geriatrics rotations.

Scheduling: Resident will forward patient information via Epic In-Basket to Assistant Practice Manager who will coordinate scheduling of the home visit with the patient, resident and faculty. The Practice Manager will print the last patient visit, complete the necessary tracking form and coordinate the preparation of the physician's bag for the date of the visit. Directions to patient's home will be included in the packet of information for the Resident/Faculty.

Methodology: Home visits should not be made alone. The resident physician should be accompanied by another health care provider such as faculty member or Home Health nurse.

Billing: A fee for the home health services by the resident physician can only be submitted if a physician faculty member is present.

Documentation: The home visits must be documented in the Family Health Center record. Visits are to be chiefed by the resident's advisor or other faculty member.
Documentation is also required in the resident's personal log in New Innovations.

14 QUALITY ASSURANCE AND SCHOLARLY ACTIVITY

Two (2) weeks of research elective can be requested for both research or scholarly projects but must be pre-approved by Research Director.

ORLANDO CAMPUS RESEARCH DIRECTOR: J Keehbauch, MD

RESEARCH PRECEPTOR: Faculty of choice

PROCESS:

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This requirement will be accomplished through one-to-one mentoring by faculty of choice and/or team work with peers and staff. The resident will also be responsible for completion of certain tasks on their own or through guidance from faculty and research coordinator.

GOAL:

Upon completion of the required research/scholarly activities, the resident will fulfill ACGME requirements of scholarly activities of developing the skills in locating and communicating sources of scientific data pertinent to patient care, analyzing research design and statistical methods, obtaining information about diagnostic and therapeutic effectiveness and applying evidence-based practices to their patient panels.

REQUIREMENTS:

In order to graduate from the Family Medicine Residency Program, residents are required to complete:

1) QI Projects
   → 1 QI Project/ year/ team
   - Each team (Red/Yellow/Blue/Red) will be required to conduct a QI project of their chosen topic.
   - Roles of the team: R1 – observe, R2 – participate, R3 – Lead/Mentor.

   → Final presentations April/May - presented by the Graduating Senior residents annually.
   - Presentations should be 10 minutes with 5-10 slides:
     1 – Title, 2 – Background/Context, 3 – Design/ Methods,
     4 – Outcomes/Results, 5 – Lessons learned/Conclusion.

2) Brief Evidence-based Appraisal of Research (BEARS)
   → PGY1 = 1 (1 in FMO)
   → PGY2 = 2 (1 in FMO; 1 in FMIG)
   → PGY3 = 2 (1 in FMO; 1 in FMI)

** ***All PICO/BEAR worksheets must be signed off by the attending of the corresponding rotations. Residents are responsible for dropping off a signed off copy of the PICO/BEAR worksheet at Research Coordinator's mail folder at DME at the end of the corresponding block.***

3) Scholarly project
   → Conduct research project - investigator initiated, ***or***
   → Write a case report submitted for publication in peer review journal, ***or***
   → Prepare literature review article submitted for publication in peer review journal, ***or***
   → Conduct a QI project, ***or***
   → Present a poster or an oral presentation at a regional or national conference, ***or***
   → Any scholarly project not listed above, needs to be approved by Research Committee.
   → To be completed by April 1 PGY-3

4) IRB certifications-Collaborative Institutional Training Initiative(CITI) & CV
   → IRB certifications are to be completed by the end of PGY-1 FH Surgery Rotation
   → One (1) ½ day research rotation will be given during FH surgery rotation to complete requirement.

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EVALUATION:

1) Completion of items 1-4 listed in the requirements section upon graduation.
2) Present an oral or poster presentation of chosen scholarly activity project to peers during research week in PGY-3 – In April
3) Submit a written paper in a publishable format on the chosen scholarly project prior to graduation – Due June 1
4) Present Team QI project to program during research week in PGY-3

REQUIRED READING/RESOURCES

- Collaborative Institutional Training Initiative Course – www.citiprogram.org

RECOMMENDED READING/RESOURCES

- Practice Based Research in Family Practice (AAFP)
- Florida Hospital Institutional Review Board Handbook
- International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals: Writing and editing for biomedical publication. http://www.icmje.org/
- Outlines and articles of how to write up case report, literature review, or scientific papers are available through research coordinator.
- Guidelines on how to prepare presentations will be provided.

Note: QI projects are not subjected to IRB approval as they are not intended to be "generalized" to outside practices, or to be published. However, potentially publishable projects are strongly encouraged to obtain prior IRB approval even if it is a pilot study.

INSTITUTIONAL REVIEW BOARD (IRB) CERTIFICATION COMPLIANCE REQUIREMENTS

Please submit the following documents to Research Coordinator by the end of your Surgery Rotation during PGY-1.

Please submit the following documents to Research Coordinator by the end of your Surgery Rotation during PGY-1.

1) Current CV
- signed and dated at top right corner of front page

2) Completion of Collaborative Institutional Training Initiative (CITI) Program
- www.citiprogram.org
- Once registered, go to Florida Hospital group.
- Select Biomedical, Social & Behavioral Focus
- Complete tutorial Question# 1 (Select GME Resident/Fellows Program)
- Complete tutorial Question# 2 (HIPS) (Select GME Resident/Fellows Program)
- Print out your course completion report

3) Current Medical License or Training Certificate

IMPORTANT REMINDERS
FOR RESEARCH OR PUBLISHABLE PROJECTS

1) ALL research projects must be submitted to the Office of Research Administration (ORA) and Institutional Review Board (IRB).

2) DO NOT begin study until IRB approval has been obtained.

3) Data collected prior to IRB approval cannot be included in the current research.

4) Any changes to a research protocol and/or investigators must be submitted to and approved by IRB.

BASIC REQUIREMENTS FOR RESEARCH PROJECTS

1) IRB/FDA Requirements:
Collaborative Institutional Training Initiative Certificate, CV, License

2) Proposal – Guidelines for case report, clinical trial, prospective & retrospective observational proposal are available through Research Coordinator or through the Office of Research Administration website.

3) IRB & ORA Applications (contact Research Coordinator to decide which forms are needed pertaining to your project).

- All documents should be typed and submitted to Research Coordinator electronically.

15 ROTATION POLICIES

15.1 General Guidelines

A lottery is performed to schedule required and elective rotations (PGY-2 and 3). Any trading of required rotations must be approved by the Rotation Coordinator and Chief Residents. Intern rotations are placed on a track schedule and are chosen on a first come first serve basis.

Staff in the Department of Medical Education can provide a list of past approved electives. If you would like to participate in an elective not listed/approved, please obtain the CV and credentials of the preceptor you would like to rotate with as well as what will occur during the rotation. This information should be present to the Medical and Associate Director for approval.

For accurate Family Health Center patient scheduling and preceptor notice, the following timetable is required for elective blocks and time away:

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15.2 Resident Responsibilities for Elective Rotations

At least 90 days in advance:

i. At monthly meeting with Advisor, discuss future curriculum (both elective and required) and past-due evaluations

ii. Select the appropriate preceptor. If you wish to review what previous residents have to say about a preceptor, DME Secretary has a file of resident's evaluations of preceptor.

iii. Sign-up rotation sheets are in the binder at DME secretary's desk; you must sign up on these sheets, noting the preceptor's requirements.

iv. If other than a sign-up rotation, you may choose a Preceptor for your desired specialty rotation from the Florida Hospital Medical Staff book. Contact the Preceptor's office for approval. To aid in FHC clinic scheduling and to make the most of available preceptor time, discuss the "routine" office and rounding schedule and plan your schedule with the preceptor (6 half-days per week). Then completely fill in the Block Application.

v. For "away" rotations, you must attach to your Rotation Application a copy of the preceptor's CV evidencing Board certification. The DME secretary must receive signed preceptor agreement within thirty (30) days in advance.

vi. Time Away -- must show on front of Block Application the dates you will be away. Must complete the back:

- If you are scheduled for an assigned rotation, the preceptor must approve your time away.
- You must at least show a telephone number where you can be reached while away. If away more than 48 hours, must show coverage information as well.

30 days in advance:

Contact Preceptor's office for reporting requirements. Look at the copy of the schedule you received. It is a copy of the schedule submitted to the Preceptor. Make sure it is correct. Contact DME Secretary, if the Preceptor's office needs to be made aware of a change.

7 days in advance:

Meet with Curriculum Coordinator to discuss rotation requirements. Review the curriculum (located in New Innovations). Gather and read required items. Review handouts given to you prior to rotation.

Within 7 days of rotation completion: (Complete rotation requirements)

- Post Test, etc. (as outlined on curriculum)
- Submit Preceptor and Rotation Evaluation by Resident to DME Receptionist. This is required for accreditation purposes.
- Make sure Preceptor has submitted Resident Evaluation, which is not

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considered completed unless entire top is filled in correctly, nor until the Post Test Results are noted by the Faculty Coordinator. Procedures are to be documented and signed off by the preceptor, or your advisor, on New Innovations. (Procedure list information is used post-graduation in answering inquiries for credentialing by medical staff.)

Prior to graduation:

In order for the residency to be in compliance with criteria set forth by the ACGME, it will be necessary that you have all evaluations in your residency file before you can graduate. The Registrar will be including this requirement in her check-off list. We understand that you may be asking your preceptor before the completion of your last block for an evaluation, but the file must be complete before you graduate.

15.3 Faculty Coordinator Responsibilities

- **7 days in advance:** Meet with resident to discuss the requirements or the forward the requirements to resident in writing.
- **At beginning of rotation:** Check the Call Schedule to identify the residents taking rotations in which they are the Coordinator. Enter the resident's name on the Rotation Requirements Completion Log Form.
- **Within 7 days of completion:** Obtain rotation requirements (Post Test, etc) from Resident and complete Line D of evaluation.
- **8 days after completion**: Submit an “ALERT!” Form to the Resident, Faculty Advisor, Rotation Coordinator and the DME Receptionist if any component of the requirements is not complete.

15.4 DME Receptionist Responsibilities

Within 35 days of completion: Tabulate the results of the Post Test and Rotation Evaluation on the Cumulative Rotation Evaluation form, entering an “incomplete” for any rotation lacking the needed requirement (evaluation and/or Post Test results).

Notify the Resident, Faculty Advisor, Rotation Coordinator and Curriculum Coordinator of incompletes.

15.5 Medical Director Responsibilities

Not allow any vacation time unless all rotations are scheduled for periods prior to vacation request. During the last 6 months of academic year, all rotations are to be scheduled prior to granting vacation time**.**

15.6 Rotation Coordinator Responsibilities

- **90 to 0 days prior to rotation**: Notifies Resident, Curriculum Coordinators and Faculty Advisor of rotation scheduling (including delinquencies in scheduling and rotations delinquent for Evaluations).
- **30 days prior to rotation:** Notifies Preceptors of resident scheduling and rotation requirements.

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15.7 Program Director Responsibilities

- Ensures evaluation files are completed during the Bi-Annual Evaluation.
- Not promote or graduate residents who have incomplete Evaluation files.

16 RESIDENT OFFICERS

Two chief residents and the president of the Resident's Association (RA) will form the core administrative body among residents. The duties of the chief residents and RA president will also be listed below.

GOALS:

i. To facilitate the educational experience of the residents.

ii. To be a liaison between the residents and faculty.

iii. To be a resource for problem solving.

QUALIFICATIONS

Two chief residents will be chosen each year. This appointment is made at the discretion of the Residency Director, and although this will be a subjective decision, the follow criteria will be considered:

i. PGY-3 resident in good academic standing - must have successfully completed USMLE Parts 1-3.

ii. Demonstrates leadership and rapport with fellow residents.

iii. Demonstrates teaching skills and interest.

iv. Demonstrates a positive attitude to residency program and resident's experience.

The Residents' Association (RA) president will be chosen by a majority vote of residents present during an annual RA elections meeting (providing a quorum is present.) The RA president must be approved by the Program Director

TERM OF SERVICE

Chief residents will serve up to twelve months during the PGY-2/-3 year. The term will begin on April 1 and will end on April 1 of the following year. Previous chiefs will mentor elected chiefs in the month of March. From April 1 until the end of the academic year, the previous chief residents will serve as consultants only.

RESPONSIBILITIES

Chief 1 (Academic)

- Annual review/update of resident handbook/manual
- Supervise scheduled review courses
- Attendance of faculty and FM department meetings
- Attendance of curriculum committee meeting
- Attendance of Education Planning Committee (EPC) meeting

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- Assist in intern orientation
- Orient medical students/externs
- Coordinate/direct bi-monthly Resident Outpatient (ROP) conference

Chief 2 (Administrative)

- Direct lottery
- Call/Pager schedule
- Holiday Schedule
- Coordinate which nursing home new 2nd years go to (usually occurs at lottery) and give information to Geriatric attending
- Manage schedule conflicts
- Oversee moonlighting
- Attendance of faculty and FM department meetings
- Assist in intern orientation

Chief 3 (Community and Resident Liaison)

- Liaison to communicate program/department issues to the Program, Medical or Associate Director as well as GME, if appropriate
- Run RA meetings
- Coordinate yearly RA election
- Attend faculty and FM department meetings as primary representative of the residents
- Form a Social committee
- Community outreach organizer/contact person
- Participate on recruiting team
- Mission opportunities contact person
- Practice and moonlighting opportunities contact person
- Jeopardy

** Duties are delineated by type but are often shared/changed among chiefs according to their strengths/weaknesses.

GENERAL RESPONSIBILITIES:

i. Advise the residency Director on issues of importance to the residency

ii. Attendance at the following committee meetings:

- Family Medicine Residency Staff - weekly. Resident is to communicate intent of decisions made in faculty meeting to the residents.
- Resident Executive Committee - as called by RA president.
- Annual Program Review
- Invited to attend monthly FHC business meetings
- Encouraged to attend monthly Research Committee meetings
- Meet with Office Manager each quarter re: FHC issues.

iii. Attendance at faculty retreats

iv. Manage any daytime scheduling conflicts for resident coverage which arise.

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v. Review this Residency Manual and update all policies. Maintain a copy of all current and relevant policies in a notebook to be kept in the residency library**.**

vii. Oversee residency scheduling, especially if the scheduling resident is not available.

viii. Appoint and oversee moonlighting coordinator (3rd year resident) who is responsible for documentation for moonlighting as needed – maintain list of approved sites.

ix. Check and process Chief Resident's mailbox every week and filing of practice opportunities in the appropriate locations.

x. Attend Family Medicine Department Credentials Committee and the Family Medicine Department meeting each month.

xi. Meet with Program Director (Dr. Gray) once a week and attend Faculty meeting.

xii. Maintain bulletin board in resident's lounge.

xiii. Participate in intern orientation each year, usually in June.

xv. Other responsibilities which may be added.

COMPENSATION--The chief residents will receive a monthly stipend of $150.00 each during the period of their appointment**.**

CLINIC DAYS--The chief residents will each have three half days per week of clinic throughout their term of office after starting the PGY-3 year. They will also be given one half day per week to be utilized for administrative duties.

RESIDENTS' ASSOCIATION

General principles

The Florida Hospital Residents' Association is composed of all residents and has an elected President. This officer is elected by majority vote at an association meeting each April. The purpose of the association is:

i. To provide a voice for the residents on various faculty committees and provide other input as needed regarding the function of the residency.

ii. To provide a mechanism for various social functions among the residents and their families.

Voted Positions

With changing residency circumstances, the exact number of positions within the Residents' Association organization will change. However, the following roles are typically filled:

i. President (elected as stated above)

ii. Social director (at times, multiple residents will share this responsibility)

iii. Florida Academy of Family Physicians representative.

iv. Other positions to be chosen at direction of President.

17 RESIDENT AWARDS

The following awards will be given out each year. Awards are typically conferred at an annual year-end awards banquet. Not all of the following awards are given to residents. Many awards are given to R3 residents only.

1. ACADEMIC AWARD: Awarded to a third year resident based upon the director's discretion, taking into consideration the resident's in-training examination composite scores, rotation evaluations over all three years, research projects, and other academic pursuits.

2. TOM ROWSELL, MD FACULTY OF THE YEAR AWARD: Voted by the residents, this award is presented to a full-time residency faculty member based on demonstrated energy and interest to teaching, role modeling, and providing an environment that is conducive to learning.

3. INTERN OF THE YEAR AWARD: The intern recipient is voted by the core faculty based on performance during core rotations, who demonstrated overall energy and enthusiasm for learning, superior performance, and a general positive attitude.

4. PRECEPTOR OF THE YEAR AWARD: Voted by the residents, this award is presented to a private physician who has provided effective teaching to enhance the residents' medical knowledge in any given specialty in a private office environment.

5. VLADO GETTING, MD, DrPH COMMUNITY SERVICE AWARD: Presented to a third-year resident who has volunteered the most number of hours to the community during residency training.

6. RESEARCH INVESTIGATOR OF THE YEAR AWARD: Presented to a graduating resident or for a qualified research project selected by the research committee.

18 ORGANIZATIONS, COMMITTEES AND SPECIAL FUNCTIONS

18.1 FLORIDA ACADEMY OF FAMILY PHYSICIANS REPRESENTATIVES (FAFP) / FLORIDA MEDICAL ASSOCIATION REPRESENTATIVES (FMA)

Membership

For membership into the FAFP, a representative is chosen from the intern class for a two-year position (alternates are chosen if others are interested or lose the election). Selection is based on interest only. This representative attends all quarterly FAFP meetings and the Kansas City recruiting meeting in July. Cost is reimbursed by the residency program.

For membership into the FMA, a representative is chosen from those who are members. A PGY-2 may be chosen if no interest is seen in the PGY-1 class. This person must attend the FMA annual meeting, in order to be voted in by the state group of residents. This representative attends two AMA meetings, two FMA meetings, and two to three resident meetings each year. Cost is reimbursed by the FMA.

18.2 FAMILY MEDICINE RESIDENCY FACULTY STAFF

Membership

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a. Program Director of Family Medicine Residency – Chairman

b. Associate Director of Family Medicine Residency

c. Medical Director of Family Health Center

d. Associate Directors of Internal Medicine, Pediatrics, Geriatrics, Preventive Medicine, Behavioral Science, Obstetrics/Gynecology and Family Medicine.

e. Full-time clinical faculty

f. Chief residents and President of Resident's Association

Function: The Family Medicine Residency Staff will meet weekly to disseminate information, provide a forum for discussion of pertinent issues, and conduct the routine business of the residency. This is an open meeting to which all residents are invited, however, only those residents who are members are expected to attend regularly.

18.3 SOCIAL COMMITTEE

Subcommittee of the Resident's Association.

Function: The Social Committee's function is to plan monthly activities for the residency. Funds are available through the social fund, and expenditures are approved by the Medical Director.

Requirements

i. A full complement of residents is required for call.

ii. Residents should understand that the retreat is not an official program holiday, and should the trip be canceled for some reason, the program is under no obligation to provide holidays or other days off for compensation.

iii. It is the duty of the chief residents, to establish an equitable method of selecting residents for call duty on the weekend of the retreat and holidays and to keep enough records to ensure fairness from year to year.

iv. All PGY-3 residents will attend the retreat. A given resident will have call obligations during the weekend of the retreat in one out of the three years of residency. In light of these call obligations; it is clear that a given resident should be able to attend the spring retreat at least two times.

v. All residents are required to attend the retreat, those who do not will be expected to take call so that other residents may go. The schedule will be created so that all residents will be able to attend the retreat at least once.

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I acknowledge that I have received a copy of the Florida Hospital Family Medicine Residency Manual, and I do commit to read and follow these policies.

I am aware that if, at any time, I have questions regarding Florida Hospital Family Medicine Residency policies I should direct them to my Program Director, Associate Director, Medical Director, Chief Residents or Program Coordinator.

I know that Florida Hospital Family Medicine Residency policies and other related documents do not form a contract of employment and are not a guarantee by Florida Hospital Family Medicine Residency of the conditions and benefits that are described within them. Nevertheless, the provisions of such Florida Hospital Family Medicine Residency policies are incorporated into the acknowledgment, and I agree that I shall abide by its provisions.

I also am aware that Florida Hospital Family Medicine Residency, at any time, may on reasonable notice, change, add to, or delete from the provisions of the company policies.

______________________________	______________________________
Resident's Printed Name	PGY year
______________________________	______________________________
Resident's Signature	Date

19 APPENDICES

19.1 Employment Manual Sections Omitted

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