

LYNCHBURG FAMILY MEDICINE RESIDENCY

This manual has been prepared for the residents of the Lynchburg Family Medicine Residency to state and to clarify the policies of this Program.

It provides strategic guidelines to allow smooth and efficient functioning in all areas of the Program: Hospital, Office, Rotations, Calls, Nursing Homes, etc.

Residents' responsibilities shall include, but are not limited to, the specific details outlined in this manual.

Revised: 2003; 2004; 2005; 2006; 2007

Charles E. Driscoll, MD
Program Director

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This is to certify that I have read and understand the Lynchburg Family Medicine Residency Policy Manual and its attachments and that I agree to abide by the rules and regulations contained therein.

I also understand that I can access the content of this manual on the shared "N:" drive. (N:/LFP Policy Man/policy2007).

Name: _____

Date: _____

POLICY ON CONFIDENTIALITY

The Lynchburg Family Medicine Residency adheres to the strictest standards of information pertaining to its employees and to any individual recipient of its services. Further, it is bound to State regulations regarding client confidentiality under the authority of Title 37.1-84.1, Code of Virginia, (1950) as amended, and by Federal confidentiality of alcohol and drug abuse patient records (42 CFR Part 1).

All Lynchburg Family Medicine Residency contractors, employees, volunteers, trainees or field placement students are ethically and legally bound to maintain the confidentiality of all information, privileged or otherwise, revealing the identity, the discourses, actions or records of patients, clients or other recipients of services, by signing this confidentiality statement.

Any unauthorized or improper release or discussion of such information is forbidden and will result in disciplinary action.

I agree to maintain all confidential and proprietary information in the strictest confidence.

Signature

Name (Printed or Typed)

Date

INTRODUCTION

Family Medicine is a comprehensive specialty. The promotion of wellness and treatment of illness are basic to the competence of the Family Physician. The Family Physician provides holistic care to the individual and family including the social, behavioral, as well as biological dimension.

The acquisition of knowledge, skills and attitudes of Family Medicine by the residents should take place during all curricular elements. A disciplined schedule for reading periodicals should also be established. The primary setting for this training is in the Family Medical Center where the resident provides continuing, comprehensive care to his/her panel of patients.

The Lynchburg Family Medicine Residency (LFMR) is a three (3) year program that starts on July 1 of any given year and ends on June 30 three (3) years later. As an employee of Centra Health, residents must become familiar and comply with Centra Health policies as stated and updated on the Centra Intranet. The on-line Administrative manual for Centra Health can be accessed by visiting the CentraPeople website and selecting "Policies" – "Personnel".

FORMAL CRITERIA FOR SELECTION OF RESIDENTS

Applicants for the program are selected based on the following criteria: US Citizen or Permanent Resident, graduation date from medical school in the past three years (consideration of up to five years is given if applicant has clinical experience in healthcare field since graduation), no visas are considered, participation with ERAS and participation in the National Resident Match Program is expected, and a score of at least 80 on Steps I and 2 of the USMLE first attempt. Applications are screened by the Director and invitations to interview are disbursed via ERAS e-mail. Applicants contact the Residency Coordinator to arrange an interview date and confirmation is sent along with a residency brochure outlining salaries and benefits, program history and affiliation, present and past residents, faculty, and curriculum descriptions.

WORK DAY

In addition to scheduled call periods and meetings, a normal working day extends from 7:00 AM to 5:00 PM Monday through Friday. During this time the resident must be readily available on pager. In the event that a resident cannot be available, the administrative secretary must be notified. The secretary in turn will notify the clinical area. Therefore when the resident is not on call, he/she is responsible for patients usually from 7:00 AM to 5:00 PM. Residents should check with the nurses for messages about their patients at midday and before going off duty.

The Lynchburg Family Medicine Center is open Monday, Tuesday, Thursday and Friday 8:15 AM until 4:30 PM, Wednesday 8:15 AM until noon and Saturday 9:00 AM until

11:30. The Big Island Family Medicine Center is open Monday, Tuesday, Thursday and Friday 8:30 AM until 5:00 PM.

HOLIDAYS

The Lynchburg Family Medicine Center OFFICE is closed on the following days:

New Year's Day
Easter Monday
Memorial Day
July 4

Labor Day
Thanksgiving Day
Christmas Day

On the days the center is closed, Family Medicine inpatient hospital rounds and messages will be handled by the resident on call. Residents will be expected to be present at their rotation unless excused by their attending. The Medicine, Pediatric, OB, Acute Care and Family Medicine services will function as a normal working day.

DUTY HOURS

A. Resident Duty Hours and the Working Environment

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

1. Supervision of Residents

- a. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
- b. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
- c. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

2. Duty Hours

a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site nor at-home beeper call.

b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

d. Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call.

3. On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

a. In-house call must occur no more frequently than every third night, averaged over a four-week period.

b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care. For family medicine programs, the only outpatient activity allowed is the scheduled continuity office hours in the FMC, and/or self-directed activities. No other clinical duties are permitted. FM residents may not have continuity office hours in the afternoon or evening following an overnight call responsibility. Directors are responsible for anticipatory scheduling to avoid having to cancel patient appointments for afternoon FMC continuity sessions following overnight call.

For programs using a night block (AC) rotation, residents may have their continuity office hours in the FMC either before or after the night block hours, as long as there are 10 hours of rest between assigned duties and all other duty hour rules are addressed.

Residents should also be available for critical events in the lives of their continuity patients such as obstetrical delivery throughout their 3 years of training but with the understanding that their subsequent schedules should be adjusted, as necessary, to comply with the duty hours restrictions.

c. No new patients may be accepted after 24 hours of continuous duty. Patients seen post call during a morning continuity session in the FMC are not considered new patients.

d. At-home call (pager call) is defined as call taken from outside the assigned institution.

1.) The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

2.) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

3.) The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

4. Moonlighting

a. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

b. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Requirements.

c. Moonlighting that occurs for compensation within the residency program, the sponsoring institution or the sponsor's primary clinical site(s), ie, internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours. A moonlighting report of hours must be submitted to the Director on a monthly basis.

5. Oversight

a. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. There is a structured and facilitated group for resident support that meets on a regular basis.

DRESS CODE

White coats are provided to each resident. The resident's coats will be laundered by Centra Health. Residents are expected to look clean and professional. Scrubs are not to be worn in the office unless the resident is participating in a surgical procedure or is following a patient in active labor. Hair and beards must be neat and trim. Name tags are to be worn at all times.

CONDUCT

Residents are expected to be considerate and courteous in all of their relationships. It is also expected that residents will be professional, respectful, and compassionate toward all of their patients and in all discussions concerning their care.

PAGER

Each resident is provided with a pager. Pagers are valuable and residents using them are responsible for their care and replacement if lost. Replacement batteries are available at no cost from the Administrative Secretary. Residents must be aware that pagers do not function well in basements and numerous other locations, therefore, the resident must take appropriate precautions. The resident on call will be contacted by the answering service either via telephone or pager. The answering service must be informed by the resident whether telephone or pager should be used. The phone number for the answering service is 522-8126.

LOSS OF PAGER, PDA, DICTATION DEVICES, COMPUTERS

These are provided on loan to each resident. The safekeeping of these resources is the responsibility of the resident. If they are lost or stolen, the cost of replacement is charged to the resident.

SALARY PAYMENTS

Resident salaries are payable every two weeks. Checks are directly deposited to resident's local bank account. ANY CHANGE OF ADDRESS OR ROUTE IS THE RESIDENT'S RESPONSIBILITY TO INITIATE THROUGH THE RESIDENCY COORDINATOR.

BENEFITS

- A. MEALS: Each hospital cafeteria provides meals (free of charge) to the residents on duty in the hospital. Food is available free of charge in the doctor's lounges at VBH/LGH when the cafeteria is closed.
- B. INSURANCES:
1. HEALTH: Piedmont Community Health Plan is provided for the residents by Centra Health. A resident's spouse and children may be covered under the Group Insurance family plan at an additional cost.
 2. MALPRACTICE: Malpractice Insurance is provided to the resident at no cost through Centra Health. This includes the tail coverage policy after graduation. However, this does NOT include moonlighting.
 3. LIFE: Life Insurance coverage is provided to the resident through Centra Health
 4. DISABILITY: Disability Insurance is provided through Centra Health.
- C. MOVING ALLOWANCE: \$1,000 per resident with receipts.
- D. PROFESSIONAL MEMBERSHIPS: Dues to the AMERICAN ACADEMY OF FAMILY PHYSICIANS, as a resident affiliate, are covered by the Lynchburg Family Medicine Residency. It is strongly recommended that all residents take advantage of this opportunity since the resident group of the AAFP is in the position to influence present and future policy of the AAFP through representation on State and National committees.
- LYNCHBURG ACADEMY OF MEDICINE: Residents are encouraged to attend scientific monthly meetings. Membership is provided free of charge.
- E. TRAVEL ALLOWANCE: A travel allowance is provided to residents in

approved rotations and electives. Residents must complete a travel invoice and turn in their request to the Residency Coordinator within thirty (30) days. Mileage reimbursement is made at the current Centra Health rate per mile.

- F. CME CONFERENCE: Residents are granted five (5) working days conference time each year with an allowance of \$600 per year. Conference time is non-cumulative from year to year unless by special permission from the director. No more than three (3) residents may be absent from the office on vacation or conference time. Requests should be made at least 8 weeks (2 months from the 1st day of the month) in advance to the chief resident unless otherwise directed by the Chief. Conference time is not counted as vacation or absence from the program. Conference time is work time. **Attending conferences away from the program is contingent on satisfactory attendance at program's required conferences.** In order to qualify for reimbursement, 70% of required conferences must be attended annually (p 45). Qualifying period is prior 6 months of the academic year. The attendance at OB Grand Rounds will be monitored separately from other conferences. Each resident is expected to attend a minimum of 9 out of 12 OB Grand Rounds annually (75%). This will be in addition to the 70% required attendance at the other conferences.
- G. IN-TRAINING ASSESSMENT EXAMINATIONS: Absence for the required ITAE is counted as work time.
- H. VACATIONS: Per the American Board of Family Medicine all residents are granted a **total of twenty (20) working days absence per year**. For vacations the following guidelines should be respected and may result in disapproval if not adhered to:
1. Vacations must be requested at the discretion of the Chief at least eight (8) weeks in advance of the first of the month in which leave is expected. A first-come-first-served basis will be used for granting requests.
 2. Request for time off must be in writing using the "Time Off Request and Approval" form (*see Appendix A*) available from the Administrative Secretary. These forms must be given to the CHIEF RESIDENT for approval. To allow for proper planning, a vacation/conference calendar is available in the Chief Resident's work station.
 3. Vacation time is not cumulative from year to year.
 4. No more than five (5) working days off per month are allowed without special permission from the director, with the exception of maternity/paternity leave.
 5. Time off is NOT permitted while on Pediatrics, Acute Care, and Nursery.

6. Multiple vacations on the same service are not permitted. (Example: Taking vacation during each OB Rotation).
7. Vacation time will NOT be approved during the last week in June or the first week in July.
8. No absence is allowed on the annual date (usually the first Friday in November) of the American Board of Family Medicine In-Training Examination. All residents are required to attend the Graduation/Award ceremonies (usually the last week of June). Also, all residents (including incoming R1's) are required to attend the Annual Family Medicine Symposium in June.
9. No more than 3 residents may be absent from the residency at any one time. This includes vacation/conference/out-of-town rotations.
10. Exceptions from these guidelines may be made **only with the permission from the director**.
11. Below is a list of items which need to be done **before** a resident leaves on vacation, conference, etc.:
 - a. Assign and check out hospital patients.
 - b. Messages completed.
 - c. Office dictation completed.
 - d. Hospital dictation completed.
 - e. Office charts completed.
 - f. Hospital charts completed.
 - g. Nursing home certifications up-to-date.
 - h. Office mailboxes cleaned out.
 - i. Hospital mailboxes cleaned out.
 - j. Check appointment book for patient days correctly marked out.
 - k. Coverage arranged for longitudinal OB patients.

FAILURE TO COMPLY WITH THE ABOVE LISTING WILL RESULT IN APPROPRIATE ACTION – LOSS OF VACATION.

- NOTE:
1. When a week of vacation is requested, an attempt will be made to free up the weekends before and after the vacation week. In all cases, however, at least one weekend will be freed in conjunction with the vacation week.
 2. It must be pointed out that yearly there have been problems with residents having leftover vacation days in the months of May and June. Vacation days are NOT transferable from year to year. Therefore, please do not save too many vacation days for this time period and note that others may be requesting vacations for the same time period, and the exact date you wish to take may not be available.
- I. ABSENCE FOR ILLNESS: In case of absence for illness, the resident must call the Chief Resident, or the appointed resident in the absence of the Chief

Resident, **and** the Residency Scheduler as soon as possible. Residents should also advise the appropriate attending of their absence. Twenty (20) working days absence per year to include vacation, sick leave and emergency leave is the maximum allowance. If absence exceeds twenty (20) working days per year, the resident's academic year will be extended for equivalent time. Five (5) days conference time is not included in the twenty working days.

J. OTHER ABSENCES:

Absence for a death in the immediate family may be credited to three (3) days bereavement leave. Immediate family members include: Spouse, Mother, Father, Brother, Sister, Child, Mother-in-law, Father-in-law and grandparents of resident. Absence for the death of other significant persons may be granted at the discretion of the Director.

SICK LEAVE - Personal sick days because of illness or family illness that requires resident to stay at home

CME- Scheduled work days away from the program to attend approved CME conference. Request must be submitted 8 weeks (2 months from the first day of the month) in advance to plan call and office scheduling. Full allotment of days is contingent on satisfactory attendance (70%) at required program conferences.

PRACTICE SEARCH TIME – THIRD YEAR RESIDENTS are permitted three (3) Practice Search days that may be time away for interviews and are counted as work days (Practice Management Time). The Chief Resident and Program Director must approve the absence four weeks in advance. The resident must notify his/her attending of the planned absence as soon as possible in advance. The resident must also sign a statement indicating that Practice Management learning occurred.

- I. MATERNITY LEAVE: A pregnant resident is expected to inform the Director of her pregnancy as early as possible. The resident is to provide a written recommendation from the physician attending the pregnancy regarding the amount of leave time necessary. The Director, Chief Resident and pregnant resident will review the resident's rotation and call schedule to decide what adjustments will be made. In an uncomplicated pregnancy, call will be suspended for the two (2) weeks prior to the expected delivery date. And for the sake of fairness and equality of calls with other residents, call distribution will be made up over the course of the ensuing year or time preceding the EDC. The resident may be granted paid leave consisting of one week of unused sick leave in addition to any unused vacation time up to the allotted 20 days per year. At the discretion of the Director, additional leave may be granted without pay. Time away

from the program beyond 20 working days per year (including vacation, sick leave and maternity leave) must be made up to fulfill the educational requirements of the Residency Program. An elective in Parental-Infant Health may be scheduled with the approval of the Director.

The same policy applies in the event of an adoption of a child.

Insurance premiums will be paid by the Residency Program during paid leave. If continued insurance coverage is desired during unpaid leave, it is the resident's responsibility to pay the premiums during that time. This should be discussed and arranged with Centra Health Personnel Department as early as possible to maintain continuous coverage.

- J. PATERNITY LEAVE: At the time of his child's birth or adoption, or within the first month after delivery, a male resident may elect to take one week paternity leave to be deducted from the allotted 20 day/year absence time. The father should be given time off while the mother is in labor. In order to accommodate the above, the resident must inform the Director of the expected delivery date as early as possible. Call will be suspended for the two (2) weeks prior to the expected delivery date. For the sake of fairness and equality of calls with other residents, call distribution will be made up over the course of the year. An elective in Parental Infant Health may be scheduled with the approval of the Director.
- K. LEAVE OF ABSENCE: In the event of significant personal circumstances, a resident may elect to request a Leave of Absence from the Residency with the approval of the Director. This allowance tends to impact adversely on the resident's individual curriculum as well as the residency as a whole and should be used with discretion. Any continuation of benefits must be discussed with the Director. The time off must be made up, postponing graduation accordingly.
- L. DOCUMENTATION OF TIME OFF: Upon written request for time off (vacation and conference) by the resident it is the responsibility of the chief resident (or assistant chief in the chief's absence) to assure that the request is reasonable, consistent with policy and does not affect negatively the smooth functioning of the residency. This preliminary approval by the chief resident is forwarded to the director (or his/her administrative assistant) who has the responsibility to oversee the request and maintain proper documentation. Sick days and unplanned absences (death in the family, etc.) must be reported to the Residency Scheduler and documented per protocol.
- M. FITNESS PROGRAMS: Free membership at Bowen Fitness Center is available for resident and spouse.

RESIDENT RETREAT

Traditionally a resident retreat is held each year and efforts will be made to honor this tradition. Its occurrence, however, is (ultimately a budgetary consideration and is) at the discretion of the Director. The Chief resident will submit the request for a retreat, including content and time, to the Director for approval. A written report of the gains from retreat will be prepared by the chief resident and submitted to the Director.

MOONLIGHTING POLICY

“Moonlighting” is defined as the rendering of professional services in the practice of Medicine or surgery before 7:00 AM or after 5:00 PM on Monday, Tuesday, Wednesday, Thursday and Friday and from 5:00 PM Friday until 7:00 AM Monday which do not coincide with assigned call duties and which are not considered to be part of the formal educational rotations at the residency as identified by the Director and approved by the faculty, and, as well, the University of Virginia and American Board of Family Medicine. No moonlighting activity is permitted without the express written authorization of the Director. Moonlighting must be in compliance with the policy on Resident Duty Hours and the Working Environment (see Section D. 4, page 5) ***FAILURE TO COMPLY WITH THIS PROVISION CAN LEAD TO DISMISSAL OF THE RESIDENT FROM THE RESIDENCY OR OTHER PUNITIVE ACTIONS AS OUTLINED BY THE DIRECTOR.***

The residents should realize that the malpractice insurance coverage extended by the Centra Health provides coverage only within the scope of their educational rotations at the Residency. The Residency will in no way extend coverage to activities done beyond the terms of its employment. The Residency specifically forbids moonlighting during normal office hours or call duties. However, with the written permission of the Director, moonlighting may occur during vacation time. In order to insure proper structure for the consideration of requests for moonlighting activities and insure proper malpractice coverage for the residents, the Director will not consider any request for written approval of moonlighting unless the following conditions are met:

1. Any activity involving the rendering of services in the practice of Medicine or surgery must be detailed in a letter addressed to the Director. (see Form Appendix B) This letter must detail the nature of the activity, the employer's name, the location, and the number of hours to be worked.
2. With the above letter a copy of the appropriate malpractice insurance policy or a letter from the employer identifying the existence of separate malpractice coverage must be enclosed.
3. The resident is in good academic standing with ITAE composite scores >400
4. A written log of moonlighting hours worked must be turned into the director monthly.

Any moonlighting activity which is felt to adversely affect the residency or the performance of the resident's duties at the residency will be terminated by the Director.

FEE COLLECTION

All patient care fees collected go into the residency education fund. This includes payments and checks made out to individual residents for legal court fees. These are to be given to the Patient Accounts Specialists for deposit. Income from moonlighting activities outside of the Residency or royalties from publication are excluded from this rule.

GIFTS AND TIPS FROM PATIENTS

Acceptance of money or other **valuable** gifts from patients is not permitted. Residents may accept **inexpensive** gifts such as food or flowers from patients who would feel offended if they were not permitted to show appreciation for the care they receive.

PHARMACEUTICAL REPRESENTATIVES

Residents are reminded of the AMA code of ethics relating to physician/ pharmaceutical representatives (<http://www.ama-assn.org/ama/pub/category/4001.html>).

Pharmaceutical representatives are not permitted to detail their products in the clinical area of the residency. Pharmaceutical teaching is provided by the PharmD faculty of the residency program.

MAILBOXES

Each resident is assigned two mailboxes and a chart rack at their office desk for charts, incoming mail, messages, etc. Residents are expected to check and empty their mailboxes each day they are present in the Center. It is important that all charts, messages, mail and memos be attended to every day.

EMAIL

Residents are required to check their "centrahealth.com" emails on a daily basis. This is the venue that will be used for all interdepartmental messages and residents will be notified when schedules are ready to be reviewed.

KEYS

Residents are given two keys, one which opens outside doors to the medical office and one which opens resident call rooms. Residents are responsible for their keys and the cost of replacement of a key if lost. These keys are to be returned to the Residency Coordinator at the termination of residency.

SECURITY SYSTEM

The Family Medicine Center and the procedure exam room are protected after hours by an electronic security system. When leaving the building late, push "Page" on the

telephone and say "leaving now-if anyone is in the building, call me now at extension xxx". If after 1-2 minutes, no one calls, arm the security lock with your passcode # and press "On" button. To disarm the system, enter your passcode and press "Off". (If you forget your passcode #, wait for security to call on 5210, answer, give your name and the company password. You will receive your passcode number and password from the Residency Coordinator during Orientation.

COPYING AND FAX MACHINES

Copy and fax machines are available and are intended for business and educational use only.

PARKING

Residents are provided with a parking card for the physicians' parking lots at Virginia Baptist Hospital and Lynchburg General Hospital. This same card opens both physician entrances into the hospitals. Residents are not to park in the Emergency Room patient parking area at Lynchburg General Hospital. *Residents are responsible for the cost of replacing lost cards.*

SMOKING POLICY

The Lynchburg Family Medicine Residency, the Big Island Family Medicine Center and all Centra Health hospitals and clinics have been designated as Smoke Free work areas.

INTERACTIONS WITH THE LEGAL SYSTEM

Whenever any legal system interactions are called for by a resident, the resident should consult their faculty advisor or the Director if the advisor is unavailable. Residents should not appear in court or meet with representatives of the legal system without their advisor and/or the Director present.

LEGAL DOCUMENTS

Residents without a permanent Virginia medical license are NOT to sign legal documents such as death certificates, mental health commitment papers and other documents of similar legal importance. Attendings should review all legal documents completed by all residents, and are available for signatures required on such documents.

DEATH CERTIFICATES

Death certificates are legal documents that can only be signed by licensed physicians (most upper level residents). Physicians with a resident's license cannot sign them (i.e.: most interns). The form must be filled out within 48 hours in **BLACK ink and free of**

ERASURES. A copy of the death certificate should be filled out by the resident, and taken with the untouched original to the appropriate attending physician for completion. Residents must ask the faculty member who was attending at the time of the patient's death to **sign** the certificate. Upper level residents must ask the attending to **co-sign or initial**. The form is color coded on the border. A certificate with a **green border** is for general purpose and is the form used by the residency. A certificate with a yellow border is for certification of fetal deaths, and a certificate with a red border is for medical examiners cases. Residents must complete the on-line tutorial dealing with Cause-of-Death (<http://www.thename.org>) and locate the link to the "Death Certificate Completion" in the main menu at the left of the screen before undertaking their first certification.

USE OF TELEPHONE

PERSONAL long distance telephone calls will NOT be made from the Center nor the hospitals unless the person charges the call to his home or uses a calling card. A toll-free number is available to the University of Virginia. The number is 1-800-552-3723. A toll-free number is also available to the Medical College of Virginia. This number is 1-800-628-4141.

To avoid a phone surcharge to the residency, Centra Health phone numbers with a "947" prefix should be dialed as a direct number using only the terminal four digits (e.g. 947-2 3 4 5).

PHONE CALLS TO RESIDENTS:

1. Residents are to be paged for emergency calls from the hospitals and from other physicians.
2. Residents who are out of the Center must call the nurses every day for messages with the exception of out of town electives. (These calls will be handled by fellow residents).
3. Any calls after 4:30 PM that are non-emergency will be held until the following day. Important calls will be relayed to the requested resident. Any messages that are not picked up will be turned over to fellow residents in the Center.
4. For residents' information, the Office Staff is expected to follow the protocol which reads:

"All calls from Critical Care Units at the hospitals must be forwarded to the residents immediately. Critical Care Units are: CCU, ICU, PCU, ICN, NICU, and the Emergency Room. The office staff is to interrupt any conference the resident may be in or page the resident on their beeper. If the office staff is unable to quickly contact the resident the message must be given to a faculty member. The office staff will note the

time all messages are taken. Additionally, if the resident is unable to be contacted the office staff must inform the faculty member how and when they tried to contact the resident in question.”

Requests for consults should also be handled as stated above. Other callers from non-critical care units must be asked whether the message is urgent or can be relayed to the resident when the resident picks up his or her messages. The time the residents are required to pick up their messages next should be stated to everyone leaving a message. This gives the caller a time frame and will avoid call backs.

OFFICE CHARTING

Patient records are filed for each individual patient.

1. Each patient is assigned a chart number.
2. Charts are color coded and filed by the first 3 letters of the last name and the first two letters of the first name, e.g. Bob White is WHIBO. Any pertinent information is filed in the chart. The physician’s name appears on the front of the chart.
3. ***ALL PATIENT CHARTS ARE TO REMAIN IN THE MEDICAL OFFICE AREA AT ALL TIMES.***
4. In the event information is required outside the Center, copies of pertinent information, abiding by HIPAA regulations may be made.
5. Any information received on a patient must be initialed by the resident before filing.
6. Allergies and Insurance information are coded through visible signs or stickers.
7. The Problem List and medication Sheet are to be updated at each office visit as needed.

DICTATION

Hand held dictating devices are issued to each resident. The resident may use these in any area of patient care (e.g. office, nursing home) and must be returned to the administrative secretary when leaving the program. Residents are responsible for the replacement cost if lost.

1. The dictating devices is intended for progress notes, letters, disability reports, referrals and other program business matters.
2. Dictations are transcribed in order of entry. Please personally notify the transcriptionist if STAT transcription is required for transfer of patient care.
3. When dictating Progress Notes, always dictate:
 - a. Personal ID# 00XXX
 - b. Record type (022: office note / 023: letter)

- c. The six digit Centra medical record number
- d. Patient Name (Spell entire name)
- e. Date of Visit
- f. Name of Resident
- g. Name of preceptor in office
- 4. All charts must be dictated within the same day of patient contact.
- 5. Progress Notes must be brief and to the point. The order of Progress Notes is S.O.A.P.
 - a. S = Subjective
 - O = Objective
 - A = Assessment- (include status change)
 - P = Plan- (diagnostic, educational, treatment and goals for care)
- 6. All outgoing patient related correspondence is reviewed and initialed by a faculty member before mailed.
- 7. A copy of all outgoing mail is filed in the patient chart. Residents MUST promptly sign all letters that are stored in the holder and return them to the Medical Records clerk immediately for mailing.
- 8. Hand written notes are permitted as long as they are legible. They are recommended at times for expediency.
- 9. Please remember to “dock” the recorder to transfer your dictation at the end of each office session.
- 10. Always update problem list and medication list at each visit.

REQUEST FOR INFORMATION

Requests for medical or psychosocial information from physicians, hospitals and other professionals regarding an office patient are done in writing at the front desk on a signed and dated form. Residents will indicate their requests on the “Patient Encounter Form”.

CONSULTATIONS

When a resident considers that a consultation is appropriate for the management of a patient in the center or hospital, he/she must first discuss this with the preceptor. Consultation requests must be made by a personal contact, either a phone call and/or a letter or by completing the consultation/referral form (see Appendix C). All referrals must be documented by the referral coordinator or nurses in the referral book.

ADVANCED BENEFICIARY NOTICE

All Medicare patients requiring an office procedure or laboratory service that is likely to be denied by Medicare, must have a completed ABN for that visit. Please consult the faculty preceptor for assistance in filling out this form.

BILLING

The "Patient Encounter Form" has been designed for the specific need of the Family Medicine Center. It is clipped to the patient chart and is completed by the resident after each patient visit. It is imperative that the resident complete the encounter form correctly by circling all performed services. It is then handed to the patient at the termination of the visit for processing through the front office. Patients are strongly encouraged to pay on the day of their visit. The resident is expected to clarify expectation of prompt payment and refer the patient to the Patient Accounts Manager if the patient needs special consideration.

While a resident, all fees generated by the residents' services to the Family Medicine Center's patients (medical, medico-legal, etc.) are paid to the residency. If a patient has a chronically delinquent account, the patient may be recommended for dismissal from the practice. This decision will be made by the Office Manager and the Physician Director of Patient Care after discussion with the resident.

Accuracy in CPT and E&M coding is essential to the viability of the practice. Claims are reviewed by third party payers and may be subject to disciplinary action by the insurance company if under or over coding is detected. Please consult faculty when level of visit charging (CPT, E&M) is in question. Code all office visit diagnoses using wall charts of CPT code numbers. **All "no charge" codes must be initialed by faculty.**

COMMUNICABLE DISEASES

In accordance with the law, all identified communicable diseases must be reported. Reporting forms are available at the Nurse's Station and are completed by the nursing supervisor who documents the report in the patient's chart at the time of diagnosis. A list of Reportable Communicable Diseases is available in the Nurse's Station and residents should be familiar with its content and use.

PRECEPTING OF PATIENTS

Faculty Preceptors are available at all times during resident patient care. Topics for discussion include appropriate diagnostic and treatment decisions and visit E&M coding. All difficulties with physician/patient interactions should be discussed. Every Medicaid patient must also be seen by faculty and a faculty note written. Patients with other insurance status are reviewed by faculty and seen as needed. Residents are responsible for insuring that preceptor notes are appropriately entered in the medical record. Chart notes are reviewed and signed after transcription. Regular chart auditing is performed by faculty. (see Appendix D for Chart Audit Form).

CONTROLLED DRUGS

No Controlled Substance will be refilled over the phone. Patients must be advised that refills will be provided only during office hours by their primary physician (or another physician if he/she knows the patient). For patients who experience severe pain after hours, arrangements should be made for them to be seen.

PRESCRIPTION OF NARCOTICS

No prescription for narcotic may be written by a resident using his/her advisor's DEA# unless a Family Medicine Residency attending is directly involved in the care of the patient. When a resident is on an "outside" rotation and if a prescription for narcotics is written for, the resident must utilize the "outside" attending's DEA#.

PATIENT EDUCATION

Educational pamphlets on various and diverse medical and psychosocial issues are available free of charge to the patient. Residents are asked to familiarize themselves with the content and variety of material and consider these materials an important educational tool. Numerous handouts are available to print from the on-line resource from the CentraPeople website home page under the menu bar "references."

A library of videotapes is available for patients to view at the request of the resident. Residents are expected to be familiar with the content and listing of these tapes and indicate on the "Patient Encounter Form" their request for the patient. The clinical staff will facilitate the mechanics and scheduling of this patient education activity.

A ringbinder of materials useful for "bedside" teaching (e.g. anatomical diagrams) is available in each exam room.

GUIDELINES FOR OFFICE SESSIONS

An office session is equivalent to 3 _ hours in the morning from 8:30 AM to Noon and 3_ hours in the afternoon from 1:00 PM to 4:30 PM. However, in view of certain rotation requirements, some schedules are altered accordingly.

FIRST YEAR RESIDENTS are expected to see patients in the Family Medicine Center the equivalent of one (1) to two (2) sessions per week. The minimum number of annual visits expected is ≥ 150 .

SECOND YEAR RESIDENTS are expected to see patients in the Family Medicine Center the equivalent of two (2) to three (3) sessions per week. The minimum number of visits expected is ≥ 500 .

THIRD YEAR RESIDENTS are expected to see patients in the Family Medicine Center the equivalent of three (3) to five (5) sessions per week. The minimum number of visits expected is ≥ 1000 .

SCHEDULING OF PATIENTS

From the first to the third year of residency, there is an increase in the number of patients expected to be seen per session. Should a resident have a question or problem regarding patient load, he/she should go to the Office Manager, NOT the receptionist. A block of time at the end of the session (e.g., 11:30 – noon or 4:30 – 5:00 p.m.) is set aside to allow for messages, phone calls, etc. Further, this schedule provides adequate time for teaching/ precepting activities regarding patient care. Residents must not change their own schedule. All changes must be made through the Office Manager and the Residency Scheduler.

FIRST YEAR RESIDENTS are expected to see initially an average of 1 patient per 45 minutes per office session, or its equivalent, if extended visits or procedures are scheduled. After the sixth month of residency, they may see a maximum of 1 patient per 30 minutes per office session, after faculty review and permission. All patients of first year residents are also seen by faculty during the first six months of the residency. Do not allow the patient to leave the office until faculty staffing is completed.

SECOND YEAR RESIDENTS are expected to see on the average eight (8) to ten (10) patients per session (e.g. 1 per 15 minutes first 6 months and increasing as capable in last 6 months), or its equivalent, if extended visits or procedures are scheduled.

THIRD YEAR RESIDENTS are expected to see on the average ten (10) to twelve (12) patients per session (e.g. 1 per 15 minutes), or its equivalent, if extended visits or procedures are scheduled. More patients may be added to the schedule at the discretion of the physician.

TIME ALLOCATION FOR SPECIFIC EXAMINATIONS

APPOINTMENTS REQUIRING 15 MINUTES:

- NO 15 MIN. APPTS. FOR 1ST YEAR RESIDENTS!
- Acute visits.
- Follow-up visits.
- Single chronic disease, including diabetes, hypertension, COPD.
- Medication check
- Routine pre-natal care return visits

APPOINTMENTS REQUIRING 30 MINUTES:

- ALL ACUTE AND FOLLOW-UP VISITS FOR 1ST YEAR RESIDENTS.
- Hospital follow-up if not an established LFMC patient.
- New patients (except 1st year residents).
- One time only patients

- PAP/pelvic exams, vaginitis, post-partum, post-abortion, post-miscarriage exams, females with abdominal pain.
- Back pain, first evaluation only.
- Head Start, sports, and school physicals except on designated school physical days.
- General adult physicals (not designated as complete physicals).
- Certain procedures (see list).
- Psychiatric problems, initial evaluation.
- Newborn's first office visit.
- Complete physical exam (male)
- Rehab physicals
- Employment physicals
- Patients with special needs
- Well child visits

APPOINTMENTS REQUIRING 45 MINUTES:

- Complete physicals with PAP/pelvic (female)
- Following procedures: (may require treatment room and faculty support)
 - Flex sigmoidoscopy
 - Colposcopy
 - Lesion removal
 - Toenail removal
- New patients for nursing home entrance physicals.

APPOINTMENTS REQUIRING ONE HOUR:

- Certain procedures (see list)
- 1st year residents until sufficient proficiency to increase number of patients
- First doctor's visit for pre-natal care.

ASSIGNMENT OF NEW PATIENTS

New patients are assigned to residents according to the following priorities:

1. In keeping with family concept, a new patient will be assigned to the resident in charge of the other family members.
2. Patient preference or request
3. Resident availability
4. At random
5. As much as possible, third year residents will stop seeing new patients three months prior to their date of graduation with the exception of one-time only patients or acute patients.

No more than two (2) new patients (including new family members) per session will be scheduled. New patients are scheduled for 30 minutes unless the patient is seen for an acute problem, in which case they will be informed of the 15 minutes allowed to take care of their acute problem only. Rescheduling for an extended visit may be advisable.

OBSTETRICAL PATIENTS

OB patients are pre-screened by the Obstetrical Nurse Coordinator or her assistant. The first OB visit with the resident is scheduled for one (1) hour. All visits scheduled thereafter for routine prenatal care are for fifteen (15) minutes with the exception of the 36-week visit, which is scheduled for thirty (30) minutes. Post-partum OB follow-up visits and post-abortion visits require thirty (30) minute appointments. In keeping with the concept of family-centered maternity care, the baby's father should be encouraged to attend prenatal visits.

OB exams and OB follow-up visits are to be scheduled with the patient's regular physician unless this physician has approved another physician seeing that patient.

To assure continuity of care with their longitudinal OB patients, the primary care resident must remain available on pager at all times beginning at 36 weeks gestational age until delivery unless other coverage arrangements have been made. Calls should go directly to the primary physician, not to the AC or FPS resident. To ensure compliance with the resident duty hours, a weekend longitudinal OB coverage schedule will be arranged by the Chief Resident. The primary physician should make every effort to be available for the delivery of their longitudinal OB patients. The resident is required to care for 12 longitudinal maternity patients in order to satisfy RRC and program requirements.

HOSPITAL FOLLOW-UP APPOINTMENTS

Hospital follow-up visits will be scheduled with the patient's primary physician or if unavailable, the resident and/or attending physician who followed the patient while hospitalized. If the patient is an established Lynchburg Family Medicine patient, the visit will be scheduled for fifteen (15) minutes with the resident who followed the patient in the hospital. If not an established Lynchburg Family Medicine patient or not followed in the hospital by primary care physician, a thirty (30) minute appointment will be scheduled.

CARE OF LFMR EMPLOYEES, RESIDENTS AND THEIR FAMILIES

The practice of medicine requires a bona fide relationship between physician and patient. For residents, treatment of self, family members, fellow residents and their families is not permitted. It is mandatory that residents and their families and employees of the Lynchburg Family Medicine Residency, Lynchburg Family Medicine Center, and Big Island Family Medicine Center, establish a relationship with a primary care physician of their choice who is not a resident or faculty member.

An exception to this rule is in the event of an **Emergency**.

The prescription of narcotics and/or Psychotropic medications to fellow residents, faculty, and LFMR employees is prohibited.

Failure to abide by this policy is cause for disciplinary action.

SAME DAY APPOINTMENTS

When a patient calls the center wishing to be seen that day for an acute problem, and if there are no open appointments, he/she will be seen on a “work-in” basis as determined by the triage nurse. Patients who present to the center without a call or an appointment are classified as “walk-ins”. “Work-in” patients are encouraged to come to the center as soon as possible in order to be worked into the schedule as openings occur due to canceled appointments or “no shows”. They are told that there may be a wait but that a doctor will see them as soon as possible. Emergent/urgent situations will be brought to a physician’s attention immediately. “Work-in” and walk-in” status will be documented on the chart by the nursing staff. The nursing staff will inform the physician of any schedule changes. If the primary physician has office hours on this day, and if his/her schedule permits, the patient will be seen by his/her primary physician. If the patient’s primary physician is not available another physician will take care of the patient. The nurse will assign these patients equally between the residents present in the center as their schedules permit. If there are no openings in the schedule, the nurse will bring this matter to the attention of the Preceptor. It will be the responsibility of the Preceptor to find a physician to see the patient.

TARDY PATIENTS

Tardy status shall be documented on the chart by the receptionist. Patients who are chronically late need to be reminded by their physician of this unacceptable behavior. If a patient is unduly tardy for his/her appointment, the physician may reschedule the patient **after receiving the approval of the preceptor and preceptor’s signature on the superbill**, provided that there is no medical emergency.

NO-SHOW PATIENTS

In a greater effort to remedy the problem of patients who do not keep their appointments, warning letters are sent after “no-show” appointments. Three “no shows” within a period of twelve (12) months is reason for dismissal of patient from our practice. Talking to patients if they sporadically do not keep appointments is often an effective deterrent. Dismissal from the practice for “no-shows” may be postponed for special patient circumstances.

PATIENTS WHO REQUEST TRANSFER TO ANOTHER PHYSICIAN

The hallmark of family medicine is continuity and care of the whole family. This goal is kept in mind in the assignment of patients to residents. In the event that a patient requests a transfer from one resident to another, the following guidelines apply:

1. The reason for the request must be identified. The resident and his/her advisor must be informed. If a decision is made for reassignment to another resident the transfer will be done per protocol.

2. The reassignment may not be made to a faculty member unless so requested by the faculty member.
3. The patient may be permitted to transfer one time only during the resident's tenure and must be advised that as a group practice any and all residents may be involved in their care. Transfer of care within our practice does not preclude contact with the resident in question.

PATIENT DISMISSAL

We reserve the right to dismiss patients when financial obligations are not met or when the quality of care is significantly impaired by the patient's uncooperative behavior.

PATIENTS CANNOT BE DISMISSED FROM THE CENTER WITHOUT:

1. Communicating clearly and in good faith with the patient regarding the identified problem and suggesting remedy – "give notice".
2. Documentation in the chart and on patient dismissal form
3. Discussion with the Director of Patient Care
4. **WRITTEN APPROVAL FROM PROGRAM DIRECTOR**
5. If action is taken to dismiss a patient from the practice, a dismissal form is signed by the director, Director of Patient care and the office manager and a letter signed by the Office Manager is sent to the patient by Certified mail with return receipt requested. Thirty (30) days notice is given for the patient to obtain care elsewhere.
6. Advise all LFMR physicians in the practice of action taken.

SATURDAY OFFICE HOURS

The office is open on Saturday morning on a walk-in basis from 9:00 AM until 11:30 AM to care for patients with acute problems. The assigned resident should arrive in the office no later than 9:00 AM. Residents are responsible for remaining in the office until noon or until all patients who have arrived by 11:30 AM have been seen. The only new patients who can be seen are members of an established family. Medicare and Medicaid patients must be reviewed with faculty preceptor.

TRANSFER OF PATIENTS OR FAMILY CARE AT RESIDENT'S TERMINATION

Patients or families whose primary care physician has either graduated or left the program will be reassigned according to the following guidelines:

1. If a member of the family has been seen by another resident, their care is referred to this resident.
2. Patient preference for a particular resident will be taken into consideration.
3. As much as possible, referral to a first or second year resident would allow for more effective long-term care.

As graduation nears, graduating residents will be provided with a form when their patients are seen instructing them to note only information needed to reassign the patient. If no decision is made, the patients will be assigned at random. At the time of reassignment, the newly assigned resident's name will appear on the front of the patient's chart.

LAB WORK

The Center is equipped with a Level II laboratory and staffed by a full-time laboratory technician from 8:30 a.m. to 4:00 p.m. The resident is to indicate on the Patient Encounter Form what laboratory work is needed for the patient along with the diagnosis justifying the test, if known. Physicians must also indicate all lab procedures performed in examining room, (e.g. GC cultures, KOH, wet preps, etc.) The physician or patient takes the form and the chart to the lab. The Lab Tech will contact the resident when the results are completed and charted. The resident then relays the information to the patient. The Lab Technician is available as a teaching resource. Specimens of interest will be brought to the attention of the residents. If the patient requires laboratory studies at a time other than the office encounter (e.g., retest of lipid profile 5 weeks later) the request for tests along with justifying information should be entered on the red lab request form in the patients' medical record.

ENCOUNTER FORMS

Physicians must endeavor to completely and accurately complete the Patient Encounter Form using appropriate coding techniques for both the E&M (diagnoses) and CPT (procedural) codes.

X-RAYS

For all x-rays, a radiological consultation sheet, available at the nurses' station, should be completed. A report will be faxed to the office when the study is completed unless the x-ray is designated "Hold and Call". A form is available at the check-out area for mammograms.

SURGICAL PROCEDURES

The Treatment Room is equipped to perform common office procedures. Residents are expected to **document all office procedures** performed and to be precepted until the attendings have assessed and certified that the resident can perform the procedure on his/her own. All Medicare patients require a preceptor in the room at all times.

According to the type of procedure, times are allocated as follows:

Wart removal	15 minutes
Incision/drainage	30 minutes
Flexible Sigmoidoscopy	45 minutes
Norplant removal	60 minutes

Removal of skin lesion	30 minutes
Colposcopy	45 minutes
Endometrial Biopsy	30 minutes
Nasopharyngoscopy	30 minutes
Vasectomy	60 minutes
IUD Insertion	60 minutes

(See attached list in Appendix E of preceptors qualified to supervise specific procedures)

LIFE SUPPORT REQUIREMENTS (ACLS, NRP, PALS, ALSO)

First year residents are required to have a current ACLS certification or to complete the ACLS Certification Course offered in Lynchburg at the first available opportunity. Second and third year residents are expected to maintain their certification. The ACLS Certification Course expenses are paid by the Program. Other courses to be completed satisfactorily during the residency include Basic Life Support (BLS), Neonatal Resuscitation Program (NRP), Pediatric Life Support (PALS), and Advance Life Support in Obstetrics (ALSO).

CODE BLUE IN THE OFFICE

CODE BLUE (and location) is called when a patient loses consciousness or is in a life-threatening situation. Code Blue is called overhead on the intercom system both up and down stairs. The office personnel call 911 immediately and request an ambulance. The patient's chart is made available.

PROCEDURE:

1. All nurses and physicians respond.
2. The nurses are responsible for bringing the Office Crash Cart and the oxygen tank to the scene.
3. The office personnel are responsible for clearing the hallways and, if patients are in rooms, to make sure doors are closed and patients stay in the rooms during the emergency.
4. The first two (2) physicians to arrive at the scene will run the Code assisted by the first nurse to arrive.
5. The second nurse is responsible for clearing the area of patients, completing the Resuscitation Data Sheet and directing the remaining office personnel as to their responsibilities.
6. The Office Crash Cart contains basic and advanced life support material common to CPR carts.

Nurses and office personnel are expected to familiarize themselves with the location of the defibrillator, office crash cart and ECG machine. Drills take place as needed.

DOCUMENTATION OF OFFICE PROCEDURES

All procedures performed in the office must be reported on the patient encounter form and documented in the resident's procedure log to include date, patient name, chart number and description/findings and the preceptor. Without documentation of procedures, the residents cannot expect to be certified as competent to perform them at the conclusion of residency. Procedures are documented on the WEB based residency information system, <http://www.myevaluations.com>.

DOCUMENTATION OF HOSPITAL PROCEDURES

Residents doing procedures out of the office must document those procedures from any web-connected computer.

HOME VISITS OR HOUSE CALLS

Even though most patients are expected to receive their medical care in the Family Medical Center or in the hospital, a few patients are restricted to home or extended care facilities and will be visited by the residents. Residents are ENCOURAGED to visit patients in their homes as long as the approach

1. is therapeutically sound, and
2. promotes better quality of care.

Residents should ask for a preceptor to accompany them. All visits must be documented in the office chart using Home Visit form and residents must report their services on myevaluations and fill out an encounter form. Two home visits per year of residency are expected by the RRC and program requirements.(see Appendix F)

NURSING HOME AND EXTENDED CARE FACILITIES

A significant portion of the practice of every Family Physician has to do with the problems of aging and the care of the aged. Nursing Home Care constitutes a facet of such care. The Lynchburg Family Medicine Residency sees patients at area nursing homes. We also provide care to some of the residents of Grace Lodge Adult Home.

The assignment of Nursing Home patients is done in a way which is fair and equally demanding of each resident. New Nursing Home patients are assigned to residents by the Chief Resident. A listing of Nursing Home patients is kept at the nursing station and with the Chief Resident. It is the responsibility of the resident to be sure that the list is updated by reporting to the Chief Resident any new patients, discharged and/or deceased patients within seventy two (72) hours. The resident's responsibility toward a Nursing home patient is dictated first by the condition of the patient and requirements of the extended care facility. Residents must report their activity on myevaluations.com.

HOSPITAL PATIENTS

Patients are admitted either at Lynchburg General Hospital or Virginia Baptist Hospital as indicated by the type of medical problem and/or patient's preference. The nurses arrange admission of office patients. The attending preceptor must be informed immediately of a possible admission, and if in the office, the patient should be seen by an attending BEFORE LEAVING THE OFFICE. A short office note, written or dictated, with major findings and admission diagnosis must be recorded in the patient's office chart. When the resident is out of the office and one of his/her patients' needs admission, the patient will be admitted to the Family Medicine Service Hospital Team by the resident who sees the patient in the office and the team will follow regular admission procedures: e.g., discussion with the attending, History and Physical, write orders, etc. The patient's primary physician shall be advised of the admission as soon as possible and will supervise the patient's care after the admission.

1. **ADMISSION PROCEDURE:** Admissions are arranged through the Admissions Office by the office staff. Residents are to personally contact the charge nurse on all CCU and ICU admissions. The admitting resident is expected to complete an admission form (by hand) which is available in the office to specify the patient status and give appropriate orders. This is followed in the hospital by dictation of information regarding patient's history and physical and treatment plan. Psychiatric admissions at VBH are done by directly contacting the psychiatry floor.

The office resident admitting a patient to the hospital will first staff the patient with the office preceptor. The resident will then notify the receiving resident in the hospital of patient's condition. The office preceptor will communicate his/her findings to the hospital faculty attending.

2. **CARE OF HOSPITAL PATIENT:**
 - a. **DURING HOSPITALIZATION:** Critical Care patients are seen at least twice daily and discussed with the attending faculty at least twice daily.
 - b. **HOSPITAL DISCHARGE:** Both hospitals use early and pre-discharge planning. Discharge summaries are dictated at the time of patient discharge. Summaries are sent to the resident, the appropriate consultants, outlying physicians and extended care facilities. Social Services is contacted as soon as possible for patients that MAY NEED nursing home or other extended care facilities, etc. Lead time for social work activities may be as long as five (5) to ten (10) days.

C. **DISCHARGE SUMMARIES:** The following guidelines are used to determine the resident responsibility for the Discharge Summary:

1. The resident name which appears on the last line of the last page of the Doctor's Order Sheet is responsible for the Discharge Summary, e.g. resident writing the discharge order.
2. In the event of changes in service, it will be the new resident's responsibility to make the necessary changes on the first Doctor's Order Sheet in order to update the information.
3. In the event a chart is routed to the wrong resident, it will be the responsibility of that resident to notify both Medical Records and the appropriate resident.
4. The hospital by-laws state that the physician who discharges the patient is ultimately responsible for the discharge summary

D. DISCHARGE SUMMARY PROTOCOL:

1. Patient Name – (For Nursery babies include Mother's name and address)
2. Hospital medical record number
3. Admission date
4. Date of discharge
5. Admitting diagnoses
6. Discharge diagnoses
7. Discharge medication and disposition
8. Brief admission History and Physical Statement
9. Brief summary of hospital course
10. Major Procedures/Surgeries and Results
11. Discharge of Physical Examination
12. Laboratory Data Summary, X-rays
13. Copies to...
14. Consultations Obtained

3. HOSPITAL MEDICAL RECORDS: The hospital policy reads as follows:

The attending physician is responsible for the preparation of a complete medical record for any patient admitted and discharged from the hospital with the exception of normal newborn infants. This record shall include identification data, chief complaint, past medical history, family history, social history, history of present illness, physical examination, progress notes, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, final diagnosis, follow-up and autopsy when available, and a discharge summary or final progress note containing the reason for hospitalization, the significant findings, the procedures performed, the treatment rendered, the condition of the patient on discharge and the specific discharge instructions. Only a discharge note is required for patients who have had a vaginal delivery, with or without post-partum tubal ligation, who have a hospital stay not more than five (5) days post-partum. A medical record will not be filed until it is complete except on order of the Medical Record Committee. **THE MEDICAL RECORD IS TO BE COMPLETED WITHIN TWO (2) WEEKS AFTER THE PATIENT'S DISCHARGE.** Any member of the Medical Staff having incomplete records after this period will be notified by the Record Librarian.

After notification, an additional two (2) weeks will be allowed for the completion of these records. And if they are not completed within this length of time, all privileges of the member will be suspended until such records have been completed except that the individual physician who is delinquent may have admission privileges for an emergency room patient received by virtue of service on the emergency call roster for either hospital. Suspension of privileges will not apply to patients already admitted, and the member will be expected to continue care until discharge. Any extenuating circumstances which the member feels are pertinent will be presented to the Executive Committee for consideration and decision. A complete history and physical will, in all cases, be written within twenty-four (24) hours after admission of the patient.

4. **SPECIAL PROCEDURES FOR HOSPITALIZED PATIENTS:**
All special procedures (e.g. lumbar puncture, bone marrow biopsy and aspiration, central line insertions, etc.) should be approved and supervised by an attending physician.
5. **ATTENDING'S PARTICIPATION:** The resident is to keep the attending physician informed about the patient's condition and to work with the attending in providing patient care. It is the attending physician's responsibility to provide the necessary chart documentation on all patients for third party reimbursement. It is the faculty's responsibility to submit charges on hospital patients on a weekly basis. Residents must keep daily entries of their activity in their PDA to document experiences for RRC review and future privileging. This should be downloaded to the Billing supervisors computer at least monthly.
6. **PRIVATE PATIENTS (IN HOSPITAL):** Permission must be obtained from the private attending physician to interview or examine any private hospitalized patients.

FACULTY PATIENTS

If hospitalization is necessary, the faculty physician shall refer the patient to the resident on call. The resident will work closely with the faculty in the care of the patient while in the hospital and refer the patient back after discharge.

CONTINUITY OF CARE GUIDELINES

The following is a system for ensuring continuity of care from the outpatient to the inpatient settings for patients of Lynchburg Family Medicine.

1. For admissions that take place during normal weekday business hours, the admitting resident shall be responsible, with the help of administrative staff, for notifying the PCP that s/he has a patient in the hospital before 5 PM. If the admission takes place after hours or on the weekend, the most junior resident on the inpatient team shall be responsible, with the help of administrative staff, for notifying the PCP by 10 AM

on the first weekday following an after-hours or weekend admission. The PCP is determined as follows.

2. The admitting resident shall ask each patient (or his/her family) who s/he believes is the primary care physician. If the patient can name or otherwise identify either a resident or attending, that person shall be assumed to be the primary care physician (PCP).
3. In the event that the patient or his/her family is unable to specify a PCP, but the patient is known or thought to be a patient of LFM, the following steps will need to be taken to identify the PCP:
 - a. The most junior resident on the inpatient team during regular weekdays will contact either the office manager or the nurse manager, and provide her with the patient's name and date of birth.
 - b. The patient's chart should then be located and examined to determine who the patient's PCP appears to be. It should *not* be assumed to be the physician identified on the outside of the physical chart or the PCP identified in the electronic medical record. The chart should be examined for the most recent office encounters. If the assigned PCP and the most-commonly seen physician are the same, then that physician should be designated the true PCP. The office or nurse manager may need to make a judgement about the physician likely to know the patient the best. It is possible that the assigned PCP has never seen the patient as an outpatient, or that the patient has been seen consistently in the office by another physician. Appropriate notations as to the "true" PCP should be made on the office paper chart and the electronic medical record.
 - c. If the patient was assigned to a physician who is no longer at Lynchburg Family Medicine, and has not been seen in the office by his/her new PCP, that patient shall be deemed an "unassigned" office patient for the purposes of this admission. This patient then becomes an office continuity patient of the junior resident on the inpatient team. Such notation should be made in the electronic medical record and the physical office chart.
 - d. In the case of newborn infants, the PCP shall be deemed to be the physician either of the parents or of the newborn's siblings.
 - e. In cases where a PCP cannot be easily identified, any available faculty can make the final determination.
 - f. The office or nurse manager should then notify the junior inpatient resident as to the identified PCP.
4. The most junior resident on the inpatient team should contact the LFM administrative staff (Cindy or Teresa) with the list of all continuity patients (this should not be a long

list in most cases), their location, and the predetermined PCP, who should then page or otherwise notify those physicians that they have a patient in the hospital. These contacts should be made as soon as possible for admissions that occur during regular office hours, or by 10 AM on the first weekday following an after-hours or weekend admission. Alternatively, it may be more expeditious for the resident to notify the PCP without involving administrative staff.

5. In the spirit of the RRC guidelines on continuity of care, the PCP must “maintain active involvement in management and treatment decisions” concerning his/her patients “when such patients require hospitalization or consultation with other providers.” This contact need not be maintained on weekends when the PCP is not on call, but should be sought during any weekday the patient is in the hospital. It should be clear from the documentation in the chart, either that of the inpatient team or of the PCP, that the PCP is actively involved in the patient’s plan of care.
6. The inpatient attending physician shall be responsible for logging patient charges.
7. For practical reasons, Drs. Pletke (outpatient privileges only) and Wortley (geographic constraints) shall be exempt from these continuity requirements.
8. Inpatients whose PCP is absent from the practice for any reason will be cared for by the inpatient team.

CALL SCHEDULE

Over the years the Call Schedule has evolved in order to work out the most convenient method of sharing call between the residents in the program. The goal of the Call Schedule is to provide sufficient clinical experience for the residents while providing quality medical care for all patients. If there are times when the regulations as herein described do not cover a particular situation, as unusual situations do arise, all residents are expected to help out in whatever way possible to give the patients of our group adequate medical coverage. The majority of call is shared between the residents on the Family Medicine, Pediatrics and A/C rotations, and with longitudinal maternity patients.

The Call Schedule is based on a call day that runs twenty-four (24) hours from 6:00 AM to 6:00 AM for the FPS and AC, and Pediatric Service. Every intern and resident is responsible for being on their pager from 7:00 AM through 5:00 PM, Monday through Friday, unless otherwise specified or arrangements have been made.

REQUEST FOR SPECIFIC DAYS ON OR OFF CALL: This request is given to the Chief Resident as he/she is responsible for establishing the call schedule. All such requests are given to the Chief Resident **EIGHT (8) weeks** ahead of the first of a given month in order to prepare the call schedule. ALL vacations must be scheduled eight (8) weeks in advance of the first of a given month or at the discretion of the Chief. An attempt is made to equalize the frequency of call as well as the holiday burden over the year.

The monthly call schedule is provided at least TWO (2) weeks prior to the month for which it is appropriate. Changes in the call schedule that are arranged by the residents after the call schedule is made must be reported to the Administrative Secretary who in turn notifies the Head Nurse, the Attending on Call, the Chief Resident, and the Answering Service.

Buying or selling call is prohibited.

A. FAMILY MEDICINE CALL

1. Second or third year Resident on Family Medicine Call

This resident may be on FPS, on AC or on another rotation as designated on the Call Schedule.

The Family Medicine resident begins call at the time consistent with intern and residents' responsibilities (See Call Schedule).

Responsibilities include:

- a. Calls on: -all in-house Family Medicine patients (received by intern)
-all in-house Pediatric patients and clinic nursery except when there is a Pediatric team on call (received by intern)
- b. After hours calls from all Family Medicine patients who call the office or answering service (until January)
- c. Calls on all Family Medicine patients in Nursing Homes (received by intern)
- d. Responding to all Family Medicine patients when we are asked by Emergency Room for evaluation and admission
- e. Consults on inpatients requested by local physicians
- f. Backing up and assisting the intern in patient evaluation and management
- g. Obstetrical coverage of patients whose PCP/backup PCP is unavailable

2. Intern on Family Medicine Call

The Intern on Family Medicine begins call at 6 AM.

The Intern will always have a second or third year resident who will assist in evaluation, admission and management of patients.

The Intern taking first call will not be responsible for outside telephone calls until the third FPM rotation of the internship year and approved by faculty.

Responsibilities 1.a., 1.d., 1.e., & 1.g. apply through the year with a second or third year resident as backup.

B. RESIDENT ON PEDIATRICS: The Pediatric Call Schedule will vary depending upon the number of residents on the rotation and their level of training. The call schedule will be designed by the Chief Resident with consultation of pediatric attendings when needed. Clarify all call changes with the attending.

General Guidelines are as follows:

1. Two person rotation: Each resident will be on call two week nights per week and every other weekend (two out of four or three out of five). The Pediatric calls and admissions on nights when there is no Pediatric resident on call will be handled by the resident designated on the schedule (typically AC or FPS).
2. Three person rotation: Each resident will be on call one third of the days of the month. Every night of the rotation will be covered by a resident currently doing the Pediatric rotation.
3. All pediatric interns will be assisted by second or third year residents whenever they are on call. The intern should refer to the schedule to see who that backup is.
4. Responsibilities of Pediatric residents include but are not limited to:
 - a. Work-ups on all admissions.
 - b. Covering current inpatients on Pediatric Ward and Newborn Nursery.
 - c. Handling calls from the ER and evaluating outpatients as needed.
5. The intern will not be on call for other services when on the Pediatric rotation, but the upper level may be required to cover FPS when needed.

New Policy as of 6/13/07:

Inpatient Pediatric Service Rotation: New Supervisory Back-up Resident Policy

Just as with any adult patient admissions

- The rotating 1st year resident covering the Inpatient Pediatric Service after-hours at night and on weekends day and night is required to contact the upper-level (2nd and 3rd year) resident on-call for the Family Practice Service or AC with all pediatric admissions
- The upper-level resident contacted is required to be present with the 1st year resident, to guide their evaluation and development of orders.

The attending physician responsible for the care of the pediatric patient may allow the upper-level resident to not be present (at the attending physician's discretion – i.e. they are already with the 1st year resident) but the upper-level resident must still be informed of the issues surrounding the patient's admission.

This policy applies to both the first and second months of a 1st year resident's Inpatient Pediatric Service Rotation and **will be reassessed in December of 2007.**

- C. RESIDENT ON MEDICINE: The Resident on the Medicine Rotation is expected to be on call when the attending is on call and at the request of the attending. The upper level may be required to cover FPS when needed.
- D. RESIDENT ON SURGERY: Surgery call is to be arranged by the intern or

resident with the attending. However, it is anticipated that the intern or resident will take call with the attending surgeon per the attending surgeon's schedule. The upper level may be required to cover FPS when needed.

- E. RESIDENT ON ORTHOPEDICS, RURAL MEDICINE, DERMATOLOGY, PRACTICE MANAGEMENT, UROLOGY, ENT, OPHT, LAB AND THIRD YEAR ELECTIVES: During these months the resident will be available for Family Medicine call as needed. Call days and nights will be distributed on a fair and equitable basis. Call with the attending may be arranged.
- F. RESIDENT ON EMERGENCY MEDICINE: Please see the Emergency Medicine Rotation. The upper level may be required to cover FPS when needed.
- G. RESIDENT ON FAMILY MEDICINE SERVICE: Please see the Family Medicine Rotation.
- H. RESIDENT ON OB/GYN: The call schedule is outlined under the OB section in the Curriculum Manual. The intern will not have any Family Medicine call. Longitudinal maternity patients should be covered by a fellow resident or resident covering LFMR call. If coverage agreements have been made, be certain that LFMR OB faculty knows who is to cover.
- I. RESIDENT ON CCU – The resident will take CCU and ICN calls as specified in the rotation protocol. No Family Medicine calls are taken during these months. The upper level may be required to cover FPS when needed.

CHECK OUT

All interns/residents who have inpatients or inpatient responsibilities must check out daily to the resident on call who will be responsible for these patients after 6 PM. Check out for the resident on call will, in general, include the following:

1. The patient's name and age
2. Location
3. Major problems and work up
4. Major treatment
5. Anticipated problems through the night
6. Treatment for anticipated problems
7. Degree of desired resuscitation by the family and physicians involved.

WEEKEND CHECKOUT

Friday check out rounds will occur in the Conference Room of the Family Medicine Center at 12:20 PM and is strongly encouraged of **ALL** faculty and residents. Attendance is taken and recorded. The on-call interns and residents for the weekend

will have an opportunity at this time to have weekend plans explained to them by the patient's primary physician.

UNASSIGNED EMERGENCY ROOM PATIENTS

The Family Medicine Service accepts two unassigned patients a day Monday through Thursday, one unassigned patient Friday morning and one unassigned patient on Sunday evening. The FMS also accepts all unassigned pediatric patients unless inappropriate to the level of call at Centra Health. When the service team is ready to receive an unassigned patient in the morning, the resident will notify the Emergency Room HUC. If the number of patients on service is excessive, the faculty may elect to notify the emergency department that no unassigned patient is to be taken on that day. They should notify the Emergency Department early in the morning (7 AM) to cancel the day patient and early in the evening (6 PM) to cancel the night unassigned patient.

OUTPATIENT DUTIES OF THE RESIDENT ON FAMILY MEDICINE SERVICE

Aside from the inpatient duties described in the Family Medicine Service protocol the resident on the FPS may be asked to do the following duties:

1. Be available, if asked, to see office patients in the event that the office is overloaded. The resident will not be expected to come to the office if the resident is tied up in patient care at either of the two hospitals or in the Emergency Room.
2. Accept all consults and admissions until 6:00 PM. If the resident is scheduled for office in the afternoon then the order of call list will be implemented.
3. Be available for:
 - A. Office emergencies
 - B. Emergency Room evaluations
 - C. Nursing Home emergencies
 - D. Questions and problems that arise on other Family Medicine patients in the hospitals if the primary physician is unavailable for the evaluation
 - E. Office patients in hospital or Emergency Room.

PDA DOCUMENTATION

Residents are required to document their activity for accreditation, credentialing, and for financial reasons. Procedures and completion of requirements should be documented in the myevaluations.com program same day performed. PDAs are issued to each resident and documentation entered in them is to be synchronized frequently (at least weekly) into designated desktop PCs. Frequent synchronization of PDAs with desktop PC is necessary to avoid loss of documentation should the PDA suffer a technical failure. Loss of documentation due to resident's failure to synchronize is their

responsibility. Faculty will submit changes on a weekly basis. If documentation is not maintained appropriately the following shall apply:

The resident's failure will be discussed at the Faculty Committee meeting if he/she fails to meet the required deadline for two consecutive months. If the resident fails to meet the deadline for two consecutive monthly periods, one vacation day will be lost. The faculty's failure will be handled by the Program Director

Residents are required to document **accurately** all of their clinical activities (patient seen/diagnosis/procedures etc.) whether in the myevaluations.com program, the Family Medicine Center (Encounter form), Extended Care facility (PDA) or Home visits (PDA and encounter form). Such documentation will be essential in the granting of privileges in later practice. A print out of all documentation synchronized into desktop PCs is available upon request. In addition, a quarterly printout of resident activity in the Center is available, giving a quantitative summary of resident's number of sessions, number of patients, cost effectiveness, and revenue.

E&M/CPT Coding: Residents must be knowledgeable and up to date on the Coding System used for billing purposes. Accuracy, honesty, proficiency and thoroughness are expected of all residents. This is an important skill to achieve and part of the hands-on practice management curriculum. Regular feedback and updates are provided by the Faculty.

COMMUNITY EDUCATION PROJECT

Over the course of the residency training, each resident is required to take responsibility for one (1) patient education or community education activity. This activity is a requirement to be satisfied for graduation. In addition to meeting the need for information and education of the community, it is an opportunity for the resident to learn to communicate with a group and provide medical information in lay terms being particularly sensitive to patients' concerns and questions. (document on MyEvaluation.com: Community Health Education Projects).

RESIDENTS AS PRECEPTORS

Residents are given the opportunity to function as office preceptors in order to learn this specific teaching skill. Third year residents may request permission from their advisor to function as office preceptor during the last year of their residency experience. Such permission is granted on merit. A resident preceptor may be scheduled for this activity at a frequency not to exceed twice a month for three months. A back up faculty preceptor will be available concurrently.

MEDICAL STUDENTS IN THE LFMR

LFMR offers clinical rotations to 3rd and 4th year medical students. Students are accepted based on review of their medical status (e.g., valid status in medical school, satisfactory academic performance and clinical experiences). The students may choose one of 4 opportunities: 1) ambulatory rotation in the LFMR office; 2) family medicine sub-internship with the LFMR hospital team; 3) rural Medicine at Big Island; or 4) 2 week blocks of a combination of experiences. The faculty and residents will share in the teaching of medical students and they are expected to attend LFMR conferences. Our policies with regard to examining patients, patient confidentiality, and compliance with staffing and documentation that exist for residents are also in effect for students. Medical student's access to patient medical information is the minimal necessary for their training. Students are required to possess and wear a valid picture identification badge at all times they are in the office or hospital, and to properly identify themselves to all patients and staff as a "student physician". Medical students may transcribe data for prescriptions or clinical notes, but all must be reviewed and signed by a licensed physician supervisor. All procedures must also be under direct faculty or senior resident supervision.

ROTATION REQUIREMENTS

All residents are expected to review curriculum and confidentiality policy before starting each new rotation.

- A. During the FIRST YEAR of residency, the intern is expected to rotate through the following services:

Family Med/Community Med.	1 month
Family Medicine Service	3 months
Pediatric Inpatient	2 months
Emergency Medicine/ Emergency Psychiatry	1 month (50 hours/week)
Maternity Care	2 months
Surgery	1 month
Internal Medicine	1 month
Orthopedics	1 month

- B. The following rotations are required and scheduled during the SECOND YEAR:

Family Medicine Service	2 months
Internal Medicine	1 month (2 weeks of 2 Subspecialties choose from Rheumatology, Nephrology, Endocrinology)
Pediatrics Ambulatory	1 month
Cardiology	1 month
Acute Care Service	1 month

Orthopedics	1 month
Elective (local)	1 month
Surgery	1 month
Newborn/Intermediate Nursery	1 month
Gynecology	1 month
Practice Management	2 weeks
Family Medicine Preceptorship	2 weeks

C. The THIRD YEAR resident will schedule his/her third year rotations under the guidance and coordination of the Faculty Advisor. Required rotations are:

CCU	1 month
Family Medicine Service	1 month
Acute Care	1 month
ENT	2 weeks
OPHT	2 weeks
Radiology	2 weeks
Dermatology	2 weeks
Laboratory	2 weeks
Urology	2 weeks
Rural Medicine	1 month
Electives	3 months

(It is recommended if the resident intends to practice maternity care, 1 or 2 months of electives should be devoted to OB.)

The following ELECTIVES are available: Infectious Disease, Radiology, Outpatient Pediatrics, Pulmonary Medicine, Plastic Surgery, College Health, Podiatry, Rural Medicine, Gastroenterology, Geriatrics, Maternal/Child Health, Substance Abuse, Neurosurgery, Oncology, and Family Medicine Teaching Elective. Additional elective experiences can be designed and tailored to resident's educational needs.

SCHEDULING ELECTIVES

At the beginning of each academic year, the faculty advisor will discuss with each resident his/her elective educational needs for the coming year. Office and elective schedule requests **MUST BE MADE TWO (2) MONTHS PRIOR TO THE FIRST OF THE MONTH FOR WHICH THEY ARE APPROPRIATE.** If the schedule request is not turned in on time, office hours are assigned without any input from the resident concerned. Elective schedule requests must be approved by the Chief Resident, the Administrative Secretary and the Faculty Advisor so that he/she can keep the office schedule running smoothly. Residents are expected to make initial contact with the attending concerned in regard to scheduling an elective in any given month. This is to be done a **MINIMUM OF TWO (2) MONTHS IN ADVANCE** of the time of the scheduled elective. If there is any question as to whether a proposed elective would be appropriate, this should first be discussed informally with the Faculty Advisor. Forms for each elective should then be completed and given to the Administrative Secretary. They will be reviewed by the Program Director and given to the Chief Resident to be

considered when office and call schedules are prepared. A letter will be mailed from the office to each proposed elective attending ONE MONTH PRIOR TO THE ELECTIVE reminding him/her of the resident's schedule. At the conclusion of each elective, residents are expected to complete an Elective Evaluation Form and return it to the Administrative Secretary. These forms will be kept in a permanent file in the office to facilitate future resident choice. A maximum of 2 months of elective time may be used for remediation.

AWAY OR "OUT OF TOWN" ELECTIVES

An "out of town" elective is an elective month scheduled at a distance from Lynchburg which does not allow performing office duties on a regular basis. These electives are only permitted during the third year of residency. Only one resident is permitted to schedule an "out of town" rotation at any given time. These electives must be scheduled at least three (3) months in advance and approved by the Program Director after initial review and approval by advisor. Electives can be no longer than 20 working days and there must be at least 2 months of patient continuity between "out of town" rotations. Each resident may have only one (1) "out of town" rotation during their residency. No away rotations may be scheduled in the month of December, The first week in July or the last week in June.(See Appendix G)

RESEARCH

Resident scholarly activity is strongly encouraged. This might include case reports, clinical reviews, poster sessions or original research submitted for publication. Faculty experienced in research and statistical consultation are available upon request. Proposals for scholarly activity could be developed in consultation with a faculty advisor with interest and expertise in the area. Funding for resident research projects is not ordinarily budgeted and residents should seek consultation with the director for potential sources of funding for their projects. Research projects must pass final review with the resident's faculty advisor and program director and must be approved by Centra Health's IRB.

DIDACTIC AND CLINICAL TEACHING

- A. **CONFERENCES:** Conferences are held on a regularly scheduled basis in the office and hospitals. The conferences are listed on the Monthly Conference Schedule. These presentations are given by lecturers from the faculty, University faculty, local physicians, health care professionals and residents. For details regarding the time, location and content of the conferences, please refer to the schedule. When a conference is required, attendance will be taken. Residents on a required away rotation or approved away rotation elective are excused from conference requirements. The excused absence form must be filled out, signed by advisor and turned into the Residency Scheduler. Residents attending to Pediatric and FPS admissions or longitudinal OB deliveries are also excused from conference.

MANDATORY CONFERENCES ARE SCHEDULED AS FOLLOWS:

1. Monday 12:20-1:00 PM, LFMR Conference Room - The following activities will be scheduled: Information Mastery; Office Rounds, QI, and Lab projects. **Required** of all residents. (Residents on AC are exempted)
2. Tuesday 12:20 – 1:00 P.M. LFMR Conference Room, Committee Meetings (i.e., Curriculum, Model Office, Recruitment, etc.) Attendance is optional, but encouraged.
3. Wednesday 7:00 AM OB GRAND ROUNDS: **fourth Wednesday** of each month at VBH. **This is a required activity for all residents and faculty, including resident on AC.**
4. Wednesday 1:00-4:00 PM Resident Conferences, (**Required-see resident responsibilities**) LFMR Conference Room. PGY1 and PGY2 AC resident expected to attend; PGY3 AC resident attendance is optional due to increased clinic assignments.
1:00-3:30 PM: Clinical Presentations, Case presentations, Medical Ethics Symposium, Practice Management, or Procedure Review
3:30-4:00 PM Residents' Meeting, Reading of Residency Committee Minutes, discussion and information session. **Required** of all residents.
On the second Wednesday of the month, Resident/Faculty meeting.
5. Thursday 12:20-1:00 PM Morbidity and Mortality Rounds focusing on hospital care, LFMR Conference Room. **Required** of all residents. (Resident on AC exempted)
6. Friday 12:20 PM Check out Rounds, LFMR Conference Room. **Required** of all residents except the resident on AC.
7. FAMILY MEDICINE SYMPOSIUM (usually last Friday in June): This is a yearly conference which involves all residents since it is sponsored and coordinated by the residency for the benefit of the residents, the LFMR graduates and the local medical community. **Required** attendance for all faculty and residents.
8. ANNUAL CARING WITH AWARENESS CONFERENCE (usually a Wednesday in April) 1:00 – 4:00 p.m. **Required** for all faculty and residents.
9. SPECIALTY CONFERENCES (i.e., Pediatric Conferences) Required for all residents while on that particular rotation.

Highly Encouraged To Attend:

- Friday 7:00 AM Clinical Pathological Conference (CPC) held on the **third Friday** of each month from October to May at VBH Auditorium. This conference can be used for extra credit towards attendance percentage. (Breakfast is provided.)
- MONTHLY GRAND ROUNDS: 6:00 PM **first Tuesday** of each month (October through June) at VBH Craddock Auditorium. This conference can be used for extra credit towards attendance percentage. Buffet dinner provided.
- ANNUAL CRITICAL CARE SERIES: 7 a.m. at VBH Auditorium (September). This conference can be used for extra credit towards attendance percentage.
- Conferences attended while on an out of town rotation may be documented and submitted for extra credit (i.e., Dermatology)
- Specialty Conferences when not on a particular rotation (i.e., Pediatrics Conference) can be used for extra credit towards attendance percentage.

Occasionally, conferences may be scheduled at other times and appropriate notice is given to the residents. (Neonatology, Tumor Board, Rheumatology, etc.) Attendance at these conferences may be reported to the Conference Coordinator to supplement conference attendance requirements.

- B. RESIDENT PRESENTATIONS – Residents are responsible for a presentation on a topic meeting the curriculum requirements.

PGY1	2 one-hour presentations on 4 th Wednesday @ 7 AM during OB rotation
PGY3	1 one-hour presentation on Wednesday afternoon 1 cost analysis of lab test presented @ lab committee 1 quality improvement study

The residents, in collaboration with the Conference Coordinator, will identify a topic and prepare a formal presentation under the guidance of a Faculty member of his/her choice. This is a formal presentation with the resident standing up in front of the group. Use of slides, PowerPoint and/or handouts is necessary. Evaluations of the presentation conclude this activity.

DOCUMENTATION OF ATTENDANCE AT CONFERENCES

When attending didactic conferences residents are expected to sign and print their name on the roster sheet. Residents are expected to be punctual and attend all required didactic conferences per protocol. They are encouraged to attend elective conferences as well. Satisfactory attendance for purposes of promotion is defined as 70% of required conferences. You must attend at least half of the lecture in order to be credited with attendance. Attendance is documented for accreditation purposes. In order to qualify for CME travel allowance, 70% of required conferences must be attended. Conference attendance falling below the required minimum is brought to the attention of the director for appropriate action. **Residents may not sign for one another.**

ADDITIONAL EDUCATIONAL ACTIVITY

- A. CHART REVIEWS: This activity intends to review office charts regarding charting and medical issues and offer constructive feedback.
- B. PRECEPTING: A preceptor is always available during office hours. First year residents are REQUIRED to present each patient to the preceptor. They are also required to have a preceptor present while performing any procedure. All residents are required to consult with a preceptor prior to referring a patient to another physician or admitting a patient to the hospital. All Medicare patients must be precepted and the preceptor must be present in the room during procedures done on these Medicare patients. Furthermore, in the first six months of the intern year, Medicare patients seen by first year residents must also be seen by the preceptor as well. All residents must staff all Medicaid patients and the preceptor must see all Medicaid patients.
- C. VIDEO RECORDING: The office is equipped with digital video recording equipment for teaching purposes. Several examination rooms are equipped with a fixed camera. Video DVDs are provided to the residents for this activity. Each resident is scheduled for a quarterly recording session. The nurses will coordinate room assignments for this activity. All patients will be duly informed by the nurse and will sign a consent form to allow recording. A patient CANNOT be recorded without a signed consent form filed in the patient's chart. DVD segments are reviewed by faculty and residents during a scheduled session. Residents are expected to record at least 4 times a year. In addition, residents may choose to record patients at any other time as long as other residents are not scheduled to use the equipment. This activity provides an effective teaching modality and an opportunity to focus on physician/patient encounters, interviewing techniques, clinical skills, etc.
- D. LIBRARY POLICY: All books in the library are property of the Lynchburg Family Medicine Residency Program, and should remain in the office for the use of all residents. When residents are finished using the books they must reshelv them

in their proper place. Virginia Baptist Hospital and Lynchburg General Hospital have libraries with sign-out capabilities.

- E. DVDs, AUDIOVISUAL CASSETTE AND VIDEOTAPES: are also available in the library. A tape player and VCR equipment are located in the large conference room with working instructions. The Continuing Medical Education Department and the Hospital Libraries offer current tapes.
- F. TEACHING SLIDES: Slides are available in the office laboratory and can be requested for review as needed from the office Laboratory Technician.
- G. PRECEPTING: A preceptor is always available during office hours. First year residents are REQUIRED to present each patient to the preceptor. They are also required to have a preceptor present while performing any procedure. All residents are required to consult with a preceptor prior to referring a patient to another physician or admitting a patient to the hospital. All Medicare patients must be precepted and the preceptor must be present in the room during procedures done on these Medicare patients. Furthermore, in the first six months of the intern year, Medicare patients seen by first year residents must also be seen by the preceptor as well. All residents must staff all Medicaid patients and the preceptor must see all Medicaid patients.

COMMITTEES

In order to maximize efficiency in the functioning of the program, committees have been established and are listed below:

1. RESIDENCY COMMITTEE –2 Wednesdays of the month 4:00 to 5:00 PM
 - INTENT: To develop overall program, make projections, develop and maintain responsibility, etc.
 - CHAIRPERSON: Program Director.
 - MEMBERSHIP: All faculty members, Nurse Manager, Office Manager, Chief Resident and Residency Coordinator.
2. FACULTY MEETING-meets first (agenda) and third (no agenda) Wednesday each month 4:00 to 5:00 PM
 - INTENT- Provide for faculty development, structured programmatic review and discussion of resident teaching/learning issues.
 - CHAIRPERSON-Director
 - MEMBERSHIP- All faculty and Residency Coordinator
3. FAMILY MEDICINE SYMPOSIUM – AD HOC COMMITTEE-meets PRN
 - INTENT: To provide graduates, present residents and the local medical community with an event for training and meeting.
 - CHAIRPERSON: Faculty member.

- MEMBERSHIP: senior residents, faculty, office staff and Residency Coordinator.
4. ANNUAL CARING WITH AWARENESS CONFERENCE
 - INTENT: To improve cultural competency of residents and faculty; improve care of minorities/subsets of patients. To develop resident ability to plan and conduct a CME conference
 - CHAIR: Program Director
 - MEMBERSHIP: One resident interested in learning to develop CME activities, Conference Coordinator
 5. CURRICULUM COMMITTEE – meets monthly
 - INTENT: To define, evaluate and improve the curriculum and to develop and evaluate new rotations and electives.
 - CHAIRPERSON: Faculty Member.
 - MEMBERSHIP: Conference Coordinator, Residency Scheduler, interested residents, nurses and faculty members-open to all
 6. LIBRARY – Task Force-meets annually or PRN
 - INTENT: To organize, review requests and make recommendations for the purchase of books, tapes and journal subscriptions.
 - Librarian: Faculty Member
 7. RECRUITMENT COMMITTEE – meets as needed
 - INTENT: To help promote the image of the program to applicants, patients and the community at large.
 - CHAIRPERSON: Director of Recruitment
 - MEMBERSHIP: Residency Coordinator, interested faculty, residents, nurses and office staff-open to all
 8. LABORATORY COMMITTEE – meets every other month
 - INTENT: To ensure compliance with CLIA, COLA, OSHA and other regulatory agency guidelines. To improve the functioning of the lab through assessment of procedures, review of equipment needs, and purchase recommendations. To develop a laboratory curriculum to disseminate information and educate residents, clinical, and clerical office personnel. To provide a forum for resident's cost analysis presentation.
 - CHAIRPERSON: Lab Technician.
 - MEMBERSHIP: physician lab director, lab technician, interested faculty, residents and staff.
 - Residents are required to attend at least 4 committee meetings to meet graduation requirements

Committees meet as needed. Committees 3 through 8 report to the Residency Committee.

RESIDENT MEETINGS: As stated earlier, regular meetings facilitated by the chief resident on Wednesday afternoon allow for discussion of problems, suggestions, etc., which pertain to the functioning of the program. Further meetings may be called with or without facilitator to address specific issues. Facilitated group meetings are requested through chief resident on a PRN basis. Mark Beck (Pastoral Care) is designated as the facilitator. The Chief Resident reports on the weekly meeting to the Residency Committee. On the first Wednesday every other month, a combined Family Meeting (faculty, residents and staff) and a resident/faculty meeting on the second Wednesday of each month is held to improve communication, raise concerns and jointly problem-solve.

CHIEF RESIDENT

One upcoming 3rd year resident (who may or may not have served as the assistant chief) is elected by the residents in February of each year to assume duties on May 1. The residents' choice is presented to the director, who in consultation with faculty, will, if acceptable, ratify the selection to serve as chief resident for a period of twelve consecutive months. The chief's actual tenure starts on May 1 and ends on April 30 of the following year. A two-month period of orientation takes place in March and April when the upcoming chief assumes duty alongside the outgoing chief. Payment of salary is disbursed to cover work from May 1 to April 30th of the following year. The chief resident's duties are described in the job description available on the Centra shared drive (N:LFP/LFP Chief Residents).

ASSISTANT CHIEF RESIDENT

One 2nd or 3rd year resident is selected in February by the residents and ratified by the director in consultation with the faculty to serve as assistant chief resident for a period of twelve consecutive months. The assistant chief's actual tenure starts on May 1 and ends on April 30th of the following year. Payment of salary is disbursed to cover work from the same time period at the end of each month. The assistant chief is not necessarily expected to serve as chief resident the following year. The assistant chief's duties are described in the job description available on the Centra shared drive (N:LFP/LFP Chief Residents).

FACULTY ADVISOR

Each resident is assigned to a Faculty advisor who is a full-time faculty member teaching in the residency. The advisor will serve as a mentor and is available for help and advice on any issue pertaining to the resident's education. The two will meet on a quarterly basis to discuss progress and concerns. The advisor also provides on-going feedback about the resident's performance and formal evaluations twice a year.

Advisors are assigned for 3 years to incoming first year residents and will attempt to establish a relationship that fosters professional and personal development. If the resident feels the match is incompatible, one change is allowed after the first 6 months to a different advisor/mentor.

CRITERIA FOR PROMOTION OF RESIDENTS

- 1) Receive a satisfactory performance rating on all rotations.
- 2) Receive a satisfactory performance rating on longitudinal evaluation of model office care and skills/family medicine competency.
- 3) A positive faculty and mentor report.
- 4) Satisfactory completion of annual specific requirements (see Page 83)
- 5) Satisfactory participation in all on-going, required activities of the program, e.g. nursing home care, maternity care, conference attendance, documentation of procedures/requirements, etc.
- 6) Must have passed USMLE III before graduation.

SATISFACTORY COMPLETION OF RESIDENCY (GRADUATION REQUIREMENTS)

In order to satisfactorily complete the requirements of the Family Medicine Residency, a resident must meet the following:

- I. Pass all required hospital rotations.
 1. If one rotation is evaluated “failed”, the resident is required to fulfill the requirements necessary to make up for the failed mark as determined by the program Director and the resident advisor in communication with the attending physician concerned.
 2. If two rotations are failed, the resident may be subject to dismissal. Proper notification is given to the resident. (See Due Process) If a resident is making up a failed rotation beyond the time of the contract, the resident will be required to work without pay.
 3. If more than two rotations are failed, the resident will be subject to dismissal.
- II. Pass all required outpatient rotations and electives. The same policy as above applies for failed marks.
- III. Receive satisfactory yearly evaluations of office performance as rated by preceptors and office faculty to include chart audits.
- IV. Complete required number of tape reviews, documentation of procedures, presentations, Patient Education Activity Projects and other miscellaneous requirements. (See appendix “Special Requirements” checklist)
- V. Attend didactic conferences regularly and punctually.
- VI. Is proficient at case presentations and at didactic presentations as required.
- VII. Has performed in an ethical and professional manner throughout residency.

- VIII. Has completed all charts, messages, Nursing Home recertifications, journals, mail and documentation and returned all Lynchburg Family Medicine Residency property which includes parking cards, dictation machines, palm pilot/visors, pagers, and office keys.

EVALUATION

1. IN THE FAMILY MEDICINE OFFICE: During office hours, preceptors are available at all times to provide teaching and feedback to residents regarding their performance. This is provided both informally and in writing on forms designed for this purpose.
2. ROTATIONS AND ELECTIVES:
 - A. Attendings and residents clarify goals and expectations at the beginning of the rotation or elective.
 - B. Attendings provide feedback to residents informally at mid-point and formally at the end of the rotation and on an ongoing basis as needed.
 - C. At the end of the rotation/elective, a written evaluation is completed by each attending and sent to the Program Director. It is posted to a secure network site (New Innovations Residency Information System) and reviewed electronically on-line by the Faculty; a copy of the evaluation is made available to the resident.
 - D. Residents complete a written evaluation of their rotation on-line at the end of their rotation. These evaluations are retained on-line and may serve as reference to residents selecting elective experiences. Internal review of rotation evaluations may serve as a trigger for curriculum improvement.
3. PROCEDURES: Office procedures must be documented and evaluated by preceptor on a three- (3) point scale. All documentation is noted in a notebook in the Treatment Room and on MyEvaluations. Procedure credentialing and evaluation of each resident is done annually by faculty.
4. CHART AUDITS: Office charts are audited monthly by faculty and preceptors. Auditor's comments are written on a designed form and procedure for feedback is indicated on this form.
5. CASE PRESENTATIONS AND DIDACTIC PRESENTATIONS: Residents are expected to do formal presentations at the Wednesday afternoon Conference per the official schedule. Peer and Faculty evaluations are filled out evaluating Resident's performance and feedback is given to the resident.
6. QUARTERLY EVALUATION: Over the course of residency, more formal individual evaluations are scheduled four times a year to include the resident and the faculty mentor. These evaluations provide opportunities for the Faculty to review accumulated evaluation material, identify areas of strength and weakness and plan for improvement. Results of the ITAE are communicated to the resident

via his/her mentor. Areas of weakness are identified and an individual learning plan is devised to improve cognitive knowledge and performance. These evaluations provide the resident with a formal opportunity to evaluate the quality of training received, to express suggestions for improvement of his/her curriculum and the program in general. After each evaluation, a written summary is reviewed by the Director and filed in the resident's personnel file. (see Appendix K)

7. **ABFM IN-TRAINING ASSESSMENT:** The ABFM In-training Assessment, frequently referred to as "in-training exam" is an annual examination which takes place on Friday in early November. The exact date and schedule are posted ahead of time. All residents are expected to take the examination. Residents will be free from any call responsibility the night before starting at 11 p.m. Residents are responsible for hospital rounds in the morning before the start of the exam and must plan accordingly. It is the responsibility of the chief resident, or his/her designee, to fairly balance the patient panel for morning rounds. Residents are free of clinical responsibilities during the examination and must turn in their pagers to the Residency Scheduler. Clinic responsibilities, rotation activities and other clinical duties resume when the exam is completed.

Results of the in-training examination provide a valuable feedback to both faculty and residents. Results are sent to the director of the program via secured email. Individual results are communicated to residents by their advisor in a called meeting. Since members of the faculty are encouraged to view the results as one measure of their effectiveness as teachers, overall program results are communicated to the faculty and specific scores in specialty areas are communicated to designated faculty.

8. **END OF RESIDENCY REVIEW:** Third year residents will meet individually with the Program Director in May prior to their graduation. A summary of evaluations will be done and procedure credentialing reviewed. This session allows for the resident and Director to exchange feedback about the residents' performance and the quality of the residency's educational experience. A final summary letter will be prepared which will serve as the program's certification of resident proficiency and preparedness for practice.
9. **RESIDENT REFERENCES:** Third year residents will sign a Release of Information Authorization to allow the Director and faculty to fulfill reference requests. No references will be done without signed, explicit permission from the resident.
10. **EVALUATION OF THE FACULTY:** Residents should provide faculty with regular and constructive feedback either informally or during the formal evaluation time regarding precepting behaviors, curriculum, etc. Residents are invited to complete the appropriate evaluation forms for this purpose

anonymously, but in a constructive fashion. Evaluations forms are available online at the New Innovations website.

11. **EVALUATION OF OFFICE PERSONNEL:** Residents are expected to observe the working habits of the office personnel, and as needed, convey feedback to the Director of Patient Care or Office Manager or Nursing Supervisor, as appropriate. A specific form is available for this purpose.
12. **PROGRAM EVALUATION BY THE GRADUATE:** It is the responsibility of the residency to maintain contact with its graduates in order to assess long term effectiveness and relevance of its training. Regular correspondence is initiated by the Lynchburg Family Medicine Residency for such feedback.
13. It is requested that all residents agree to the release of their certifying board scores back to the program in order to help curriculum planning for future classes.

PROGRAM WEB SITES

A WEB site for the Lynchburg Family Medicine Residency is updated regularly. The URL address is <http://www.lynchburg-fm-residency.com> and it is open to medical students interested in applying for rotations, prospective resident applicants, and the public. The purpose is to promote awareness of the many positive aspects of the residency program and maintain a communication link with our graduates. There is also a link to our WEB site and to patient education resources from the Centra health WEB page, <http://www.centrahealth.com>.

RESIDENCY INFORMATION SYSTEM

A secure WEB-based server is used for maintaining up-to-date department schedules, procedure documentation, an evaluation system, and personnel data. This system is confidential and HIPAA compliant. The WEB site is **MyEvaluations** and can be found at www.myevaluations.com. Each resident and faculty member, community teachers, hospital administration and nursing has access through a user ID and password to the site from any PC equipped with a WEB browser and internet connection. Scheduling is at www.amion.com where you may review all call and clinic schedules. Access to the system is provided at different privilege levels of access dependent on the duties of the individual and rights to the information contained on the WEB site. Only residents, their advisor and the Program Director have access to evaluation material.

RELEASE OF INFORMATION

Requests regarding the release of information on a resident's performance or credentials will not be discussed without a signed authorization from the resident in question. Release of Information forms can be found in the mailroom.

MEDICAL ERRORS

Centra Health acknowledges the high risk, error-prone nature of modern Medicine due to:

- Many and varied interactions with technology
- Many individuals involved in care; multiple handoffs of care
- High acuity of illness or injury
- Environment routinely prone to distraction
- Need for rapid decisions; time pressure
- High volume; unpredictable patient flow

Centra Health recognizes that medical errors are due to a breakdown in systems and processes and not the intent of individuals. Our goal is to continuously improve the systems and processes to ensure the safety and best outcomes for our patients. This goal cannot be achieved in an environment in which caregivers believe that they will be punished for making or reporting medical errors.

All employees of Centra Health and its medical staff have shared responsibility for identifying and reporting process/system weaknesses and medical errors in a timely manner and for participating in efforts to reduce risks to patients. This interdisciplinary approach is based on a foundation of blameless culture that encourages open communication in a non-punitive environment.

It is the policy of Centra Health that no disciplinary action will be taken against any persons involved in or discovering a medical error. Employees are encouraged to report all medical errors to facilitate process and system evaluation and improvement. Written Variance or Medication Error Reports are expected to be completed and forwarded to Quality Support Services within 24 hours of the occurrence of the medical error. **Employees who knowingly fail to report a medical error will be subjected to disciplinary procedures.** As necessary, retaining and/or reassignment of job duties may occur to ensure employees competency and patient safety.

IMPAIRED RESIDENTS

The goal of the Family Medicine training program is to promote fully competent physicians. Impaired residents cannot achieve this goal. The Virginia Department of Health defines impairment as “a physical or mental disability, including but not limited to substance abuse, which substantially alters the ability of a practitioner to practice [Medicine] with safety to his/her patients and the public”. The Virginia code further identifies conducts which render a physician unfit for the performance of his/her professional obligations and duties. In essence those are:

- Prescribing or dispensing any controlled substance with intent or knowledge that it will be used otherwise than medicinally, or for accepted therapeutic purposes, or with the intent to evade any law with respect to sale, use or disposition of such drug.

- Knowingly or willfully committing any act that is a felony under the law (state or federal) or misdemeanor involving sexual turpitude.
- Practicing medicine in a manner contrary to accepted ethical standards.
- Practicing medicine in such a manner as to be a danger to one's patients or the public.
- Inability to practice medicine with reasonable skill or safety because of illness or substance abuse.

In addition the state imposes **a duty on hospital and health care professionals to report impairment.**

It is, therefore, the responsibility of the faculty to identify and appropriately intervene on behalf of the impaired resident(s). It is the responsibility of the program to promote the well-being of physicians and prevent physician impairment.

Counseling and/or referral of residents and resident's family are available through the Residency program via Mark Beck, LPC or the program director. Impaired residents can be dismissed from the program after appropriate due process. Unethical behavior warrants dismissal without prior notice. (See Grievance Procedure, page 63).

PROGRAM CLOSURE

In the event that Centra Health determines that it cannot, for educational, financial, or any other reasons, or that it chooses not to, continue the Lynchburg Family Medicine Residency (LFMR), Centra Health will notify the Residency Director and the residents at the earliest possible time, so that arrangements can be made to continue the residents' education at alternative sites. The program will not recruit, and Centra Health will not hire any residents after the date that the program is notified of termination. Centra Health and LFMR will work diligently to find alternate residencies for any residents who are in the first year at the time the program is terminated. If no alternatives can be found, Centra Health will continue the program until these residents have graduated. If all first-year residents have been placed in other programs, Centra Health will continue the program until those who are in their second-year class at the time the decision is made to terminate the program have graduated or have withdrawn from the program. Centra Health will also ensure that the program's faculty consists of at least the Residency Director and one additional full-time faculty member until the last resident has graduated. This policy is consistent with the ACGME's requirements for closure of residency programs.

**LYNCHBURG FAMILY MEDICINE RESIDENCY
POLICY FOR THE ASSESSMENT OF PERFORMANCE OF RESIDENTS,
PROMOTION AND DISCIPLINARY ACTIONS, AND FORMAL GRIEVANCE
PROCEDURE**

I. BACKGROUND

Responsibility for judging the competence and professionalism of residents in medical graduate education programs rests principally with program directors. These educators are guided in their judgment of resident performance by the Accreditation Council for Graduate Medical Education (“ACGME”) and its Residency Review Committees, by certifying and licensing Boards, by ethical standards for their specialties and the medical and dental professions, and by applicable policies of the Centra Health Hospital Health System. Residents are associated with the institution in an educational and training relationship. Residents are compensated as employees of Centra Health (“CH”). The resident’s employment relationship with CH is derivative of and dependent upon his or her continued enrollment in a graduate training program affiliated with CH.

The following Policies and Procedures for the Assessment of Performance of Residents in Graduate Medical Education (hereinafter “Performance Policy”) apply to all residents enrolled in graduate medical education program affiliated with CH. The Performance Policy governs the qualification of residents to remain in training as well as their completion of residency certification requirements, and its provisions apply in all instances in which such qualification and/or certification is at issue.

II. RESIDENCY PROGRAM ASSESSMENT STRUCTURE AND PLAN

The program director for the residency program has primary responsibility for monitoring the competence and professionalism of program residents, for recommending promotion and certification, and for initial counseling, probation or other remedial or adverse action. Residents will be evaluated on individual specialty requirements as well as program requirements. All residents are expected to be in compliance with CH and Lynchburg Family Medicine Residency (“LFMR”) policies, as they are amended from time to time, which include but are not limited to: sexual harassment, moonlighting, infection control, and completion of medical records. A faculty education committee of LFMR may assist a program director in these functions. Where circumstances warrant, the membership of an education committee may be altered to avoid a potential conflict of interest, or to protect the privacy of the resident. The Senior Vice-President (“SVP”), or his/her designee, may or may not exercise the option to become a member of the education committee or to serve as the final decision-maker in response to the committee or program director’s recommendations. Each program’s assessment structure and plan must be in writing.

III. PERFORMANCE REVIEWS

LFMR Faculty must provide written summary performance reviews to residents at regular intervals, preferably in person. The ACGME Residency Review Committee (or other appropriate accrediting agency) for each specialty usually specifies the desirable frequency of such reviews. At a minimum, a semi-annual, written summary performance review must be provided to each resident. It is recommended that a review of the resident's experience and competence in performing clinical procedures be included in these summaries when appropriate. Summary performance reviews may be written by program directors, designated faculty members, or members of a program's education committee consistent with the assessment plan of the program. It is also recommended that the resident acknowledge receipt of each summary performance review in writing.

IV. PROMOTION

Those residents judged by a program to have completed satisfactorily the requirements for a specific level of training will be promoted to the next higher level of responsibility. No resident may remain at the same level of training for more than 24 months, exclusive of leave. A resident whose performance is judged to be satisfactory will advance until the completion of the program/certification requirements.

V. PROBATION

A. Initial Probation: If, after documented counseling, a resident is not performing at an adequate level of competence, demonstrates unprofessional or unethical behavior, engages in misconduct, or otherwise fails to fulfill the responsibilities of the program in which he/she is enrolled, the resident may be placed on probation by the program director or program education committee. The resident must be informed in person of this decision and must be provided with a probation document which includes the following:

1. A statement of the grounds for probation, including identified deficiencies or problem behaviors;
2. The duration of probation which, ordinarily, will be at least three months;
3. A plan for remediation and criteria by which successful remediation will be judged;
4. Notice that failure to meet the conditions of probation could result in extended probation, additional training time, and/or suspension or dismissal from the program during or at the conclusion of the probationary period; and
5. Written acknowledgment by the resident of the receipt of the probation document.

B. Extended Probation: The status of a resident on probation should be evaluated periodically, preferably every three months, but at a minimum, every six months. If, at the end of the initial period of probation, the resident's performance remains unsatisfactory, probation either may be extended in accordance with the above guidelines (V.A.1. – V.A.5.) or the resident may be suspended or dismissed from the program (hereinafter "adverse action").

VI. SUSPENSION AND DISMISSAL

- A. Suspension of Clinical Activities:** A resident may be suspended from clinical activities by his or her program director, SVP, or CH President/CEO. This action may be taken in any situation in which continuation of clinical activities by the resident is deemed potentially detrimental or threatening to Centra Health Systems operations, including but not limited to patient safety or the quality of patient care, a suspension or loss of licensure, or debarment from participation as a provider of services to Medicare and other federal programs patients. Unless otherwise directed, a resident suspended from clinical activities may participate in other program activities. A decision involving suspension of clinical activities of a resident must be reviewed within three working days by the SVP (or his or her designee) to determine if the resident may return to clinical activities and/or whether further action is warranted (including, but not limited to, counseling, probation, fitness for duty evaluation, or summary dismissal). Suspension may be with or without pay at the discretion of institution officials.
- B. Program Suspension:** A resident may be suspended from all program activities and duties by his or her program director or SVP. Program suspension may be imposed for program-related conduct that is deemed to be grossly unprofessional, incompetent, erratic, potentially criminal; or threatening to the well-being of patients, other residents, faculty, staff, or the resident. A decision involving program suspension of a resident must be reviewed within three (3) working days by the SVP (or designee) to determine if the resident may return to some or all program activities and duties and/or whether further action is warranted (including, but not limited to, counseling, probation, fitness for duty evaluation, or summary dismissal). Suspension may be with or without pay at the discretion of institution officials.
- C. Dismissal During or at the Conclusion of Probation:** Probationary status in a residency program constitutes notification to the resident that dismissal from the program can occur at any time during or at the conclusion of probation. Dismissal prior to the conclusion of a probationary period may occur if the conduct which gave rise to probation is repeated or if grounds for Program Suspension or Summary Dismissal exist. Dismissal at the end of a probationary period may occur if the resident's performance remains unsatisfactory or for any of the foregoing

reasons. Prior to dismissal, the SVP at Centra Health must be notified of the dismissal of any resident during or at the conclusion of a probationary period.

- D. Summary Dismissal:** For serious acts of incompetence, impairment, unprofessional behavior, falsifying information, or lying, the Director or SVP may immediately suspend a resident from all program activities and duties for a minimum of three (3) days and, concurrently, issue a notice of dismissal effective at the end of the suspension period. The resident does not need to be on probation, nor at the end of a probationary period, for this action to be taken.
- E. Notification of Suspensions and Dismissals:** The resident must be notified in writing of the reason for and terms of suspension and dismissal, have an opportunity to respond to the action before the dismissal is effective, and be given a copy of the GME Appeals Process. Prior to the dismissal, the SVP must be notified of any dismissal of any resident during or at the conclusion of a probationary period.

VI. GME APPEALS PROCESS

In the event a resident (i) is not promoted, (ii) is suspended, (iii) is dismissed from a program, or (iv) is the subject of any adverse action that is reportable to the State Board of Medicine, Dentistry, or Pharmacy or a relevant specialty board, the resident may appeal such non-promotion, suspension, dismissal, or adverse action as follows:

- A. Residency Appeal:** A resident may initiate a residency appeal by submitting a written notice of appeal to the program director (with a copy to the Residency Office) within ten (10) working days of the date of the appealable action (hereinafter “adverse action”). A faculty committee will hear the appeal, which ordinarily will be the same faculty committee that initiated the adverse action. If a faculty committee did not initiate the adverse action, the SVP will appoint an institutional appeals committee. An appeals hearing will be held within thirty (30) calendar days following receipt of the notice of appeal and appointment of the departmental review committee. The resident may have a faculty advocate appear and participate on the resident’s behalf at the hearing. It is the responsibility of the resident to secure the voluntary participation of a faculty advocate. Prior to the hearing, the resident must notify the program director of the number of witnesses (if any) the resident expects to call and whether the resident will be accompanied by a faculty advocate and/or legal counsel. At the appeals hearing, the program director (or his or her designee) will present a statement in support of the adverse action and may present any relevant records, witnesses, or other evidence. The resident will have the right to present evidence, call and question witnesses, and make statements in defense of his or her own position. Legal counsel may be present to provide advice and counsel to the resident and the department but counsel will not be permitted to actively participate in presentation of testimony, examination/cross-examination of

witnesses, or oral arguments. A record of the hearing will be kept. After presentation of evidence and arguments by both sides, the appeals committee will meet in closed session to consider the adverse action. The committee may uphold or reject the adverse action or may impose alternative actions which may be more or less severe than the initial action. The committee's decision must be submitted to the resident within ten (10) working days of the close of the hearing.

B. Appeals to the Chairman of the Lynchburg Family Medicine Residency

Board (CLFMRB): If the adverse action is upheld by the review committee, or if the committee recommends alternative action which still is not acceptable to the resident, the resident may appeal the committee's decision to the CLFMRB. The resident must deliver a written appeal to the CLFMRB within ten (10) working days of receipt of the notification of the action of the institutional appeals committee. The resident must state as clearly and as fully as possible the reasons for seeking modification of the decision. The CLFMRB will review the resident's training file, evidence presented during the appeals hearing, and any other relevant materials. The CLFMRB's responsibilities are to:

1. Determine whether applicable LFMR and/or Centra health System policies were fairly and appropriately applied; and
2. Determine whether there is sufficient evidence to support the adverse action or other action recommended by the appeals committee. The CLFMRB may uphold or reject the adverse action, may uphold or reject other action recommended by the appeals committee, or may recommend to the SVP, or his/her designee that another course of action be pursued to include return of the case to the residency committee for further consideration. The decision of the CLFMRB will be submitted to the resident, the program director, and the SVP, or designee within thirty (30) calendar days of the notice of appeal.

C. Appeal to the SVP: Either the resident or the SVP, or designee, may, within ten (10) working days of the decision by the CLFMRB, appeal the decision of the CLFRPB by written notice to the Administrative Office of Centra Health. Within five (5) working days, the Administrative Office of Centra Health will notify the SVP (or designee) who will appoint an Appeals Committee composed of no less than seven (7) physicians from outside the residency. The Appeals Committee will review the record submitted to it by the Administrative Office and may consider any other written material or oral testimony it deems relevant. The Appeals Committee will submit a written recommendation regarding the matter to the SVP within fifteen (15) working days of the closure of the Committee's review. The CLFRPB will review the recommendation of the Appeals Committee and accept or reject it within ten (10) working days. The SVP's decision is final within Centra Health.

VII. OTHER CONSIDERATIONS

External rules, regulations, or law governs mandatory reporting of problematic behavior or performance to licensing agencies or professional boards. The fact

that such a report is made is not a matter which may give rise to the appeal process, only the adverse action as specified by Section VII of this document is appealable. Where mandatory reporting of problematic behavior or performance occurs, external agencies will be notified of the status of any internal appeal regarding the matter reported and its outcome. Residents should be aware that participation in the GME Appeals Process does not preclude investigation or action on the part of external entities.

Approved, Chair LFMR Board of Directors: _____

Approved, General Counsel for Centra Health: _____

Approved, LFMR Program Director: _____

Approved, Senior Vice-President: _____

Approved, Chair, UVA Department of Family Medicine, _____

Added to LFMR Policy and Procedure Manual: June 2007

LYNCHBURG FAMILY MEDICINE RESIDENCY GRADUATE MEDICAL EDUCATION GRIEVANCE POLICY AND PROCEDURE*

Closely Adapted from University of Virginia Health System GME Grievance Policy and Procedure Manual

I. Purpose

To provide a mechanism for resolving disputes and complaints which may arise between postgraduate residents (hereinafter referred to as “resident”) and their program director or other faculty member.

II. Policy

Postgraduate residents may appeal grievable (as defined herein) disagreements, disputes, or conflicts with their program using the procedure outlined below.

III. Definitions

A. A Grievance is any unresolved dispute or complaint a resident has with the policies or procedures of the residency training program or any unresolved dispute or complaint with his or her program director or other faculty member.

B. Covered Grievances:

1. The following grievances shall be subject to this procedure and thus are considered “grievable”:
 - a. disputes or complaints related to, unfair or improper application of a policy, procedure, rule, or regulation;
 - b. unresolved disputes or complaints with the program director or other faculty member not related to performance or appointment actions;
 - c. retaliation as a result of use of this procedure.
2. Complaints based solely on the following actions are not subject to this procedure and thus are considered “not grievable” under this policy:
 - a. establishment and revision of salaries, position classifications, or general benefits;
 - b. work activity accepted by a resident as a condition of employment or work activity which may reasonably be expected to be part of the job;
 - c. the contents of policies, procedures, rules, and regulations applicable to residents; such as, Moonlighting Policy.

- d. discrimination on the basis of race, national origin, religion, sex, age, or handicap;
- e. means, methods, and personnel by which work activities are to be conducted;
- f. transfer, assignment, and retention of residents within the Health System;
- g. relief of residents from duties in emergencies.
- h. suspension or dismissal of residents provided in the Policy and Procedure for the Assessment of Performance of Residents, Promotion and Disciplinary Actions, and Formal Grievance Procedure.

IV. Informal Resolution

- A. Step 1: A good faith effort will be made by an aggrieved resident and the program director to resolve a grievance at an informal level. This will begin with the aggrieved resident notifying the program director, in writing, of the nature of the grievance within thirty (30) calendar days of the event or action giving rise to the grievance. This notification should state the nature of the complaint, all pertinent information and evidence in support of the claim, and the relief requested. Within seven (7) calendar days after notice of the grievance is given to the program director, the resident and the program director will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Step 1 of the informal resolution process will be deemed complete when the program director informs the aggrieved resident, in writing, of the final decision following such discussion. This written response should address the issues and the relief requested.
- B. Step 2: If the program director's final written decision is not acceptable to the aggrieved resident, the resident may choose to proceed to a second informal resolution step which will begin with the aggrieved resident notifying the Centra Health's Senior Vice-President of Medical Affairs (SVP) of the grievance in writing. Such notification must occur within ten (10) working days of receipt of the program director's final decision. This notification should include all pertinent information, including a copy of the program director's final written decision, evidence that supports the grievance, and the relief requested. Within seven (7) calendar days of receipt of the grievance, the resident and the SVP will set a mutually convenient time to discuss the complaint and attempt to reach a solution. The resident and the SVP may each be accompanied at such meeting by one person, other than legal counsel. (Legal counsel shall not be permitted to participate in Step 1 or Step 2 discussions.) Step 2 of the informal process of this grievance procedure will be deemed complete when the SVP provides the aggrieved resident with a written response to the issues and relief requested. Copies of this decision will be kept on file in the office of the SVP and sent to the President/CEO of Centra Health.

V. Formal Resolution

A. Request for Formal Resolution

If the resident disagrees with the final decision of the SVP, he or she may pursue formal resolution of the grievance. The aggrieved resident must initiate the formal resolution process by presenting a written statement to the Chair of LFMR Board (hereinafter "CLFMRB") within fifteen (15) working days of receipt of the SVP's final written decision. The statement should describe the nature of and basis for the grievance and include copies of the final written decisions from the program director and the SVP and any other pertinent information. Failure to submit the grievance in the fifteen-day period will result in the resident waiving his or her right to proceed further with this procedure. In this situation, the decision of the SVP will be final.

B. Determination of Grievability

Upon timely receipt of the written grievance, the CLFMRB will notify the resident and SVP in writing whether the complaint is grievable or not, together with the reasons for any finding of non-grievability. If the complaint is grievable, the CLFMRB will appoint a Grievance Committee via the composition of said committee described below. The Grievance Committee will review and carefully consider all material presented by the resident and his or her program director or the grievable party at a scheduled meeting, following the protocol outlined in Section VI.B.

VI. The Grievance Committee

A. Composition of the Grievance Committee:

Upon request for a formal resolution and following a determination of grievability by the CLFMRB, the CLFMRB will select a Grievance Committee composed of two (2) housestaff members, two (2) program directors, and a representative from UVA Administration. No members of this Grievance Committee will be from the aggrieved resident's own residency. The CLFMRB will choose a member to be the chair of the Grievance Committee. Both parties involved in the conflict will be notified of the Grievance Committee composition and may object in writing to a particular composition. The CLFMRB will evaluate any objection within five (5) working days of the notification and may decide to appoint one or more alternates. Either party will have only one opportunity to object to the selected Grievance Committee members. Once the selection of the Grievance Committee is complete, a copy of the resident's written grievance will be sent to each member of the Grievance Committee by the CLFMRB.

B. Grievance Committee Procedures:

1. Hearing Date: The Chair of the Grievance Committee will set the date, time, and place for a hearing which is mutually convenient to the Grievance Committee, the resident, and the SVP.
2. Attendance: All Grievance Committee members shall be present throughout the hearing except for brief periods due to emergencies. The resident must appear personally at the Grievance Committee hearing. The resident, the SVP, and a representative of each one's choice is entitled to be present during the entire hearing, excluding deliberations. The Grievance Committee will determine the propriety of attendance at the hearing of any other persons. Witnesses other than the resident, the SVP, and their representatives may remain in the hearing room only while giving their testimony unless the Grievance Committee, the resident, and the SVP agree otherwise.
3. Conduct of Hearing: The Chair of the Grievance Committee will preside over the hearing, determine procedure, assure there is reasonable opportunity to present relevant oral or written information, and maintain decorum. Both the resident and the SVP, or their representatives, will have the right to present evidence, call and question witnesses, and make statements in defense of his or her position. Before testifying, each witness shall affirm that his or her testimony shall be the truth, the whole truth, and nothing but the truth. The Grievance Committee Chair will determine if information is relevant to the hearing and should be presented or excluded. The Grievance Committee Chair is authorized to exclude or remove any person who is disruptive.
4. Legal Representation: The Grievance Committee shall be entitled to have an attorney present to advise the Grievance Committee on procedural and evidentiary issues. Both the resident and SVP may choose to have legal counsel present, but such counsel will not be permitted to participate in the proceeding.
5. Recesses and Adjournment: The Grievance Committee Chair may recess and reconvene the hearing, continuing for such additional sessions, as the Grievance Committee deems necessary. Upon conclusion of the presentation of oral and written information, the hearing record is closed. Once the hearing is completed, it may be reopened, for good cause, by the Grievance Committee at any time prior to the rendering of its written decision. The Grievance Committee will deliberate outside the presence of the involved parties.
6. Decisions: Decisions are determined by a majority vote of members of the Grievance Committee and are final. After deliberation, the written decision will be reviewed and signed by the Grievance Committee members.

7. Burden of Proof: The party asserting a fact or proposition shall have the burden of proving such fact or proposition by a preponderance of the evidence.
8. Meeting Record: Arrangements will be made for the hearing to be accurately recorded and for any transcription of the recording it determines to be appropriate, or which the resident or SVP requests, upon payment by the requester of reasonable transcription charges. Such recordation and transcription may be made by such University employee or employees as the Grievance Committee may designate. The final written decision of the Grievance Committee and the transcript, if one is prepared, will be placed on file in the SVP's office.

C. Final Decision of the Grievance Committee:

The Grievance Committee will provide the aggrieved resident, the SVP, and the CLFMRB with a written decision within ten (10) calendar days of the meeting and a copy will be placed on file in the Medical Staff Office. The decision shall consist of two sections, one containing findings of fact, and the other containing recommendations to the CLFMRB. The recommendations may include affirmation, reversal or modification of action taken with respect to the resident, and also may include suggested changes in Lynchburg Family Medicine Residency policies and procedures that the Grievance Committee feels would be appropriate in light of the grievance. The recommendations also may include any suggested action that should be taken with respect to persons other than the resident and any other suggestions that the Grievance Committee feels appropriate. The decision of the Grievance Committee will be final.

VII. Confidentiality

All participants in the grievance process are expected to maintain confidentiality by not discussing the matter under review with any third party except as may be required for purposes of the grievance procedure.

VIII. Amendments

This procedure may be amended any time, or from time to time, in writing, by the Graduate Medical Education Committee.

Approved, Chair LFMR Board of Directors: _____
 Approved, General Counsel for Centra Health: _____
 Approved, LFMR Program Director: _____
 Approved, Senior Vice-President: _____
 Approved, Chair, UVA Department of Family Medicine, _____
 Added to LFMR Policy and Procedure Manual: _____ June 2007

Appendix

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**LYNCHBURG FAMILY MEDICINE RESIDENCY
TIME-OFF REQUEST AND APPROVAL**

ROTATION: _____

ATTENDING PHYSICIAN: _____

NAME: _____

FIRST DAY OFF: _____ **LAST DAY OFF:** _____

Check One: _____ **Vacation** _____ **Conference**

TOPIC & LOCATION IF CONFERENCE: _____

SUBMITTER'S SIGNATURE

DATE

APPROVED BY:

CHIEF RESIDENT

DATE

RESIDENCY SCHEDULER

DATE

DIRECTOR'S SIGNATURE

DATE

Lynchburg Family Medicine Residency

**HOUSE STAFF PHYSICIAN REQUEST TO ENGAGE IN PROFESSIONAL
ACTIVITY OUTSIDE THE TRAINING PROGRAM**

To: _____
(Residency Director)

Requested By: _____
(Name)

(Applicable to Third year Residents with an active license only)

Reasons Necessitating This Request:

Type of Professional Activity Outside The Training Program: (Indicate nature of the professional activity outside the training program, its educational value and supervision characteristics):

Number of Hours To Be Devoted To Professional Activity Outside The Training Program On A Weekly (Specify Days and Times) Basis:

Name of Supervisor for Outside Professional Activity _____

Telephone #: _____

MEDICINE Site _____
(City) (State)

(Name of Hospital and/or Doctor's Office – If Applicable)

Please indicate your permanent physician license number _____

Please attach a copy of the professional liability insurance certificate provided by the site.

I understand that if this request is approved, the approval is for only one program year. I understand that this approval may be revoked pursuant to department policy. I further understand that by engaging in professional activity outside the training program I do so as a private practitioner and that neither Lynchburg Family Medicine Residency nor Centra Health accept any responsibility for outside medicine; that a Commonwealth of Virginia "Temporary License" is not valid for professional activity outside the training program and that I am solely responsible for obtaining appropriate licensure; and that I am exclusively responsible for all liability (**attach copy of liability insurance policy face sheet**) or other legal matters associated with such outside professional activity. I also understand that total hours worked, including those hours associated with my assigned training program, as well as those hours devoted to professional activity outside the training program may not exceed a) 80 hours per week when averaged over a four week period, or b) the standards set by the applicable Residency Review Committee. I agree to provide a monthly summary of hours worked outside the educational program. If my commitment to professional activity outside the training program changes from that specified above, I will notify my program director immediately.

I hereby authorize Lynchburg Family Medicine Residency and Centra Health, its clinical staff and their representatives to consult with members of the administration and medical staffs of other hospitals for whom I have engaged in professional activity outside Lynchburg Family Medicine Residency's training program, including malpractice carriers, for the purpose of verifying the nature, scope and schedule of any professional activities. I hereby release from liability Lynchburg Family Medicine Residency, its clinical staff and all representatives of Centra Health and its clinical staff for their acts performed without malice in connection with evaluating this application and monitoring my professional activities. I hereby release from liability any and all individuals and organizations who provide information to Lynchburg Family Medicine Residency, or to members of its clinical staff, without malice, concerning outside professional activities in which I engage including but not limited to, work hours, nature and scope of duties and performance thereof, and I hereby consent to the release of this information.

Signature – Resident

Date

I approve this request.

I do not approve this request.

Signature – Residency Director

Date

Copy to Resident's Permanent File

*****SAMPLE***
GERD Chart Audit**

Physician Cook
Patient Name

Reviewer Cook
MRN#

Date 8/16/07

- | | | |
|---|------------------------------|--|
| 1. Is the medication list satisfactory? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Was the last encounter coded correctly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Is the problem list up to date? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Is the PPIP* sheet being utilized? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Chart is well organized? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | |
| 6. Symptoms of GERD documented? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. PPI prescribed for therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Endoscopy done if refractory? | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 9. Patient Education for TLC** documented? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Complications <u>or their absence</u> documented? | | |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Barrett's | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stricture | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

* = Putting Prevention Into Practice Form

** = Therapeutic Lifestyle Changes

General Comments:

Instructions: Please initial and return to Cindy Allen when reviewed. If you wish to make any response to the audit, do so below.