Shenandoah Valley Family Practice Residency Program

Policy and Procedures Manual

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Section I:
About the Program

Introduction

Welcome to the Shenandoah Valley Family Practice Residency Program. Your first year is based mainly at the Winchester Medical Center (WMC). Your last two years are based mainly at Front Royal Family Practice (FRFP) and the adjacent Warren Memorial Hospital (WMH). However, even during the first year, we want you to consider the Family Practice Center to be your professional home.

Residency, as you know, is the transition from academic to clinical medicine. Your attitudes, knowledge and skills will undergo major changes as you adjust from medical school learning to resident responsibilities first in a regional medical center and then in a small community hospital and practice, but always remember that you have a home in the Family Practice Center. During this transition period, you will often find yourself in situations with which you will have had little or no experience - an anxiety provoking experience but a necessary part of your continuing medical education. To minimize your stress and maximize your educational experience, don't hesitate to ask questions of the residency director, your faculty advisor, other faculty, other residents, and the nursing staff and office personnel. We are here for you and we are looking forward to learning together with you!

This is an exciting and challenging time for residents, as well as your faculty- a time that is often exhilarating but sometimes overwhelming. Our hope is that we will provide a solid base for your continuing growth as a family physician and that you will graduate in three years with fond memories of your time with us, but most of all that you will recognize in yourself the compassionate, competent family physician you want to become.

History

In 1995, Valley Health System (VHS) first envisioned a family practice residency to help meet the primary care needs of the region. A committee was formed which included representatives from VHS, Virginia Commonwealth University Medical College of Virginia (VCU/MCV), and the medical staff of WMC and WMH. The committee first met in December 1995 and began to look at potential learning environments, faculty and financing needs. FRFP was represented on the committee and caught the vision early on. With the healthcare providers of FRFP becoming the core faculty, two out of three of the residency needs were substantially addressed, i.e. learning environment (WMC, WMH and FRFP) and core faculty (FRFP). Financing was the final hurdle, but with anticipated Medicare graduate medical education funds supplemented by state funds expected through affiliation with VCU/MCV, VHS fully committed to the residency program. In cooperation with VCU/MCV a search for a residency director was successful and he was hired the same year the American College of Graduate Medical Education (ACGME) made a site visit.

In September 1997, the Shenandoah Valley Family Practice Residency (SVFPR) received a three-year provisional accreditation from the ACGME, the maximum accreditation a new program can receive.

In 1997-98 numerous milestones were reached:

1. a contractual partnership was reached by FRFP with VHS to share their practice with the residency and serve as full-time faculty - including four board-certified family physicians, all of whom included obstetrics in their practice, and a certified family nurse practitioner;

2. these faculty completed faculty development fellowships at VCU/MCV during this time period, and the residency director completed a fellowship through the National Institute of Program Director Development;
3. additional faculty were recruited including a clinical pharmacist from the Shenandoah University School of Pharmacy, and rotation coordinators from WMC for the first year hospital based rotations;
4. on-site faculty development was begun for all faculty;
5. four first year resident applicants were successfully recruited;
6. a new Family Practice Center adjacent to Warren Memorial Hospital was designed to house the residency, construction begun, and equipment planning initiated; and
7. planning for all first year rotations and ambulatory family medicine curriculum in FRFP was completed.

In 1998-1999, 1) the new Family Practice Center was completed and Front Royal Family Practice was moved into its new home; 2) a clinical psychologist for the Family Practice Center was recruited; 3) a second full class of residents was recruited via a full NRMP match; and 4) planning for all second year rotations and the longitudinal curriculum was completed.

In 1999-2000, 1) a third full class of residents was recruited; and 2) planning for third year rotations completed.

In 2000-2001, we graduated our first class of four residents. Two went into solo practice and three are practicing in small town or rural settings. Scholarship by faculty was begun in earnest.

In 2001-2002, 1) we graduated our second class of five residents. Of the total graduates in the first two graduate classes, all successfully received board-certification, seven entered practices in Virginia (six of which entered small town or rural practice), and four started a solo practice. 2) Practice-based research was begun.

In 2002-2003, 1) the residency practice implemented an Electronic Medical Record, completing its original plan for state-of-the-art ambulatory practice training and improve our practice-based research capabilities. Prince William Hospital (PWH) joined WMC and WMH as participating hospitals in the residency. 2) The residency received an accreditation for an American Osteopathic Association (AOA) approved internship and a formal relationship with the Appalachian Osteopathic Postgraduate Training Institute Consortium (A-OPTIC) was established.

In 2003-2004, 1) our evaluation system was converted to an online version. 2) A new contractual relationship between FRFP and VHS was formed to incentive patient visits by residents in FRFP.

In 2004, Frank Dennehy, MD became the Residency Director.

In 2004-2005, 1) developed a new GYN clinic at the FPC on Wednesday mornings, 8:00am-12:00pm each week for the resident on the Obstetrics rotation, 2) developed new ICU rotation at WMC under the direction of Greg Stanford, M.D. (Board Certified in Critical Care), 3) Dr. Dennehy was named as Residency Program Director.

In 2005, the residency received accreditation for an American Osteopathic Association (AOA full three-year residency.

In 2006, Bret Ripley, DO was recruited as Associate Director of the Residency and named Director of the Osteopathic Family Practice Residency.

In 2008-2009, our program was re-accredited for another three years by the ACGME. Our accreditation was extended to four years by the AOA, which is unusual for a new AOA program.

In 2010, Accreditation was extended to 10 years from ACGME, and 5 yrs by AOA. We remain continuously accredited.

In 2015, with the combined AOA-ACGME accreditation process, we received the additional "Osteopathic Recognition" by the ACGME. Only a small number of residency programs have this recognition.

In 2015, Jef Groesbeck, DO joined us as the Osteopathic Director and Assistant Program Director.

In 2018, Tamara Spriggs, MD, and Ellis Johns, MD both joined the Faculty. Both are graduates of our program.

David Flack, DO became our Osteopathic DME (2013) and our Allopathic DIO (2016). He is a graduate of our program.

In June 2021, Front Royal Family Practice and Warren Memorial Hospital moved to the new campus just outside Front Royal.

In 2021, Candace Wise, DO joined the faculty. She is a graduate of our program.

In 2023, Candace Wise, DO became the Residency Director.

Program Goals and Objectives

To train new quality family physicians for practice in Virginia's rural areas and small towns who will be competent to practice in any environment. Also, to provide high quality, cost effective, readily accessible care for our patients, their families, and our community.

To this end, it is the goal of the program to train graduates who are skilled in the ACGME competencies and the seventh osteopathic competency for osteopathic graduates. These are:

1. **Patient Care**

   Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health, and must be able to evaluate and treat patients efficiently enough to meet resident responsibilities.

2. **Medical Knowledge**

   Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. The resident must demonstrate knowledge in the biopsychosocial and patient-centered care approach to patient care.

   Graduates will possess sufficient depth of medical knowledge to pass the certifying examination of the American Board of Family Medicine, and for osteopathic graduates, the American Osteopathic Board of Family Practice, and to maintain certification over the years of practice.

   Graduates will also possess skills in common family practice procedures.

3. **Interpersonal and Communication Skills**

   Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, peers, faculty, and other healthcare providers.

4. **Professionalism**

   Residents must demonstrate a commitment to consistently carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to demonstrate an absence of violation of professional or institutional codes of conduct including racism, sexual harassment, any sexual relationships with patients, and inappropriate sexual relationships with staff or colleagues; absence of violation of any relevant state or federal laws and absence of any criminal conduct; absence of impaired function due to physical, mental or emotional illness or substance abuse.

5. **Systems-Based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

6. **Practice-Based Learning and Improvement**

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

7. **Osteopathic Philosophy and Osteopathic Manipulative Medicine**

For D.O.s (osteopathic graduates), graduates will be competent in osteopathic manipulative medicine knowledge and the basic skills of osteopathic manipulative treatment techniques for independence in practice. They will also possess the skills and knowledge to pass the certification examination of the American Osteopathic Board of Family Practice. Also, for allopathic (M.D.) graduates, exposure to and familiarity with the basics of osteopathic manipulative treatment.

Program Mission

Our mission is to train new quality family physicians for practice in Virginia's rural areas and small towns who will be competent to practice in any environment. Also, to provide high quality, cost effective, readily accessible care for our patients, their families, and our community.

Section II
Curriculum

Curriculum Requirements

The residency has both rotational and longitudinal curriculum requirements. Each year has rotations and components of the longitudinal curriculum that must be satisfactorily completed to progress to the next year of training. Specific rotation and longitudinal goals and objectives, core content, approaches to learning and evaluation tools can be found in the orientation manual.

Rotation Curriculum

First Year:

2 months:	Internal Medicine
2 months:	Pediatrics
2 months:	Night Float
2 months:	FPC Clinic
1 month:	Emergency Medicine
1 month:	Surgery
1 month:	Obstetrics and Gynecology
1 month:	Outpatient Pediatrics

Second Year:

2 months:	Family Practice Inpatient
2 months:	Geriatrics
1 month:	Outpatient Pediatrics
1 month:	Orthopedic Surgery
1 month:	Emergency Medicine
1 month:	Obstetrics and Gynecology
1 month:	Dermatology/Ophthalmology
3 months:	Electives

Third Year:

2 months:	Community Medicine/Outpatient Gynecology/Sports Medicine/ Occupational Medicine
2 months:	Family Practice Inpatient
3 months:	Electives
1 month:	ICU
1 month:	Senior Resident – WMC
1 month:	Cardiology
1 month:	ENT
1 month:	Urology

Longitudinal Curriculum (2nd and 3rd year)

Ambulatory Primary Care and Prevention
including Ambulatory Procedures and Patient-Centered Care
Behavioral Health/Psychiatry
Clinical Pharmacy
Community Medicine
Ethics and Spirituality in Medicine
Evidence-Based Medicine/Information Mastery
Family Centered-Center Maternity Care/Gynecology
Geriatrics
Information Technology
Practice Management
Sports Medicine

Call and Clinic Requirements

R-1: Internal Medicine, Pediatrics and Surgery will be 10-hour shifts, 5 days a week, Monday thru Friday. Saturday coverage is 24-hour call starting @ 7a.m. Service coverage at Winchester Medical Center is via a night float system for pediatrics and internal medicine services. Emergency Medicine requirements include four nine-hour shifts at Winchester Medical Center per week. The Night Float has responsibilities from 5:00 p.m. to 7:00 a.m. Monday – Friday. Obstetrics requirements include four (Mo/Tu/Th/Fr) approximately 14 hour flexible shifts. Your backup is always the private attending physician (or covering physician) or hospitalist for the patient you need backup. Other clinical requirements include one to two half-day per week in the Family Practice Center for patient care.

R-2: All call is in-house at Warren Memorial Hospital for the Family Practice Inpatient Service and Front Royal Family Practice telephone calls, except during the Obstetrics. Your back up is the on-call Front Royal Family Practice attending or the nighttime Hospitalist. Residents are required to stay for the morning sign out at the end of their call shift. Obstetrics requirements include three (Mo/Tu/Fr) approximately 14 hour flexible shifts. There will be a minimum of two (2) Saturday shifts. Other clinical requirements include two to four half-days per week in the FPC. All PGY-2 residents are required to take Warren Call as in-house call. Residents are required to stay for the morning sign out at the end of their call shift.

R-3: All call is in-house at Warren Memorial Hospital for the Family Practice Inpatient Service and Front Royal Family Practice telephone calls. Your backup is the on-call Front Royal Family Practice attending or the nighttime hospitalist. All PGY-3 residents are required to take Warren Call as in-house call. Residents are required to stay for the morning sign out at the end of their call shift.

Resident Clinic Schedule

Please reference AMION for call and clinic schedules.

Teaching Rounds and Conferences

Residents are required to attend all teaching rounds relevant to the rotation they are on and are required to attend all conferences relevant to year of training. Conference attendance is mandatory, unless a true patient care emergency prevents attendance. Conference attendance is not only important for your own professional growth, but your absence is demoralizing to the conference presenter and your colleagues. Your timely conference evaluation using the standard E*Value form is critical to improving the conference series. Residents who fail to document 80% or more conference attendance on E*Value will be required to complete remedial learning assignments or will not be promoted/graduated.

R-1: Teaching Rounds

- Monday morning 7:00am Internal Medicine teaching rounds
- Thursday morning 7:30am Pediatric teaching rounds

Conferences

Tuesday 7:00 am: Winchester Specialty at WMC
Wednesday 12:00pm: Practice Management in the Family Practice Center
Wednesday 12:30pm: Ambulatory Care in the Family Practice Center
Thursday 12:00pm: Winchester Specialty at WMC
Friday 7:00am (or 6:30am): Winchester Specialty at WMC
One Friday per month – Ultrasound Teaching at WMC

You are required to attend all lectures. If you are on vacation, CME or sick, you will be excused. If you are rounding, in surgery, etc, you will be required to read an article on the missed subject from a peer reviewed source (i.e. Up-to-Date, DynaMed, AAFP, Cochrane Database, etc.). You are then required to write a short summary of the article and submit the summary to Associate Program Director or WMC Coordinator within two weeks of the lecture. If the summary is not turned in within the two week time frame, you may be counted as absent.

- A current ACLS certificate is required for all PGY years.

R-2: Teaching Rounds

- Daily Family Practice Inpatient at WMH when on the Family Practice Inpatient Service.
- Thursday AM Community Medicine Project (2nd Thursday)
- Thursday AM Longitudinal Curriculum Workshops as scheduled
- Geriatrics: Two hours of work rounds at the teaching nursing home followed by a home visit one Thursday per month (1st or 3rd Thursday).

R-3: Teaching Rounds/Conferences

- Thursday AM Longitudinal Curriculum Workshop every fifth Thursday of the month
- Daily Family Practice Inpatient at WMH when on Family Practice Inpatient Service
- Geriatrics: Two hours of work rounds at the teaching nursing home followed by a home visit one Thursday per month (1st or 3rd Thursday).

R-2/R-3: Shared Conferences (Longitudinal Curriculum)/Teaching Rounds

- Grand Rounds at WMC; Wednesday, 12:30pm to 1:30pm (WebEx)
- Family Practice at the Family Practice Center: Tuesday; 1:30pm to 5:00pm

Included but not limited to:
- Practice Management
- Geriatrics and End of Life Care
- Behavioral Health
- Ambulatory Family Practice/Director
- FCMC/GYN
- Evidence-Based Medicine/Information Mastery
- Clinical Pharmacy
- OMT
- Ethics
- Cognitive Behavioral Training
- Specialty Lectures from outside lecturers

- Osteopathic Teaching Rounds at Warren Memorial Hospital Monday and 2nd and 4th Thursday 12:00 to 12:30 pm.
- Board Review: Every Tuesday from 1:30pm to 2:00pm

R-2/R-3 Resident Projects
A group Community Oriented Primacy Care Project and group Scholarly Project with written reports is required. A group Practice Management Project with written report is required. Participation in research is required.

Personal and Professional Growth Support Systems

At the end of each block, all available R-1's, R-2's, and R-3's meet at various locations in the area for a outing/support group. A Reflection and Resiliency group meets monthly at WMC for R-1's. The residency director meets with the R-1's at WMC for the first six months.

At the Family Practice Center our behavioral health specialist and your faculty advisor, team attending(s) and preceptor(s) are available for support and may be the easiest to turn to, but the Residency Director and Residency Staff are also committed to promoting your personal well-being, as well as, your professional growth.

If you develop a more serious problem like major depression, substance abuse, a deteriorating marital relationship, recurrent unprofessional behavior, or incompetence in an area of responsibility, please approach us as soon as you recognize the problem. We will strive to help you resolve your problem, taking advantage of in-house or outside resources as needed.

Resident Evaluation

Residents formally meet with their faculty advisor every three months for feedback on resident progress and performance, as well as soliciting resident suggestions for program improvement. Review is conducted constructively and is intended to help make each resident a better physician and our residency a better program. Each resident should seize the opportunity to receive feedback in order to maximize professional growth. Residents formally meet with the Residency Director every six months. Osteopathic residents meet formally with the Osteopathic Director of Medical Education every 6 months.

Rotation evaluation forms for every rotation and many longitudinal curriculum are in this orientation manual and can also be viewed on Residency Management System. The rotation coordinator and other faculty at the end of every rotation evaluate residents. The longitudinal

curriculum faculty coordinator evaluates residents semi-annually. Residents are encouraged to ask the rotation coordinator and other faculty half way through the rotation any areas they perceive as deficient so that they can be addressed before the rotation ends.

Every six months every resident undergoes a formal semi-annual Clinical Competency Committee Review (see Policy and Procedures Section VI for details). The resident progress appraisal forms and advancement criteria summary forms are in this orientation manual and can also be viewed on the Residency Management System. Remember, we believe the main purpose of evaluation is educational, i.e. to help each resident identify his/her strengths and weakness (and weaknesses are often strengths overdone). We have found that most residents will discover, on their own, ways to overcome their weaknesses once they are identified; however, the faculty is ready to help when a resident cannot overcome a weakness on his/her own.

Residents must pass all the required rotations and the longitudinal curriculum requirements to graduate, as well as meeting ABFM competency requirements. Failure to pass a required rotation will necessitate repeating the rotation using elective rotation time. If a resident fails to pass two or more required rotations, the Residency Director may ask the Graduate Medical Education Committee to consider dismissing the resident. If not dismissed, the resident will be required to extend their residency program to make up rotation deficiencies. If a resident fails to pass three or more required rotations or fails the same rotation twice, the Residency Director will ask the Graduate Medical Education to consider dismissing the resident from the program.

If a resident fails to pass a longitudinal curriculum, the resident will be required to fulfill the requirement the following year or during a residency extension. If a resident fails to pass two or more longitudinal curricula, the resident will be required to fulfill the requirement the following year and will be required to extend their residency program. If a resident fails to pass three or more longitudinal curriculum or the same longitudinal curriculum in two successive years, the Residency Director will ask the Graduate Medical Education Committee to consider dismissing the resident from the program.

Experience Documentation

Records need to be kept on procedures done by you during your entire residency. You are required to document competency procedures as required by the ABFM for board eligibility. Hospitals and health systems are increasingly asking for documentation of our clinical skills including both cognitive and procedural skills. The institutions may request this documentation where you apply for privileges as a basis for granting those privileges. In addition, procedure lists must be kept for the Residency Review Committee that is responsible for residency accreditation.

Any procedures performed must be recorded in the Residency Management System and are available for review at any time. These include but are not limited to vaginal deliveries, assists at Cesarean births or surgery, scopes, stress tests, and neonatal or adult resuscitation.

Section III
The Family Practice Center

The Family Practice Center is an office practice (Front Royal Family Practice--FRFP) that provides access to a diverse small town and rural patient population with all of the common and many uncommon primary care problems encountered by family physicians in small community practices.

The success of the office practice depends on: 1) a patient-centered practice, and 2) a mutual respect for and collaboration with all members of the healthcare team. The success of the practice is, in other words, part of your responsibility.

Team Approach

You will be assigned to one of six Front Royal Family Practice teams. The team approach is helpful in assuring continuity of care for the team's patients. The teams include one or more faculty and three residents (an R-1, R-2 and R-3).

If one of your patients is hospitalized at Warren Memorial Hospital, it is suggested you visit your patient.

Precepting

R-1's must precept every patient at the time of the patient encounter. During the first six months of their internship, the preceptor must actually see and evaluate every patient. R-2 residents must average 50% and R-3 residents must have 25% precepting. All Medicare patients must be precepted at the time of the patient encounter. To code a Level 4 or 5 visit on Medicare patients, the preceptor must actually see and evaluate the patient regardless of the resident's level of training. All OB patients must be precepted and all office procedures must be discussed with preceptor prior to performing.

Charges and Collections

Each resident is responsible for accurate ICD-10 diagnoses, and appropriate CPT codes for accurate billing. You must bill for your services when seeing Front Royal Family Practice patients both in the Family Practice Center and in Warren Memorial Hospital. Begin good habits now and it will become second nature.

Accurate ICD diagnoses and CPT codes must be documented in Epic. Having to resubmit claims to insurance companies because of inaccurate ICD diagnoses and CPT codes is a waste of resources. This information is also necessary for documenting the number and diversity of resident patient encounters. We use this data to help assure that your patient care experience is optimal. If you are unsure of an appropriate ICD diagnosis or CPT code, just ask your preceptor. Also, every service provided, including medical supplies, injections, in-office tests and procedures, and out of office laboratory tests must be documented.

Charting

It is important to record accurate and relevant but concise information in the medical record for all patient encounters. All telephone calls placed or received must be documented in Epic at the time of the encounter.

During hospital based rotations the resident is responsible for writing admission notes, documenting history and physical examinations, writing orders (after discussing with the attending physician) and daily progress notes, discharge summaries, enter daily billing codes, etc. consistent with hospital and rotation policies. Faculty signs history and physicals and discharge summaries.

When the Residency Director is informed of any resident having delinquent medical records either in the Family Practice Center or in the hospitals, he will see that it is brought to that resident's attention. It is the resident's responsibility to correct the situation as soon as possible. The Director may require a resident with delinquent medical records to use weekend or vacation time to complete them. Responsible charting is one of the criteria evaluated at your Clinical Competency Committee performance review.

Family Practice Call Schedule and Responsibilities

For Family Practice Inpatient Service and Front Royal Family Practice telephone call, responsibilities begin at 5:00 PM on the night of coverage and end at 7:00 AM the following morning. On weekends, call responsibilities begins at 7:00 AM on Saturday or Sunday and ends at 7:00 AM the following day. On call responsibilities include:

1. Responding to all telephone calls that occur after the regular office hours of Front Royal Family Practice patients. Every telephone call will be answered promptly and courteously and the relevant content of the phone call entered into Epic.

2. If you recommend that a patient go to the ER, you must meet the patient there to evaluate them. The resident must always precept with an Emergency Room physician or Family Practice attending.

3. Managing all Family Practice Inpatient Service patient care issues, including admitting patients to the service when appropriate after discussing with the on call FRFP physician. Mandatory morning report to the on-service R-2 and R-3 FPIS residents the day following call to discuss call issues including patient dispositions and admissions.

Please remember that in order to learn, you must see patients. Some of the best cases come in "after hours." Look upon night call as a positive learning experience while you are serving our patients and remember that physician availability and responsiveness are among our patients' biggest concerns.

The holidays during which there are not regular office hours in the Family Practice Center include July 4th, Labor Day, Thanksgiving, Christmas, New Year's, Easter, and Memorial Day. Call responsibilities on holidays are similar to weekends.

Family Practice Center Obstetrical Call

R-2 and R-3 residents must provide longitudinal obstetrical care to a total of at least ten patients. Every resident needs to be continuously available for those patients for whom he/she is the primary resident obstetrical care provider from the time a patient reaches 37 weeks gestation until delivery. This is a unique opportunity to share in a truly family centered process. However, to allow for flexibility in the resident schedule, the primary resident provider must introduce the patient to his/her resident partner during the second trimester who will be a “back-up” in case of the unavailability of the primary resident obstetrical provider (e.g. planned vacation time, call at WMC, illness, post-call fatigue that might jeopardize patient care). The patient should have an opportunity to develop a relationship with the “back-up” resident through occasional routine prenatal care visits during the third trimester.

Section IV
Program Policies

Family Practice Resident Contract

The Shenandoah Valley Family Practice Residency Program shall provide residents appointed or reappointed to the Residency with a contract that is consistent with ACGME requirements. At a minimum, the policy will include salary, benefits and conditions of employment and termination in the contract itself or references to GME Committee approved policies and procedures in the Residency Policy and Procedure Manual for all 20 items listed in 11.C.3-4 of the Internal Review Document.

Selection Criteria

Reference Institutional Policy 17195449 Resident/Fellow Recruitment, Selection, Eligibility, and Appointment in Policy Stat or in last section of orientation manual.

Equal Employment Opportunity

We are committed to a policy of Equal Employment Opportunity and will not discriminate on any legally recognized basis, including but not limited to race, age, color, religion, sex, marital status, national origin, citizenship, ancestry, handicap, disability, veteran status, or sexual orientation.

Process for Screening Applications to SVFPR

REASON: SVFPR gets many hundreds of applications each year for its five PGY-1 spots in the Residency Match. These come through the ERAS application system. There must be a screening process to allow SVFPR to interview the best applicants, with the goal to fulfill the mission of placing high quality Family Physicians in the Valley Health region and rural Virginia.

SVFPR prioritizes applications by academic success, likelihood of success in the Residency Program and becoming a high-quality Family Physician, and likelihood of staying to practice in the VH region and rural Virginia, to fulfill the Mission of the SVFPR. Priorities are based on information over many years from the American Board of Family Medicine (on who is most likely to fail on the ABFM Board Certification Exam), from Family Medicine Residencies' experience nationally, and from our own Program's experience.

EXCLUDED APPLICATIONS:

1. Visa applications: VH does not support Visas; SVFPR considers applications from US citizens or Permanent Residents, (on website)
2. Years since Medical School Graduation: SVFPR considers applications from those graduating within the last 2 years, or with ongoing active licensed medical practice or accredited residency in the US. (VCU has a maximum policy for its residencies of considering applications 4 years from graduation, but the failure rate is high at that point.) There is a very high failure rate in residency with increasing years since medical school graduation. (on website)
3. Graduates of international medical schools that are not on the California Board of Medicine approved list. Many states' licensing boards now use the California approved list for their own licensing decisions, and preclude graduates from schools not on the list.

4. Multiple failures on the USMLE or COMLEX licensing exams. (on website) Past failure predicts higher likelihood of future failure.

PREFERENCE: because of a limited number of expensive and time-consuming interview spots, applicants are prioritized and interviews offered to the top applications.
Initial priority is given to:
- US MD and DO medical school graduates (overall higher rates of ABFM Board Exam pass rates than international school graduates).
- No failed classes or failed licensing exams.
- Applicants from the VH region or with close ties to Virginia. These are more likely to Match with the program if interviewed and more likely to stay to practice in the region later (the Mission of SVFPR).

Other considerations that help prioritize:
- Reputation of the medical school over time and of its graduates
- Student Rotation in our program, and performed well.
- High grades and class standing
- High USMLE or COMLEX licensing exam scores
- International medical school graduates with high grades and high USMLE scores and no failures
- Indications of hard work ability: eg, worked full time while in college, NCAA athlete while pre-med in college, worked during medical school, Eagle Scout, others.
- Indicators of strong character.
- Service and leadership indicators, volunteering, etc.
- Understanding of Family Medicine as a specialty and commitment to the specialty
- Prior work/career experience

Based on the above, applications are prioritized, and interviews are offered to the top applicants until spots are full.

Medical License

All residents are required to pass Part III of the USMLE or COMLEX by January 1 of their R-2 year. Residents who do not pass Part III may be dismissed from the residency program, or they may be required to extend their residency and not progress to an R-3 level of training until they do.

All R-3 residents are required to have a permanent Virginia State Medical License and a Controlled Substances Registration Certificate (DEA). Residents who do not meet the requirements may be dismissed or may be required to extend their residency and not graduate until they do.

All incoming residents are responsible for completing an application for a medical training license and ensuring all related documentation required (listed on license application) is sent with the license fee and license application to the Virginia Board of Medicine. The license application, documentation and fee can be sent by the resident directly or through the residency program. Each resident is responsible for ensuring that his/her license application, documentation and fee are sent to and received by the Virginia Board of Medicine in a timely manner which allows time for the application to be processed and the training license to be issued to the resident before the resident is scheduled to start his/her patient care duties within the residency program. All Virginia medical training licenses expire after one year. Each resident

will receive a notice to renew their license from the Virginia Board of Medicine approximately 90 days before the expiration of their license. Each resident is responsible for completing the license renewal application and sending it with the fee to the Virginia Board of Medicine allowing enough time for the application to be processed and the license renewed before its expiration date. If an incoming resident does not get his/her training license processed by the start date of his/her patient care responsibilities with the residency or if a current resident allows his/her training license to expire, the resident will be required to take any action(s) deemed necessary by the Residency Director to ensure his/her license application is processed as quickly as possible. This may include requiring the resident to drive to the Virginia Board of Medicine in Richmond, Virginia with any missing application materials. Any time the resident misses from performing residency responsibilities due to a delay in getting an original or renewed training license will be taken from the resident's allotted vacation time. Once the medical license is received (both training and permanent) the original must be presented to either the Program Coordinator or Assistant Coordinator so that a copy can be made of it for the residency program files.

Absences

Reference Institutional Policy 17400575 Resident/Fellow Vacation and Leaves of Absence in PolicyStat or the last section of orientation manual for the GME General policy.

Absence from the Family Practice residency, in excess of 21 total work days within the academic year (R-1, R-2 or R-3 year), must be made up before the resident advances to the next training level, and the time must be added to the projected date of completion of the required 36 months of training.

Leaves of Absence from the residency, exclusive of vacation/sick time, may interrupt continuity of patient care for a maximum of three (3) months. Following a leave of absence of any duration, the resident must return to the program and maintain care for his or her panel of patients for a minimum of two months before any subsequent leave.

Family/Extended Medical Leave

Reference Institutional Policy 17400575 Resident/Fellow Vacation and Leaves of Absence in PolicyStat or the last section of orientation manual for the GME General policy.

Qualifying Family Leave (Maternity/Paternity/Adoption or close family Caregiver Leave) and Qualified Extended Medical Leave (major surgery or extended hospitalization) are a special category of Leave. The Program/Valley Health will support the resident during this time for up to six (6) weeks of full pay and benefits. This is accomplished by a combination of personal PTO/Sick Days + Short-Term Disability + VH coverage of the remainder, during that 6 week period. One week of the six (6) guaranteed weeks[$$] (5 work/business days) of PTO will be kept in reserve for the resident for that year for future needed time off per the ACGME policy requirements[$$]. The Leave should be arranged upon confirmation of the pregnancy or anticipated adoption or leave, but no later than 4 months prior to expected time off (except in the case of an urgent problem). The resident will notify the program of the expected leave and coordinate with the Program and VH Human Resources to arrange this special Family/Extended Medical Leave. Short and minor illnesses do not fall under this Leave, but rather are managed by using usual PTO and Sick Time as noted below.

Per the ABFM, the residency must also allow for an additional six weeks of unpaid FML[$$].

There will be an option for a Family Medical Leave Elective. This will require the resident to complete one half day of continuity clinic per week. The Elective also requires weekly check-ins with the resident advisor and a PowerPoint be completed on the agreed upon Elective topic that will be presented to the resident peers upon returning from leave. The resident will still be required to extend to complete any time missed in excess of the 21 days per academic year (not including elective time). [$$]

For any extended Leave from the Program, the resident may require an extension of promotion or graduation date, in order to meet the training requirements of the Program, the ACGME, and Board Eligibility requirements of the ABFM or AOBFP.

Except for Family Leave, leaves of absence in excess of three months are considered a violation of the continuity of care requirement of the Board. The Board may require the resident to complete additional continuity of patient care time beyond what is expected to complete training requirements in order to be eligible to make application for certification.

Sick/Emergency Leave

If you need to call out sick or have an emergency, you will be required to use your days of PTO/Sick/Personal time. A resident exceeding 21 total work days off in an academic year (Vac + Sick + Personal/Emergency but does not include CME and residency business/recruiting) must extend that year of training.

Residents who are sick enough to be excused from work must personally notify the attending on the rotation to which they would first report and the residency program coordinator or assistant program coordinator.

Some conditions require notification of Employee/Occupational Health (see Employee's Notice of Reportable Conditions). Since some reportable conditions will exempt residents from patient care, but not necessarily from other resident responsibilities, the residents still must notify the attending on the rotation to which they would first report and the residency program coordinator or assistant program coordinator also.

Vacation

Reference Institutional Policy 17400575 Resident/Fellow Vacation and Leaves of Absence in PolicyStat or the last section of orientation manual for the GME General policy.

The American Board of Family Practice states that, "Absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one (1) month per academic year."

Residents are given eighteen (18) days of vacation and 3 days of Personal/Emergency leave per year in all three years of the residency for a total of 21 days. There will be three days of CME in the second year and 5 days of CME in the third year.

At least five of the 18 days must be taken during the first half of the academic year (by the end of block 5). Vacation periods may not accumulate from one year to another. Annual vacations must be taken in the year of the residency for which the vacation is granted. The resident does not have the option of reducing total residency time required by forgoing vacation time. No more than one week of vacation may be taken in any one block.

The residency director determines when residents will take Vacation/CME. The Director will work with the Chief Resident to complete an equitable schedule. When Vacation/CME time has been selected by the resident, he/she should turn in the appropriate forms at least three months ahead of the planned time off to the residency coordinator to be given to the residency director for approval. If the residency director fails to approve the time off he/she is required to give the resident a justifiable reason for the denial.

Box Coverage

Each resident is responsible to assign box coverage during Vacation, Leave of Absence or Away Electives. If it is a last minute absence, the resident should work with the chief resident to arrange for box coverage. Box coverage cannot be assigned to the same resident more than 1 week at a time.

Residency Closure/Reduction

Reference Institutional Policy 17195047 Closures and Reductions in PolicyStat or the last section of orientation manual for the GME General policy.

Workload/Duty Hours/Call

Reference Institutional Policy 17194830 Clinical and Educational Work Hours in PolicyStat or the last section of orientation manual for the GME General policy.

Transitions of Care

Transitions of care of each patient (handoff of care from one physician to another) are managed in a formal way. There is daily 8 am Morning Report/sign-out meeting of the entire Warren Memorial Hospital FP Inpatient Service, with the prior night on-call resident, the whole inpatient team, and the inpatient attending. All new admissions are presented, night problems are reported and discussed, and all inpatients are discussed along with daily plans. Each evening is the 5 pm sign out from inpatient daytime resident to night time on-call resident, as well as from the week's Family Practice Inpatient attending to the on-call attending. The same occurs at 7 am and 5 pm at Winchester Medical Center for the inpatient Pediatrics and inpatient Internal Medicine services. Patient handoffs use the printed Epic patient list. The handoff process includes presenting each patient, reason for admission, background medical problems, treatments, expected problems and plans for the day or night. At the end of each attending week, there is also a lengthy sign-out of the FP Inpatient Service's patients, attending to attending, for the oncoming attending physician.

For hospital patients: the FP Inpatient team reconciles medications at Admission and at Discharge. For office admissions directly to the hospital, there is direct office attending/ preceptor to inpatient attending discussion of reason for admission, concerns, plan, etc., before the resident and inpatient attending examine the patient. For admissions from the WMH Emergency Department, the ED attending discusses the patient's problems, reason for admission, concerns, testing, and ED treatments given. The ED attending is available to the FP Inpatient attending and resident to clarify items as needed when the resident and FP attending examine the patient. Practice patients are followed up after hospital discharge by the office PCP or a member of the inpatient team, and a short summary of Diagnosis and Medication changes and plans are entered into Epic directly, for quick access by the office staff and physicians (along with the usual hospital-linked copies of Admission H+P, labs, results, and DC Summary). For patients not in continuity care by the Residency practice, follow up is arranged before discharge with the patient's outside PCP, and the discharge summary is available directly to that PCP. For complex or difficult discharges, there may also be direct contact with the outside PCP practice, to coordinate details. The same applies with discharges of hospital patients to Skilled Nursing or Nursing Homes, though most of the Nursing Home patients are our own FP continuity patients followed regularly by our own resident Nursing Home service with resident PCP who continues care in follow-up.

Moonlighting

Reference Institutional Policy 17195280 Moonlighting by Residents/Fellows in PolicyStat or the last section of orientation manual for the GME General policy.

Residency training is a full-time responsibility. The residency director will monitor the effects of outside activities, including moonlighting inside or outside the participating institutions, to ensure that the quality of patient care and the resident's educational experience are not compromised. Therefore, the resident must petition the residency director in writing for the privilege of moonlighting. The residency director will review the request and provide a written response as to whether the request has been approved or denied. Residents may not be involved in any medical moonlighting activities until the second quarter of their second year of training and must have an unrestricted license to practice medicine. No resident on probation may moonlight.

Schedules will not be changed nor will early release from residency responsibilities be allowed for moonlighting. At no time will moonlighting exceed 40 hours per month; however, any moonlighting which decreases a resident's ability to attend to clinical and academic responsibilities is excessive, in which case, the residency director will remove or restrict the privilege. Moonlighting must be counted toward the 80-hour weekly limit on duty hours and the resident is responsible for reporting hours of moonlighting to the residency. No resident will ever be required or pressured into moonlighting. The residency malpractice policy does not cover any activity outside residency training and the residency does not cover any outside malpractice costs.

Interactions with Vendors

Reference Institutional Policy 17397206 Resident/Fellow Interactions with Vendors in PolicyStat or the last section of orientation manual for the GME General policy.

Non-compete Clause

Reference Institutional Policy 17195314 Resident/Fellow Non-competition in PolicyStat or the last section of orientation manual for the GME General policy.

Substantial Disruptions

Reference Institutional Policy 17195550 Substantial Disruptions in Patient Care and Education in PolicyStat or the last section of orientation manual for the GME General policy.

Artificial Intelligence

Reference Valley Health Policy 16830890 Use of Generative/Augmented Artificial Intelligence in PolicyStat or the last section of orientation manual for the GME General policy.

For PGY-3 residents only, access to Epic DAX AI scribe software will be available starting in September. Being placed on warning or probation is an automatic withdrawal from DAX privileges.

Section V
Supervision Policies

Reference Valley Health Policy 17397346 Supervision of Residents/Fellows in PolicyStat or the last section of orientation manual for the GME General policy.

Winchester Medical Center Family Practice Resident Supervision Policy

1. Family Practice Resident Physicians must be 1) resident physician employees of the Shenandoah Valley Family Practice Residency Program (SVFPR) of Valley Health System (VHS) or 2) resident physician employees of other ACGME accredited family practice residency programs participating in an elective with the Shenandoah Valley Family Practice Residency Program.

2. Residents may admit, consult, evaluate, write or dictate into the medical record, write orders on and discharge patients only under the supervision of credentialed medical staff members [attending(s)] and the attendings may supervise resident consistent with their hospital privileges. Residents agree to abide by the Inpatient Supervision Policy (see attached) and ICU Supervision Policy (see attached). Residents on probation are more closely supervised (see above two policies) and those residents suspended, dismissed or graduated from the program have no privileges even under supervision.

3. Supervising attendings may or may not be recognized faculty of the SVFPR but must agree to abide by this policy and the 1996 Health Care Financing Administration's guideline to Medicare Part B carriers for processing claims by teaching physicians, Section 15016, entitled "Supervising Physicians in Teaching Settings" [revised 11/22/02].

4. Supervision of residents performing procedures is addressed in the Resident Procedure Supervision Policy (attached).

5. All residents undergo a semi-annual performance review by the Clinical Competency Committee. This review identifies resident deficiencies that may affect resident status (e.g. probation, suspension, dismissal, promotion, graduation).

6. For significant resident deficiencies identified between reviews there is a special policy (see attached Procedure for Deficiencies in Clinical Competence, Technical Skills, Professional Behaviors and Physician Impairment).

7. Any change in status of a resident is immediately reported by the residency director [Director] to the DIO and all attendings involved in the supervision of the resident.

8. The Graduate Medical Education Committee (GMEC) of VHS has approved all of the above policies and periodically reviews them.

9. The GMEC meets at least four times annually during which it addresses patient safety and quality of care issues as well as medical education. The Chief Quality & Patient Safety Officer reports any issues regarding patient safety and quality of care concerns by attendings supervising residents or residents to the Director who will report to the GMEC. The Chairperson of the GMEC will relay urgent patient safety and quality of care issues back to the Chief Quality & Patient Safety Officer.

Warren Memorial Hospital Family Practice Resident Supervision Policy

1. Family Practice Resident Physicians must be 1) resident physician employees of the Shenandoah Valley Family Practice Residency Program (SVFPR) of Valley Health System (VHS) or 2) resident physician employees of other ACGME accredited family practice residency programs participating in an elective with the Shenandoah Valley Family Practice Residency Program.

2. Residents may admit, consult, evaluate, write or dictate into the medical record, write orders on and discharge patients only under the supervision of credentialed medical staff members [attending(s)] and the attendings may supervise resident consistent with their hospital privileges. Residents agree to abide by the Inpatient Supervision Policy (see attached) and ICU Supervision Policy (see attached). Residents on probation are more closely supervised (see above two policies) and those residents suspended, dismissed or graduated from the program have no privileges even under supervision.

3. Supervising attendings may or may not be recognized faculty of the SVFPR but must agree to abide by this policy and the 1996 Health Care Financing Administration's guideline to Medicare Part B carriers for processing claims by teaching physicians, Section 15016, entitled "Supervising Physicians in Teaching Settings" [revised 11/22/02] (see attached guideline summary).

4. Supervision of residents performing procedures is addressed in the Resident Procedure Supervision Policy (attached).

5. All residents undergo a semi-annual performance review by the Clinical Competency Committee. This review identifies resident deficiencies that may affect resident status (e.g. probation, suspension, dismissal, promotion, graduation).

6. For significant resident deficiencies identified between reviews there is a special policy (see attached Procedure for Deficiencies in Clinical Competence, Technical Skills, Professional Behaviors and Physician Impairment).

7. Any change in status of a resident is immediately reported by the residency director (Director) to the Vice President of Medical Affairs (VPMA) of WMH and all attendings involved in the supervision of the resident.

8. The Graduate Medical Education Committee (GMEC) of VHS has approved all of the above policies and periodically reviews them.

9. The GMEC meets at least four times annually during which it addresses patient safety and quality of care issues as well as medical education. The VPMA of WMH reports any issues regarding patient safety and quality of care concerns by attendings supervising residents or residents to the Director who will report to the GMEC. Chairperson of the GMEC will relay urgent patient safety and quality of care issues back to the VPMA of WMH.

Inpatient Supervision Policy

1. On inpatient rotations, attending physicians, or their on-call designees, must be immediately available by telephone for resident consultations on the attendings' patients they are caring for. Attending physicians or their on-call designees must be able to be physically present for any emergencies within time limits established by hospital policies. Under no circumstance

will an attending physician, or their on-call designees, fail to personally evaluate, in compliance with hospital policies, any patients of which the residents are involved in their management, e.g., evaluating acute care patients on a daily basis.

2. Attendings will always review resident admission and discharge orders prior to their institution. This can be accomplished by:

    a) a comment written in the resident's admission or discharge orders that all orders including all medications have been approved by the attending.

3. All resident admission notes must be written at the time the admission orders are written.

4. All resident discharge notes must be written at the time discharge orders are written and co-signed by the attending when they are reviewed.

5. All resident H&P's must be documented on the day of admission and must be reviewed and co-signed by the attending, or his/her on call designee.

6. All resident discharge summaries must be documented on the day of discharge and co-signed by the attending when they are reviewed.

7. The nurse may contact the attending directly, regardless of the circumstances, but especially if there is concern that the attending may not have a clear picture of a patient's condition or if there is concern regarding the resident's clinical judgment.

ICU Supervision Policy

1. Warren Memorial Hospital has a combined Critical Care Step Down unit.

2. Patients admitted to the CCSD who are critically ill must be seen by the attending within 1 hour of admission even if a resident initially assesses the patient.

3. Critically ill patients include:

    a. On I.V. medication drips of pressor agents or Insulin or arrhythmia controlling medications.
    b. Ventilatory support including ventilator, BIPAP or CPAP continuous (and not night time CPAP for obstructive sleep apnea.
    c. Acute MI with planned cardiac catheterization in the coming hours.
    d. Critically ill sepsis patients with uncertain prognosis.
    e. Medical floor transfer to the CCSD for acute clinical deterioration.

4. Admission orders written by the resident must be cosigned by the attending prior to their implementation.

5. If a patient deteriorates, reassessment of the patient's condition and treatment plan needs to involve the attending.

6. The nurse may contact the attending directly, regardless of the circumstances, but especially if there is concern that the attending may not have a clear picture of a patient's condition or if there is concern regarding the resident's clinical judgment.

7. When a consultant makes a significant patient care recommendation that the resident is informed of or involves the resident in a procedure, the resident needs to promptly inform the attending.

Outpatient Supervision Policy

In the Family Practice Center, there must always be at least one physician faculty preceptor whose primary responsibility is resident supervision (with no direct patient care responsibility) for every four residents in compliance with Graduate Medical Education funding requirements.

The attending physician must personally evaluate all nursing home and home visit patients, unless the medical problem is minor <u>and</u> the attending physician does not bill for the resident visit.

Resident Procedure Supervision Policy

1. Residents shall be directly supervised by the attending (attending physically present) during all procedures except for procedures listed by the residency as not requiring supervision (see attached). Exceptions will be when the resident has been deemed competent in the procedure by the faculty.

   The resident procedure documentation report is a compilation of individual procedures registered in the Residency Management System by the resident. Competency cannot be granted by the faculty advisor until the resident has been directly supervised for the appropriate number of procedures with the attending.

2. Residents shall be indirectly supervised by the attending (attending approval required for each procedure performed) when the resident has documented competency in the procedure.

3. Attendings will only supervise (directly or indirectly) procedures for which they have clinical privileges.

4. Once competency for a specific procedure has been achieved, the residency will notify the Medical Affairs office. Medical Affairs will notify hospital staff which procedures the resident is competent to perform by indirect attending supervision. A list of resident procedures will be maintained in the Medical Affairs office.

<u>Procedures Not Requiring Documented Supervision</u>

Resident needs to demonstrate proficiency first or have discussion with faculty prior to performing these procedures.

- Anterior Nasal Septum Cautery
- Bladder Catheterization
- Blood Drawing (venous and arterial)
- Cerumen Disimpaction
- Cryosurgery of Non-Malignant Skin Lesions
- Florecein Dye Evaluation of Cornea
- Foreign Body Removal from the Conjunctiva and Lids
- Intravenous Line Placement (except central lines)
- Local Anesthesia

<u>Procedures Requiring Documented Supervision</u>

Procedures requiring Direct Supervision of procedures with the attending signing off on individual procedure documentation cards that no significant verbal input or technical assistance was required.

- Arterial Line Placement
- Casting
- Circumcision
- Colposcopy
- Code Blue Management
- Code Pink Management
- Conscious Sedation
- Endometrial Biopsy

- Endotracheal Intubation
- Excision Greater than 2 cm
- Excision of Skin Lesion (up to 2 cm)
- Excision of Thrombosed Hemorrhoid
- Fetal Scalp Electrode Placement
- Hemorrhoidal Banding
- Joint Injection or Aspiration (major joints - 2, minor joints - 2)
- Lumbar Puncture (adult patients - 2, pediatric patients - 2)
- Nasal Packing
- Nasopharyngoscopy
- Placement of Intrauterine Catheter
- Punch Biopsy of Skin Lesions
- Rapid Sequence Intubation
- Reduction of Shoulder Dislocation
- Removal of Foreign Body from Cornea
- Simple Incision and Drainage of Skin Abscess
- Simple Laceration Repair
- Third Trimester Ultrasound (fetal position + AFI)

Procedures That Must Always Be Supervised

- Central Venous Line Placement
- Flexible Sigmoidoscopy
- Paracentesis
- Stress EKGs
- Thoracentesis
- Vaginal Deliveries
- Vasectomy

Section VI
Performance Criteria and Procedures

Reference Valley Health Policy 17195089 Resident Promotion and Renewal of Appointment in PolicyStat or the last section of orientation manual for the GME General policy.

Resident Evaluation Policy

The decision whether to promote a resident from R-1 to R-2, R-2 to R-3 and R-3 to graduate shall be determined by the Residency Director with input from the faculty. (See "Semi-Annual Resident Performance Review Policy.") By itself, the passing of rotations is not sufficient for promotion or graduation.

The method of evaluation shall consist of direct observation of the resident as well as indirect observation through oral communication or written documents, rotation and longitudinal curriculum evaluations, conference attendance, procedure documentation, and written examinations, e.g. In-Training Exams, USMLE Part 3, etc. It is required that the resident participates in all aspects of the curriculum. It is further required that the resident complete all administrative responsibilities of a resident, including licensure, credentialing, etc., in a timely fashion, as well as the periodic evaluation of the residency, faculty and learning experiences.

The criteria for advancement/promotion shall be based upon the ACGME General Competencies (ACGME Institutional Requirements III.E) plus some of our residency specific criteria. The six competencies used to evaluate all residents are:

1. **Patient Care**

   Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health, and must be able to evaluate and treat patients efficiently enough to meet resident responsibilities.

2. **Medical Knowledge**

   Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. The resident must demonstrate knowledge in the biopsychosocial and patient-centered care approach to patient care.

   Graduates will possess sufficient depth of medical knowledge to pass the certifying examination of the American Board of Family Medicine, and for osteopathic graduates, the American Osteopathic Board of Family Practice, and to maintain certification over the years of practice.

   Graduates will also possess skills in common family practice procedures.

3. **Interpersonal and Communication Skills**

   Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, peers, faculty, and other healthcare providers.

4. **Professionalism**

Residents must demonstrate a commitment to consistently carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to demonstrate an absence of violation of professional or institutional codes of conduct including racism, sexual harassment, any sexual relationships with patients, and inappropriate sexual relationships with staff or colleagues; absence of violation of any relevant state or federal laws and absence of any criminal conduct; absence of impaired function due to physical, mental or emotional illness or substance abuse.

5. **Systems-Based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

6. **Practice-Based Learning and Improvement**

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

7. **Osteopathic Philosophy and Osteopathic Manipulative Medicine**

For D.O.s (osteopathic graduates), graduates will be competent in osteopathic manipulative medicine knowledge and the basic skills of osteopathic manipulative treatment techniques for independence in practice. They will also possess the skills and knowledge to pass the certification examination of the American Osteopathic Board of Family Practice. Also, for allopathic (M.D.) graduates exposure to and familiarity with the basics of osteopathic manipulative treatment.

Clinical Competency Committee Semi-Annual Resident Performance Review Policy

At orientation before the PGY-1 and PGY-2 years, the competencies for the upcoming PGY levels in the Resident Progress Appraisal are reviewed with the residents. The residents are expected, at a minimum, to receive all $\geq$ "2" for their respective PGY level competencies before advancement. At orientation before the PGY-1 year, the Criteria for Promotion along with the Advancement Criteria Summary are also reviewed with the residents.

Twice annually a review of every resident's performance is undertaken in the following manner:

1. The resident, team leader and faculty advisor separately complete a resident progress appraisal evaluation form. These are presented to the Clinical Competency Committee to review. Based on the Clinical Competency Committee input, a composite evaluation is completed that includes scores and comments.

2. At the same Clinical Competency Committee meeting the advancement criteria summary, which has to be completed by the program staff, is presented to the faculty.

3. Based on the resident progress appraisal composite evaluation and the advancement criteria summary a decision as to the resident's status and anticipated future status is determined and an individual learning plan for each resident is developed.

4. The results of this review are presented to the residents by their faculty advisor at the next semi-annual faculty advisor meeting along with rotation evaluations, longitudinal curriculum evaluations, procedure documentation, etc. This meeting is scheduled within six weeks of the review. A summary of the meeting is documented by the faculty advisor and signed by the resident.

5. The program director semi-annually reviews the semi-annual faculty advisor meeting reports since the last review, the resident progress appraisal, the advancement criteria summary and the individual learning plan. At a minimum the program director discusses current and anticipated future resident status and the individual learning plan with each resident. The winter semi-annual review by the program director must be completed before March 1 for any resident whose promotion on July 1 is in question. A summary of the meeting is documented by the program director and signed by the resident.

6. Copies of the resident progress appraisal, advancement criteria summary, individual learning plan, quarterly faculty advisor meeting report and semi-annual program director report are kept in the resident's evaluation binder, along with all other evaluation forms.

Procedure for Deficiencies in the Seven Competencies / Appeals Process

Reference Valley Health Policy 17195175 Due Process for Residents/Fellows in PolicyStat or the last section of orientation manual for the GME General policy.

This procedure will be used in conjunction with VHS policy for alleged sexual harassment, violence (or threats of violence) and discrimination; and in conjunction with the residency's Procedure for Physician Impairment for alleged physician impairment.

Procedure for Physician Impairment

An impaired physician is one who may be unable to practice medicine with reasonable skill and safety because of excessive use or abuse of alcohol or other substances, physical or mental illness including deterioration through the aging process or loss of motor skills. The definitions applicable to impairment include:

- Practicing the profession while impaired by alcohol, drugs, physical or mental disability; or
- being dependent on or a habitual user of alcohol or drugs (unless the use of drugs is part of an approved therapeutic regimen and does not impair the physician's ability to practice); or
- having a psychiatric condition which impairs the physician's ability to practice.

If there is evidence that a resident is impaired as defined above, the resident shall be so informed in a confidential meeting with his/her faculty advisor or the Residency Director with written documentation of the meeting. At the discretion of the Residency Director, input by other faculty may be solicited.

If a judgment of probable impairment is made, the following options are available:

1. If the impairment is judged to be so severe as to represent an ongoing risk to patient care or has already resulted in significant harm to patients or the reputation of the Residency or Hospital, the Director may request suspension or dismissal from the program.
2. In situations judged to represent principally potential impairment rather than actual impairment or risk to patients, the Director may formulate and implement a plan of in-hospital monitoring and assistance. Physicians who do not cooperate with this will have the option of suspension and/or mandatory referral to the Virginia Impaired Physicians Program.
3. In cases of actual impairment, risk to patients or recurring or longstanding problems, the Director is required to report the individual to the Virginia Impaired Physicians Committee and to establish a monitoring system meeting the guidelines. Any significant deviation from the treatment or monitoring plan established with the Committee should result in a recommendation for suspension or dismissal from the Residency and reporting of the involved resident.

If dismissal from the Residency program is recommended by the Residency Director, the procedure for Deficiencies in Clinical Competence, Technical Skills and Professional Behaviors shall be followed as outlined in Section V. The resident has the option to request a review of the dismissal before a subcommittee as outlined in that procedure.

The procedures referred in this document support Valley Health System corrective action policy (HR501), grievance policy (HR502) for matters dealing with residents, and the Valley Health System policies HR523 Mandatory Reporting Requirements and HR602 Impairment and Fitness for Duty Process. This procedure is also in compliance with the Virginia Medical Practice Act.

Summaries of all corrective actions shall also be forwarded to the Vice-President, Human Resources of Health System, for inclusion in the resident's confidential employment files and to the Chairperson of the GME Committee.

Grievance/Complaint Procedure

Reference Valley Health Policy 17195245 Resident/Fellow Grievances in PolicyStat or the last section of orientation manual for the GME General policy.