FAMILY MEDICINE RESIDENT POLICY AND PROCEDURE HANDBOOK

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER-SHREVEPORT/MONROE FAMILY MEDICINE RESIDENCY

MONROE, LOUISIANA
JULY 2024

ADMINISTRATIVE AUTHORITY

Effective October 2013 the administrative control of this residency was transferred from E. A. Conway Medical Center to Louisiana State University Health Sciences Center-Shreveport, now LSU Health Shreveport, hereafter referred to as LSUHS. This residency falls under the control of the Graduate Medical Education Committee (GMEC) and the Designated Institutional Official (DIO) at LSUHS, currently Dr. James Morris. The policies and procedures detailed in the LSUHS House Staff Manual, GMEC Policies and Procedures Manual, and Human Resources Department are applicable to this residency. This handbook details policy and procedures that apply specifically to the Family Medicine Residency Program at Ochsner LSU Health Monroe Medical Center (OLHM). If at any time there is conflict between this manual and the Shreveport resources, the policies and procedures of LSUHS shall prevail.

This residency is a subordinate branch of the Department of Family Medicine Shreveport. The Department Chairman is Dr. Peter Seidenberg. Dr. Shivlal Pandey is the Director of Family Medicine for Monroe, and Dr. Teri O'Neal is the Program Director for the Monroe Family Medicine Residency.

Updated July 2024, Teri B. O'Neal, MD

MISSION STATEMENT

The mission of the LSUHS Family Medicine Residency at Ochsner LSU Health Monroe Medical Center is to train resident physicians with the necessary knowledge and skills to provide autonomous, quality, competent, longitudinal, and comprehensive Family Medicine Care.

VISION STATEMENT

It is the vision of the LSUHS Family Medicine Residency at Ochsner LSU Health Monroe Medical Center to be a center of excellence for training Family Physicians to meet future demands of medical practice within the specialty of Family Medicine. This vision will be accomplished by training resident physicians who will be eligible for board certification by the American Board of Family Medicine upon their graduation. These residents will have maintained steady progression in Family Medicine Milestones throughout their training, and upon completion of their residency will meet all criteria for competency and autonomous practice as described in the Competency Based Core Outcomes from the ABFM.

CLINICAL CURRICULUM

The 36 month training program is structured to comply with the Institutional, Common and Specialty Requirements for Residency Training in Family Medicine approved by the Accreditation Council for Graduate Medical Education (ACGME) and its Review Committee for Family Medicine (RC-FM). The most current iteration of the ACGME Program Requirements for Graduate Medical Education in Family Medicine may be found on the ACGME Website: http://acgme.org/acgmeweb/

Current Block Schedule beginning July 2024:

ROTATION	PGY-1	PGY-2	PGY-3
Fam Med Inpatient	8 weeks	6 weeks	8 weeks
Night Admit	6 weeks		
Night Float		4 weeks	2 weeks
Pediatrics Inpatient*	4 weeks		
Pediatrics	4 weeks	4 weeks	8 weeks
Surgery	4 weeks		
Radiology/Psychiatry	2 weeks		
Obstetrics	8 weeks		
Gynecology		4 weeks	
Emergency*	4 weeks		
Fam Med Clinic**	7 weeks	6 weeks	14 weeks
Sports Medicine*		4 weeks	
Neurology		4 weeks	
Eye ENT	2 weeks		
Cardiology		4 weeks	
Dermatology*		4 weeks	
Electives*		8 weeks	16 weeks
Vacation	3 weeks	4 weeks	4 weeks

*Pediatrics inpatient and Emergency rotations currently in Shreveport. Some electives will be in Shreveport. (apartments are furnished for mandatory rotations and most electives)
**Family Medicine Clinic blocks are in addition to half days which are routinely scheduled during other rotations.
Multiple longitudinal rotations exist with assignments throughout the course of the residency and include Population Health and Community Health.
(See also the attached block schedule for the current academic year.)

DIDACTIC CURRICULUM

Mandatory didactic conference is scheduled weekly from 12:30 until 3:30 on Fridays, with residents being excused from clinical duties at this time. The inpatient FM (Tiger Team) service is covered by attending faculty to allow residents to attend. Other service chiefs (Pediatrics, Surgery, etc) are required to arrange coverage for residents on their service as well. Excused absences will be granted at the discretion of the Program Director for very limited reasons including:

1. Some out of town rotations (but generally the resident will be required to return to this campus for continuity clinic Friday morning and for didactics in the afternoon).
2. Participation in a clinical EMERGENCY during the conference (explanation must be submitted to the PD immediately).
3. Scheduled annual leave, CME or Administrative leave approved PRIOR to the conference.
4. Sick leave.
5. In the event of a potential duty hour violation (PD and/or Program Administrator should be informed PRIOR to the absence).
6. Other requests will be considered but must be discussed with the PD and or Program administrator PRIOR to the absence (except in case of unexpected EMERGENCY situations, which should be reported as soon as possible).

These sessions include presentations by residents, faculty, and guests to cover the breadth of family medicine. Most presentations are live, but some are in virtual or pre-recorded formats. A variety of presentation types are employed including lecture, group discussion, and Q&A (such as board review question sessions). Workshops for actual hands-on training in subjects such as ACLS, musculoskeletal exams/sports medicine, casting and splinting are also utilized.

The didactic curriculum is structured to maintain longitudinal coverage of all major areas encompassed by Family Medicine. Resident presentations follow the 36 month cycle in FP Essentials, with the contents of one monograph covered each month. Additional sources of curricular content may include the STFM, AAFP, ABFM, ACGME, and AFMRD websites as well as other appropriate resources that become available. Each academic year begins with a “Critical Care Series” of lectures presented by IM and FM faculty to review skills needed to address some of the most common serious illnesses admitted to our service (DKA, ACS, CVA, COPD, etc).

In addition to mandatory Friday conferences, there are other opportunities for didactic learning including multiple service grand rounds broadcast from Shreveport. Alternate Tuesdays feature a noon Zoom conference with a variety of topics, as well as Board Review Q&A sessions.

Attendance for mandatory didactic sessions is recorded and unexcused absences will require make up work at the discretion of the PD.

SUPERVISION AND ESCALATION OF CARE

Attending faculty physicians have the ethical and legal responsibility to ensure that patients receive the level of care expected from a specialist in the field of Family Medicine. Appropriate

supervision of residents at all levels is essential to carry out this responsibility. According to the ACGME Program Requirements for Family Medicine: *"All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety individual needs and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care."*

There are multiple levels of supervision used in graduate medical education. See the attached **Resident Levels of Care** to determine year level and specific circumstances that fall under these types of supervision.

- Direct Supervision: The supervising physician is physically present with the resident and patient during the key portions of the exam or procedure. Senior residents may be granted supervisory authority by faculty for some circumstances, according to their demonstration of increasing ability.
- Indirect Supervision: The supervising physician may not be physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.
- Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

When residents provide care the patient should be made aware that a faculty attending is ultimately responsible for all aspects of care and that supervising physician should be identified for the patient. Whether inpatient or outpatient, the resident is expected to contact the responsible faculty attending for problems or questions at any time. At any point that a patient experiences clinical deterioration, a significant event (stroke, seizure, etc) or requires a move from the floor to ICU (or from the clinic to the ED), the faculty attending should be contacted at once. (See also the attached **Policy for contacting attending faculty on call for inpatient services** and **Policy for contacting attending physicians.**) Faculty attending physicians should also be notified of any procedures prior to the performance of said procedure. At that time, the attending faculty will determine the appropriate level of supervision indicated for the procedure.

For the first 6 months of their first year residents in the FM Clinic will discuss EVERY patient with the clinic faculty BEFORE the patient is discharged. The attending faculty physician will see each patient in-person prior to discharge. Following that time period, graded responsibility may be employed on an individual basis as ability and performance warrants. It is expected that upper level residents will be able to manage clinical situations with less input from the attending faculty in real-time, however all residents are encouraged to contact their faculty at any time they feel necessary. Faculty and residents will discuss every case prior to the end of the clinic. Faculty will see all patients in the following categories:

All patients new to the clinic.

All patients with a visit that merits a charge higher than 99213 (regardless of payor source).

EVALUATION of RESIDENTS

While many factors go into evaluations, most are based on the ACGME Competencies for Graduate Medical Education, which are integrated into the program curriculum. According to the ACGME Common Program Requirements, *"The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty."*

The ACGME Competencies for Family Medicine are:

1. Professionalism. Residents must demonstrate a commitment to professionalism and an adherence to ethical principles.
2. Patient Care and Procedural Skills. 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.
3. Medical Knowledge. Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.
4. Practice –based Learning and Improvement. Residents must demonstrate the ability to investigate and evaluate their care of patients to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.
5. Interpersonal and Communication Skills. Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals.
6. Systems-based practice. Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources in the system to provide optimal health care.

These Competencies are assessed in a longitudinal manner in the Family Medicine Milestones. Milestones are utilized by the program in a semi-annual review of resident performance, and are then reported to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the six Competencies organized into a developmental framework. They include narrative descriptions for resident performance and they provide the Clinical Competency Committee (CCC) with a framework to track the progress (or regression) of each resident. The most current iteration of the ACGME Program Requirements for Graduate Medical Education in Family Medicine may be found on the ACGME Website: http://acgme.org/acgmeweb/

In addition to Milestones, multiple other methods of evaluation are employed. Each resident will receive an electronic evaluation at the end of every rotation. These will be entered into New Innovations by the faculty responsible for evaluating the rotation. . Faculty members on all rotations are encouraged to provide formative feedback (real time, designed to help improve performance then and there) and summative feedback (assessment of overall performance) for the rotation. Ideally this feedback is provided in a face to face session, as well as in the electronic submission for the rotation. Other data points will be collected in a 360 degree evaluation annually, with input from patients, nursing staff, peers, and faculty including those from other services as appropriate.

FM residents are required to take the FM In-Training Exam (ITE) every fall. While this exam has no bearing on whether a resident is promoted or graduated, the exam provides useful information to identify areas that need additional study in order to improve clinical performance as well as improve the likelihood of being successful with the ABFM Board Examination. All residents scoring greater than 1 SD above their PGY peer national average scaled score on the exam will be awarded an additional $500 in educational funds. All residents scoring lower than 1 SD below their PGY peer national average scaled score will be required to complete a course of focused learning directed by the resident's faculty advisor. Other performance improvement requirements may be implemented at the program director's discretion**. All residents are expected to develop an Individualized Education Plan based on The ITE results. Faculty advisors will actively assist in this process.**

Residents will be required to meet quarterly with their Faculty Advisor (assigned upon joining the program) and with the Program Director (or Associate Program Director) at least semi-annually to review their progress in the program and identify strong points as well as areas that might need improvement. ITE scores will be reviewed during these meetings to enable the development of an appropriate Individualized Education Plan (IEP). All residents are encouraged to perform self-assessment with the Milestones periodically and to discuss their results with their Faculty Advisor. This is an opportunity for clarification of resident expectations as opposed to faculty expectations and perceptions. The Family Medicine Milestones can be found on the ACGME Website previously cited.

Other methods of resident evaluation may be implemented from time to time at the recommendation of the CCC, Program Evaluation Committee (PEC) or Faculty and the approval of the Program Director.

Patient charts are reviewed in the hospital and FMC on a regular basis to determine quality of care, outcomes, and follow-up. Residents are involved in performance improvement activities and patient safety initiatives. Feedback to the resident will be provided when indicated.

Residents are accountable to the department, the GMEC and OLSU-M for their duty hours. As such each resident should record their duty hours in the form and within the timeframe set by GMEC policy and/or procedure. Failure to do so may result in an adverse consequences for the resident. See also Duty Hours.

PROMOTION and PERFORMANCE IMPROVEMENT/PROBATION

The Clinical Competency Committee (CCC) is responsible for providing semi-annual FM Milestones assessments of all residents and provides a recommendation to the Program Director regarding suitability for promotion. It is anticipated that a resident who has achieved satisfactory evaluations for all rotations without other significant deficiencies will be promoted within and graduated from the program. (See Requirements for Promotion and Graduation section.)

If evaluations have been satisfactory, but other requirements have been unmet, it is possible that the resident may be assigned "Incomplete" status. This designation serves as formal notification of lack of performance in a given area or areas. This does not rise to the level of probation and should not be considered a formal adverse action for reporting purposes. The resident will be notified in writing and given about 3 months to correct the deficiency as determined by the Program Director. Should the deficiency not be corrected within 3 months (or prior to the end of residency whichever is shorter), then the resident will be formally placed on probation *which is an adverse action and is reportable*.

Residents with significant deficiencies will receive verbal and written feedback from the Program Director and the CCC. Written feedback may be in the form of a "Notice of Concern" which details all areas of concern, organized under the ACGME Competencies, and necessary steps to correct the deficiencies. The Notice of Concern does not rise to the level of an adverse action, but should be seen as an indication that immediate action should be taken to correct the deficiencies noted.

When an evaluation indicates many major deficiencies in performance or a critical performance deficiency, the resident concerned will be placed on immediate probation unless the incompetence is considered to be of a magnitude as to warrant dismissal from the program. This rating, termed unsatisfactory, implies failure of the rotation and requires that the rotation be repeated in order to receive credit for the curriculum requirement. The repeated rotation will be incorporated in the block schedule so as to disturb the master resident schedule as little as possible. Promotion to the next year and/or graduation cannot occur without satisfactory completion of the rotation. When the incompetence is extreme, dismissal from the program will be recommended. Should a resident receive an unsatisfactory evaluation twice within the same academic year, dismissal will again be recommended. Failure to correct a "Probation" status due to an "Incomplete" status can result in dismissal from residency at the end of 3 months of probation or prevent the "verification of completion of residency" from being sent to the ABFM.

Negative evaluations of a resident's performance can adversely affect not only his/her status in the program, but can also impact his/her professional career following postgraduate training. Therefore, when a department discerns that there are important or major deficiencies in a resident's work, this needs to be communicated to both the resident and the Program Director as early into the course of the rotational block as possible (preferably within the first two weeks of the rotation). An early awareness of problems will provide the opportunity to rectify the problem or problems. Adverse events may be eligible for review under the "Due Process" provisions of LSUHS. See the **LSU Health Shreveport House Staff Manual**.

In addition to clinical and academic performance issues, professional incompetence/negligence or unprofessional demeanor can incur one of two disciplinary actions by the program. For matters of a gross nature, the resident's contract may be immediately rescinded. Otherwise, the resident may be placed on probation. When a resident is placed on probation, he/she receives intensified supervision. If satisfactory improvement is shown as outlined in the probation documents, the resident is restored to "good standing" status within the program at the end of the probationary period. If, however, the resident's performance does not improve satisfactorily during the probation period, the resident's contract may be rescinded at that

time. Due process is afforded to the resident with an adverse determination as outlined in the LSUHS current House Staff manual.

REQUIREMENTS FOR PROMOTION/GRADUATION

Scholarly Activity: Each resident is required to complete a minimum of two scholarly activity projects during their training. These activities should include collaboration with a faculty member from OLHM, and may be done with a team of residents. Inter-professional collaborations with pharmacy students, PA students, medical students or other specialties is encouraged.

1. The ACGME requires that at least one of the projects be a QI activity.
2. The LSUHS Family Medicine Department requires that a poster be prepared and presented at the Annual Family Medicine Symposium in Shreveport (this could be based on the QI project).
3. Publications are strongly encouraged, with PUBMED ID preferred. (Submission to a PUBMED eligible journal will be considered completion of this option, even if the submission is not accepted for final publication.)

Obstetric Requirements: Each resident is required to perform at least 5 continuity deliveries prior to completing the program. (A "continuity delivery" is defined as an obstetrical delivery of a patient in which the resident participated in the patient's prenatal care, their labor and delivery and post-partum care. Documentation of all three phases of care is required and must be reviewed and approved by the Program Director.) 20 total obstetrical deliveries are also required.

Completion of the residency program will not be certified until both of these goals have been met in addition to those listed below.

Promotion Requirements from PGY-1 to PGY-2

1) Satisfactory rotation evaluations for each block
2) Satisfactory correction/completion of any problem areas, deficiencies or periods of probation for any cause as approved by the Program Director.
3) Satisfactory completion of one of the ABFM's Maintenance of Certification modules (either KSA or PI module) as approved by the Program Director.
4) Completion of a minimum of 150 outpatient visits through the Family Medicine continuity clinic. You are encouraged to see more than this minimum expectation.
5) Must **have taken the USMLE Step 3**. Failure to do so will result in termination (See the LSUHS Shreveport House Officer Manual policy on USMLE Step 3.)

Promotion Requirements from PGY-2 to PGY-3

1) Satisfactory rotation evaluations for each block
2) Satisfactory correction/completion of any problem areas, deficiencies or periods of probation for any cause as determined by the Program Director.

3) Satisfactory completion of all 50 points of the ABFM's Maintenance of Certification modules (including at least one each of KSA and PI modules) as approved by the Program Director in accordance with the ABFM's requirements.

4) Completion of a minimum of 500 outpatient visits through the Family Medicine continuity clinic. These 500 visits are to be accomplished exclusively in the PGY-2 year and in addition to the 150 achieved in the PGY-1 year so the expected total visits seen will be a minimum of 650 visits by the end of your PGY-2 year. You are encouraged to see more than this minimum expectation.

5) Have achieved a minimum of 20 total obstetrical deliveries and

6) Completed and provided all required documentation of 5 continuity deliveries as approved by the Program Director.

7) Have documented 75 significant care events for ICU patients as approved by the Program Director.

8) Have completed a minimum of 5 Pre-participation physical examinations.

9) Have completed at least one scholarly activity project as discussed above and approved by the Program Director.

10) Have participated in at least one community service or advocacy activity (approved by the Program Director).

11) **Have taken and passed USMLE Step 3**, failure to do so will result in termination. (See the LSUHS Shreveport House Officer Manual policy on USMLE Step 3)

Graduation requirements:

(In addition to the promotion requirements above)

1) Satisfactory rotation evaluations for all blocks
2) Satisfactory correction/completion of any problem areas, deficiencies or periods of probation for any cause as determined by the Program Director.
3) Documentation of a minimum 20 total Obstetrical deliveries
4) Documentation of a minimum of 5 Continuity Obstetrical deliveries as discussed above
5) Completion of 1650* encounters for FMC panel patients (*this number is representative of a "sufficient" number of patient encounters per the ACGME and ABFM. The Program Director has some discretion in enforcing this number).
6) Documentation of a minimum of 1000 hours in continuity clinic involving direct patient care over 3 years and a minimum of 40 weeks each year with continuity clinic activity.
7) Documentation of 750 significant care encounters for inpatient adult medicine
8) Documentation of 125 significant care encounters for geriatric patients
9) Documentation of 100 significant care encounters for pediatric patients (defined as age 18 and younger). 50 encounters each in the ED and inpatient setting.
10) Documentation of at least 125 adult ED patient encounters
11) Documentation of at least 5 Pre-participation physical examinations
12) Completion of fifty (50) MC-FP points
13) Satisfactory completion of all scholarly activity as approved by the Program Director
14) Must sit for the ABFM Certification exam prior to the conclusion of residency

Failure to successfully complete <u>ALL</u> of the above will result in either:
1) No recommendation to sit for the ABFM certification examination and/or no certificate of completion of residency being issued and/or
2) Extension of your residency until all requirements are completed at the Program Director's discretion and if adequate funding exists and if approved by the GMEC and DIO.

Every resident must remain in good standing within the residency, must remain in compliance with the terms of the residency contract and satisfy promotion requirements as outlined above. In addition, a resident must have a current medical license or training permit issued by the Louisiana State Board of Medical Examiners.

Employment contracts are reviewed annually. If renewed, residents are expected to sign employment contracts three and a half months prior to the beginning of each subsequent academic year. Residents must maintain all testing and training required by OLSU-M and LSUHS. This testing includes taking of the USMLE Step 3 prior to the end of the PGY-1 academic year. Failure to comply will result in dismissal from the residency program as determined by the GMEC in Shreveport. The USMLE Step 3 must be passed prior to the end of the PGY-2 academic year in order for the Louisiana State Board of Medical Examiners to issue a training permit for the PGY-3 year. Failure to achieve a passing result prior to the PGY-3 year will result in dismissal from the residency program as determined by the GMEC in Shreveport.

SERVICE OBLIGATIONS AND CALL

A resident's responsibilities on any service depend upon: 1) his/her level of training, 2) the number, level, and specialty orientation of other house officers concurrently assigned to that service, and 3) the particular dictates of the senior LSUHS resident (OB/GYN, General Surgery, Psychiatry or Ophthalmology), attending faculty and service chief. For this reason, rotational duties may vary somewhat from one month to the next on the same service. However, efforts are made to maintain educational consistency. Residents are primarily accountable to their attending faculty. However, on the General Surgery and OB/GYN services the Chief Resident frequently functions in this capacity. Most rotations will be carried out at Ochsner/LSU Health Monroe Medical Center (OLHM).

The faculty and staff consider the routine workday to begin at 8:00 AM. Should you enter the hospital to begin your day earlier than this, it is your responsibility to notify your attending because this could impact duty hour restrictions. Please refer to the section on Duty Hours.

POSTGRADUATE YEAR I (PGY1):

Evaluation of patients in the ED or clinic for possible admission to the Family Medicine** inpatient team is generally the responsibility of the resident on Night Admit, or a Tiger Team resident assigned by the senior resident on that team. When hospitalization is warranted, the resident performs the admission history and physical examination and documents appropriately. Ideally, the senior resident on duty for the service will accompany the PGY-1 resident for the key portions of evaluation. Initial and subsequent management plans are determined after appropriate consultation with the upper level resident and attending faculty. Outpatient management decisions made in the ambulatory clinics are also discussed with senior residents and/or faculty. No patient shall be evaluated and either admitted OR discharged without consulting the faculty on call.

Nights and weekends on the adult medicine service are covered by a senior resident in house (night float) who will serve as a backup to the on duty junior resident (night admit) and be responsible for management of the Tiger Team. Faculty physicians will continue to serve as primary backup for all residents. Faculty will always be available for phone consultation and will be immediately available to provide assistance in person should the need arise. (See attached **Policy for contacting attending faculty on call for inpatient services** and **Policy for contacting attending physicians.**)

Rounding on in-patients and writing progress notes is a daily responsibility of the first year resident while on an inpatient rotation.

The FM Inpatient team (Tiger Team) consists of one FM Faculty member attending the team and 3 or 4 residents (at least one senior and 2 or 3 junior) who manage adult patient load capped at 16 and following maximum admission caps as well. The Tiger team will also admit uncomplicated pediatric patients to the inpatient service when needed, up to a maximum patient load of 20. An assigned “ED Admitter” from the Internal Medicine/Hospitalist Department will be responsible for assessing consults from the ED during the day and assigning them to the hospitalist teams in rotation. FM patients (followed in resident or core faculty continuity clinics) will be preferentially admitted to the Tiger Team, unless the team is at cap. Once hospitalized, these patients are followed throughout their course by the admitting team

including any required intensive care. Management decisions are made in consultation with team upper level residents and faculty.

Pediatrics Clinic operates five full days each week. Resident attendance is expected unless FMC or mandatory didactics preclude it..

On the Pediatrics Inpatient rotation at Ochsner LSU – Shreveport St Mary's Medical Center, the PGY1 resident will be assigned to a team and function under the direct supervision of an upper level Pediatric resident and faculty. The schedule and duties will be determined by their usual scheduling methods and in accordance with ACGME guidelines.

On Obstetrics, the PGY1 resident serves in the labor and delivery area and also covers the postpartum unit. Assigned time in OB clinic will be included as well. Hands-on experience for deliveries is encouraged. Residents should remain immediately available to the LU staff and residents to facilitate this. Activities of the PGY1 resident are monitored by the OB/GYN residents from Shreveport and faculty including nurse midwives. The proper completion of the paper work associated with deliveries is important. Weekly service conferences include OB/GYN grand rounds.

On General Surgery, PGY1 responsibilities include the ward, the clinic, the ED, and the OR. The General Surgery chief resident delegates responsibilities to all members of the surgical team. Senior Surgery residents will provide supervision for FM PGY-1 residents when appropriate.

On Psychiatry, PGY1 residents are instructed in the basic psychiatric interview and in diagnosis and management of many commonly encountered psychiatric diagnoses under the guidance and direction of the faculty overseeing Behavioral health. Residents also gain experience in substance abuse and addiction at Palmetto Addiction Recovery facility. Residents are exposed to acute and in-patient Psychiatric issues at OLHM in the ED and during inpatient staffing sessions.

The mandatory ED rotation is conducted at OLSU Shreveport, and PGY-1 residents are instructed by ED physicians including faculty and residents. Duties are outlined by these ED physicians.

The ENT rotation is conducted at Affinity Clinic with Dr. Taliaferro. Eye rotation takes place at Ophthalmology department at OLHM. Duties are outlined by respective departments.

<u>POSTGRADUATE YEARS II AND III (PGY2 and PGY3):</u>

The PGY2 and PGY3 residents should assume increasing responsibility and independence as they rotate onto services for the second and third time. Clinical experience broadens during the upper level years on required rotational blocks: Sports Medicine, Dermatology, Health Neurology, Cardiology, Ophthalmology, and Otolaryngology. Upper level residents can also begin to direct their attention to particular areas of interest during three months of elective time. Subspecialty rotations, both elective and required, may completed with physicians in the community as well as at the Shreveport Academic Medical Center.

Increased supervisory duties will include managing/leading the FM Inpatient Team (TigerTeam). Senior residents on that rotation will be responsible for balancing the workload and assisting junior residents as needed. They should also be conscious of modeling appropriate habits and behaviors for juniors in order to be a mentor for professionalism.

Night Float is a block rotation* to cover nights on the inpatient FM service. This resident will be responsible for responding to the needs of the inpatient service and directly supervising the junior night admit resident whenever possible. It is anticipated that the Night Float resident will attempt to be present during the key portions of history and exam for new admissions overnight, and to assist the night admit resident in formulating a plan. At times, the Night Float will respond to an inpatient consult from another service for an FM patient. When there is a pediatric emergency (delivery or nursery) the Night Float will respond to assist until Pediatric Faculty is available.

Generally, weekday night duty runs from 5:00 PM to 8:00 AM. On weekends and holidays, call is 8:00 AM to 8:00 AM. Call the service chief (or on call faculty) and senior resident if other program duties will delay your arrival to assume call or night responsibilities.

*During a few weeks of the academic year, there is not block coverage for this position (predominantly July and December). During these times, the Chief Resident will call upon residents on other services to fill in the Night Float positions.

DOCUMENTATION/INPATIENT CHARTING

The hospital is responsible for recovering its budget from generated revenues therefore it is imperative to complete charts in a timely fashion so that billing can take place. Noncompliance with Joint Commission and CMS regulations in this area also threatens the hospital's eligibility for CMS reimbursement. Multiple physician signatures for a single record is not at all unusual, and considerable time may be required to complete that series of signatures. You are required to review your Epic in-basket daily and keep your delinquent chart tally at zero. Your cooperation in this matter is not optional. Your delinquent chart number is counted weekly and reported to the hospital Medical Director. Upon notice from the hospital Medical Director that you have one or more delinquent charts, residents will have 48 hours to bring that number to zero. Failing to do so, residents will be suspended without pay from the residency program until this is corrected as outlined by Chancellor's Memorandum-17. This suspension time may be a cause to extend your residency. Residents with chronically incomplete charts reflect poor professionalism and systems based practice and will risk unsatisfactory performance reports, additional duties assigned by the program director, and ultimately probation or dismissal from the residency.

Documentation of Procedures

It is the responsibility of the residency program to document the procedures that each resident has performed, to evaluate his or her competence and to maintain a record of this documentation. This information enables the program to monitor the educational experience and becomes critically important when a graduate applies for hospital privileges in the future. Documentation of procedures and diagnoses correctly will benefit the resident in accurately portraying their experience and clinical expertise for credentialing purposes in the future. The residency will utilize the New Innovations electronic platform for logging all procedures as well as other types of educational experience. Residents are responsible for logging each and every procedure and assigning it to an appropriate faculty member for co-signature.

In addition, special documentation must be provided to the Program Director regarding obstetrical deliveries, especially continuity deliveries. A copy of the delivery record for each obstetrical delivery and C-section is available to the performing resident for a permanent record of the experience. These should be collected from the Labor Unit by each resident at the end of each OB rotation. Residents should specifically document continuity deliveries performed. Five of these continuity deliveries must be documented prior to completion of the residency.

Patient diagnoses are recorded through the EHR. The accuracy of this record is dependent on the accuracy of the diagnosis listed by the physician in the "Visit Diagnosis" section of the electronic record (Epic) at each visit. A summary of the number of patients with each diagnosis should be available for each resident. Numbers of encounters for age and diagnosis must be adequately documented to ensure ACGME requirements have been met. (See the ACGME Program Requirements for Family Medicine on the ACGME website).

CHIEF RESIDENTS

Chief residents are appointed by the Program Director each year. Nominations will be accepted from the residents prior to the appointments. Residents who are in difficulty, on probation, or off-cycle are not eligible to serve as a Chief.

Requests, reports of scheduling problems, and other issues should be submitted to the Chief Resident by the individual resident submitting the request and NOT a surrogate for the resident (spouse, partner, parent, child or other).

Roles and Responsibilities of Chief Residents

- Act as a liaison between the residency and the program director, associate director, coordinator, and Program Evaluation Committee with regard to policies and procedures within the program.

- Assist with orientation of the interns to ensure continuity of service and care for all patients. Assist residents with transitions to the next clinical sites.
- Assist the program with recruitment and active participation in the interview process of applicants for the residency program.
- Provide an avenue of communication for an environment in which interns and residents may raise and resolve issues without fear of intimidation or retaliation.
- Set and maintain the standard of professional conduct for the entire program.
- Review program policies.
- Review rotation and didactic goals and objectives

Chief Resident (Administrative)

1. The Chief Resident (Administrative) is responsible for the development and modification of resident schedules and arranging back-up coverage for unplanned absences.
2. All changes in the call schedule must be reviewed by the chief resident with final approval lying with the service chief and program director. This is to ensure compliance with ACGME limits on resident work hours and other scheduling issues such as clinic schedules.
3. Support the program director, associate program director, and program administrator
4. Conduct resident meetings as deemed necessary to assess resident needs, and concerns.
5. Provide program with the monthly call schedule ensuring equitable schedules for each class.

Chief Resident (Education)

1. The Chief Resident (Education) assists the program director, associate program director, and administrator in developing the weekly didactic lecture schedule, inclusive of case conferences, journal club, and grand rounds, etc.

2. Encourage, monitor, and assist residents in identifying and participating in appropriate scholarly activities.

3. Encourage upper-level residents to take active role in the education of medical students and lower level residents.

4. Provide didactic lectures to interns, residents, and medical students on relevant topics as needed.

FAMILY MEDICINE CENTER

The Family Medicine Center (FMC) is the model clinic of the residency program. During the entirety of their training, Family Medicine residents in this setting learn to provide longitudinal, comprehensive, family-oriented care associated with their specialty. Each resident establishes his/her own panel of patients and their families for whom acute ambulatory care, inpatient care, routine health screening, counseling, and patient education are provided. FMC duties include Ambulatory blocks, during which a resident does not have additional clinic duties, and otherwise averages one half-day per week the first year, two half-days the second year, and three half-days the third year on most rotations. Additional half-day clinics may be assigned to a resident at the discretion of the program director. In the FMC, residents will be supervised by preceptors who are available at all times to teach by consultation, chart review, observation and direct patient care. Residents without 1 full year of U.S. residency training, however, are required to present each patient they see in the FMC to the preceptor for at least their first six months of training in this program. In these cases, the preceptor will examine the patient as well. When warranted by the complexity of a patient's problem, input from other specialties can be obtained through consultation.

It is a goal of the Monroe Family Medicine Residency to achieve a “Clinic First” culture. Residents should make every attempt to be present in clinic for the first appointment. Late arrival will be monitored and if habitual will be considered a lapse in professionalism. The clinic charge nurse and the Program Director should be notified at once if a resident anticipates being late to clinic for any reason. Excused tardiness will be considered for personal emergencies (illness, transportation issues, etc) and inpatient emergencies requiring the resident’s presence. Should a resident encounter difficulty in being excused from another service to be on time for clinic (or to remain in clinic until all patient visits are completed) the Program Director should be made aware of the nature of the difficulty so that a resolution can be found.

A professional appearance should be presented at all times. Business casual attire is appropriate. Lab coats should be clean and pressed. If scrubs are worn they should be clean and free of wrinkles as well. A lab jacket or professional pullover jacket should be worn with scrubs. (See the Department Chairman’s Policy on Professionalism, attached).

Additional clinic operations are addressed in the following policies:

1. FMC Hours are 8:00 until 5:00 weekdays except holidays as designated by the LSU system. There will be a break for lunch between morning and afternoon clinics.
2. Both new and established patient appointments will be made for all residents. If a resident wishes to refer a patient to themselves they should obtain permission from the Program Director.
3. **Scheduling:** Each PGY1 will be scheduled for 2-4 patients per clinic during the first quarter of the year, increasing gradually to 6 patients, PGY2 6-8, and PGY3 9-12 (more patients are scheduled in an afternoon clinic than a morning clinic and these templates may be changed at the discretion of the program director). Generally, each year level is booked for fewer appointments in the early part of the year, and more toward the end. The RC-FM and ACGME requirements mandate that a “sufficient” number of significant care encounters for FMC resident patients will be performed over the three years of residency. 1650 has been long held to be the required number, but the program director now has some discretion with this. Failure to reach progress benchmarks may result in additional new patients being added to that resident's panel, an extra weekly FMC, in that resident seeing a disproportionate number of "walk-ins", failure to promote to the next academic year or extension of residency before graduation.
4. **Patient Flow:** Patients check in at the front desk upon arrival to the FMC. They are screened by the registration clerk at every visit. Vital signs and routine Joint Commission screening information are entered into the electronic chart prior to the physician seeing the patient. When the patient is discharged from the clinic, return appointments are arranged at the convenience of the patient, family, and the resident.

Residents may specify a specific return date if it is an important matter. Otherwise, please give a general timeframe, i.e. “about 6 weeks”. This will permit more flexible scheduling and keep over booking to a minimum. Each resident is allowed to overbook their clinic by two patients (unless the clinic manager or Program Director decide otherwise). Once this limit is reached, the resident is responsible to get the Program Director’s approval for further over book appointments. Arrangements for notification of the patient for any ordered lab or diagnostic tests should be made prior to the patient's departure unless the patient wishes to be notified at a later date through the “My Chart” functionality of Epic, sent electronically via e-mail or have the information mailed to them via US Postal Service.

5. **Lab:** Lab is basically of two varieties: 1) results which are needed prior to a making a disposition on a patient, and 2) results which are not essential for discharging the patient. When ordering the lab make sure the nursing personnel understands which variety you are requesting. The former is usually indicated by a "now” or "stat" designation. It is the responsibility of the resident to follow-up abnormal tests
6. **Admissions:** Patients requiring hospitalization should be discussed first with the FMC preceptor and then with the on-call faculty member or resident on the Family Medicine Inpatient (Tiger Team) service. It is the responsibility of the admitting team to perform and document the history and physical and write the admission orders*. Each resident is required to participate as much as possible in the hospital care of his/her FMC patients. With faculty consent, you may assume responsibility for the patient and coordinate all of the inpatient care. At discharge, the patient should return to the resident in the FMC for continuing care within a time frame appropriate for the patient’s needs. FMC patients admitted by other than their own resident physician should have their regular FMC physician made aware of the admission. The regular FM resident is expected to round on their patients that have been hospitalized and to participate in the care of their patient in the hospital. * If a patient requires urgent interventions (fluids, medications, monitoring, etc), they should be transferred immediately to the ED by wheelchair or stretcher accompanied by a nurse (and physician if indicated). The Resident will contact the ED physician directly to provide a hand-off report.
7. **Patient Telephone Calls:** Incoming patient telephone calls during office hours will usually be fielded first by the nursing staff. Many problems are resolved at this level. If not, you will be made aware of your patient's needs. Patients are directed to seek care in the ED if their complaint warrants immediate attention. All such telephone encounters should be documented in the electronic health record. Use of personal cell phones is strongly discouraged.
8. **Procedures:** Patient procedures you wish to schedule which will necessitate more time than a normal patient visit or utilization of the treatment room require notification of the preceptor and the FMC nurse to ensure adequate staffing. The preceptor will authorize blocking your schedule and ensure that a qualified faculty is in clinic on the day the procedure is scheduled (generally a Friday morning during “procedure” clinic).
9. **Continuity OB Deliveries:** Residents are strongly encouraged to follow their prenatal FMC patients through labor, perform the delivery, and provide post-partum care. At the present time, 5 continuity deliveries are required of each resident in order to graduate (as well as 20 total deliveries). To ensure that you are called when a patient is admitted in labor, give that patient a note asking the Labor Unit staff to page you at the time of admission.
10. **Medication Refill Requests:** Telephone requests for medication refills by patients are the responsibility of the resident primarily responsible for the care of the patient. Clinic personnel will take the incoming call from the patient or pharmacy. The person receiving the call will then create a refill request note in the electronic Health Record (EHR) which will appear in the resident’s in-basket. In general, it is expected that these will be reviewed and completed within one business day of the request being received. If you have any questions regarding the validity or accuracy of a medication refill, contact your preceptor. You should review the chart to be sure the patient is not past due for an appointment, and refills should only be provided for enough medication until the next appointment is due. (Don’t give a year’s worth of refills if someone has not

been seen in clinic in a year, for example.) Occasionally, you will be asked to call in a refill on the spot if the situation is deemed urgent by the patient or nursing staff.

11. **Charts:** At the completion of each patient visit, you must complete all visit orders, visit diagnoses, LOS (billing) information, follow up directions, patient instructions and visit notes. Best practice is for visit progress notes to be completed prior to leaving clinic, but in no case should completion occur more than 48 hours after the visit and all encounters must be closed by that time. Remember that timely documentation is critical for billing and other metrics for our clinic, and your faculty must have the opportunity to co-sign your notes in a timely manner as well. Failure to comply with this will result in consequences as determined by the Program Director.
12. **Patient encounters:** All patient encounters will take place within the walls of the FMC except for approved home visits, and at times when the resident may be assigned to work in Faculty Clinic or other primary care areas.
13. **Care of Colleagues:** Residents will not be permitted to provide care for other residents or family members unless this is discussed in advance with the attending faculty in the clinic at the time. Residents shall not "call in" or send electronic prescriptions for other residents or their families without a documented clinic visit. All residents are cautioned not to enter a colleague's chart unless it is during a clinic encounter or for follow up on the encounter, even if permission has been given by the colleague. Consult a faculty member in these cases as needed. Likewise, **a resident shall not access their own chart or a family member's chart for information (except through MyChart). This may be a HIPAA violation.**
14. **Family Medicine same day clinic ("urgent care").** "Walk-ins" are a reality in private practice and thus, will be a component of each resident's FMC experience. Same Day clinic in the FMC will be staffed by residents assigned to that duty from 9:00 am until 4:30 pm Monday through Thursday and from 9:00 am until noon on Fridays. These residents will be supervised by FM Faculty assigned to the FMC for the day. If the patient presents with an emergency condition, the clinic staff will triage and stabilize the patient before transporting them to the Emergency Room or appropriate clinic. This service is predominantly for the convenience of our FM Patients whose PCP does not have an appointment available as soon as needed. However, other patients may be accepted for the Walk-In Clinic as well. Please note the following considerations when assigned to Walk-In:
    a. Do not refill chronic narcotic prescriptions through the walk-in clinic. (An exception might be for one of our regular patient whose PCP has been out due to illness, etc. This should be discussed with a preceptor before the medication is provided. All stipulations of the existing pain contract should be followed.)
    b. Refills on chronic medications should only be provided for short periods of time (1-2 months). This prevents the patient from running out of medication prior to an appointment, but does not encourage the patient to cancel an appointment with their PCP.
15. **Controlled and Dangerous Substances (CDS) prescriptions.** Prior to any CDS prescription being written, the Louisiana Prescription Monitoring Program (LaPMP Aware) should be accessed to evaluate a history of these medications being prescribed to the patient. For a patient on chronic opioid treatment, an appropriate medication contract and an opioid risk screening tool (in EPIC) should be completed. Urine Drug Screens should be ordered at intervals, and the patient should be followed at regular intervals. Patients receiving CDS medications should be presented to the clinic preceptor prior to discharge.

CLINICAL EXPERIENCE AND EDUCATION: 80-HOUR WORK WEEK POLICY (FORMERLY REFERRED TO AS "DUTY HOURS")

• Clinical and Educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and moonlighting. (This does not include time spent studying, completing scholarly activities, or preparing for exams.)

• Resident should have eight hours off between scheduled clinical work and education periods.
    - o There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and one-day-off-in-seven requirements.

• Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

• Residents must be scheduled for a minimum of one day in seven free of clinical work and required education when averaged over four weeks.

• Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. o Up to 4 hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.
    - o Additional patient care responsibilities must not be assigned to a resident during this time.

• Clinical and Educational Work Hour Exceptions
    - o In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
        - ▪ To continue to care for a single, severely ill or unstable patient; humanistic attention to the needs of a patient or family, or to attend unique educational events.

• At Home Call. There is no at home call assigned for our residents.

The ACGME background and intent regarding the Maximum Hours of Clinical and Educational Work per Week affirms that *"Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded."* While the program is responsible for scheduling clinical duties appropriately to avoid violations, residents are also responsible to review their own schedules to identify potential problems in advance. Any issues of this type should be brought to the attention of the Chief Administrative Resident and the Program Director or Administrator immediately so that alterations in the schedule can be made.

Resident clinical and educational experience ("duty hours") will be carefully planned and balanced with concerns for patient safety and resident well-being. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care, 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. This time does not include reading and preparation time spent away from the duty site.

Adequate time for completing electronic charting is incorporated into the schedule and expected at the time of service. Time spent in charting away from the hospital is counted toward duty hour determinations

All residency programs at LSU Health Shreveport use New Innovations to record Clinical and Educational work hours, and monthly reports are monitored by the Graduate Medical Education (GME) office for compliance and for the purpose of providing an audit trail for reimbursement purposes. For that reason, it is very important to properly and honestly record actual worked hours and reflect the rotation on which residents are working. Also, the GME office emphasizes that residents must never enter hours in advance. The GME office requires that residents enter and submit all hours worked on a weekly basis. The Residency Administrator will then complete a report which verifies and confirms all hours are correct and submit to the GME office on the 1st day of the month, but no later than the 5 th day of the month.

The New Innovations system automatically provides a warning notification to residents when hours reflected are non-compliant, which gives the resident an opportunity to explain the situation or event, for example, in the area of “minimum time off compliance” resulting in less than 8 hours off between shifts, a resident could logically explain with the statement, “Unstable patient. Continuity of care.” The resident is responsible for monitoring and recording hours worked. All violations must be justified in writing to the Residency Administrator and Program Director.

The Department of Family Medicine insists on strict compliance with the mandates set forth by the ACGME. Everyone must understand that the Program will be in jeopardy if Clinical Work and Education Hours’ compliance is not maintained. Therefore, residents must always be mindful of their hours and notify their faculty and upper level residents if they are approaching 80 hours or any other potential hours-related violation. If at any time your compliance is blocked or hindered by a faculty member or chief resident, it is imperative that you let the Chairman and/or the Program Director know immediately. The problem will be corrected, and measures will be taken to comply with the rules. Intimidation or retaliation will not be tolerated by the Department if a resident is complying with clinical experience rules.

Clinical and Educational work hour non-compliancy issues are discussed openly in the monthly GME meeting, with all Program Directors and Residency Coordinators at LSU Health Shreveport that are present.

MOONLIGHTING

Residents in the Monroe Family Medicine Residency may be permitted to moonlight if they possess a valid unrestricted license to practice medicine from the Louisiana State Board of Medical Examiners (LSBME). The Program Director MUST approve all moonlighting activity and may grant permission for moonlighting provided the resident is not having academic or clinical performance issues, including professionalism lapses. Any moonlighting activity will be canceled if it produces detrimental changes in resident performance. Moonlighting must be taken into account for Duty Hours, and must comply with LSUHS GMEC and ACGME rules.

DRUG TESTING

State policy requires that all State employees be willing to undergo random urine drug testing when requested. Failure to consent to urine drug testing when requested will be regarded as a positive test and may result in suspension or dismissal from the program.

RESIDENT WELL-BEING AND IMPAIRMENT

The goal of the Family Medicine Residency Program at OLSU-M is to produce fully competent physicians capable of providing high quality, unsupervised care to their patients. To prevent impairment and promote physician well-being, residents are expected to learn to balance personal and professional responsibilities in a manner which can be reflected throughout their careers.

It is the responsibility of the residency program to monitor the working conditions of the residents, to promote their well-being, to identify resident impairment, and to intervene if there is evidence of such impairment. Feedback from the faculty and residents themselves (and particularly the Chief Residents) serves as the primary means to monitor working conditions. Residents are expected to communicate their concerns promptly to the Chief Residents or the Program Director. This can be done informally, or during the formal meetings between the residents and the Program Director.

Fatigue Mitigation is covered in our didactic lecture series by our faculty. Small group (round table) discussion groups address this topic as well. Finally, the AMA GME competency program modules required of all residents include modules that address this topic to improve awareness and recognition of fatigue in themselves and their colleagues. Call rooms are made available if the HO is too fatigued to drive home. Residency personnel can be relieved of duties to provide safe transportation to take the HO home. The resident should contact the Chief Administrative Resident (or if he/she is unavailable, the Education Chief) and the Program Director or on call faculty to advise that they require fatigue mitigation. The Chief Resident will attempt to identify another resident to cover the duty period involved. Failing that, the Faculty on call will assist in covering patient care duties as needed. Effective handoff of patient information should occur before the fatigued resident leaves the site.

The relatively small size of the program, and the close working relationships between the faculty and the residents, makes it likely that resident impairment would be identified relatively early. The department behavioral science professional will meet at regular intervals (determined by the program director) with any resident that is under contract with the Physician Health Foundation. In addition, all health care providers with a history of substance abuse fall under the requirements outlined in Chancellor's Memorandum 20.

A formal process exists for placing a resident on probation and the Program Director, upon the recommendation from a psychiatrist, may grant a request for a leave of absence from the residency program if this is judged to be in the resident's best interest. Ultimate approval is granted by the Department of Family Medicine.

Please refer to the LSUHS House Staff Manual regarding the Employee Assistance Program (EAP). The EAP is a sponsored service which is designed to encourage employees to take the initiative or their own health and wellness. With the assistance of professional consultation, employees can solve a wide range of personal problems that could adversely affect their personal lives of professional careers. <u>You may contact the EAP at (318) 675-7397</u>. This service is provided free of charge to LSUHS employees. See also Appendix B.

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

Every Family Medicine resident should apply for licensure or Graduate Education Training Permit to the Louisiana State Board of Medical Examiners as early as allowed by the LSBME. When a license or GETP is granted, application should be made for federal and state narcotics

licenses. Continuation in the program beyond the second year requires passing USMLE Step 3 and an unrestricted Louisiana medical license or valid Graduate Education Training Permit (GETP). Failure to pass the USMLE Step 3 prior to the end of your PGY-2 year with result in voiding your educational contract with LSUHS and termination from the residency as determined by the GMEC. (Please be reminded that the LSUHS GMEC has determined that the first attempt on to USMLE Step 3 exam must be completed prior to the end of your PGY-1 year. Failure to achieve either will result in termination of your residency position.)

AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)/PROFESSIONAL ORGANIZATIONS
Every Family Medicine resident should apply for resident membership during the month of July. Those upper level residents who have already established their membership during the previous year(s) will automatically have it renewed by the Department of Family Medicine. Residents are also strongly encouraged to join the Louisiana State Medical Society and the Ouachita Medical Society.

CONTRACTS
Those residents continuing in the program sign renewal contracts annually. Failure to do so within the timeframe indicated by the program director will free a resident's position to be offered to other qualified applicants.

CONTACT INFORMATION FOR RESIDENTS
Each resident will be assigned a "mailbox" in the FMC. The mailing address is:

Ochsner/LSU Health Monroe Medical Center
Family Medicine Clinic
4864 Jackson Street
PO Box 1881
Monroe, Louisiana 71210-1881

Each resident will be assigned an email address for the LSUHS system. <u>This will be the official manner in which you will receive important notifications and assignments.</u> Each resident is responsible for checking their email very regularly (preferably daily).

The contact number for NON-PATIENT MATTERS in the Department of Family Medicine in Monroe is 318-330-7650. (Ms. Amy Johnson).

LEGAL MATTERS/ATTORNEYS
Residents are advised against speaking with any attorney regarding patient matters, or anything to do with the hospital or clinic without first speaking with the Program Director (Dr. Teri O'Neal) and Legal Affairs in Shreveport (Mr. Carranza Pryor's office). Upon being contacted by anyone identifying themselves as a legal representative (Attorney, Paralegal, etc) take their contact information and ask for a brief description of the issue at hand. <u>Do not answer questions.</u>

EMPLOYEE HEALTH
Residents must maintain compliance with employee health and infection control policies and procedures of the hospital.

RESIDENT ELIGIBILITY. See appendix A.

FACULTY

Multiple LSU departments comprise the faculty on the OLHM campus: Family Medicine, OB/GYN, Surgery, Medicine, Pediatrics, Psychiatry, Anesthesiology, Emergency Medicine, and Pathology. The following list is not exhaustive and includes faculty members most often in contact with Family Medicine Residents.

James Morris, MD	DIO, LSUHS GME Office

Department of Family Medicine:

Peter Seidenberg, MD	Chairman, Dept. of Family Medicine LSUHS
Donald Givler, MD	Assistant Director, Dept. of FM
Shivlal Pandey, MD	Director, Dept. of FM, Associate Program Director
Teri O'Neal, MD	Program Director, Family Medicine Residency
Gyanendra Sharma, MD	Assistant Program Director, Family Medicine Residency
Shweta Sharan, MD	Family Medicine, MS Clerkship Director
Esha Sharma, MD	Family Medicine, Research Director
Marina Jeffery, DO	Family Medicine, Liaison to VCOM
Miguel Lopez, MD	Family Medicine, Sports Medicine

Department of Internal Medicine:

Richard M. Cavell, MD	Chief, Section on Internal Medicine
Janice Ford, MD	Internal Medicine/Pediatrics
Julia Rodgers, MD	Hospital Medicine
Pramod Savarapu, MD	Hospital Medicine
Sourabh Bidhan, MD	Hospital Medicine
Nirmal Basaula, MD	Hospital Medicine
Michael O'Neal, MD	CMO, Internal and Hospital Medicine
Sylvester Mapoh, MD	Hospital Medicine
Mohammad Salloum, MD	Hospital Medicine
Praneet Iyer, MD	ICU Chief/Pulmonary and Critical Care Medicine
Dominique Beaudry, MD	Cardiology
Jean C. Uwamungu MD	Cardiology
Cresha Davis, MD	Neurology

Behavioral Medicine:

Rachel Voss, MD	Chief, Psychiatry

Department of Surgery:

Lester Johnson MD	Vice Chancellor Rural Initiatives Chief, Section on Surgery
Joann Alley, MD	Surgery, Trauma Service Director
Henry Zizzi, MD	Surgery
Kathryn Rhymes, MD	Surgery
Russell Lolley, MD	Surgery
Steven Flynn, MD	Chief, Section on Ophthalmology
Randy Taylor, MD	Chief, Section on Orthopedics
Sunny Gupta, MD	Orthopedics

Department of OB/GYN:

Gary Menefee, MD	Chief, Section on OB/GYN
Janice Pharr, MD	OB/GYN

	Meeli Ghandi, MD	OB/GYN
	Maira Qayyum, MD	OB/GYN

Pediatrics

	Umashankar Kandasamy, MD	Chief, Section on Pediatrics
	Ayushma Subedi, MD	Pediatrics

Emergency Medicine

	Nicholas Lewing, MD	Chief, Emergency Medicine

Appendix A

Resident Eligibility and Selection

Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME)
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA). Graduates of the osteopathic schools must meet license requirements of the Louisiana State Board of Medical Examiners
3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
    1. Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates or
    2. Have a full and unrestricted license to practice in a U.S. licensing jurisdiction.
4. Graduates of medical schools outside the United States who have completed Fifth Pathway program provided by an LCME-accredited medical school.

Applicants should meet the requirements as established for licensure/permit as outlined by the Louisiana State Board of Medical Examiners.

Appendix B

Monroe FM Residency Program:
https://www.lsuhs.edu/departments/school-of-medicine/family-medicine/family-medicine-residency-monroe

Accreditation Council for Graduate Medical Education (ACGME):
http://www.acgme.org

ACGME Family Medicine Homepage:
http://www.acgme.org/Specialties/Overview/pfcatid/8

ACGME Milestones page:
http://www.acgme.org/Portals/0/PDFs/Milestones/FamilyMedicineMilestones.pdf?ver=2017-01-20-103353-463

American Board of Family Medicine (ABFM):
https://www.theabfm.org/

American Academy of Family Physicians (AAFP):
https://www.aafp.org/home.html

Louisiana Academy of Family Physicians (LAFP):
https://www.lafp.org/

Louisiana State Medical Society (LSMS):
https://lsms.site-ym.com/

Louisiana State Board of Medical Examiners (LSBME):
http://www.lsbme.la.gov/

Ouachita Medical Society (OMS):
http://www.ouachitams.org/

Louisiana State University Health Sciences Center – Shreveport (LSUHS):
https://www.lsuhs.edu/

LSUHS House Officer Manual 2023-2024
https://resources.finalsite.net/images/v1693941887/lsuhscshreveportedu/u9pj3pap23zxebveyv7r/HouseOfficerManual2023.pdf

LSUHS Employee Assistance Program:
https://inside.lsuhs.edu/human-resources/human-resources/employee-assistance-program

Appendix C

Department of Family Medicine Professionalism Policy
2/5/2021

Part 1: Professional Appearance

The Department of Family Medicine desires to pursue professionalism and excellence in all that we do. A professional appearance helps our patients feel confident and comfortable with the care we provide. In addition, the Department offices have a prominent location in the School of Medicine. Our highly visible locale invites a constant flow of visitors to include administrators, colleagues from other departments, residents, and medical students. As such, our appearance needs to be consistent with our culture of professionalism and excellence. This includes having clean, well-organized work areas.

It also includes maintaining a professional personal appearance. Business and business casual attire is the preferred dress for the department. Jeans and t-shirts are not consistent with our desired level of professionalism and should not be worn to work.

In patient care settings, the minimum standard for physician providers is business casual. Scrubs are acceptable if they are clean, not wrinkled, and worn with a clean, pressed lab coat or clean quarter zip pullover (preferably logoed). Casual sweatshirts, such as hoodies, worn over scrubs are not appropriate.

Part 2: Clinic Hours

It is essential that providers are in their clinic locations for the duration of the clinic's hours. On the Shreveport and Monroe campuses, faculty clinics run from 8 -12 in the morning and 1-5 in the afternoon. Providers will be in the clinic no later than the beginning of clinic hours and will stay until the end of the session. The end of the session is defined as when providers (including APPs) have finished seeing patients or 20 minutes after the last appointment on the schedule template. If patients are not scheduled until the end of the session, providers will still stay until its completion to accommodate add-ons, patient questions, care team communication, and support for our advanced practice practitioners.

When precepting resident clinic, attendings will be in the clinic prior to the first appointment (e.g. 7:40 am in Shreveport) and will stay until all residents are done seeing patients or until the end of the clinic session as stipulated above (whichever is later).

Peter H. Seidenberg, MD, MA, FAAFP, FACSM, RMSK
Professor & Chair Department of Family Medicine

APPENDIX D
Contacting attending physicians
Requirements to contact faculty on call
Communications expectations for residents (pagers and inbasket)
Leave policy
Travel and reimbursement

Policy for contacting attending physicians
Luther, Euil M.D.
Fri 6/21/2019 9:54 AM

To all residents and faculty,

Questions have been raised regarding the appropriate manner to contact attending physicians. Traditionally, faculty has been contacted through the beeper system. If a faculty member chooses to make other arrangements with a resident, then follow those instructions (cell phone, etc.).
However, If a resident encounters difficulty contacting a faculty member, the following instructions should be followed:

1. Page the faculty member. Wait 10 minutes. *
2. If no response, page the faculty member a second time. Wait 10 minutes.
3. If no response from the faculty member, page the service chief.
4. If no response at this time, contact any other faculty member by pager or cell phone.
5. Notify service chief by email of inability to contact the responsible faculty member.

*If there is an emergency situation requiring immediate assistance, contact any available faculty (including the ED physician) by pager, or by cell phone.

Thank you,
Euil E. Luther, MD, FAAFP
LSU Health Shreveport Department of Family Medicine
Monroe Residency Program
(318) 330-7650 (office)
(318) 330-7613 (fax)

Policy reviewed 5/11/2021
Teri O'Neal, MD
Policy Reviewed 7/9/24
Teri B. O'Neal, MD

Policy for contacting Attending Faculty on call for inpatient services.

The following guidelines should be observed by all residents while on call for inpatient services in regards to need for contact with on call faculty. These circumstances indicate that contact should be made.*

1. Family Medicine Inpatient (Tiger Team) Service
    a. All initial consults from ED (once evaluation complete or sooner if critical need)
    b. All initial consults for other inpatient services (once evaluation complete or sooner if critical need)
    c. Refusal of a transfer for any reason (before refusal is communicated to sending facility)
    d. Before initiating transfer to higher level of care (unless previously discussed and anticipated by on call attending faculty)
    e. When a patient experiences deterioration/an event that requires transfer to ICU (code, intubation, etc.)
    f. Residents are additionally expected to contact the attending faculty for any situation which is beyond their comfort level to manage or for any questions

*This is not meant to be an exhaustive listing. Individual cases and resident-dependent factors should be considered at all times. It is expected that upper level residents will be able to manage clinical situations with less input from the attending faculty in real time, however all residents are encouraged to contact their faculty at any time they feel necessary.

Teri B. O'Neal, MD, Program Director
24 January 2020

Policy reviewed 5/11/2021
Teri O'Neal, MD

Updates 7/11/21
Teri B. O'Neal, MD

Update 7/9/24
Teri B. O'Neal, MD

COMMUNICATION EXPECTATIONS FOR RESIDENTS

Pagers. All residents will be assigned a personal pager and will be expected to keep that pager in their possession at all times during periods of duty. The exception to this is to contact the switchboard and have your pages forwarded automatically to your cell phone. Carrying the common on-call pagers does NOT replace having your personal pager available (or forwarded to your phone). If program faculty or administration needs to reach a resident, the cell phone and personal pager will be the primary means of contact.

Epic Inbasket. As noted in clinic information, residents should check their inbaskets daily and manage information/refill requests in a timely fashion. All this should be cleared in 3 business days or less. When a resident goes on leave and will not be checking their inbasket, it is their responsibility to provide a member of their clinic team with access to the basket to ensure prompt response to all messages during their absence. Contact Ms. Hodge for assistance in granting access to your inbasket. Failure to comply will reflect on professionalism and patient care evaluations and milestones. Repeated lapses may result in disciplinary action at the discretion of the PD.

Reviewed 7/10/24
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LEAVE POLICY

Leave shall be accounted for in compliance with the LSUHS Policy and Procedure manual, as well as requirements of the ABFM and ACGME. No more than 30 days away from training in any single academic year will be allowed without possible extension of residency. Annual leave (vacation) is built in to the block schedule for each PGY level. Requests for change in the schedule (once published) will be considered, but may not always be possible. Requests should be made at least 90 days in advance unless an emergency arises. Requests will be reviewed by the PD/APD and Program Administrator and the resident will be notified of a decision within 3 business days (unless special circumstances warrant additional review by GMEC, etc).

Annual leave should be used for interviews regarding job and fellowship applications.

At the discretion of **the** PD, administrative/special leave days may be used for absence due to presentation of scholarly work at regional or national events, or other activities that promote the reputation of the program and/or institution.

Residents and the program have a shared responsibility to maintain awareness of number of days of leave used/remaining in order to avoid an extension of their residency.

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Travel and Reimbursement

Reimbursement for travel due to presentation of scholarly work or representing the residency at a regional or national event will be managed according to the guidelines set forth by the GMEC and Department of Family Medicine for LSUHS. The program administrator (Ashley Roberts) and program director (Dr. Teri O'Neal) should be notified of the possibility of travel for scholarly activity, etc, as soon as possible so that appropriate approvals may be obtained.

As a general rule, a poster or other scholarly presentation may be presented by ONE author at ONE conference or meeting only with departmental or GMEC/CERF financial support. A resident has the option to use their annual leave and personal funds to present at additional venues with the same poster if they so desire.

Each resident will be afforded ONE opportunity to attend/present a regional or national event each academic year with GMEC/CERF or Departmental financial support. Exceptions may be made when a resident is awarded a scholarship to attend a conference or meeting. The program administrator and program director should be notified of this occurrence as soon as possible.

Policy reviewed 7/10/24
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