TO ALL FAMILY MEDICINE RESIDENTS

This policy manual was updated in July, 2008. It is a compilation of departmental policies and information, all of which have a direct bearing on you as a resident physician in the KU Department of Family Medicine.

Questions regarding this information may be addressed to the Program Director, Belinda Vail, MD, or to the Associate Residency Program Director, Deborah Clements, MD. Residents within the Department of Family Medicine have been responsible for the development of much of the contents and will assist in updates.

This manual is the Family Medicine Department addition to, not a substitution for, the **University of Kansas Medical Center Housestaff Manual** which has been distributed to all KUMC Housestaff. It is also published on the Graduate Medical Education website on the KUMC Pulse. The Internet address for the KUMC Housestaff Manual is:

**http://www.kumc.edu/som/gme**

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# I. Introduction

## A. Mission Statement

To provide excellent family medicine education in the context of high quality patient care.

## B. Structural Framework

Medical Education is the centerpiece of our Department. This includes the education of residents as well as extensive involvement in the education of medical students. Our residents are involved not only as active learners, but also as teachers.

The KU Family Medicine Residency Program is sponsored by the University of Kansas, School of Medicine. It consists of a traditional university-based 9/9/9 program with two of these positions conducting continuity clinic at a community office at KU MedWest in Shawnee, KS and a One-plus-Two Rural 1/1/1 program for Junction City, KS.

The training program complies with the special requirements for family practice of the Residency Review Committee (RRC), the Accreditation Council of Graduate Medical Education (ACGME), and the American Board of Family Physicians (ABFM). Both block and longitudinal formats are utilized.

## C. Educational Goals

To effectively educate resident physicians for the demands of a career in family practice, the following training goals are established for the program:

1. Residents are provided with opportunities which will assure that an excellent cognitive knowledge of family medicine will be gained by any resident who graduates from the program.
2. Residents have extensive "hands on" training in the outpatient clinic, in various hospital inpatient settings the nursing home and the home to ensure that they will be competent in patient care in a variety of practice settings.
3. Residents are provided training which assures the development of adequate procedural skills required of family physicians in a variety of practice settings.
4. Residents will obtain skills to ensure competent communication with their patients, colleagues, referral sources, and staff.
5. Residents will be assisted in developing competency in professionalism.
6. Residents will acquire the skills and attitudes necessary to become life-long students of medicine.
7. Residents will learn to navigate the entire medical system and learn to work with all aspects of the medical community.
8. Residents develop insight into their personal thoughts and emotions about the practice of medicine and their interaction with patients.

## D. Administrative Organization and Faculty

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|---|---|
| Joshua Freeman, MD | Professor, Chairman, Dept. of Family Medicine |
| Belinda Vail, MD | Professor, Vice-Chair and Residency Program Director |
| Deborah Clements, MD | Assistant Professor, Associate Residency Director |
| Allen Greiner, MD | Associate Professor, Research Director |
| John Delzell, MD | Associate Professor, Undergraduate Director |
| Dan Swagerty, MD | Professor, Director of Geriatric Medicine |
| Mark Meyer, MD | Associate Professor, Dean of Students |
| Michael Kennedy, MD | Associate Professor, Dean of Rural Medicine |
| Heidi Chumley, MD | Associate Professor, Senior Associate Dean of Education |
| Donald Milligan, MD | Assistant Professor, Director of Inpatient Services |

## FACULTY MEMBERS

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|---|---|
| Diane Ebbert, PhD | Clinical Assistant Professor |
| Hanna Maxfield, MD | Assistant Professor |
| Mary McDonald, MD | Assistant Professor |
| Shelley Bhattacharya, DO | Assistant Professor |
| James Birch, MD | Assistant Professor |
| Phyllis Sullivan, DO | Assistant Professor |
| Anh Vinh, MD | Assistant Professor |
| Patricia Fitzgibbons, MD | Assistant Professor |
| Bruce Liese, PhD | Professor |
| Eleanor Lisbon, MD | Clinical Assistant Professor |
| Moya Peterson, PhD | Assistant Professor |
| Mary Redmon, DO | Clinical Assistant Professor |
| Kim Kiminau, PhD | Assistant Professor |
| Brenda Almaguer | Assistant Professor |

## CHIEF RESIDENTS

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|---|---|
| Jamie Kirby, MD | KUMC |
| Jana Zaudke, MD | KUMC |

E-mail addresses of faculty members and other Family Medicine staff are accessible on Groupwise.

The Family Medicine Department's Website can be accessed at: www.kufammed.com

## E. CURRICULUM BLOCK DIAGRAMS

### 1. BLOCK ROTATIONS FOR KUMC AND KU MEDWEST

**PGY 1**

| 2 wk Orientation | 2 blocks Fam Med Inpatient | 2 blocks Medicine Leaven-worth VA | 1 blocks Pediatrics CMH | 1 block Pediatrics KUMC | 1 block FTN KUMC | 1 block Gynecology KUMC | 1 block Obstetrics KUMC | 1 block ICU KUMC | 1 block ER KUMC | 1 block Surgery LVAMC |
|---|---|---|---|---|---|---|---|---|---|---|
| **FPC 1 NO VAC** | **FPC 2 NO VAC** | **FPC 2 VAC** | **FPC 1 NO VAC** | **FPC 2 VAC** | **FPC 2 VAC** | **FPC 2 VAC** | **FPC 2 VAC** | **FPC 1 NO VAC** | **FPC 2 NO VAC** | **FPC 2 VAC** |

**PGY 2**

| 3 blocks Family Medicine | 1 block Night Float/ ENT | 1 block Ophth/ Prac Mgt Proced. | 1 block Urology/ Night Float | 1 block Dermatology KUMC | 1 block Sports Medicine | 1 block Obstetrics Ft. Riley | 1 block Cardio KUMC | 1 block Orthopedic | 1 block Peds Out-Pt KUMC | 1 block Radiology KUMC |
|---|---|---|---|---|---|---|---|---|---|---|
| **FPC 3 NO VAC** | **FPC 3 VAC** | **FPC 2 NO VAC** | **FPC 3 VAC** | **FPC 3 VAC** | **FPC 3 VAC** | **FPC 0 NO VAC** | **FPC 3 VAC** | **FPC 3 VAC** | **FPC 3 VAC** | |

**PGY 3**

| 1 block Comm Med | 1 block OB or Track | 1 block Supervise | 1 block Sup/NF | 1 block Surgery | 1 block Geriatrics/ Rheum | 1 block Sports Medicine/ Occup Med | 1 block | 2 blocks Tracks | 3 blocks Elective | |
|---|---|---|---|---|---|---|---|---|---|---|
| **FPC 4 VAC** | **FPC 4 VAC** | **FPC 2 NO VAC** | **FPC 4 VAC** | **FPC 4 VAC** | **FPC 4 VAC** | **FPC 4 VAC** | **FPC 4 VAC** | **FPC 4 VAC** | **FPC 4 VAC** | |
| | | | | | | | | | | |

| LONGITUDINAL EXPERIENCES | |
|---|---|
| TYPE OF EXPERIENCE | HOW STRUCTURED/AMOUNT OF TIME |
| Geriatrics | FOR ALL ACADEMIC YEARS<br>1 half day Orientation to long-term facility during PGY-1 Orientation: 1 half day every 60 days during remaining PGY years. Residents go to Kansas City Presbyterian Manor and Aberdeen Village Nursing Homes to care for their continuity nursing home patients |
| Behavioral Science | FOR ALL ACADEMIC YEARS<br>Psychology preceptor available in clinic 2 days per week. |
| Emergency Medicine | PGY-2 and 3. Residents have 12 hour Friday evening ED shifts (12 noon to 12 MN or 8 PM to 8 AM) Residents have 5 or 6 shifts each year for a total of 120 to 132 hours. |

## 2. Block Rotations for Junction City

### PGY 1

| 1 block Orientat | 2 blocks Fam Med | 1 block Internal Medicine | 1 block Cardio | 1 block ER | 1 block NICU | 1 block Gyn KUMC | 1 block Obstetrics KUMC | 1 block ICU | 1 block Pediatrics Inpatient | 1 block Derm |
|---|---|---|---|---|---|---|---|---|---|---|
| FPC 2 NO VAC | FPC 2 NO VAC | FPC 2 VAC | FPC 2 VAC | FPC 2 NO VAC | FPC 2 VAC | FPC 2 VAC | FPC 2 VAC | FPC 1 VAC | FPC 1 VAC | FPC 2 VAC |

### PGY 2

| 1 month GYN | 1 month ER | 1 month Fam Med | 2 months Internal Medicine | 1month Orthopedics | 1 month Surgery | 1 month Pediatrics | 2 months Obstetrics | 1 month ½ mo ENT ½ mo Ophthal | 1 month Sports Medicine |
|---|---|---|---|---|---|---|---|---|---|
| FPC 2 VAC | FPC 2 VAC | FPC 2 VAC | FPC 2 VAC | FPC 2 VAC | FPC 2 VAC | FPC 2 VAC | FPC 2 No VAC | FPC 2 VAC | FPC 2 VAC |

### PGY 3

| 1 month Fam Med | 1 month Urology | 1 month Surgery | 1 month Ortho | 1 month Derm | 1 month Cardio | 1 month Pulm | 1 month Int Med | ½ mos Psych/BS ½ mos Radiol. | 3 mos Elective |
|---|---|---|---|---|---|---|---|---|---|
| FPC 3 VAC | FPC 3 VAC | FPC 3 VAC | FPC 3 VAC | FPC 3 VAC | FPC 3 VAC | FPC 3 VAC | FPC VAC | FPC 3 VAC | FPC 3 VAC |

| LONGITUDINAL EXPERIENCES FOR JUNCTION CITY RESIDENTS | |
|---|---|
| TYPE OF EXPERIENCE | HOW STRUCTURED/AMOUNT OF TIME |
| Behavioral Science | Geriatric Psychiatry Unit - Longitudinal inpatient experience under staff psychiatrist. |
| Practice Management | ½ hr weekly with office staff learning office business procedures. |
| Urology | 8 hr/wk x 10 wks = 80 hrs. |
| Dermatology | 8hrs/mo x 6 mo = 48 hrs. |

# II. Policies and Procedures

## A. AMERICAN BOARD OF FAMILY PRACTICE (ABFM) POLICIES

Residents' absence from the program should not exceed one month per academic year and vacations periods may not accumulate from one year to the next. Vacation may not be taken back-to-back in June and July. Continuing medical education (CME) and educational time away from the program does not count as time off as long as it does not exceed five days per year. For a complete list of ABFM policies, residents should refer to the ABFM Policy Manual given to all residents during their first-year orientation.

## B. ABSENCES

Absences in excess of one month by any combination of vacation, sick leave, or any other leave (except educational leave) will result in an extension of the residents' training by the length of leave days.

## C. POLICIES REGARDING VACATION, PERSONAL LEAVES, AND LEAVES OF ABSENCE

### 1. SICK OR PERSONAL LEAVE

**IF YOU ARE UNABLE TO REPORT TO DUTIES AS ASSIGNED** *you must* call the following:

1. Residency Coordinator (588-1959 or 588-1902, *leave a message*)
2. Designated Rotation Contact Person and/or the Rotations Attending Physician.
3. ***Additionally, if you cannot report to the Family Medicine Clinic*** *you must* call the Clinic Front Desk (588-2451 or 2456)

Residents' will not receive pay for greater than 10 personal/family illness days. Additional days will have to be taken as vacation or residents will need to use FMLA and will be required to make up that time prior to completion of the residency (see leave of absence policy).

### 2. LEAVE OF ABSENCE

Leave of Absence (LOA) may be necessary for maternity or paternity purposes, extended illness, surgery, disciplinary action, or other unforeseen circumstances. **Arrangements for leave of absence must be made with the Program Director as much in advance as possible**. A formal request must be submitted in writing. A LOA agreement will be drawn up and signed by the resident and Program Director. During all time periods which require residents to be off state payroll, the resident is responsible for payment of health insurance premiums.

A LOA from the residency, *exclusive of the 15 days of vacation and 10 sick days*, may interrupt continuity of patient care for a maximum of three (3) months in each of the PGY-2 and PGY-3 years of training. Leave of Absence may be interspersed throughout the year or taken as a three-month block of time. Following a leave of absence of any duration, the resident must return to the program and maintain care of their patient panel *a minimum of two months* before a subsequent leave.

In cases where a resident is granted a LOA by the program, or must be away because of illness or injury, the Program Director must promptly inform the ABFM in writing of the date of departure and expected return date. The resident will not advance to the next training level until the leave time is made up and this time will be added to the projected date of completion of the required 36 months of training. Residents will not be permitted to take vacation time immediately prior or subsequent to a Leave of Absence.

A LOA in excess of three months is considered a violation of the continuity of care requirement by the ABFM. 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.

Remote site training (i.e. elective, rural training) must comply with the ACGME "Special Requirements".

To make arrangements for continued health insurance while on a LOA or for any other absence which requires the resident to be off state payroll, the resident will contact the KUMC Benefits office, 588-5087.

**NOTE:** Residents may not sit for the Board Exams in July/August unless all requirements for residency training are completed prior to June 30 of that year. They may be eligible to sit for the Board Exams in December of that year, depending on their completion date.

### 3. Maternity/Paternity Leave

Residents should notify the Program Director promptly regarding the need to plan for maternity/paternity leave. The *resident is responsible* for advising the attending, rotation contact, and/or supervising resident in advance of the potential for abrupt leave for maternity./paternity purposes. In some instances, a monthly rotation schedule may be modified to accommodate maternity/paternity needs.

### 4. Vacations

| GENERAL GUIDELINES FOR VACATION REQUESTS |
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| a) All vacation requests for the academic year must be submitted for approval prior to July 1 each year. Vacations for Block I or II must be submitted prior to June 1 of the previous academic year |
| b) ONE WEEK of vacation time consists strictly of five working days and two weekend days.<br>TWO WEEKS of vacation time consists strictly of ten working days and four weekend days. |
| c) Residents should avoid ending vacations on Friday to be faced with call duties on Saturday or Sunday. In this case, the returning resident would have limited knowledge of the recently hospitalized patients. |
| d) Vacations will be scheduled for no less than seven days at a time and no greater than 14 days at a time, except PGY3 residents who may split one week to facilitate the scheduling of job interviews. |
| e) Residents who do not submit vacation requests will be assigned vacation time. |
| f) Scheduled vacations should not be changed. Requested changes must be submitted at least 3 months in advance and require approval by the Program Director, Belinda Vail, MD; and the Clinic Director, Diane Ebbert, PhD, and the rotation affected. |
| g) Legal holidays should not be included in the vacation block. Residents should not assume that time off for a legal holiday would be tied to the beginning, middle, or end of a vacation block. Residents are required to cover call on legal holidays. If a resident takes vacation around a legal holiday, he/she is responsible for checking the call schedule. |
| h) Vacation periods may not accumulate from one year to another. No two vacation periods may be concurrent - last month of the PGY2 year and first month of the PGY3 year in sequence. A resident does not have the option of reducing the total time required for residency (36 calendar months) by forgoing vacation time. |

| SPECIFIC RESTRICTIONS FOR VACATION REQUESTS |
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| **1. First Year Residents** |
| a) Three weeks of vacation time is allowed. This may be taken as three one-week blocks, or one two-week block and one one-week block. |
| b) Two-week vacations may not be taken within the same Block Rotation. |
| c) NO vacations may be taken during Orientation, Inpatient Pediatrics at Children’s Mercy, ER, or ICU |

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| d) Vacation on FM Inpatient Service is subject to the number of residents on service. The resident is responsible for coordinating any necessary changes in Call coverage with the Chief Resident |

| **SPECIFIC RESTRICTIONS FOR VACATION REQUESTS (cont)** |
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| **2. Second Year Residents** |
| a) Three weeks of vacation time is allowed. This may be taken as three one-week blocks, or one two-week block and one one-week block. |
| b) Two-week vacations may not be taken within the same Block Rotation. |
| c) CME **may not** be tied on to vacation time. |
| d) Vacation **may not** precede or follow an elective rotation in which the resident has not been scheduled for Family Medicine clinic session. |
| e) A resident **may not** have both Christmas and New Year's as a scheduled vacation time. |
| f) NO vacations or CME may be taken during Obstetric rotations, ER, or CCU. |
| g) Family Medicine: Vacation on FM service is subject to the number of residents on service. The resident is responsible for coordinating any necessary call coverage with the Chief resident. |
| **3. Third Year Residents** |
| a) Three weeks of vacation time is allowed. This may be taken as three one-week blocks, or one two-week block and one one-week block. |
| b) Two-week vacations may not be taken within the same Block Rotation. |
| c) As senior residents **<u>one week only</u>** may be split up for purposes of job interviews. |
| d) **No** vacation is allowed in the last two weeks of residency. |
| e) CME **MAY NOT** be tied to vacation time. |
| e) Vacation **MAY NOT** precede or follow an elective rotation in which the resident has not been scheduled for Family Medicine clinic sessions. |
| f) NO vacation is allowed during supervision of the family medicine inpatient service |

**5.Holidays**

SECOND YEAR RESIDENTS are responsible for Family Medicine Inpatient Call on **all** major and minor holidays. The Chief Resident who coordinates the Call Schedule will obtain requests for preferences prior to July 1 of the academic year. He/she will make final assignments.

| **Major and Minor Holidays** | | |
|---|---|---|
| Memorial Day | Labor Day | Martin Luther King Day |
| New Year's Eve<br>New Year's Day | Christmas Eve<br>Christmas Day | Thanksgiving Day +<br>Friday After |
| Independence Day | Easter | |

Institutional policies on resident Clinical Duty Hours and Call Policies, and Policies Regarding Vacation, Personal Leaves, and Leaves of Absence are also discussed in the University Housestaff Manual.

## D. ACGME/Residency Review Committee (RRC) Requirements – Continuity of Care

The residency program is structured to insure continuity of care in that residents maintain their panel of patients over three years of training. During the first year, continuity may be interrupted for a maximum of one month for training on an off-site rotation. During the last two years of training, the resident may not be away for remote assignments longer than two months and these two periods may not be consecutive. After the first remote experience, the resident must return for at least two months to provide continuity for their patient panel before leaving for another remote experience.

Continuity of care for patients is a primary goal in the Family Medicine Department. Reassignment of patients is best carried out by formally introducing the patient to the new resident. A simple explanation of the reason for reassignment would be appropriate. Each resident's effort towards continuity of care is important to the success of the whole effort.

| **The following guidelines assist in the promotion of continuity of care:** |
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| 1. Residents may be asked to work-in established patients for acute care problems. |
| 2. Third-year residents, near graduation, should re-assign and/or familiarize another resident with the following types of patients:<br>a) OB patients whose due dates fall after the completion of their residency<br>b) Patients with chronic and/or complicated conditions<br>c) Patients with pain contracts |
| 3. Vacationing residents should familiarize another resident with patients with chronic and/or complicated conditions and patients with pain contracts. |

## E. MENTOR/MENTEE SYSTEM

Every resident will be assigned a faculty mentor for the duration of the residency training period. The mentor will meet with the resident a minimum of three times per year as assigned. Additional mentor meetings may be required based on a resident's needs.

The meetings will pertain to reviews of evaluations, rotations, curriculum, documentation of procedures, and progress on Scholarly Projects. The mentor and mentee are required to fill out a Mentor/Mentee Form. The completed form will be kept in the resident's permanent file. *Should a resident wish to switch advisors s/he must request such in writing from the residency program director with approval of the current advisor.*

## F. CHIEF RESIDENT

### Chief Resident Selection

The Chief Residents are selected in the spring of each academic year. Given the additional responsibilities and educational requirements, the individual in this role should not only demonstrate the leadership and management skills necessary to represent the residents but, more importantly, must have the academic capability to meet the challenges of this position.

Evaluation of candidates will be based on academic review, resident evaluations, and leadership skills. All candidates will be required to submit a Chief Resident Application which will be reviewed by the residency directors and the faculty. Selection (subject to residency director approval) is by election by the residents and faculty.

### 1. Chief Resident Job Description

The chief resident serves a number of roles. S/he is responsible for leadership, administration, education, and supervision activities of the residency. The chief resident reports directly to the residency director. The chief resident works with the residency coordinator, faculty and the clinic director in the daily operations of the program. The primary responsibility of the chief resident is that of liaison between residents and faculty. Other specific activities include the following:

**a. Administrative**

- Develops and distributes the Family Medicine Call Schedule.
- Takes an active role in recruitment and works in conjunction with the residency directors and coordinators.
- Resolves resident scheduling controversies.
- Arranges call coverage for Holidays and special events as needed.
- Serves on the recruiting, residency advisory, and Core Conference Committees.
- Develops the Core Conference schedule in cooperation with the residency director and residency office assistant.
- Assists in New Resident Orientation.
- Facilitates Resident Meeting
- Participates as directed in
  - National Conference – Recruiting and assisting in Procedures Workshops
  - Primary Care Week – Discussion Panels and Recruiting Activities
  - Procedures Day – Teaching Assistants
- Attends the following meetings as directed:
  - Faculty and REC meetings
  - University Chief Resident meetings
  - Faculty Retreat(s) *by invitation*
  - Residency Fairs

**b. Educational**

- Serves as a role model through active teaching and assisting of residents and medical students.
- Coordinates call schedules and service responsibilities to maximize teaching/supervising of junior residents and medical students.
- Serves as a resource for seminars and workshops given by the residency and coordinates resident participation in the workshops.
- When possible, attends one national meeting annually (eg, STFM, National Conference, RAP)
- Presents relevant lectures as directed.
- Assists in the teaching and supervision of medical students.
- Develops and organizes the Family Medicine Resident Library.

**c. Leadership**

- Serves as a role model through active teaching and assisting of residents and medical students.
- Discusses procedural questions with residents on an as-needed basis. Residents are, whenever possible, to go to the chief resident with problems, then to the residency director if necessary. The chief resident should serve as primary problem-solver for resident issues regarding call, vacation, and rotations.
- Participates in making clinic policies and serves as a spokesperson for the residents in initiating changes in the FPC and in the residency program in general.
- Maintains an atmosphere of cooperation among residents.

## G. RESIDENT CODE OF PROFESSIONAL AND PERSONAL CONDUCT

The Resident Code of Professional and Personal Conduct (including professional deportment, dress, and alcohol, drugs and tobacco issues) is legislated by the Kansas University Graduate Medical Education Office and is described in the University Housestaff Manual. Family Medicine residents are expected to adhere to this Code at all times.

## III. EVALUATION

Throughout the thirty-six month residency training program, various evaluation techniques are utilized to monitor the progress of individual residents in the program. All evaluation forms and anecdotal notes pursuant to performance are copied to or discussed with the individual resident and become a part of the permanent residency file. The majority of evaluations are competed on the E-Value system which allows residents and faculty to evaluate each other and to view those evaluations at any time.

Evaluation is also discussed in the Kansas University Housestaff Manual and includes Resident Standing, Promotion, and Program Completion, Remediation and Probation, Corrective Actions – Suspension and Termination, Appeal and Fair Hearing, Grievances, and Other Forms of Severance of the Resident Agreement.

### A. Block Evaluation

The following Evaluation Forms are completed at the end of each Block rotation.

1. ***Rotation Attending Evaluation Form***

This evaluation is related to resident performance on Rotations and is completed by the rotation attending at the end of each Block. These evaluation forms are distributed to the attending by the MyEvaluation web-based system or by a hard copy, which ever the attending prefers.

2. ***Family Medicine In-patient Mid-Point Evaluation***

This evaluation is related to resident performance on Family Medicine In-patient and is completed by the In-patient Attending. The In-patient Attending meets with the resident to discuss performance on the In-patient Team mid-point in the rotation.

3. ***Clinic Preceptor Evaluation Form***

This evaluation is related to resident performance in Family Medicine Continuity Clinic and is completed by an outpatient preceptor at the end of each Block. These evaluation forms are distributed for completion by a faculty member who has precepted the resident in that block. An attempt is made to select varied faculty members to complete the evaluation in order that a broad range of input as to the resident's performance may be obtained.

4. ***Resident Evaluation of the Rotation***

This evaluation is related to the rotation experience and rotation attending, and is completed by the Resident at the end of the block. The information collected from these evaluations is reported to the rotation attending anonymously every six months.

### B. Quarterly Evaluation or Semi-annual Evaluations

1. ***Mentor/Mentee Evaluation***

This evaluation is related to the resident's overall progress and includes a review of the summation of rotation and clinic evaluations, assessment of Inservice Exam scores, review of documentation of procedures and progress on scholarly project. These evaluations are completed quarterly by the resident and their faculty mentor in conference. The resident completes a portion of a pre-printed self-evaluation form prior to a scheduled conference with their mentor. The mentor completes a portion of the form during or after the conference. A current printout of the resident's Documentation of Procedures is due at this meeting.

***2. Evaluation of History and Physical Exam***

This evaluation is related to an observation of the residents as they perform a complete History and Physical examination. These evaluations are completed annually by a faculty preceptor in Family Medicine Continuity Clinic. The resident and the observing faculty member review the session together and documentation are placed in the resident's permanent file.

***3. Peer and Self Evaluations***

Residents are to complete self evaluations and these are contained within their portfolio. Peer evaluations also occur during the family medicine inpatient rotation, and may occur at other times as prescribed by the program director.

***4. Evaluation by the Program Director***

This evaluation is completed semi-annually. During the mid-year evaluation, progress of the resident is discussed (including the in-training exam) and residents are counseled on their progress in their particular year of training. At the end of each academic year this evaluation is utilized to decide on the eligibility of the resident to promote to the next post-graduate year of the residency or to graduate. In addition, following the final evaluation, a standardized reference letter is composed from this conference and is used in response to all requests for Letter of Recommendation by the Program Director.

**C. Supplementary Evaluation**

Supplementary evaluation may be mandated by the Program Director for residents with noted performance and/or knowledge base deficiencies. In this instance, these evaluations of the resident will be used to determine specific educational goals and objectives to remediate as necessary. This process is detailed in a separate document available in the Residency Office on request.

**D. Evaluation by Exam**

***1. In-Service Examination***

The Inservice Training Exam is given to all residents of the Department of Family Medicine annually. This exam is sponsored by the American Board of Family Practice and is mandatory for all residents. It is conducted on the first Friday in November each year at KUMC. All Family Medicine residents are released from clinical and rotational responsibilities during the hours of the exam.

***2. USMLE Step 3***

The USMLE Step 3 must be completed and passed before residents are eligible to sit for the Family Practice Board Certification Exam and before they can obtain permanent medical licenses. The USMLE Step 3 is administrated year round by computer.

Step 3 is administered through medical licensing authorities and not through the NBME. **Residents must contact the licensing authority** in the jurisdiction for which they intend to sit for Step 3 in order to obtain application materials, information about Step 3 eligibility requirements, application deadlines, fees, test center locations, and other information. Applications are not sent to program directors for distribution to residents. Residents who wish to sit for Step 3 in Kansas may call **Marjory Savoy at the Kansas State Board of Healing Arts - (785) 296-7413.**

*3. **Family Practice Board Certification Exam***

The American Board of Family Practice administers the Certification Examination in various centers throughout the United States annually on the second Friday in July. **Candidates must complete all training requirements of the Board no later than June 30 of the year of the examination. Residents who complete their training at an interim date must write to the**

**Board for an application.** Applications are supplied to the residents who complete the required training by June 30 through the Program Director. **NOTE**: Physician practice opportunities and salaries may be impacted by delay in sitting for this exam.

All candidates for the Certification Examination must hold a currently valid, full and unrestricted license to practice medicine in the United States or Canada at the time of application. No candidate will be allowed to take the examination without a valid and unrestricted license, and full payment of fees.

For more information on the Exam, contact:

American Board of Family Practice
2228 Young Drive
Lexington, KY 40505-4295
(859) 269-5626 ext. 228 or 220

Applications will be available after January 31st of each year. Deadline for submission of all application materials is February 28th of that year.

## IV. FAMILY MEDICINE RESIDENT CLINICAL DUTY HOURS, CALL POLICIES, AND OTHER CLINIC POLICIES

### A. CLINICAL DUTY HOURS

Resident clinics are scheduled from 8:00 am to 12:00 pm Monday through Friday and from 1:00 pm to 5:00 pm on Monday, Tuesday, Thursday, and Friday. Wednesday afternoon clinic hours are after the Core Conference from 4:00 pm to 7:00 pm. Clinic schedules are completed at least three months in advance. ***All requests for vacation must be submitted by July 1*** prior to the new academic year. CME requests and other requests for time off such as Locum Tenens, must be submitted ***no later than 6 weeks in advance***.

Requests for changes in time off will be approved at the discretion of the Program Director with the assistance of the Clinic Director. Extenuating circumstances may allow a resident approval for changes in time off. In this event ***the resident must assist in rescheduling the affected patients***.

A Master Clinic Schedule for the Block can be found in each suite Resident Room. Residents are responsible for checking the Master Clinic schedule and their IDX schedule periodically to ensure awareness of changes which affect their clinic sessions.

### B. ACUTE CARE CLINIC SESSIONS

Presently, the Family Medicine Clinic has Acute Care Clinic sessions each day for patients with acute health care needs. Residents and faculty are assigned to cover these acute care sessions. Nurse practitioners may assist in covering acute care sessions.

In addition to the acute care sessions, all resident and faculty clinic sessions contain one hour of Acute Care appointments. These designated Acute Care appointments are not to be filled prior to the day of visit.

Predominately, patients with Acute Care needs are scheduled by triage nurses. Patients with Acute Care needs are scheduled to open appointment and Acute Care appointment slots first. If none of these slots are available, these patients wait to be seen by their assigned physician.

### C. PATIENT SCHEDULING

Scheduling personnel include Triage Nurses and Patient Service Representatives. They operate under the following rules:

1. To contribute to continuity of care, patients are scheduled with their customary provider whenever possible.
2. All open appointment times may be filled up to the start time of the appointment.

3. Changes in the resident's assigned clinic times CANNOT be made by the resident. All changes must be approved by Dr. Vail, who will inform the scheduling coordinator. Do NOT ask the suite clerks to change your schedules.
4. Suite clerks do not give medical advice.

**D. Resident Block Schedules**

Individual preliminary schedules are submitted to the residents at least one month prior to the start of new rotations. Residents who are aware of prior commitments i.e. wedding, graduation, etc. should notify Dr. Vail, Residency Coordinator, and the Chiefs well in advance. **Noted discrepancies should be addressed as soon as possible to Dr. Diane Ebbert, Clinic Director.**

1. Patient appointment times are opened at least three months in advance. All requests and changes that affect the residents' availability for patients must be submitted.
2. Written requests for changes must be submitted to the residency office for all changes in resident availability. (i.e., vacation, CME, etc.) These change requests must be limited. Request forms are currently available in the wall pockets of the residency office hallway.
3. Residents must assist the clinic scheduler in rescheduling patient appointments.

**E. PHONE MESSAGE PROTOCOL**

***1. During clinic hours***

a) Phone messages are entered into the Centricity Electronic Medical Record. **It is that physician's** responsibility to call the patient back.
b) Phone messages must be answered promptly. (i.e., before leaving each day)
c) Residents must check for phone messages prior to leaving for the day – this includes following Core Conference.
d) Advice given must be clearly documented in the electronic medical record.
e) If the patient is not available by phone, the time the attempt(s) was/were made must be documented in the electronic medical record.

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***2. After clinic hours***

After hours, the hospital operator functions as the Family Medicine Department answering service. When a patient calls after clinic hours, the on-call resident will be paged and given a verbal phone message. The resident should respond as soon as possible. **The resident is responsible for documenting all patient phone calls and the responses in the electronic medical record and routing them to the patient's physician. (see above)**

**F. MEDICAL RECORDS: HOSPITAL AND FAMILY MEDICINE**

The ***Resident is Responsible*** for prompt and accurate completion of medical records. Satisfactory performance in the residency program includes timely medical record completion. This includes within the Family Practice Center, the Kansas University Medical Center and other hospitals where rotations are based. In the event the residents' hospital privileges are suspended due to incomplete records, one day of CME or vacation will be docked for each suspended day. In addition, CME and/or vacation days will be docked if medical records for outside hospitals are reported to be delinquent.

*1. KU Hospital Medical Records*

The Hospital Medical Record Department standards indicate that a medical record is delinquent 48 hours following the patient's discharge. ***Hospital privileges are suspended*** by the Hospital Chief of Staff if Medical Records are not completed within 7 days.

*2. Family Medicine Center Medical Records*

Family Medicine Department medical records must be completed ***within 48 hours***. If a resident is delinquent in completing Family Medicine medical records for more than three instances in a two month time period, CME and Vacation days will be docked.

### G. Family Medicine Call Policies

Family Medicine Call is divided between **DAY Call** (7 am – 6:30 pm) and **NIGHT FLOAT** (6:30 pm - 7 am). The supervising resident is responsible for the monthly call schedule and the chief residents are responsible for the master call schedule and vacation calls.

Requests regarding changes in the call schedule should be limited and must be submitted to the supervising resident coordinating the call schedule. If approved, the supervisor will inform the scheduling coordinator.

1. *Responsibilities*

a) The resident responsible for DAY CALL is responsible for both ER and Clinic admissions. She/he will evaluate patients presenting to Labor and Delivery, answer phone calls, and deal with other emergent inpatient problems. This resident may be asked to see patients who present to the ER if the resident in the ER has a question regarding a patient's history.
b) The NIGHT CALL resident is responsible for all of the above activities from 6:300 pm to 7:00 am. Check out is at 6:30 am and involves the night float resident, all residents on the inpatient service, and the attending faculty.
c) First-year residents will not take in-house call alone for the Family Medicine Service. The more senior in-house resident will supervise and assist the first-year resident to assure that patient care is carried out in a timely fashion. The more senior resident is to be actively involved in the call and is **not** on call in a supervisory capacity only (i.e. the first year resident is not to be the sole provider for the patient) ***SEE MORE SPECIFIC EXPLAINATION IN FAMILY MEDICINE INPATIENT ROTATION DESCRIPTIONS**.

2. *SICK CALL*

**If the resident on Call is ill**, the Supervising Resident will be responsible for first trying to switch call between the residents on service including him/herself. If this is not possible, the supervisor will contact the chief residents, and a back up resident will be assigned the call.

## V. EXTRA-INSTITUTIONAL PRACTICE, MOONLIGHTING AND LOCUM TENENS POLICIES

### A. MOONLIGHTING

Residents at PGY-2 and above may be granted permission to moonlight **only if they have obtained full licensure from the Kansas State Board of Healing Arts and have their own individual DEA registration number**. First year residents are not permitted to engage in moonlighting activities. **The University of Kansas policy limits residents to no more than 72 hours during any two-month period.** Any resident who performs moonlighting activities not approved or not in compliance with department or residency policies may subject him/herself to probation or dismissal.

In advance of engaging in any Moonlighting activity, residents must submit a

1. Request for Extra-Institutional Practice Privileges forms, available in the residency office. This form requires the signatures of Program Director and the Dean of the School of Medicine.
2. A copy of valid applicable permanent license
3. Proof of medical liability coverage

Moonlighting must never interfere with regular resident responsibilities. Moonlighting residents are expected to be present (and appropriately rested) in their educational setting during all prescribed hours. Approval for participation in Moonlighting activities is granted on an individual basis.

Residents on probation and/or who have less than average performance ratings on evaluations will not be granted approval for additional clinical activities such as Moonlighting and Locum Tenens. The privilege of moonlighting and other such activities will be terminated by the Program Director if interference in residency performance is noted.

The Temporary Medical Licenses in Kansas and Missouri and the professional liability insurance do not apply to moonlighting. They are exclusively provided for residency-related activities.

Program Directors, acting as agents of the Dean and the university, will establish policies governing moonlighting activities for their residents that are in compliance with university and Residency Review Committee guidelines. These policies establish the maximum number of hours that a resident will be permitted to moonlight per week, month and year. Policies and procedures for requesting and granting permission for moonlighting are the responsibility of each Residency Program and its Program Director and/or Departmental Chairman and the Dean.

Residents are provided professional liability insurance via a State of Kansas self-insurance program. This insurance (occurrence type with tail and with the following limits: basic coverage $1,000,000/3,000,000) covers residency-related acts performed under the supervision of a member of the residency teaching staff and approved locum tenens, but DOES NOT cover moonlighting activities. It does cover locum tenens that is arranged through the rural health office. **Additional claims** made with tail coverage insurance, with limits of coverage not less than those provided via the state plan, **must be arranged to cover moonlighting activities**. Such insurance may be purchased by the resident or may be arranged by another individual/agency (i.e., the moonlighting employer). If the resident is not personally responsible for purchasing the additional coverage, he/she must request a certificate of insurance to document the existence of the appropriate coverage.

**Residents who live in a state other than where they are “moonlighting” should confirm valid malpractice coverage.

### B. LOCUM TENENS

Second and third year residents are allowed to participate in one week of Locum Tenens experience. Locum Tenens are intended to provide a brief practice experience in rural locations in Kansas while supplying practice coverage relief for family physicians in Kansas. PGY 2 and 3 residents may participate in an additional Locum Tenens in lieu of the 5 days of CME time. Stipends for locum tenens may be issued directly to the resident.

Locum tenens activities for residents are coordinated through ***the Rural Health Office. The office phone number is 588-1228.***

Locum tenens activities approved, in advance, by a resident’s Program Director and Departmental Chairman, and the Dean, will be covered by the resident’s state-provided insurance and do not require the purchase of additional coverage. Locum tenens activities are considered to be controlled situations in which a Residency Program (or institutional representative) responds to a request from a Kansas physician for a qualified resident to provide “coverage” for him or her while away from the usual site of practice for a limited time due to illness, vacation or attendance at a continuing medical education activity.

Locum tenens activities will typically occur only in “rural” communities. A request for a locum tenens activity in a more urban setting will not be approved unless there are unusual extenuating circumstances. Resident coverage for a practicing physician should not be requested unless coverage via other physicians in the community is impossible or inappropriate.

Recommendations regarding whether locum tenens activities are to be covered by the state-provided insurance are the responsibility of the Program Director and Departmental Chairman and are to be submitted at least **ONE MONTH** in advance to the Dean’s office. Final authority for decisions in these matters rests with the Dean. Forms to be used in requesting approval for coverage of locum tenens activities by state-provided insurance are available in the Residency Office.

**In addition, the following restrictions apply:**

1. Physician back up from an appropriately licensed physician must be available within 15-20 minutes in person and 24 hours a day by phone.
2. One week maximum (5 days and 2 weekend days) in continuity is allowed per locum tenens during both second and third years. Additional locum tenens will require the use of one week of vacation. No additional week-long locums may be scheduled.
3. Locum tenens sites, which require approval by the residency director for specific privileges to be granted, must request this information in writing.
4. The Kansas temporary resident license will apply to locum tenens.
5. Application for site approval and requests for time off must be completed and submitted to the scheduling coordinator, in accordance with the deadlines for vacation requests.
6. Residents may participate in additional locum tenens during their vacation time.

**WEEKEND Locum Tenens must adhere to the above regulations AND**

1. Must be counted toward time allotted for "moonlighting".
2. Must not conflict with patient care or other rotational responsibilities.

**Note:** Only by adherence to these restrictions are locum tenens covered by the residents housestaff malpractice insurance.
**** Additional clinical activities will not be allowed during the third-year Supervising month.**

Extra-institutional Practice, Moonlighting and Locum Tenens Policies are also discussed in the Kansas University Housestaff Manual.

## VI. PROFESSIONAL MEDICAL LICENSE

All Family Medicine resident physicians at the University of Kansas Medical Center are required to have either temporary or permanent Kansas and either contiguous or permanent Missouri licenses when they are rotating in Missouri. Permanent licensure and individual malpractice coverage, at the resident's expense, are required for moonlighting privileges.

****Temporary and contiguous licenses are rendered invalid when permanent licenses are obtained. Residents who obtain permanent licensure in Kansas and/or Missouri are required to issue a copy of their valid license to the residency office**.

### A. KANSAS

#### *1. KS LICENSURE – TEMPORARY*

A temporary Kansas license can be issued to resident physicians in training in an AMA approved program at KUMC upon application and payment of assessed fees. The fee for the temporary license for Family Medicine residents is paid by the Family Medicine Department.

This temporary license is valid for thirty-six months while the resident is enrolled in residency training. It is only for medical practice associated with the residency training program.

All resident physicians must have a temporary license prior to beginning the Family Medicine Residency Training Program. Students who are not required to take National Boards part I and II, or AOA Boards Part I and II at their medical school must sit for and pass the exams no later than December of their first year of residency to maintain valid temporary licensing in the State of Kansas. **Residents must submit proof of passing USMLE Step 1 and 2 or NBOME Part 1 and 2 by the end of the first twelve months of residency to continue participation in the residency program**. USMLE has replaced the FLEX exam, the National Boards, and ECFMG.

In the event the residency is extended beyond 36 months, a formal request from the residency director must be submitted to the Kansas Board of Healing Arts for extension of temporary license privileges.

#### *2. KANSAS LICENSURE -PERMANENT*

Residents must show proof of having passed National Boards Part 1, 2, and 3, USMLE Steps I, II, and III, OBME Parts I, II, and III, or Flex Exams Component I, II, and III, for eligibility for a permanent Kansas license. Currently, residents who request application to USMLE III are required to complete application for permanent Kansas license

Kansas law requires at least one year of residency training after medical school for US medical school graduates to be eligible for permanent licensure. International medical school graduates must have a total of 3 years of residency after medical school to be eligible for permanent licensure in Kansas. One of those years must have been completed in the United States.

USMLE Part III and MD and DO permanent Kansas license applications can be obtained by calling Marjorie at the Kansas State Board of Healing Arts office at (785) 296-7413. All related fees are to be paid by the resident. **Deadlines for application to take USMLE Part III are approximately four months in advance of exam.**

### B. Missouri

#### *1. MO Licensure - Contiguous*

A Missouri Contiguous License is required for all rotations that are located in the State of Missouri, except for the KCVA. This license must be renewed annually. A renewal application form will be submitted to each resident near the end of each academic year to be completed ASAP and returned to the Residency Coordinator. Fees for temporary Missouri Licenses will be paid by the Family Medicine Department.

The Missouri Board will issue a license certificate that will be maintained in the department files. **A wallet-sized card with the licensing information is also issued and is to be kept by the resident to be presented on the first day of each rotation located in Missouri.**

#### *2. MO Licensure - Permanent*

A permanent Missouri License is required to “moonlight" at a Missouri location. Applications and information can be obtained by calling the Missouri Board at (573) 751-0171. Their address is PO Box 4, Jefferson City, MO 65102. Fees for permanent license are paid by the resident.

**PLEASE NOTE: The licensure process for both Kansas and Missouri is extremely cumbersome. Prompt and careful attention to completion of the applications in their entirety is imperative.

Residents cannot participate in rotations without proper licensure and may have to delay starting or continuing the residency if proper licenses are not maintained.

## VII. Professional Liability and Risk Management Policies and Procedures

Persons engaged in KU post-graduate medical training are provided coverage pursuant to KSA 40-3401, et seq. The coverage is provided to residents for acts while in the training program without regard to their state of residence.

In general, extracurricular, extra-institutional medical service for which extra compensation is received is not covered by the state-provided insurance. Approved *locum tenens* experiences are, however, covered by the state.

A. **Residents away from KU who provide services pursuant to a KUPI negotiated contract under the direction of KU faculty are provided coverage.** However, an agreement must be in place between the institution and the foundation which has been approved by the department chair, the executive dean, legal counsel and the executive vice-chancellor.

B. **Residents under supervision of faculty at other institutions are provided coverage**. However, an agreement must be in place as outlined above and the supervising faculty must have a KU faculty appointment.

C. **Residents in Missouri with KU faculty member are provided coverage.** The resident must obtain a Missouri license. Be aware that KU physicians who are not residents of Kansas are not provided coverage for services outside of Kansas under the KU physician self-insurance program. Coverage for services outside of Kansas under the KU physician self-insurance program requires a separate policy. A separate policy would need to be purchased for the non-resident faculty member. The VA is an exception as explained below.

D. **Residents at federal institutions are provided coverage.** Residents must have a Missouri or a Kansas license. The Federal Tort Claims Act coverage applies to residents and faculty members at federal institutions.

E. **There are no exceptions to the above.** Coverage for "moonlighting" is not provided under the provisions of KSA 40-3401, et seq. If "moonlighting" has been approved by the departmental chair and executive dean, the residents must purchase insurance coverage at the highest excess limits for total coverage of $1,000,000/$3,000,000. A request for Resident Extra-Institutional Practice Privileges Form must be submitted to the Office of the Executive Dean for approval.

Professional Licensure, Liability and Risk Management Policies and Procedures are also discussed in the Kansas University Housestaff Manual.

## VIII. DEA REGISTRATION

All Residents are required to obtain a DEA number at their own expense. Forms can be picked up from the Outpatient Pharmacy or the Residency Office. A copy of the valid DEA certificate must be kept on file in the residency office.

## IX. STIPENDS AND OTHER BENEFITS

### A. FY 2003 RESIDENT STIPENDS

Residents receive annual stipends according to their current post-graduate year. The following amounts are subject to Federal, State, and Local taxes.

| | ANNUAL | BI-WEEKLY |
|---|---|---|
| **PGY 1** | **$ 42,773** | **$ 1645.11** |
| **PGY 2** | **$ 44, 000** | **$ 1692.30** |
| **PGY 3** | **$ 45, 385** | **$ 1745.58** |

### B. MEDICAL PROFESSIONAL CERTIFICATIONS

Residents are certified in BLS, ACLS, and PALS prior to starting residency. NRP is obtained in the first month, and ALSO in the fall of the first year. The following guidelines apply:

1. Residents are responsible for checking the expiration date of their certifications.
2. Valid certifications in BLS and ACLS are required throughout residency training. These recertification courses are available at KUMC and are coordinated through the Office of Education and Development, 588-6551 or 588-3214.
3. A copy of all valid certification cards should be copied to the resident's portfolio.

Note: An ATLS course is now available at KUMC and may be arranged by the resident as a CME activity in his/her second or third year. You can contact the Surgery Trauma Office at 588-5429.

### C. CONTINUING MEDICAL EDUCATION (CME)

The Family Medicine Department allows time and funds for the support of R2 and R3 residents to engage in approved Continuing Medical Education activities, contingent upon the resident's 75% attendance at Core Conferences and maintenance of good standing in the residency program. Residents on academic probation are not approved for CME.

Five days of CME are allowed. The number of days allowed for CME include the travel time involved**.** Residents are allowed to use the 5 days CME time to participate in a Locum Tenens.

**CME time cannot be tied to the front or rear of a regular vacation or locum tenens block** and must be scheduled at least two months in advance to accommodate the scheduling of patient care sessions. Emergency changes will be handled on an individual basis.

The maximum amount of allowable support funds is $600 for R-2's and $700 for R-3's, per fiscal year. The maximum allowable number of working days is five per fiscal year (fiscal year is July 1 to June 30). Residents not selecting a CME Course can use these funds for books and/or home study courses. All receipts **must be submitted to the Residency Office prior to the end of that fiscal year** (June 30) for reimbursement.

Resident Request Forms for CME are available in wall pockets in the resident's room or in the Residency Office. These must be filled out by the resident with the CME information attached and submitted to the Residency Office for approval. The Residency Office will record this information and submit it to Dr. Belinda Vail, Residency Director, for approval.

**Residents should retain a copy of all request forms submitted for approval.** Upon approval, residents will receive a copy of the request with the appropriate signatures.

### D. INSURANCE: HEALTH/DENTAL/DISABILITY

Individual and dependent health care insurance is offered to all resident physicians through the State of Kansas. Health insurance coverage begins the first day of the month following 60 days of employment. Each resident is responsible for his/her own health insurance during the waiting period. Suggested alternatives include continuation of student or present coverage, temporary coverage by Alumni Association or present insurance company (i.e., homeowners, auto). Dental insurance is provided at a minimal fee per pay period.
KUMC provides a special disability insurance program for residents. Each eligible resident and fellow is provided with a comprehensive disability plan.

1. Upon *graduation* residents and fellows can take a considerable amount of coverage with them—<u>without medical questions and with a 30% premium discount.</u> This is a Special Portability Feature.
2. <u>Current residents (those not graduating) can obtain more coverage, now</u>—an additional $3,000 of monthly benefits, which includes a 30% permanent premium discount.

## X. OTHER REQUIRED ELEMENTS OF RESIDENCY TRAINING

### A. CORE CONFERENCE

Core Conferences are held every Wednesday from 12:00 noon to 3:30 PM in the Sudler Auditorium. Attendance is required and must not fall below 75%. Attendance is taken by the residency office staff. Core Conferences have been instituted to assure that basic principles of Family Medicine are taught to all KUFM residents. Suggestions for speakers and topics can be forwarded to the residency office for consideration.

Residents are released from rotation duties to attend conferences on all but a few rotations (listed below). Residents, by contract, are required to attend at least 70% of the conferences. **CME time and money are not granted if the resident has not maintained 75% attendance at the time of the request**.

Residents are not expected to attend the core conference if they are at Fort Riley or on a rural or away rotation where distance makes attendance impractical. The night float resident is unable to attend due to duty hours restrictions. These absences are included in the 25% allowable absence, along with personal or family illness, medical appointments, and ob-deliveries. Residents on other services are also expected to attend conferences in the departments in which they are rotating.

Residents are expected to make every effort to attend residency conferences. Attendance is taken at each conference and records of attendance will be provided to residents periodically as part of their overall performance evaluation.

The following meetings are held in Core on a regular basis and are vital to clinic and residency communications and problem solving.

- Chief Chat
- PGY Level Discussion Groups
- Quarterly financial meetings
- Department Meetings

Regularly scheduled conferences include:

- Geriatric Journal Club
- Orthopedic/Sports Med
- Morbidity and Mortality

## B. SCHOLARLY PROJECT

Completion of a Resident Scholarly Project is a required part of the KUMC Residency Program. Drs. Allen Greiner and Kim Kiminau are the faculty co-coordinators of the Resident Scholarly Project.

The residents will begin their scholarly project in PGY-1 by selecting a topic and a faculty advisor. They should meet with their faculty advisor and formulate a research hypothesis. The hypothesis should be formulated based on the resident's literature review and on discussions with their selected faculty mentor.

Ideally during PGY-2, the resident will complete data collection and analysis. Residents will conduct a presentation of their work at Core Conference and will submit a written form of their presentation during the PGY-3 year.

Residents are encouraged to consider an accelerated schedule to complete the project early in order to present in other local, regional, or national forums and/or to submit to various journals. Faculty coordinators will have information regarding this type of opportunities.

Basic Requirements:

A. Residents will conduct hypothesis-based projects.
B. Residents will use existing empirical literature in the formulation of their questions and hypotheses.
C. They will search the literature, select seminal (empirical and review) articles, and read these prior to conducting their projects.
D. After preparing in this manner, they will collect data that systematically addresses their hypotheses or questions.
E. When data collection is complete, residents will analyze the results and prepare presentations.

All information for completing the projects is contained within the Resident Research Manual given to all residents at the beginning of the residency.

## D. DOCUMENTATION

All Family Medicine Residents are required to document their experiences while on all services during the thirty-six months of residency training. Both significant procedures and significant diagnoses (i.e.

Myocardial Infarction, Diabetic Ketoacidosis, Respiratory Failure, etc.) should be recorded. Procedure Logs are available on the E-Value system for recording this information. Procedure cards are present in the residency office and are encouraged as they document the level of competence of the residents on a particular procedure. Residents must also record their continuity nursing home patients, ICU patients, and obstetrics patients (denoting method of delivery and their panel patients). These should be completed by the resident and signed by the preceptor at their interval meetings.

Residents are to enter this information into the computer documentation format in the E-Value program. **Residents are responsible for submitting their updated computerized documentation to their mentor in quarterly Mentor/Mentee meetings**. The Residency Coordinator will track submission of this documentation. (i.e., September, December, March, and June). Residents who do not submit updated documentation as required will be docked CME or vacation time.

Credentialing at future practice locations is often contingent upon meticulous documentation of residency experiences. The Program Director will not support privileges for procedures or diagnoses that are not documented in the resident's permanent file. Therefore, computerized documentation of procedures is very important. Patient name, medical record number, diagnosis, and procedure should be included for each record. The information must be formatted so that the numbers of a particular procedure carried out or diagnoses dealt with can be quickly determined. Diagnoses and procedures should be named precisely and consistently.

### E. MEDICARE TIME RECORDS

Medicare time keeping and duty hours is to be entered via the GME website http://apps.kumc.edu/gme/residenttimeentry/ by Monday AM of each week for the prior week worked. All residents must complete this time record. Medicare requires that we keep detailed records in order to retain reimbursement related to medical education. Hours entered on this time record should be rounded to the nearest half-hour. There are strict guidelines that restrict residents from working over 80 hours/week averaged over a four week period. The GME Director has strict consequences for those residents delinquent in inputting their time via the web.

### F. PAGERS

Residents are required to carry their pagers at all times, unless out of town or on a designated day off. Pages must be answered promptly (within 3 to 5 minutes). Prior to leaving town and upon return, the resident is responsible for notifying the KU page operator, 588-5155, to adjust his/her pager status.

**When residents are assigned pagers by the rotation:**

1. The residency coordinator should be notified of those pager numbers.
2. KUFM pagers should also be worn.
3. Residents are responsible for returning those pagers at the end of the rotations.

Residents are responsible for keeping their assigned beeper intact and safe. KU beepers must be returned by the resident upon graduation/ termination from the residency program. Residents are responsible for the cost of damage to the pager or for replacement cost if a pager is lost or irreparable.

## XI. MISCELLANEOUS ROTATION INFORMATION

For more detailed information regarding individual rotations is available on the Rotation Description Section of this Policy Manual.

### A. INPATIENT SERVICE

First and second year residents on FM service will be assigned inpatients by the supervising resident. Sit-down rounds may vary from month to month to provide variety and to increase educational content.

For example, the attending staff may require each on-service resident to present a five-to-ten minute talk or each on-service resident may be required to discuss the technique of a specific procedure.

### B. INPATIENT SUPERVISOR

The role of the Supervising Resident is explained more thoroughly in the Rotation Description for Supervising resident.

1. The supervising resident is to be notified of all admissions, changes in all critically ill patients, and any major change in the status of any patient. He/She will notify the attending physician.
2. The supervising resident will be available by beeper to the on-call resident for telephone consultation or to come in to the hospital promptly if needed.
3. The supervising resident will have overall responsibility for the inpatient service. He/She will conduct morning report, in-patient work rounds and sit-down rounds with the current attending staff.
4. The supervising resident is scheduled for two hours of clinic (non-acute care) time in the afternoons unless she/he is post-call.
5. The supervising resident takes a 24 hour in-house call with a first year resident. He/she will be a back-up for any problems or questions which may arise on any night.
6. The supervising resident is responsible for selecting cases for Radiology Conference. These are reviewed with a radiologist on Wednesday at 8:15 am
7. The supervising resident is responsible for keeping the inpatient database current and for confirming that each patient has a discharge summary sheet placed into the Family Medicine chart after discharge.
8. The supervising resident is responsible for facilitating the flow of information between attendings and residents.

### C. ELECTIVE ROTATIONS

The Family Medicine Residency curriculum includes six elective months in the third academic year. This may include one full-time elective which may be arranged with the approval of the residency director, and half-time electives. A full time elective allows the resident to be excluded from Family Medicine continuity clinic for that month if the elective is out of town. A half-time elective requires that resident be in clinic 4 sessions per week plus Core.

A variety of electives are available. Residents arrange their own electives to meet specific educational interests they may have. Approval from the residency director is required.

Electives which are outside of the hospital system require that appropriate paperwork be completed and signed by the Department, GME Office, and the Elective Site. This takes at least one month advance preparation.

REQUESTING ELECTIVES:
The residency office has the forms which residents are required to submit when requesting approval for Electives. These Elective Request Forms **must be filled out completely and submitted by the resident to the Residency Office three months prior to the elective month**. Specific clinic session requests cannot be honored with late elective requests.

## XII. GRADUATION/TERMINATION FROM THE RESIDENCY PROGRAM

Upon graduation/termination from the residency program, the resident is responsible for completing the following tasks:

1. Turning in all keys to the residency coordinator.
2. Turning in pagers to the residency coordinator.
3. Turning in KUMC ID cards to the residency coordinator.
4. Giving a forwarding address and telephone number to the residency coordinator.
5. Clearing the resident suite office and desk of personal items.
6. Returning all books to the Family Medicine Library.

7. Returning any Family Medicine equipment, instruments, and books to the Department.
8. Completing all Hospital and Department Medical Records.
9. Completing all Medicare Time Entry on the web.
10. Notifying all journal and magazine companies of new addresses. **These will not be forwarded.**

**The purpose of this manual is to keep all members of the residency aware of the rules and regulations regarding residency training. It is to be used as a resource. All questions regarding issues addressed within this manual should be addressed to the program director.**