CONROE MEDICAL EDUCATION FOUNDATION
GENERAL INFORMATION FOR RESIDENTS
July 1, 2021 – June 30, 2022
Prepared: March 25, 2021

INTRODUCTION

The following information has been compiled by The Conroe Medical Education Foundation (CMEF) for use by the residents, program director, faculty, staff, CMEF Board Members, Graduate Medical Education Committee, affiliated primary teaching hospitals, administrative personnel of CMEF and Lone Star Community Health Center (LSCHC). CMEF is committed to offering a family medicine residency program as a part of its educational mission and has established mechanisms to ensure that its residency program and associated subspecialty programs is in compliance with the Institutional, Program and Subspecialty Requirements for Residency Training as promulgated by the Accreditation Council for Graduate Medical Education (ACGME) including the notification of residents of any adverse accreditation action related to their specific residency program.

SECTION I - APPOINTMENT INFORMATION

A. APPOINTMENT/REAPPOINTMENT

Resident appointments are assigned at a postgraduate year (PGY) level commensurate with the ACGME (see APPENDIX 1A & 1B) and American Board of Medical Specialties' (ABMS) guidelines. Resident appointments are recommended by the Program Director. All appointments are one year in length and are renewable annually on the recommendation of the Program Director. Decisions not to reappoint will be based on the residents' evaluations and also his/her ability to work and learn effectively within that resident group. Failure to reappoint may be grieved by the resident as per Section III.

B. ORIENTATION

CMEF has developed an orientation program for all residents newly appointed to CMEF regardless of the training level to which appointed. Attendance is mandatory and the resident is paid for these days as ordinary workdays. The intent of the orientation is to provide general and specific information about the institution which will facilitate the new resident's entry into CMEF's programs, allow completion of processing as a new employee of LSCHC, comply with health service requirements including immunization and TB testing, compliance with LSCHC drug and alcohol policies, and allow an opportunity for the new residents to meet each other socially, and to get to know the residents already at CMEF. CMEF provides specific details about the orientation to new residents prior to their arrival.

C. HOURS OF DUTY, ASSIGNMENTS, LECTURES AND WORKSHOPS

The hours of and the duration and sequence of assignments will be as determined by the Program Director or his/her designee. Residents agree to participate fully in the educational activities of the program, and as required, assume responsibility for teaching and supervising other residents and students. Residents agree to participate in designated committees and meetings as may be required by the CMEF or to respond to requirements of the Accreditation Council for Graduate Medical Education. Residents agree to participate and support all recruiting activities of their program.

D. EMPLOYMENT CERTIFICATION

Residents applying for mortgage loans, student loan deferments, etc., may instruct the lender to direct requests for information or certification to the Medical Education Director.

E. PHYSICIAN-IN-TRAINING PERMITS

All residents who are not fully licensed to practice medicine in the State of Texas are required by the Texas Medical Board (TMB) to hold an individually held Physician-in-Training (PIT) Permit. The fee for this permit must be submitted as directed by TMB. The permit does not allow a resident to practice clinical medicine outside of his/her educational training program. Once permanent medical licensure in Texas is obtained, the CMEF Program Office should be sent a copy of the current physician permit, showing license number and expiration date.

Information about this permit is presented to all applicants for GME programs. All residents at CMEF will be required to have an appropriate TMB issued PIT or a permanent Texas Medical License as a condition of appointment by the first day of employment. If the training permit is not received within 30 days of the initial agreement, the Program Director may void the agreement.

To expedite the PIT Permit and to ensure that all residents hold a valid permit, CMEF requests that all information pertaining to the permits be sent to the CMEF Medical Education Director. Your signature on the CMEF Resident Work Agreement gives your approval to use the CMEF Residency Program address.

It is the personal financial responsibility of the resident to obtain his/her PIT permit.

The permits are valid in this Texas training program only. If you do an elective rotation outside of Texas, you must obtain a permit to practice medicine from the appropriate State Board of Medical Examiners. Additional information can be obtained from the Medical Education Director.

Texas Medical Board Annual PIT Reports

The TMB requires that certain information be submitted regarding PIT holders. The residency program will assist both the program director and the residents in this regard. Information which must be submitted includes:

(1) Information regarding the permit holder's criminal and disciplinary history, professional character, mailing address, and place where engaged in training since the Program Director's last report;

(2) Certification of the permit holder's training;

(3) Such other information or documentation the TMB/Executive Director deem necessary to ensure compliance with TMB Rules, other Board Rules, the Texas Medical Practice Act, and the Texas Occupational Code.

F. LICENSURE AND LICENSURE EXAM REQUIREMENTS

It is the personal financial responsibility of the resident to obtain and renew his/her medical license. The CMEF Residency Program Office should be notified immediately upon medical licensure/relicensure in Texas and a copy of the physician permit portion of the license should be submitted to this office. The Texas Medical Board's address is: P. O. Box 2018, Austin, TX 78768-2018.

It is the responsibility of the resident to maintain current medical licensure, which may be a Physician in Training Permit or a full Texas Medical License. Full state licensure is required by the ABFM for board certification. In view of these facts, and upon the recommendation of the Texas Medical Board (TMB), all residents are required to adhere to the following timeline for full licensure in Texas:

June 30th of PGY 1	Must pass Step 3
August 1st of PGY2 for US Graduates; August 1st of PGY 3 for International Graduates	Must submit complete TMB application for licensure, including all supporting documents and sitting for the Jurisprudence Examination
Upon receipt of medical license	Register License and Apply for DEA Number
Within 30 days of receiving license	Furnish proof of DEA Application to the Medical Education Director

Failure to adhere to the above timeline may prevent a resident from advancing to the next level of training within the residency program.

Upon receipt of each license, medical and DEA, a copy must be provided to the Medical Education Director.

The licensure fee charged by the TMB will be paid by the Program on behalf of residents who adhere to the requirements outlined above. Registration and renewal fees are the responsibility of the resident.

Fees to obtain licensure in another state will not be paid by the Program.

G. INSTITUTIONAL DEA NUMBER

Those residents covered under a Physician in Training Permit will be assigned two Institutional DEA Numbers, one for Conroe Regional Medical Center (CRMC) and one for Conroe Medical Education Foundation. CRMC will issue numbers directly to residents for use in that hospital only. CMEF will issue a DEA number which will be a one to three digit suffix to be used in conjunction with the DEA institutional number of the Conroe Medical Education Foundation. This number will provide the resident prescription writing privileges in the affiliated sites, other than CRMC, and LSCHC.

IMPORTANT NOTE: Prescription order forms should show in addition to a legal signature:

1) prescribing physician's name printed in full and legible;
2) DEA number for controlled drugs; and
3) patient's name and address.

H. DEA NUMBER

Since an Institutional DEA number cannot be used once individual medical licensure is obtained, all eligible residents are responsible for obtaining/renewing their individual Federal Drug Enforcement Agency (DEA) number once licensed in Texas. The Federal DEA charges a fee for this license; payment of these fees and/or renewal fees is the responsibility of the resident. The CMEF Residency Program Office should be notified immediately upon licensure/renewal and should be provided copies of these documents when obtained. See timeline in Section I.F.

I. BLS, ACLS, ALSO, NRP, PALS AND OTHER CERTIFICATION

Incoming residents are to be BLS and ACLS certified before beginning their residency, and are to maintain certification the duration of their residency program. The NRP and ALSO courses are provided by the program during orientation; NRP renewal is offered by the program during new

resident orientation. Any resident not present, including those on approved leave, when these courses are offered are responsible for arranging for their certification/recertification prior to expiration of their current certification and for any associated expenses. PALS certification is provided by CRMC. Renewal expenses for all certifications are the responsibility of the resident. All residents will take these courses and be certified. The program will pay for residents to take the ATLS courses if taken during the second year of training.

J. LEAVES OF ABSENCE

In the event of a resident's absence from a training assignment, other than on vacation or sick leave, a formal leave of absence (with or without pay, depending on the circumstances and at the discretion of the Program Director, under institutional guidelines) will be recognized. Residents should be aware that completion of residency training and eligibility for Board certification depend on the completion of certain "time in training" requirements specific to the medical specialty. Extended absences from the program may require additional time and training. This can be best clarified by discussion with the Program Director.

In circumstances where a resident completes a Parental/Physician-as-Patient/Caregiver Rotation, and additional time away from the program is needed, the resident may take sick or vacation time followed by a Board Review Rotation which will include attendance at didactics as well as full patient care responsibilities in the clinic.

K. MAXIMUM HOURS OF CLINICAL AND EDUCATIONAL WORK

It is the policy of Conroe Medical Education Foundation that its graduate medical education programs be and remain in compliance with the Institutional Requirements and Program Requirements promulgated by the Accreditation Council for Graduate Medical Education with respect to the clinical and educational work hours. Further information concerning this topic can be found in Appendix I.C.

L. "MOONLIGHTING" BY CMEF HOUSE STAFF

"Moonlighting" is defined as any professional or patient care activity outside your assigned duties as a resident at CMEF for which you receive compensation in cash or kind in exchange for functioning as an independent physician outside of training. When a resident "moonlights," it should be with the knowledge that:

1. Completion of one year of postgraduate training is mandatory;

2. Independent licensure by the State of Texas for the practice of medicine is mandatory outside of CMEF or LSCHC;

3. Outside CMEF or LSCHC, no malpractice insurance is provided nor will any other fringe benefits ordinarily afforded to the resident will be in effect;

4. No resident may "moonlight" during assigned duty time, including call;

5. Specific written permission of the residency Program Director must be obtained prior to arranging to "moonlight" and will become part of the resident's permanent file. Such permission request must be in writing and accompanied by a copy of state license, DEA licensure, and proof of malpractice insurance, list stating the moonlighting location and the

proposed moonlighting schedule must be given to the Program Director. The Program Director shall acknowledge in writing that (s)he is aware that the resident is moonlighting, and this information shall be part of the resident's permanent file. Moonlighting will be monitored as required by ACGME for compliance with the maximum hours of clinical and educational work. Moonlighting is a privilege dependent upon the Program Director;

6. The resident must be in good standing in the residency program.

7. The resident's performance will be monitored for the effect of these activities upon performance and adverse effects may lead to withdrawal of permission to moonlight;

8. The residency program shall have no responsibility to the resident in such endeavors. **Professional liability insurance provided by CMEF and LSCHC will not cover or protect the resident for any liabilities incurred in such professional activity.**

9. "Moonlighting" must not interfere with training program schedules or responsibilities (faculty members will be the sole determiners of what constitutes an appropriate amount of moonlighting as needed and on an individual basis) and may not exceed 40 hours per month;

10. Moonlighting hours count toward the maximum hours of clinical and education work;

11. The U.S. Code of Federal Regulations clearly prohibits exchange visitors (J1 visa holders) participating in programs of graduate medical education from pursuing work outside of their training programs. Therefore, any house staff officer holding a J1 visa may not moonlight or earn extra income under any circumstances;

12. All residency responsibilities must be current, for example medical records must be completed, scholarly activities must be on track;

13. The resident must have received good 360-degree evaluations from clinic staff;

14. The faculty must believe that the resident's in-training examination score indicates a good knowledge base and the ability to pass the American Board of Family Medicine Certification Examination;

15. Moonlighting at LSCHC requires credentialing and approval by LSCHC's Board and/or Designee; and

16. Residents are not required to engage in moonlighting.

M. DISASTER PLAN

All residents should become familiar with the CMEF, LSCHC, and affiliated teaching hospital's disaster plans and understand that they will be designated as essential employees during a disaster and are required to remain in the hospital or area assigned until formally released at the conclusion of the disaster period.

N. HEALTH INFORMATION MANAGEMENT

Timely completion of medical charts and general compliance with the rules and regulations of the CMEF, LSCHC and the affiliated primary teaching hospitals is considered an integral component of graduate medical education. This includes signing orders, completing H&P's, discharge summaries, progress notes, and death summaries. Residents should note: admission notes must be complete at the time of admission; progress notes should be completed before the start of rounds and must be completed by the end of rounds; discharge summaries must be completed within 48 hours of discharge. Residents will complete all medical record assignments in a timely manner and accept responsibility for familiarizing themselves with hospital medical records policy. Failure to complete medical records, as prescribed by applicable Medical Staff Bylaws, hospital rules and regulations, clinic rules and regulations, and/or departmental policy, may result in corrective action, which may include extra call, suspension without pay, and/or probation.

If any resident has delinquent hospital charts, he or she will receive an extra call night assigned at the Program Director's discretion. If a resident received more than two extra call nights in a six month period, he or she will be suspended for five days. If the offense occurs again, the resident will be permanently suspended.

In the State of Texas a doctor can lose his or her license for delinquent medical records.

Ideally medical records in the Family Medicine Practice will be completed at the end of the clinic session. CMEF strongly encourages completion after each patient while the details are fresh in your mind. Residents are held responsible by the program and by attorneys for the quality of your medical records. Send reports to faculty for review as instructed in training. Residents *must* complete charts within 48 hours of the visit. Residents who fail to do so will be notified of their noncompliance. If this occurs again in the academic year, the matter will be referred to the faculty for disciplinary action that may include suspension and/or academic probation for failure to meet the core competencies. All Allscripts inboxes should be cleared within 24 hours. Faculty will monitor by doing spot-checks of the inboxes. Residents are to select a buddy within their clinic to ensure that inboxes are cleared. The Medical Education Director should be notified by July 10th of each resident's designated buddy. Further information concerning medical records may be found in the *Rules of the Road.*

A Certificate of Completion of residency training will not be issued until all medical record assignments are completed at the end of the training period.

O. HOUSE STAFF DIRECTORY

It is essential that the CMEF Residency Program Office maintain accurate and up-to-date information on residents including home address, telephone number, etc. Any change in this data should be reported promptly to the Residency Program Office.

P. INTERNATIONAL MEDICAL GRADUATES

Individuals who received their medical education outside the United States must be sponsored through the Educational Commission for Foreign Medical Graduates. Any unique circumstances requiring visa definition should be brought to the attention of the CMEF Residency Program Office well in advance of arrival for residency training.

Q. OFF-CAMPUS ELECTIVES

The Program Director must approve off-campus electives in advance. An affiliation letter and a business associate agreement must be fully processed before the elective begins to ensure that appropriate criteria are met. Electives must be in an ACGME accredited program and/or count toward residency and/or specialty board requirements. If a resident's off campus elective is outside Texas, the resident is responsible for taking appropriate steps to obtain licensure to practice in that state. Adequate liability coverage must be provided by the off campus facility. The Program Director must approve these before scheduling with an off-campus facility. Procedures for off-campus electives are available in the CMEF Residency Program Office.

Residents will be excused from clinic responsibilities during approved Parental/Physician-as-Patient/Caregiver, out-of-state, away, and rural rotation, with a maximum two excused rotations during 3-year term, with no more than one rotation per training year. Absences from clinic responsibilities will comply with ABFM requirements.

R. **HARASSMENT AND SEXUAL HARASSMENT**

Residents are subject to the provisions and protection of the institutional policies and procedures related to this issue.

S. **PHYSICIAN IMPAIRMENT**

Physician impairment falls under the CMEF policy entitled "Evaluation and Treatment of Impaired Physicians".

T. ACCOMMODATION FOR DISABILITIES

It is the policy of CMEF to abide by all EEOC laws, including nondiscrimination for disabilities. CMEF is able to accommodate residents with documented disabilities to the extent that these accommodations do not interfere with the education of other learners and to the extent that all requirements for graduation are met. Further, these accommodations are limited to adjusting testing arrangements and to altering rotation assignments for residents. Requests for additional accommodations will be considered by the GMEC on a case-by-case basis.

U. **RESIDENCY CLOSURE/RESIDENT COMPLEMENT REDUCTION**

In the event that CMEF reaches a decision to reduce the size of the residency or to close a GME program, all residents in training, or applying for such program, will be informed as soon as possible. In the event of such a reduction or closure, all residents already in the program will be allowed to complete their GME educational program at CMEF or, where this is impossible, will be assisted in enrolling in an ACGME accredited program in which they can continue their GME educational program.

V. **VENDOR INTERACTIONS**

The CMEF Vendor Policy is available in the Residency Program office and is for use by all employees of CMEF or LSCHC who interact with vendors.

W. **AMERICAN BOARD OF MEDICAL SPECIALTIES SPECIALTY CERTIFYING BOARD**

Information relative to requirements for Board Certification in Family Medicine by the American Board of Family Medicine may be found at www.theabfm.org. Note all residents must take the ABFM Certifying Board Exam in their final year of training. The residency will pay for residents to take initial certification examinations; payment will be the fee charged for the earliest application submission date.

X. **ACCREDITATION COUNCIL OF GRADUATE MEDICAL EDUCATION (ACGME)**

In order to ensure program compliance with ACGME requirements, the residency is required to enter CMEF institutional, program and resident data in the ACGME's Accreditation Data System (ADS). ACGME may be requested to share certain data collected from the residency with relevant certifying boards, research entities or to a new program (e.g., fellowship or transfer) upon matriculation into such program. Resident data (which may include social security numbers) and Milestone data may be shared with certifying boards. Residents should contact the program director regarding any questions or concerns.

Y. **NOTIFICATION OF CHANGES IN THIS DOCUMENT**

In the event of change in this document entitled "CMEF--General Information for Residents," efforts will be made to notify members of the CMEF Residency Program, in writing, at least six weeks prior to such a change becoming effective. The Director, however, will maintain the necessary authority to make allowances for emergency situations if justification is properly documented. All changes will then be recorded in an Appendix to be distributed to all residents and faculty.

Changes to be suggested by resident physicians should be presented to the program director through the Chief Resident. These may be discussed as needed in the subsequent Resident/Faculty meetings, Faculty meetings and/or GMEC meetings.

SECTION II - SALARY AND FRINGE BENEFITS; VACATION AND LEAVE

A. **SALARIES AND PAYROLL POLICIES**

Each CMEF resident signs a contract with LSCHC which allows the resident's salary to be paid by LSCHC every two weeks for a total of 26 checks per year. The current salary schedule for various house staff appointment levels is listed in APPENDIX 2. Residents should check with LSCHC Administration regarding distribution of paychecks. Paychecks are automatically deposited directly to the resident's bank.

B. **FRINGE BENEFITS - GENERAL**

Excellent insurance programs are available to the CMEF resident as a LSCHC employee including health, dental, accidental death and dismemberment, and life insurance. A Long Term Disability Insurance Program covers all residents. It is designed to provide comprehensive coverage that is uniquely tailored to resident physicians needs. Specifics of each of the insurance programs are available to residents.

C. **HEALTH AND DENTAL INSURANCE**

The LSCHC provides residents and their legal dependents with several health, dental and vision insurance options. Insurance premiums are subsidized by Lone Star Family Health Center and vary by the plan selected.

There is an annual open enrollment period in December for employees to make changes. If you have a qualified family status change, such as a marriage, divorce, or a newborn, you can make changes within 30 days of the change.

D. **WORKER'S COMPENSATION**

Worker's compensation insurance is provided. Any on-the-job injury must be reported immediately to the resident's supervisor. If the on-the-job injury is such that you need to report to the Hospital Emergency Room, advise the Hospital that your injury was received on the job. Reimbursement for on-the-job injury cannot be considered unless an appropriate report has been filed. This must be done within 24 hours of the incident.

E. COUNSELING, PSYCHOLOGICAL, AND OTHER SUPPORT SERVICES

Residents as both employees and students in a particularly stressful assignment are eligible for the counseling and support services provided by CMEF and LSCHC with Program Director approval. Faculty advisor, other faculty members, and the program director are available as a resource for residents during training here. Human Resources has information regarding LSFHC's employee assistance program. The Program will also arrange Balint meetings, wellness programs and retreats for residents and faculty to interact.

F. RETIREMENT BENEFITS

Each resident, as an employee of LSCHC is provided with a retirement plan

G. PROFESSIONAL LIABILITY INSURANCE

Professional liability coverage for CMEF residents for LSCHC sponsored patient care (inpatient and/or outpatient) activities is provided through the Federal Tort Claims Act (FTCA) coverage afforded deemed Community Health Centers. Coverage begins on the effective date of the contract and covers all claims for activities, which occur during the contract, and covers all claims for activities that occur during the contract period even though not asserted until after the termination of the contract. No coverage is provided, however, for "moonlighting" outside of LSCHC or for activities occurring after the termination of the contract period. Any resident who even suspects the possibility of an incident which might provoke a malpractice suit is required to simultaneously: 1) call the Program Director or his/her designee, and; 2) notify the LSCHC Compliance Manager.

H. VACATION LEAVE

Paid vacation leave of 15 working days per year is provided for all residents.

No vacation or CME leave may be taken when a resident is on a primary service (Pediatrics, Medicine, Obstetrics), on Gynecology, Night Float, Practice Management, Family Medicine Practice, or any two-week rotation. Vacations and CME during the last two weeks of June or the first two weeks of July are discouraged and will be at the discretion of the program director. No vacation may be taken by substituting CME leave.

Requests for vacation must be in writing and submitted to the Medical Education Director not less than 60 days prior to and not greater than 90 days prior to the anticipated absence. Approval by the Program Director or his/her designee is needed. Residents must arrange for their patient care responsibilities to be covered during an absence. The resident agreeing to provide this coverage must indicate this by signing the vacationing resident's leave request form. Vacation requests are generally granted on a first come first serve basis. Vacations do not carry over to the next year.

No more than 10 consecutive working days may be taken without special permission. Vacation days must be coordinated so that night call arrangements are covered for all three resident levels.

Vacation pay-out will be in compliance with LSCHC policy.

I. SICK LEAVE

The resident shall, without deduction in salary, be entitled to sick leave subject to the following conditions:

The resident shall earn sick leave entitlement beginning on the first day of employment and terminating on the last day of duty (last day of duty defined as termination of contract or completion of residency program.) Sick leave entitlement shall be earned by a full-time resident at the rate of six days per year, and shall accumulate with the unused amount of such leave carried forward each month. Sick leave accrual shall terminate on the last day of each academic year.

Sick leave with pay may be taken when sickness, injury, or pregnancy and confinement prevent the resident's performance of duty or when a member of his/her immediate family is ill and requires the resident's attention. A resident who must be absent from duty because of illness shall notify the Program Director or the Program Director's designee to request permission; the Medical Education Director must be notified, also.

In accordance with ABFM attendance requirements, only six days of sick leave may be taken each year without extending the resident's date of graduation from the program. Residents leaving the program will not be compensated for accumulated sick leave. Residents on a primary service must notify their attending; also the Medical Education Director must be notified so that appropriate clinic personnel will be informed. Residents scheduled in clinic must notify the medical education director, their nurses, and their buddy when they call in sick.

In the event an illness exceeds allotted sick and vacation time, a leave of absence may be granted. This, however, may extend the resident's date of completion of residency training. If total time away exceeds that allowed by the ABFM, the resident's completion date must be extended.

J. MATERNITY LEAVE

There is no separate policy or benefit for maternity leave. Please see "Family and Medical Leave Act".

K. FAMILY AND MEDICAL LEAVE ACT

Eligible LSCHC employees may take up to 12 weeks paid or unpaid leave under certain qualifying conditions based on the terms of the Family and Medical Leave Act of 1993 (FMLA).

Eligible employees are entitled to a total of 12 weeks of leave time during any 12-month period for any one or more of the following qualifying reasons: birth or adoption of a child; placement of a foster child; or a serious health condition of an employee or an employee's dependent, defined as a child, parent or spouse (excluding parent-in-law).

Employees must exhaust all sick and vacation accruals before going out on "leave without pay".

During pregnancy, a female resident may be able to continue to work as long as she is able to carry a regular schedule and fulfill the duties and responsibilities of the position in the judgment of her Program Director. The Program Director may not require that a pregnant resident take the full six weeks of postpartum leave as long as a doctor's release is provided. Additional time may be authorized by the Program Director if needed. The amount of time to be made up will be determined by the Program Director, subject to residency program and specialty board requirements.

NOTE: Residents should be aware that graduation from residency and Board certification depends on the completion of certain time in training requirements. Extended absences from the program may require additional time and training. For more information, employees should contact and discuss their FMLA options with their supervisor.

L. EDUCATIONAL LEAVES

Second and third year residents are allowed 5 working days for Continuing Medical Education, including travel. CME leave time does not carry over to the next year. Unused CME time is not paid upon termination. CME time may not be taken when a resident is on a primary service (Pediatrics, Medicine, Obstetrics), Gynecology, Night Float, Family Medicine Practice, or any two-week rotation. CME leave is discouraged during the last two weeks of June or the first two weeks of July; approval will be at the program director's discretion. No more than 10 consecutive working days may be taken without special permission. Travel time must not extend beyond the dates of the meeting plus the time necessary to travel (based on direct air route), usually one day to go and one day to return. Additional days will be considered as vacation time.

CME requests must be submitted to the Medical Education Director eight (8) weeks in advance and approved by the Program Director. The conference content must be presented for review and approval. Residents who will be away must arrange for coverage of their patient care responsibilities. The resident agreeing to provide coverage must indicate this. Residents must furnish proof of their participation in any CME activity for which they were granted CME leave.

M. UNIFORMS AND LAUNDRY SERVICE

All residents are initially furnished lab coats and one shirt with the CMEF and/or LSCHC logo(s). Additional uniforms are provided each year. Laundry services for lab coats are provided.

N. MEALS ON-CALL

Meals are provided at Conroe Regional Medical Center.

O. PAGERS

Residents are paged via a cell phone application installed on the resident's personal cell phone. Should a resident decline to install the application, the resident will be provided with a pager. Residents are responsible for replacement in the case of misuse or loss. If the pocket pager is lost or broken, the resident will be charged for a new one. If a resident's pager is broken or forgotten, the Medical Education Director should be notified so that a spare pager may be activated.

Pages must be answered promptly as patient care may otherwise be impaired. Access to pagers and/or pagers must be left on unless the resident is on vacation with previously designated coverage.

P. **CALL ROOM**

Sleep rooms for residents are provided 500 Medical Center Blvd.; the door to each room has a lock. The exterior door has a combination lock.

Q. **TRANSITION ALLOWANCE**

Residents initially joining a Conroe Medical Education Foundation training program are provided a $2,500.00 transition allowance payable within 30 days of signing the Resident Work Agreement. Should the resident leave the program during the academic year, the resident agrees to repay CMEF a pro rata amount of the transition allowance based on the remaining term of the resident's contract.

R. **DISCRETIONARY FUND**

All residents are provided $1,000.00 for reimbursable educational expenses each academic year. Approval for use of these funds must be obtained prior to an expenditure for which a resident intends to be reimbursed. The "Physician Education Expense Reimbursement Request Form" should be used for this purpose and approval must be obtained from the Program Director. Unexpended discretionary/educational funds do not carry over to the following academic year and are not payable to the resident upon termination.

S. **PARKING**

Free parking is available to the residents at Conroe Regional Medical Center and at the LSCHC.

T. **HOUSING**

Based on a decision that providing the maximum salary possible by the institution was the preferred approach to such a diverse group of employee/trainees, housing is not provided as an institutional benefit.

U. **TRANSFER POLICY**

Residents who desire to transfer from CMEF to another GME program should notify the Program Director in writing of their decision to pursue a transfer immediately upon their decision. Residents will be allowed to use vacation time to interview for another GME position, in accord with the requirements for taking vacation leave. The Program Director, faculty and staff will to the extent possible assist the resident in transferring to another program by providing letters of reference on the resident's behalf; however, this assistance will not be allowed to interfere with the education of other learners and must be requested by the transferring resident in a timely manner with adequate lead time.

It is the responsibility of the resident to obtain information about the impact that transferring could have on their obtaining a medical license, qualifying for ABFM Specialty Board certification, required time in residency training, and benefits.

Residents desiring to rescind their request for a transfer should make this known to the Program Director in writing. Acceptance of this request will be at the discretion of the Program Director with appeal to the GMEC following the procedure outlined in Section III.I. of this document.

SECTION III - DUE PROCESS; GRIEVANCE

A. GENERAL PRINCIPLES

Although CMEF's residents are LSCHC employees and do render professional medical services to CMEF and LSCHC patients, CMEF's residency training program is primarily educational. The entire accreditation process under the auspices of the ACGME acknowledges this academic focus, and the standards for accreditation require that: academic goals be set by the residency training program; academic resources including appropriate faculty, facilities, equipment and clinical material be provided; and regular evaluation of the trainees related to academic achievement occur and be documented. Appropriate policies and procedures for due process also are required for ACGME accreditation, but such policies and procedures are in the context of a primarily academic educational process. In fact, the ACGME accreditation standards explicitly protect the residents against excess service employment obligations that interfere with their training programs.

Since the CMEF residency training program is primarily an educational program, the institution vests responsibility and authority for conducting the program and determining the success of academic achievement of the individual trainee in the program faculty and the program director, with the program director ultimately responsible for process management.

The program director and faculty responsible for the training of residents have an obligation to: provide appropriately organized educational opportunities to the trainees; convey clearly the educational objectives of the program and the performance required by the trainees for academic success (including those patterns of individual personal behavior that reasonably should positively impact patients, institutional employees and/or other trainees); and develop a regular evaluation process that alerts trainees to academic and performance deficiencies and provides direction in their correction. These requirements are integral elements of the ACGME accreditation standards.

The program director and faculty responsible for training residents additionally are obligated to apply these academic standards to each individual trainee in the program to protect both the individual patients who are the source of the trainees' opportunities to learn in a practical way and the public at large who rely on the process to protect them against unqualified practitioners claiming expertise of a specific type. This obligation includes removal from the program of (or a decision not to reappoint) those trainees who are academically unsuccessful or whose behavior creates a risk for patients, disrupts the multidisciplinary health care team, or interferes with the educational program of other trainees. This obligation also includes imposing probationary status on those training residents whose academic performance or behavior indicate that closer supervision or other restrictions may be required for a period of time.

Finally, the program director and faculty must attest to the satisfactory completion of the academic training program for each trainee seeking certification from the American Board of Family Medicine to acknowledge the trainee's qualifications as a Family Physician.

Residents have the responsibility: to satisfactorily perform the customary services of the Program, to the best of the resident’s ability; to develop a personal program of self-study and professional growth with guidance from the teaching staff; to participate in safe, effective and compassionate patient care under supervision, commensurate with the resident’s level of advancement and responsibility; and to comply with the responsibilities outlined in Section I.C. of this document.

In conclusion, residency training is primarily an academic and educational process and the development of institutional policies and procedures for due process and oversight of those policies must be based on this guiding principle.

B. APPOINTMENT OF RESIDENTS

Initial appointments of residents are in general through the applicable matching program. Appointments at CMEF are formalized through a CMEF Resident Work Agreement and generally are for one (1) year. Reappointment annually until the conclusion of the particular trainee's program will be based on the applicable resident's acceptable academic and professional performance.

C. TRAINING PROGRAM OVERSIGHT

A process of regular institutional oversight and periodic internal review of the residency training program is in place through the Graduate Medical Education Committee as required by the ACGME's Institutional Requirements. It is through this process that the institution monitors training program compliance with the accreditation standards including those related to the development of educational objectives, appropriate academic structure and function, and regular evaluation of trainees.

D. RESIDENT EVALUATION

CMEF GME training programs will provide each resident with access to an electronic evaluation completed by supervising faculty and/or residents at the end of each rotation. A minimum of two written composite evaluations by program faculty will be provided to each resident each year. Residents should document by signature on the composite faculty evaluation that their evaluations have been reviewed with them. These written evaluations are intended to document the strengths and weaknesses of the resident's knowledge and/or performance, including the core competencies required by ACGME and including procedures. The training program is expected to notify the resident at the earliest time possible of significant deficiencies in knowledge or performance, document plans for correction or improvement, and monitor success or lack thereof in doing so. Evaluations completed on each resident are to be retained in the Program Director's files permanently. At the end of each rotation, residents are required to evaluate their faculty and upper level residents, as well as the rotation.

The Clinical Competency Committee will review all resident evaluations semi-annually; prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, advise the program director regarding resident progress, including promotion, remediation, and dismissal.

E. UNSATISFACTORY PERFORMANCE

Reasons for disciplinary action include but are not necessarily limited to:

1. Unprofessional conduct or conduct deemed harmful to a patient or the program;
2. Lying or falsifying medical records;
3. Insubordination;
4. Substance abuse;

5. Failure to comply with the rules and regulations of the program.

    a. If according to the guidelines established by the training program, a resident's academic performance (including patterns of personal behavior that may or do negatively impact patients, institutional or affiliates' employees and/or other trainees) and overall progress in the training program is deemed unsatisfactory, a consultation shall be held between the resident and the applicable Program Director or his/her designee to discuss all aspects of the problem and to develop appropriate remedial actions on the part of the resident. This consultation shall not of itself constitute a Corrective Action and shall not preclude the Program Director from also recommending simultaneously a formal Corrective Action. The consultation shall be documented in the resident's file and the expected efforts at correction and time lines for carrying them out sufficiently detailed as to allow periodic assessment of the resident's success or lack thereof.

    b. A consultation is not a prerequisite for Corrective Action when, in the opinion of the Program Director or his/her designee, a determination is made that a resident's discharge of clinical responsibilities would expose patients to unnecessary medical risks and the CMEF, LSCHC or an affiliated primary teaching hospital to unnecessary liability. In this case, a resident may be temporarily relieved of his/her clinical responsibilities, with pay, reassigned to other duties with pay or suspended with pay pending the outcome of an investigation by the Program Director. A resident who has been so relieved/reassigned with pay or suspended with pay pending the outcome of an investigation, shall receive, within a reasonable length of time, not to exceed ten (10) working days, a written statement from the Program Director or designee containing a description of the deficiencies in the performance of the resident. Expected corrections and time lines for achieving them also should be sufficiently detailed in this statement and the resident's file as to allow periodic assessment of the resident's success or lack thereof. Action taken pursuant to this paragraph shall be deemed a Corrective Action, subject to the ten-day notice specified above and the other requirements set forth in Section III. G., and shall not preclude further action being taken.

F. PROBATION

For the purposes of this document, "probation" means a set period of time during which the resident is under special supervision and expected to remedy the behavior for which the probation was instituted. It can also include a period of time during which certain privileges will be denied such as operating privileges. This is coordinated with the director and often with the help of the faculty advisor.

1. The Program Director must be notified in advance and approve the placement of a resident on probation.

2. The decision to place a resident on probation for educational reasons such as inadequate reading or lack of adequate knowledge base generally evolves over time and is supported by evaluations of the resident which reflect inadequate performance. Interactions between the Program Director and the resident concerning inadequate performance should be documented and reflect that lack of improvement led to the decision for probation.

3. The decision to place a resident on probation may occur abruptly because of problems in the delivery of clinical care. These problems may be of such acuity as to require modification of

clinical assignment along with probation. In such cases, it is possible that previous documentation of inadequate performance may not exist.

4. After appropriate discussion and advice, the recommendation to place a resident on probation may be made by the Program Director. The Program Director shall advise each resident placed on probation of the conditions and period of time of the probation, including a description of the additional supervision and additional restrictions placed on such probationary resident.

5. The nature of the deficiencies of the resident should be listed and it should be stated whether these deficiencies might impact clinical performance. The terms of the probation must be delineated in writing by the Program Director based on identified problems. If a limitation of clinical duties is deemed necessary or if there is any obligation of the resident to obtain extra supervision during clinical duties, these terms must be delineated.

6. The Program Director must notify the Board of Directors of CMEF, the Graduate Medical Education Committee ("GMEC"), , the Designated Institutional Official, and the Director of Medical Education of the probationary status of a resident.

7. The Program Director must notify all faculty who will be working in a clinical setting with the resident of the probation status of a resident. The decision to inform other personnel who have a need to know, will be at the discretion of the Program Director.

8. The resident may challenge the decision for probation using the standard policies for grievance for residents. If a resident appeals probation, probation will be delayed until the final appeal decision is reached. Any modification in clinical assignment or privileges that was instituted in the probation will remain in effect until final disposition of the appeal. If the probation is upheld after appeal, the Texas Medical Board will be notified of the probationary status, in accord with the rules of the Texas Medical Board.

9. At the end of the probationary period, documentation should be made of satisfactory or unsatisfactory remediation by the resident. The Board of Directors of CMEF, the Graduate Medical Education Committee ("GMEC"), the Designated Institutional Official, the Director of Medical Education, and all faculty working with the resident should be informed of his/her return to regular working status.

G. CORRECTIVE ACTIONS IN GENERAL

1. If the time periods specified in a consultation or a Corrective Action have lapsed without correction of the resident's performance deficiencies, he or she will be subject to initial or further Corrective Action, as the case may be, including without limitation reprimand, probation, suspension or termination for unsatisfactory knowledge and/or performance by recommendation of the Program Director. Any recommendation for Corrective Action shall be in writing, delivered to the resident by registered mail, (return receipt requested); shall describe the deficiencies in performance; the reasons why the specific Corrective Action is being taken; and (unless the Corrective Action is termination), expected corrections and time lines for achieving them.

2. Corrective Actions, except termination, will be final on receipt of the Program Director's written notice unless the resident successfully grieves the action, any time away from the training program will have to be made up by the resident in order to graduate. The

Corrective Action of termination will be final on receipt of the Program Director's written notice unless the resident successfully appeals the action pursuant to Section III.H.

H. **APPEAL RIGHTS AND PROCEDURES FOR TERMINATION**

The resident subject to the Corrective Action of termination shall have the option to appeal the action in writing. The resident must first appeal to the Program Director within ten (10) working days after being notified of the Corrective Action of Termination. Failure to appeal within such time shall constitute waiver of the option of appeal. Upon timely receipt of the resident's written appeal of termination, the resident may meet personally with the Program Director to discuss the reasons for the recommended termination and to present the resident's response. After this meeting the Program Director shall notify the resident in writing by registered mail, return receipt requested, whether he/she shall either uphold or rescind the termination. Should the termination be upheld, the resident shall have the option to appeal to the GMEC within ten (10) working days of receiving notice that the termination has been upheld. Such appeal must be made by the resident's notifying the GMEC of the resident's election to appeal. Failure to appeal within the prescribed ten working days shall constitute waiver of the option of appeal. Upon timely receipt of the resident's written appeal of termination, the resident may elect to meet personally with the GMEC to discuss the reasons for the recommended termination and to present the resident's response. Regardless whether the resident elects to meet with the GMEC, the GMEC shall, within ten (10) working days of receiving the appeal, conduct a thorough review of the process that led to the recommended termination, including the documentation in the resident's file. After such review, the GMEC shall notify the resident in writing by registered mail, return receipt requested, whether he/she shall either uphold or rescind the termination with a copy to the Program Director. No compensation, whether salary or other benefit, may be withheld from a resident appealing his/her termination until a written decision at the final level appealed to is rendered upholding the termination. A final decision to uphold a resident's termination shall also terminate any reappointment of the resident to any subsequent year of training with Conroe Medical Education Foundation. No specialty or sub-specialty certifying board or national state or local medical organization shall be notified of a Corrective Action until a final determination has been made.

I. **GRIEVANCE PROCEDURE FOR CORRECTIVE ACTIONS OTHER THAN-TERMINATION**

If a resident has a grievance related to his/her training program or has been subject to any Corrective Action other than termination, the resident may first attempt to resolve the matter informally by consulting with the Chief Resident and/or Program Director. If a resident in is unable to resolve the matter informally the resident should next consult with the Program Director. If the resident still is unable to resolve the matter or wishes to grieve a Corrective Action other than termination, he/she must present his/her grievance in writing to the GMEC within 20 (twenty) working days from the date the resident first received notice of the Corrective Action other than termination. The GMEC shall notify the resident in writing of its decision regarding the matter, or to uphold or rescind the Corrective Action other than termination, within 20 (twenty) working days of receiving the written grievance, unless extended by the GMEC's and resident's mutual agreement. The decision of the GMEC is final.

J. **REAPPOINTMENT**

1. A decision not to reappoint a resident does not constitute Corrective Action. If a resident is not to be reappointed to the next year of training, he/she should receive written notice (by registered mail, return receipt requested, or hand delivered with written acknowledgment of receipt) from the Program Director by March 1st of the current contract year, or four (4)

months prior to the last date of the current contract if the resident was appointed other than in the late June or early July time frame. However, if the primary reason(s) for the nonrenewal or non-promotion occurs within the four months prior to the end of the contract, institutions must ensure that programs provide their residents with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the contract. The GMEC is to be copied on the notifications of intent not to reappoint. If grieved in writing by the resident, the GMEC will review a decision not to reappoint a resident. Such grievance will be subject to the grievance procedures stated in above.

2. Residents who plan not to continue in the succeeding year of their training program should notify the Program Director in writing by March 1st of the current year, or four (4) months prior to the last date of the current contract.

3. The Board of Directors of CMEF, the GMEC, the Program Director, the Designated Institutional Official, and the Director of Medical Education are to be copied on the notifications of intent not to reappoint or intent not to accept reappointment referenced above.

4. If grieved in writing by the resident, such grievance will be subject to the grievance procedures stated in Section III.I.

K. **NOTICES**

All Notices under Part III of this document shall be as follows:

1. To the Resident: by U.S. Mail, Registered, properly addressed to the Resident's residence address as shown on the records of the CMEF. Trainees are responsible for keeping the records of CMEF current as to their residence mailing address. Residents may elect to receive additional notices under this document at any other address, including email or facsimile address.

2. To CMEF at:
   Program Director
   Conroe Medical Education Foundation
   605 South Conroe Medical Drive
   Conroe, Texas 77304
   Telephone: 936-523-5247
   Fax: 936-539-3635

2. Notices properly addressed, postage prepaid and properly dispatched shall be effective when sent.

POSITION DESCRIPTION OF RESIDENT

1. The resident meets the qualifications for resident eligibility outlined by the Accreditation Council of Graduate Medical Education.

2. As the position of the resident involves a combination of supervised, progressively more complex and independent patient evaluation and management functions and formal educational activities, the competence of the resident is evaluated on a regular basis. The program maintains a confidential record of the evaluations.

3. The position of the resident entails provision of care commensurate with the resident's level of advancement and competence, under the general supervision of appropriately privileged attending teaching staff. This includes:

    - participation in safe, effective and compassionate patient care;

    - developing an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical education and of how to apply quality improvement and cost containment measures in the provision of patient care;

    - participation in the educational activities of the training program and, as appropriate, assumption of responsibility for teaching and supervising other residents and students, and participation in institutional orientation and education programs and other activities involving the clinical staff;

    - participation in institutional committees and councils to which the resident is appointed or invited; and

    - performance of these duties in accordance with the professionalism and established practices, procedures and policies of the institution, and those of its programs, clinical departments and other institutions to which the resident is assigned; including among others, state licensure requirements for physicians in training, where these exist.

ACGME CORE COMPETENCIES

All CMEF programs integrate the following competencies into the curriculum. More detailed information regarding these competencies may be found at: www.acgme.org.

1. Institutions must ensure that each program has defined, in accordance with the Program Requirements, the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the following:
    a. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles;
    b. Patient care and procedural skills which are compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;
    c. Medical knowledge must be demonstrated with regard to established and evolving biomedical, clinical, epidemiological and social-behavioral sciences and the application of this knowledge to patient care;
    d. Practice-based learning and improvement including the investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and continuously improve their patient care based on constant self-evaluation and life-long learning;
    e. Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals; and
    f. Systems-based practice which demonstrates 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 to provide optimal health care.
2. In addition, institutions must ensure that residents achieve the following:
    a. Develop a personal program of learning to foster continued professional growth with guidance from teaching staff;
    b. Participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervising other residents and students;
    c. Participate in appropriate institutional committees and councils whose actions affect their education and /or patient care;
    d. Submit to the program director or to a designated institutional official at least annually confidential written evaluations of the faculty and of the educational experiences.
3. The sponsoring institution must ensure that residents submit to the program director at least annually confidential written evaluations of the faculty and of the educational experiences.

ACGME: The Learning and Working Environment

The information below is excerpted from the ACGME's Common Program Requirements. Residents must become familiar with the guidelines in full; these can be found at www.acgme.org.

> Residency education must occur in the context of a learning and working environment that emphasizes the following principles:
>
> - Excellence in the safety and quality of care rendered to patients by residents today
> - Excellence in the safety and quality of care rendered to patients by today's residents in their future practice
> - Excellence in professionalism through faculty modeling of:
>   - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
>   - the joy of curiosity, problem-solving, intellectual rigor, and discovery
> - Commitment to the well-being of the students, residents, faculty members, and all members of the health care team

Residents and faculty members must demonstrate an understanding of their personal role in the: provision of patient- and family-centered care; safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; management of their time before, during, and after clinical assignments; and, recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

Patient Safety, Quality Improvement, Supervision, and Accountability

Patient Safety and Quality Improvement

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.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will

apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

Patient Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement. Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals. Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

Supervision and Accountability

Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care. Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth. Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

Levels of Supervision

- Direct Supervision – the supervising physician is physically present with the resident and patient.
- Indirect Supervision:
  - with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
  - with Direct Supervision available – the supervising physician is not 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.

Progressive Authority

- The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
- The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.
  - Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.
  - Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
- Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).
  - Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.
  - Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available.
- Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.

Residents and faculty members must demonstrate an understanding of their personal role in the: provision of patient- and family-centered care; safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; management of their time before, during, and after clinical assignments; and, recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

Clinical Responsibilities, Teamwork, and Transitions of Care

Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services.

Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system.

Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training. Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers. Faculty and residents are encouraged to alert the program director or other designated personnel when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation or potential for violence.

Clinical Experience and Education

Maximum Hours of Clinical and Educational Work per Week

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 all moonlighting. (Core)

Mandatory Time Free of Clinical Work and Education

Residents should have eight hours off between scheduled clinical work and education periods. 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 the 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). At-home call cannot be assigned on these free days.

Maximum Clinical Work and Education Period Length

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

Clinical and Educational Work Hour Exceptions

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 provide care to a single severely ill or unstable patient; humanistic attention to the needs of a patient or family; or, to attend unique educational events. These additional hours of care or education will be counted toward the 80-hour weekly limit.

Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

At-Home Call

Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

APPENDIX 2

CMEF HOUSE STAFF BASE SALARIES

Effective 7/1/2021 – 6/30/2022

PGY-1	$53,000.00
PGY-2	$54,000.00
PGY-3	$55,000.00