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**THE
UNIVERSITY OF
ILLINOIS
COLLEGE
OF MEDICINE**
ROCKFORD CHICAGO PEORIA URBANA



RESIDENT SUPERVISION PROGRAM LETTER OF AGREEMENT

PURPOSE

The purpose of this policy is to outline the minimal supervision requirements for all University of Illinois College of Medicine Rockford residency/fellowship programs. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth. One of the core principles of graduate medical education is the concept of graded and progressive responsibility. As residents gain experience and demonstrate growth in their ability to care for patients; they assume roles that permit them to exercise those skills with greater independence.

POLICY

It is the responsibility of each program director to establish detailed written descriptive policies delineating supervision requirements for each level of training in the program. These requirements must be distributed annually and/or made readily available in a web-based format to all residents and faculty for each program. The requirements for on-site supervision will be established by the program director in accordance with ACGME institutional, common, and program-specific requirements. Supervision of residents must be graded to provide increasing responsibility and maturation into the role of the independent-functioning licensed provider, with sound judgment and good technical skills.

PROGRAM LETTERS OF AGREEMENT

In order to ensure residents receive appropriate educational experience under the appropriate level of supervision, programs should annually review resident clinical assignment and update the Program Letter of Agreement (PLA) for each participating site providing a required program assignment. The program director must monitor resident supervision at all participating sites and should review faculty supervision assignments to determine if they are of sufficient duration to assess the knowledge and skills of each resident and delegate to each resident the appropriate level of patient care authority and responsibility. An updated PLA must be signed annually by the program director and site director and must include the following information:

- identify faculty name/or general faculty group who teaches/supervises residents;
- specify their responsibilities for teaching, supervision, and formal evaluation of residents;
- specify the duration and content of the educational experience; and
- state that residents must abide by the policies of the site, the program, and the GMEC.

A copy of the signed PLA will be sent to and maintained in the GME office.

SUPERVISION OF RESIDENTS

In the clinical learning environment, each patient must have an identifiable, appropriately credentialed and privileged attending physician (or licensed independent practitioner as approved by each ACGME Residency Review Committee) who is ultimately responsible for that patient's care.

- This information should be available to residents, faculty members, and patients.
- Residents and faculty members should inform patients of their respective roles in each patient's care.

Programs must demonstrate that the appropriate level of supervision, as defined by ACGME, is in place for all residents who care for patients. Supervision may be exercised through a variety of methods.

- Some activities require the physical presence of the supervising faculty member.
- 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 or resident physician, either in the institution, or by means of telephonic and/or electronic modalities.
- In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

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. When available, evaluation should be guided by specific national standards-based criteria.

Based on the needs of the patient and the skills of the residents, faculty members functioning as supervising physicians should delegate portions of care to residents.

Senior residents or fellows should serve in a supervisory role of 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. A more senior resident may be designated by the program director as a supervising physician when he/she has demonstrated the medical knowledge, procedural competency skill set, and supervisory capability to teach and oversee the work of junior residents.

Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available as described in the following four levels of supervision.

[Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]

LEVELS OF SUPERVISION

Programs must use the following classification of supervision to ensure oversight of resident supervision and graded authority and responsibility:

- 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*.
- Indirect 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.

The program director, in conjunction with the program's Clinical Competency Committee and faculty, must provide written descriptions of the roles, responsibilities, and patient care activities of the residents by level. These must be available to the supervising faculty, residents, and health care staff in the clinical work environment.

PROGRAM –LEVEL SUPERVISION POLICIES AND PROCEDURES

Each ACGME-accredited training program is required to establish a written program-specific supervision policy consistent with GME institutional policies and individual Residency Review Committee (RRC) requirements. Programs must use the ACGME classification of supervision and must demonstrate the appropriate levels of supervision are in place. Program-specific policies and procedures should include the following:

- Definition of who is qualified to supervise residents (in addition to faculty attending's) including more advanced residents/fellows or licensed independent practitioners as specified by each RRC
- Criteria in compliance with individual RRC requirements that define when a resident is approved to safely and effectively perform certain procedures or clinical activities without direct supervision. The Program Director will define the mechanism by which residents can be deemed competent to perform a procedure(s) under indirect supervision or oversight. Lists of approved clinical activities should be maintained for each resident so that they can be made available for review by all patient care personnel.
- Requirement that PGY-1 residents (if applicable to program training levels) should be supervised either directly or indirectly with direct supervision immediately available and, if defined by a program's RRC, a listing of achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.
- Guidelines for circumstances and events when residents must contact appropriate supervising faculty, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. These guidelines should be specific to patient situations, resident level, who is to be contacted (by position) and what to do if the contact does not respond.
- A description of clinical responsibilities for each resident based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. (RRC may specify optimal clinical workloads.)

- Educating residents and faculty on supervision policies and procedures including the ACGME requirement that residents and faculty members should inform patients of their respective roles in each patient's care.
- Faculty supervision assignments should be of sufficient duration to allow for the assessment of the skills, knowledge, and professional attitude development of each resident in order to facilitate the assignment to the appropriate level of care responsibility and authority.

Programs should annually review faculty supervision assignments and the adequacy of supervision levels. A copy of each program's current supervision policy should be submitted to GME along with a sample procedure/clinical activity competency list. Compliance with these requirements will be monitored by the GMEC through periodic audits, review of annual program evaluation meeting minutes, and the internal review process.

PATIENT CARE SETTING RESIDENT SUPERVISION STANDARD

The following are minimum standards for resident supervision and documentation in patient care settings. They are designed to promote patient safety, provide educational excellence, but maintain autonomy based on demonstrated educational competence. These requirements are effective in all training sites without regard to patient insurance status or time of day. Residents and faculty members in training programs under the auspices of ACGME will abide by the supervision and documentation schema as noted below. Individual programs and hospitals may have more stringent supervision and documentation requirements.

All residents' patient care activities are ultimately supervised by a credentialed and privileged attending physician (or an approved licensed independent practitioner). **Programs must define the resident procedures or clinical tasks that are permitted by year of training with and without direct supervision.** **Programs must maintain records of each resident's attainment of procedural/clinical task competence.**

<u>Supervision Setting/Clinical Activity</u>	<u>Required Supervision Level/Description</u>
A. Operating/Delivery Room	<ul style="list-style-type: none"> • Direct Supervision by Attending Physician Departmental attending must be physically present and immediately available to the resident and patient, for the major components of the procedure. The departmental attending must be notified prior to the scheduling of the procedure and must be aware of the documented competency level of the resident.
B. Non-Routine, Non-Bedside, Non-OR Procedures (e.g., Cardiac Cath, Endoscopy, Interventional Radiology, etc.)	<ul style="list-style-type: none"> • Direct Supervision by Attending Physician Departmental attending must be physically present and immediately available to the resident and patient, for the major components of the procedure. The departmental attending must be notified prior to the scheduling of the procedure and must be aware of the documented competency level of the resident.

<u>Supervision Setting/Clinical Activity</u>	<u>Required Supervision Level/Description</u>
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C. Emergency Department	<ul style="list-style-type: none"> Direct Supervision by Attending Physician Departmental attending must be physically present and immediately available to the resident and patient, for the major components of the procedure. The departmental attending must be notified prior to the scheduling of the procedure and must be aware of the documented competency level of the resident.
D. Emergency Care-Immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician is contacted.	<ul style="list-style-type: none"> The departmental attending must be notified prior to the scheduling of the procedure.

In the following patient care settings, the Program Director may designate a more senior resident/fellow to supervise a junior resident.

E. Inpatient Care/ New Admissions	<ul style="list-style-type: none"> Indirect Supervision with Direct Supervision Available Oversight The departmental attending physician must see and evaluate the patient within one calendar day of admission.
Inpatient Care/ Continuing Care	<ul style="list-style-type: none"> Oversight
Inpatient Care/ Intensive Care	<ul style="list-style-type: none"> Indirect with Direct Supervision <i>immediately available</i>
Inpatient Care/ Hospital Discharge and Transfers	<ul style="list-style-type: none"> Oversight The attending must be involved in decision to discharge or transfer patient
F. Outpatient Care/ New Patient Visit	<ul style="list-style-type: none"> Indirect with Direct Supervision <i>immediately available</i>
Outpatient Care/ Return Patient Visit	<ul style="list-style-type: none"> Oversight
Outpatient Care/ Clinic Discharge	<ul style="list-style-type: none"> Oversight
G. Consultations Inpatient, Outpatient and Emergency Department	<ul style="list-style-type: none"> Oversight Post-hoc review with feedback by supervising faculty/resident physician
H. Routine Bedside and Clinic Procedures	<ul style="list-style-type: none"> Indirect Supervision with Direct Supervision Available

Approved: 4/25/2017

Program Letter of Agreement
Between
and
Effective Date:

**Residency
Program:**

Program Directors:

I. Individuals who assume administrative, educational and supervisory responsibility for the residents while rotating at:

Rotation Site Director:

Rotation Teaching Faculty:

Rotation Name	Faculty
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Responsibilities:

Of The Rotation Site Director:

- Coordinate the resident rotation schedules
- Ensure that evaluations are completed for the resident and returned to the Program
- Ensure that there is an identifiable, appropriately-credentialed and privileged attending physician preceptor supervising the resident physician in the clinical setting

Of The Teaching Faculty:

- All patient care provided by a resident physician while on rotation at _____ must be supervised by the assigned preceptor(s)
- Provide residents with rapid, reliable systems for communication with supervising preceptors(s)
- Oversee the residents' overall clinical experience including performance of any technical procedures
- Ensure that training goals and objectives are completed for each resident
- Evaluate resident performance on the rotation
- Communicate with the residency Program Director regarding specific resident issues or concerns

The _____ Family Medicine Residency Program Director has primary responsibility to see that objectives and goals of the training program are fulfilled for each rotation. It is the responsibility of the _____ Family Medicine Residency program to provide the preceptor(s) with any specific supervision guidelines pertaining to the rotation.

The _____ Family Medicine Residency assumes responsibility for ensuring that Caregiver Background Checks are completed for all residents, and that each resident has received training in blood-borne pathogens and HIPAA privacy requirements.

II. Educational content:

Educational goals and objectives for each _____ Family Medicine Residency program rotation are attached. Additionally, specific rotation requirements are outlined by the _____ and Accreditation Council on Graduate Medical Education (acgme.org) websites.

III. Duration of Assignment:

PG Level	Duration of Assignment

IV. Funding responsibility for rotations at _____

_____ remains responsible for the resident compensation and benefits during these training rotations. Residents on training rotations have medical malpractice and liability insurance coverage through _____.

V. Policies and procedures governing family medicine residents while rotating at _____

Residents are required to follow the policies and procedures of _____ and _____. Violations by residents should be reported to the _____ Program Director and/or Residency Coordinator for follow-up and/or disciplinary action as may be appropriate.

VI. Renewals and Updates.

This Program Letter of Agreement will be revised and renewed at least every five years. Updates of educational goals and objectives, name(s) of teaching faculty, and other changes may be provided as an amendment to this agreement annually, and more frequently as may be appropriate. The _____ Family Medicine Residency will also communicate names of residents on rotations, schedule dates, and other pertinent information as appropriate.

VII. Counterparts

This Agreement may be executed by electronic or facsimile means and in counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

VIII. Signatures in acknowledgement of this Program Letter of Agreement.

_____	Date _____
_____	Date _____
_____	Date _____
_____	_____

IX. Program Contact Information

_____, Fellowship Coordinator

CHIEF RESIDENTS

The Chief Resident is a senior resident appointed by a residency program to supervise junior residents, develop rotation schedules, and perform other administrative duties as assigned. The Chief Resident reports to the Program Director and residents.

The Chief Resident shall function as the main liaison between the residents and program director, faculty, and administrative staff. He/She functions to facilitate communication between residents and faculty, insure a high level of educational opportunity as well as oversee the functioning of the residents within the program. He/She assumes the responsibility of providing educational leadership and being a role model for other residents. Essential to this role is confidentiality, especially when dealing with personnel issues of the residency and hospital. There is a continued obligation upon completion of the residency to hold confidential any information secured during the time served as Chief Resident.

No program is required to appoint a Chief Resident for the purpose of fulfilling this policy.

REQUIREMENTS

The Chief Resident must be a senior resident in good standing. He/She must be respected clinically as an excellent physician. The Chief Resident must demonstrate exceptional leadership, communication, and organized skills. He/She must also be able to interact and support the program administration and have a commitment to work for the good of the entire program. He/She must be willing to invest the time and accept the responsibilities required by the position. He/She must have common sense and patience that is required in negotiating with the various aspects of the program and the medical community. The Chief Resident must have an understanding of conflict management. He/She must have or develop managerial and leadership skills.

APPOINTMENT PROCEDURE

- The selection process will be the responsibility of the director and core program faculty.
- The Program Director reserves the right to remove the Chief Resident from their position in consultation with program faculty in the event that the selected resident loses their eligibility for the position due to personal or professional circumstances which compromise the resident's ability to perform the duties of the position.

REMUNERATION:

- The Office of GME will make all stipend adjustments for Chief Residents.
- Fund and time to attend a Chief Resident training course will be made available at the cost of the residency program.
- An additional stipend of \$2000 annually.
- The stipend will be paid monthly from July 1-June 30.

PROGRAM GOALS AND OBJECTIVES

GME programs at the University of Illinois College of Medicine Rockford (UICOMR) are required to have goals and objectives for each rotation and training level. These goals and objectives, along with teaching and evaluation methods, are essential to a competency-based education. The following ACGME general competencies have been integrated into our curricula:

1. Patient Care

Resident must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

2. Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

3. Practice-Based Learning and Improvement

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

4. Interpersonal and Communication Skills

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

5. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

6. System-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Goals and objectives will be distributed annually to residents, fellows, and faculty and reviewed by the residents/fellows at the beginning of each rotation. Each program will evaluate the curriculum at least annually.

OFF-SITE ROTATION APPROVAL (ELECTIVE APPROVAL)

The purpose of off-site rotations is to provide training experiences outside University of Illinois College of Medicine Rockford affiliated hospital system. These assignments, when performed outside the system and on an irregular basis, will be referred to as "electives".

University of Illinois College of Medicine Rockford residents may with the Program Director's permission participate in training programs outside the Universities affiliated hospital system. The Program Director is ultimately responsible for the ability of his/her program to meet ACGME requirements within UICOMR facilities whenever possible. In order to request an additional training experience outside of UICOMR facilities, completion of the following procedure is required in writing, and information provided should include:

- Request for Approval using the Elective Approval Form
- Requests must be submitted at least twelve (12) weeks in advance of the starting date
- Letter from off-site supervising faculty/institution supporting and verifying the rotation;
Or if required by the rotation site, the host institution's Off-Site Affiliation Agreement
- Goals and objectives for the rotation

Upon receipt of the completed Elective Approval Form and accompanying documentation, GME staff will present the request to the DIO for approval.

GME Committee will consider the request and if approved, GME staff will send the request to the Program Director when the DIO gives final approval. Likewise, the GME Office will send notice of denial to the Program Director if the request is denied.

While it is within the Program Director's discretion to allow electives, the appropriate justification should be to provide training experience not available in the University of Illinois College of Medicine Rockford system.

The resident and Program Director are jointly responsible for determining that the resident has obtained professional liability coverage for the off-site rotation. The program director's office can furnish a letter providing proof of liability insurance coverage for residents planning to take elective rotations that are out of the University of Illinois College of Medicine Rockford affiliated hospitals, clinics, or an affiliated institution.

Residents taking electives at hospitals outside of Illinois should make arrangements for required licensing well in advance of their starting dates.

Program Directors may not certify malpractice coverage for the resident's participation in the elective. This must be done through the University Risk Management Office. The GME Office will handle all requests for malpractice certification.

Latest Revision: 4/3/2017

Approved: 4/25/2017

ELECTIVE APPROVAL FORM

NAME: _____

DATE: _____

1. Elective Approval Forms must be submitted to the Program Director at least 16 weeks prior to the rotation start date.

2. Dates of Elective Rotation: _____

3. Preceptor Name: _____

4. Facility Name: _____

5. Because being away from the clinic takes you away from being able to care for your patients, what experience or knowledge will you obtain through this elective that cannot be obtained locally?
- _____
- _____
- _____
- _____

6. Submit preceptor CV and letter of acceptance

7. Submit time away form for away rotation

	Initial	Date
Elective request form submitted to residency office	_____	_____
Goals and Objectives attached	_____	_____
Letter of acceptance attached (away rotations)	_____	_____
Preceptor CV attached (away rotations)	_____	_____
Program Director Approval	_____	_____

Signature - Designated Institutional Official (DIO) _____ Date _____

**Permission granted only if all affiliation agreements obtained.

RESIDENT TRAVEL PROCEDURES

All resident travel requires prior approval of the Program Director.

The Program Director or Program Coordinator must notify a Travel Authorization for residents by emailing the GME Office. Once the request has been approved, in order to submit travel expenses for reimbursement, the resident must complete the Resident Travel Form.

PROCEDURE

Employees should submit claims for reimbursement of travel expenses no later than thirty (30) days after completion of travel. Timely submission of claims will allow departments to more effectively approve travel.

Travelers should submit travel claims to the appropriate department/unit designee assigned for processing travel reimbursements. The designee should enter the reimbursement in TEM and submit as soon as possible.

RECEIPTS

An acceptable original, itemized receipt must be submitted for lodging, registration fee, airline tickets, rental cars, or any other allowable expense.

An acceptable receipt for the cost of the ticket should be supported by the original passenger coupon which includes proof of payment.

REQUEST FOR TIME AWAY FROM THE ROCKFORD RESIDENCY PROGRAM

PHYSICIAN: _____ DATE: _____ Rotation (during time away): _____

1. Request for vacation and CME must be submitted at least six weeks prior to date requested.

- i. The only exception will be in the event of true emergency or illness in which case approval from (Residency Coordinator) is necessary.

Approval Signature _____

2. The following information must be completed and **ALL APPROPRIATE AUTHORIZATION OBTAINED BEFORE time away will be approved.**

3. Once all authorization has been obtained, the **RESIDENT is ultimately responsible for delivering and **VERIFYING** notice of time away to clinic schedulers.**

4. You must check with the clinic schedulers prior to your time away to verify that your name has been removed from the schedule.

5. Are you on call or post-call? No Yes
(If post-call you are not allowed to take time off)

6. Are you on a call rotation? No Yes
(No time away allowed if on a call rotation)

7. If on call, call change request form completed? No Yes

8. Are you at risk? No Yes

9. If you are at risk, _____ is covering.
(The person covering must sign on the line.)

YOUR TIME AWAY IS CONSIDERED "NOT APPROVED" UNTIL ALL CALL CHANGES AND AT RISK COVERAGE IS TAKEN CARE OF.

DATES REQUESTED FOR TIME AWAY: _____
REASON FOR TIME AWAY _____ (Vacation, CME, Sick)

Proxy Assigned by (Residency Coordinator) _____

Resident Requesting Time Away (Signature) _____

Initial	Date
---------	------

Residency Office (Is time available?): _____

Put in Google: _____

Blocked Clinic: _____

Updated AMION: _____

Updated Student Schedule: _____

****Be sure to notify your rotation preceptor at the start of your rotation or as soon as you get the approval if you are currently on the rotation****

REQUEST FOR TIME AWAY FROM THE MONROE RESIDENCY PROGRAM

PHYSICIAN: _____ DATE: _____

- 1) Request for vacation and CME must be submitted at least six weeks prior to date requested.
- 2) Personal time, search time and other more urgent circumstances that arise are somewhat negotiable but should be submitted as early as possible.
- 3) ***IF TIME OFF IS REQUESTED ON SHORT NOTICE (LESS THAN SIX WEEKS IN ADVANCE,) RESIDENTS WILL BE REQUIRED TO RESCHEDULE ALL PATIENTS ALREADY SCHEDULED.***
The only exception will be in the event of a true emergency or illness.
- 4) The following information must be completed and ALL APPROPRIATE AUTHORIZATION OBTAINED BEFORE time away will be approved.
- 5) Once all authorization has been obtained, the RESIDENT is ultimately responsible for delivering and VERIFYING notice of time away to clinic schedulers.
- 6) You must check with the clinic schedulers prior to your time away to verify that your name has been removed from the schedule.
- 7) If absence is five days or longer, all evaluations, duty hours, hospital records and clinic charts must be up to date prior to time away. If these are not up to date, absence is considered unexcused.

DATES REQUESTED FOR TIME AWAY: _____

REASON FOR TIME AWAY: _____

Obtain the following approvals in order:

	Signature	Date
Residency Office (Is time available?):	_____	_____
Rotation Preceptor Approval:	_____	_____
Residency Director Approval:	_____	_____
Clinic Manager/Schedule Notification	_____	_____

Monroe Clinic Rural Family Medicine Residency **Time off Request Form**

This form is to be used for any time away from the program or any change to your current schedule. Please complete this form and submit it to Lori Rodefeld, Residency Coordinator.

Requests must be approved by the Program Coordinator, Program Director and Family Medicine Coach.

CTO Date:

Reason for request:

Requested by

_____ _____
Resident Physician _____ Date

Approved by

_____ _____
Program Coordinator _____ Date

Approved by

_____ _____
Program Director _____ Date

Approved by

_____ _____
Family Medicine Coach _____ Date

PROGRAM CLOSURE/REDUCTION

The University of Illinois College of Medicine Rockford is committed to providing residents/fellows with a complete, high-quality educational program. In the event the University should make a decision to reduce the number of positions in a training program or close a training program, the GMEC, DIO and all trainees in that program will be notified as soon as possible. Current trainees in the program, including trainees who have not yet initiated training but who have been notified that they are accepted into the program, will be permitted to continue their education until completion of the total number of year defined by the ACGME for that program. In the event that a trainee chooses to leave the program, the program director will take any and all actions reasonable and appropriate to assist the residents in locating another ACGME accredited program.