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PROGRAM INFORMATION

WELCOME

LifeLong Medical Care developed this program to provide a robust educational experience for the next generation of family medicine physicians. Our organization has more than 40 years of experience caring for a complex safety net population of all ages, strong clinical and outreach programs, and longstanding community relationships. We offer you the optimal learning environment to become a leader in healthcare.

We aim to educate and train a thriving workforce of highly qualified and diverse residents who are inspired to address the comprehensive healthcare needs of underserved communities.
LifeLong Medical Care is a Federally Qualified Health Center that has been serving low-income communities of the East Bay since 1976. What began as a single clinic providing care for older adults has grown to a multisite safety-net provider of primary care medical, dental, and behavioral health services to more than 66,000 patients of all ages. Health services are provided at more than 40 locations in Alameda, Contra Costa, and Marin Counties, including comprehensive health centers, school-based sites, supportive housing locations and mobile clinics. In multidisciplinary care teams, more than 150 clinical providers care for people of all ages with a special focus on serving seniors and adults with complex health needs including the homeless, people with HIV, and people with mental health and substance use disorders. LifeLong operates a large nursing home practice, a growing home visiting program for low-income seniors, and a growing street medicine program for people experiencing homelessness. Other specialized services include HIV and Hepatitis C care and a MAT program for opiate use disorder.

Our Mission
The mission of the LifeLong Medical Care Family Medicine Residency Program is to educate and train a thriving workforce of highly qualified and diverse family medicine physicians who are inspired to address the comprehensive healthcare needs of underserved communities.

Our Vision
We envision a residency program that provides health care to our community with an emphasis on health equity, social determinants of health, and cultural humility. We aim to develop family physicians as drivers of health care change and leaders in their work and community.
INSTITUTIONAL STRUCTURE
Dr. Eric Henley

Designated Institutional Officer

Dr. Eric Henley is an experienced family and public health physician. In the past 10 years, he was CMO of two large FQHCs, one urban in California’s East Bay and one rural in Flagstaff, AZ. He also spent 13 years as an academic physician at the University of Illinois regional campus in Rockford, 9 years as department chair. At University of Illinois, he oversaw the family medicine residency and taught medical students and residents. At LifeLong, he expanded medical education programs, implemented a successful Nurse Practitioner residency, and led the Health Center in achieving initial ACGME accreditation for the Family Medicine Residency Program in April 2019.
Dr. Deborah Simon-Weisberg is an experienced full-scope family medicine physician active in outpatient primary care and inpatient clinical work. She has expertise in women’s health and obstetrics and advanced skills in outpatient procedures. Prior to her role as residency Program Director, Dr. Simon-Weisberg held leadership positions within LifeLong Medical Care, most recently as the Medical Director of a large family practice clinic. She also served as core faculty focused on obstetrics and women’s health for the family medicine residency at the San Joaquin General Hospital for three years, and she supervised Family Medicine residents on the perinatal unit and in the continuity clinics at Contra Costa County Medical Center for two years. Subsequently, she spent four years with Kaiser Northern California working with OBGYN and Pediatric residents. In the past four years, Dr. Simon-Weisberg has continued to be active in medical education as a preceptor for medical students as well as supervising UCSF family medicine residents in the perinatal units at Alta Bates Hospital and supervising pediatric residents at Kaiser Permanente Oakland.
Dr. Serena Wu
Core Faculty and Behavioral Health Curriculum Director

Dr. Serena Wu is a dual board certified family physician and psychiatrist who specializes in the intersection between physical and mental health. As Deputy Chief Medical Officer of LifeLong Medical Care, she spearheaded multiple medical education partnerships with local residencies and medical schools including the development of a residency track in conjunction with Kaiser Internal Medicine residency. Dr. Wu will assume the role of Core Faculty of LifeLong’s Teaching Health Center Family Medicine Residency Program in 2020.

Jeana Radosevich, MD
Core Faculty

Dr. Radosevich is thrilled to be a core faculty member for the Lifelong Family Medicine Residency Program. She grew up in El Cerrito, CA and completed my education at UC Berkeley (BA, 2006) and Albert Einstein College of Medicine (MD, 2011). She did her residency training at Contra Costa Family Medicine Residency and completed the UCSF Faculty Development Fellowship in 2018. After finishing residency, she worked for several years as a hospitalist and urgent care provider. She joined LifeLong in October 2019. In her free time, she enjoys catching up with family and friends, exploring the natural world, gardening, and cooking. While trekking in Peru for her honeymoon, she and her husband got stranded in a blizzard for 36 hours and lived to tell the tale!
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PROGRAM GOALS AND OBJECTIVES

Goals
Throughout the LifeLong Family Medicine Residency Program, our goal for residents is to achieve high-level learning and understanding in treating medically hospitalized adult and senior patients. This will be achieved through hands-on hospital experience under the direct supervision of experienced core faculty at affiliated hospitals. Teaching physicians will serve as role models and implement the skills, knowledge, and conduct needed for residents to confidently and accurately diagnose patients from complex and diverse backgrounds. During this time, senior residents will function as teachers to guide junior residents under the attending physician.

The LifeLong Family Medicine Residency Program will graduate board-certified family physicians who will:

- Provide competent, comprehensive primary care to the general population across the spectrum of healthcare, home, and community settings;
- Address the special healthcare needs of vulnerable populations including issues of access, affordability, and unique medical problems;
- Consider establishing their practice in an underserved area, especially in urban underserved areas of East San Francisco Bay Area.

Objectives
Graduating residents will have demonstrated competence in:

- **Patient care and procedures**
  - Providing primary care for all ages and genders, including problem-based and preventive care, cognitive and procedural care, and office, hospital, home, and long-term residence-based care.

- **Medical knowledge**
  - Maintaining a working knowledge of current best evidence-based practice of Family Medicine; achieving and maintaining Board certification in Family Medicine.

- **Practice-based learning and improvement**
  - Lifelong learning, self-evaluation, and professional improvement; accessing and utilizing current evidence to improve care; application of quality improvement tools to improve practice; adoption of new information technology; educating medical students, residents, and other health professionals.

- **Interpersonal and communication skills**
  - Building collaborative relationships with patients, their families, colleagues, and other health professionals to provide patient-centered team-based care.

- **Professionalism**
  - Respecting the rights, values, needs, and autonomy of all patients, colleagues, co-workers, and students; respecting the unique perspectives of people diverse in age, gender, ethnicity, religion, physical abilities, and sexual orientation; and contributing to the improvement of the profession.

- **Systems-based practice**
  - Functioning effectively as a member and leader of health care teams and systems, and contributing to improvements in the value of health care at the systems level.
POLICIES & PROCEDURES

ANNUAL INSTITUTIONAL REVIEW POLICY

According to the ACGME Institutional Requirements I.B.5, the Graduate Medical Education Committee (GMEC) must demonstrate effective oversight of the Sponsoring Institution’s accreditation through an Annual Institutional Review.

The following performance indicators will be reviewed by the DIO and GMEC immediately following the end of each academic year:

1. The most recent ACGME institutional letter of notification
2. Data collected from the Programs’ Annual Program Review Reports
   a. In-Training Exams
   b. Scholarly Activity (Residents and Faculty)
   c. Faculty Development
   d. Graduate Performance
   e. Program Quality
   f. Program Strengths & Weaknesses
   g. Yearly Action Plans
2. Programs’ involvement and policies in the following areas:
   a. Patient Care and Safety
   b. Quality Improvement
   c. Transitions of Care
   d. Supervision
   e. Clinical Education and Experience Hours/Learning Environment
   f. Professionalism
2. Aggregated results of the ACGME surveys of residents and core faculty
3. Each of its ACGME-accredited programs’ ACGME accreditation information, including accreditation statuses and citations.

An action plan will be developed by the DIO annually as a result of the AIR process. The DIO will annually submit a written executive summary of the AIR to the Sponsoring Institution’s Governing Body following the Review Process with the GMEC. The written executive summary must include:

- A summary of the institutional performance on indicators for the AIR; and
- Action plans and performance monitoring procedures resulting from the AIR.
CLINICAL COMPETENCY COMMITTEE POLICY

Purpose
The LifeLong Medical Care Family Medicine Residency Program will comply with the Program Requirements for Family Medicine Residency Clinical Competency Committee (CCC) as set forth by the ACGME.

The program director must appoint the Clinical Competency Committee for Resident Evaluation and at a minimum the Clinical Competency Committee must be composed of three family medicine residency faculty (no residents are on this committee).

The program director may appoint additional members of the Clinical Competency Committee. These additional members must be physician faculty members from the family medicine residency program, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care Chief residents who are eligible for specialty board certification may be members of the Clinical Competency Committee. Members will include:

- Family Medicine Program Director
- Family Medicine Practice Director
- Family Medicine In-Patient Services Director

There must be a written description of the responsibilities of the Clinical Competency Committee (see Procedure for CCC meetings below).

Definition
- ACGME: Accreditation Council for Graduate Medical Education
- ADS: Accreditation Data System
- CCC: Clinical Competency Committee
- FM: Family Medicine

Affected Departments/Services
1. Family Medicine Residency Program
2. Residency Clinic Core Faculty
3. Attending physicians

Policies and Procedures
A. The Clinical Competency Committee Responsibilities
1. Review all resident evaluations semi-annually
2. Prepare and ensure the reporting of Milestones evaluation of each resident semi-annually to ACGME; and
3. Advise the program director regarding resident progress, including promotion, remediation, and dismissal

B. Procedure for CCC Meetings
1. Documentation and Review
   a. Sign attendance sheet that documents absences, date, and time of meeting
   b. Pass out documents to review; agenda, evaluation dashboards, FAQs, CCC Manual
c. Note start time of meeting (typical duration is one hour)
d. Discuss/set date and location for next semi-annual CCC Milestones meeting
e. Discuss individual documentation of completed resident evaluations
f. Review and finalize summary documentation of resident evaluations, provided by FM Coordinator

2. Set date to submit Milestones to ACGME/ADS (Note the final due date)
3. Discuss a remediation plan for residents performing sub-optimally (program director implements any needed remediation plan). Flag individual competencies that require attention.
4. Set "timely" date for Program Director to discuss Milestones with individual residents

C. Assessments/Evaluations
1. Discuss adjustment of number (more or less) of assessments and (of what type) that are needed for any given milestone
2. Determine how to best aggregate/interpret data
3. Individual faculty review, then discuss and average or discuss as group and come to consensus
4. Note any challenges in the evaluation process (e.g. faculty members not completing assignments, Milestones for which no assessment is currently done) and improvement plan for evaluation process
5. Identify where each Milestone is taught in the curriculum
6. How/where/by whom each Milestone is assessed
7. Identify any gaps in teaching and assessment and what are the plans for addressing them
8. Identify any expectations the program has of residents that are not captured in current specialty Milestones

D. CCC Process to Be Reviewed with Members at Every Meeting
1. Define CCC process:
   a. Include in FM program manual
   b. Process **must** be updated annually, therefore must ensure it is up-to-date and reflective of the actual process
   c. Set time to review process with residents and faculty members by program at least annually
   d. Address resident grievances with a CCC assessment
   e. Determine which established hospital policies will govern the procedure for formal resident grievances

E. Discuss Educational Opportunities
1. The Program Director provides and informs members of educational opportunities required for professional development around CCC members' role on the committee
2. Discuss attendance at state, regional or national meetings that provide continuing education about Milestones evaluations at least once a year by at least one program faculty member

F. Follow-Up
1. Set "timely" date for the Coordinator, to distribute minutes (hard copy and/or electronic) of the committee meeting.
2. Discuss storage of CCC minutes in the residency program records.

G. Continuous Educational Quality Improvement
1. Debriefing
   a. After debriefing, identify at least one (1) way to improve assessment in program.
   b. Identify who will do what and when the change will be implemented.

H. Appeals Process
1. The Resident will be notified by the program director as soon as reasonably possible that s/he has been identified by the CCC as needing remediation for an overall marginal or unsatisfactory rotation or annual evaluation.
2. The Resident will be provided with the name of and manner by which to contact the Clinical Competency Committee Chair if s/he desires to appeal the CCC’s decision directly.

I. Request a Review
1. To request a review of the Program's decision by the Clinical Competency Committee, the Resident must, within seven (7) days from the date of the notice by the program director, provide Program Director with a written statement detailing the reasons s/he believes s/he should not be required to be subject to remediation. The Program Director will convene the Clinical Competency Committee to review the Resident's statement within seven (7) days of its receipt.
2. The Resident must appear at the Clinical Competency Committee hearing. Failure to appear in person will be deemed a voluntary dismissal of his/her complaint, acceptance of the academic action, and waiver of the right to appeal. While attorneys are not allowed in the hearing of the Clinical Competency Committee, the Resident may be assisted by another person of his/her choice.
3. The Clinical Competency Committee will orally notify the Resident of its decision within three (3) days of its meeting, and provide the Resident a written decision within seven (7) days of the oral notification.

J. Final Decisions: The decision of the Clinical Competency Committee will be final
CLINICAL EXPERIENCE AND EDUCATION POLICY

Policy
It is the policy of the LifeLong Medical Care (“LifeLong”) and its Graduate Medical Education Committee to follow guidelines established by the ACGME regarding clinical experience and education hours for residents in accredited training programs.

Scope
- Residents are responsible for accurately reporting their Clinical Experience and Education Hours, including all time spent in Internal and External Moonlighting (in cases where eligible), per program requirements.
- Program Director(s) must monitor and enforce compliance with clinical education and experience hour guidelines.
- If specialty/subspecialty-specific program clinical education and experience hour requirements as defined by an individual RRC for that specialty/subspecialty are more restrictive than the common program requirements, then the clinical experience and education hour requirements of that RRC must be included in the policy of that specialty/subspecialty program and will supersede the institutional requirements.
- Concerns regarding clinical experience and education hours should be reported to the Program Director(s) or the DIO.

Purpose
Clinical experience and education hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care; time spent in-house during call activities, and scheduled activities, such as conferences. Clinical experience and education hours do not include reading and preparation time spent away from the duty site.

Procedure
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.

Mandatory Time Free of Clinical Work and Education
Each residency program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.

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**
The Review Committee for Family Medicine will not consider requests for exceptions to the 80-hour limit to the residents’ work week.

**Moonlighting**
Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident’s fitness for work nor compromise patient safety.

Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.

Senate (SB) 798 (Hill, Chapter 775) revised postgraduate training and licensing requirements for physicians and surgeons beginning January 1, 2020. Due to these policies, moonlighting may not be permitted until 36 months of ACGME-accredited postgraduate training is completed.

**In-House Night Float**
Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.

Night float experiences must not exceed 50 percent of a resident’s inpatient experiences.

**Maximum In-House On-Call Frequency**
Residents must be scheduled for in-house call no more frequently than every third night (when average 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.

**Monitoring**
Program Director(s) must monitor call-from-home Clinical Experience and Education Hours in terms of frequency and characteristics to assure that residents and fellows are following basic guidelines established by the ACGME.

Residents in core programs are expected to log Clinical Experience and Education Hours weekly in the New Innovations residency management software.

The GME office will audit the program reports on a periodic basis to ensure that they reflect the actual clinical education and experience hours of the residents.

**Education**
Program Director(s) must provide information to residents, fellows and faculty members regarding effects of loss of sleep and chronic fatigue. Currently, the GMEC recommends using the SAFER program available at https://tinyurl.com/y55vto7x.

The cost of the individual online version will be reimbursed by the institution to the individual resident.

**Reporting Structure for Off-Service Rotations**
Problems regarding compliance with clinical education and experience hour guidelines should be reported to the Chief Resident of the accepting training program. If that Chief Resident does not respond to the report of noncompliance, then the resident should report to the Program Director(s) of the sending program. The Program Director(s) of the program must address the issues that led to the violation of the guidelines. The resident may notify the GME Office at any time. The DIO for GME will report to the Chair of the training program if the issues are not settled on an immediate basis.

The GME office maintains an online portal to receive confidential complaints about all issues including clinical experience and education hours. The Director of Compliance will respond to these reports as appropriate.
CLINICAL LEARNING ENVIRONMENT POLICY

Professionalism
As the Sponsoring institution, LifeLong Medical Care will:

- Provide a culture of professionalism that supports patient safety and personal responsibility
- Educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients

LifeLong Medical Care will provide systems for education in and monitoring of:

- Residents’ and core faculty members’ fulfillment of education and professional responsibilities, including scholarly pursuits, and
- Accurate completion of required documentation by residents.

LifeLong Medical Care must ensure that its ACGME-accredited program(s) provide(s) a professional, respectful, and civil environment that is free from unprofessional behavior, including mistreatment, abuse and/or coercion of residents, other learners, faculty members, and staff members.

As the Sponsoring Institution, LifeLong Medical Care will have a process for education of residents and faculty members regarding unprofessional behavior, and a confidential process for reporting, investigating, monitoring, and addressing such concerns.

Well-Being
LifeLong Medical Care will oversee its ACGME-accredited program(s) fulfillment of responsibility to address well-being of residents/fellow and faculty members, consistent with the Common and specialty/subspecialty-specific Program Requirements, addressing areas of non-compliance in a timely manner.

LifeLong Medical Care will educate faculty members and resident in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. This responsibility includes educating residents and faculty members in how to recognize those symptoms in themselves, and how to seek appropriate care.

As the Sponsoring institution, LifeLong Medical Care will:

- Encourage residents and faculty members to alert their program director, DIO, or other Personnel or programs when they are concerned that another resident or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence;
- Provide access to appropriate tools for self-screening; and
- Provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

LifeLong Medical Care will ensure a healthy and safe clinical and educational environment that provides for

- Access to food during clinical and educational assignments; and
- Safety and security measures for residents appropriate to the participating sites.
DISASTER PREPAREDNESS POLICY

Purpose
The purpose of this policy is to provide guidelines for communication and assignment of Residents in the event of disaster and the policy and procedures for addressing administrative support in the event of a disaster or interruption in normal patient care. It also provides guidelines for communication with Residents and program leadership to assist in reconstituting and restructuring educational experiences as quickly as possible after a disaster, or determining the need for transfer or closure in the event of being unable to reconstitute normal program activity.

Scope
- All LifeLong Medical Care administrators, faculty, staff, Residents, and academic affiliates shall understand and support this and all other policies and procedures that govern GME programs and Resident appointments at LifeLong Medical Care.
- This policy is in addition to any emergency preparedness plans established by LifeLong Medical Care.

Definition
A disaster is defined within this policy as an event or set of events causing significant alteration of the residency experience.

This policy and procedures document acknowledges that many types of disasters may occur:
- Acute disaster with little or no warning (e.g., earthquake or bombing)
- Intermediate disaster with some lead time or warning (e.g., flooding)
- Insidious disruption or disaster (e.g., Flu, SARS, Ebola, etc.)

This document will address disaster or disruption in the broadest terms.

Resident Duties in Disasters
In the case of anticipated disasters, Residents are expected to follow the rules in effect for the training site to which they are assigned at the time. In the immediate aftermath, Residents are expected to attend to personal and family safety then render humanitarian assistance where possible. In the case of anticipated disasters, Residents who are not “essential employees” and not included in one of the clinical site’s emergency staffing plans should secure their property and evacuate if ordered to do so.

If there is any question about status, they should contact the Disaster Preparedness representative or Program Director before the pending disaster.

Residents who are displaced out of town will contact the Program Director as soon as communications are available.

During and/or immediately after a disaster, Residents will be allowed and encouraged to continue their roles where possible and aid in disaster recovery efforts.

Manpower/ Resource Allocation During Disaster Response and Recovery
- All residency programs at LifeLong Medical Care are required to develop and maintain a disaster recovery plan.
● These plans should include, but are not limited to, designated response teams of appropriate faculty, staff, and Residents, pursuant to LifeLong Medical Care.
● These response team listings should be reviewed on a regular basis, and the expectations of those members should be relayed to all involved.
● As determined necessary by the Program Director and/or Chief Medical Officer, physician staff reassignment or redistribution to other areas of need will be made.
● Information on the location, status, and accessibility and availability of Residents during disaster response and recovery is derived from the Designated Institutional Official (DIO) or their designee in communication with Program Directors and/or program Chief Residents.
● The DIO will then communicate with the CEO as necessary to provide updated information throughout the disaster recovery and response period.

Communication
The GME Office and/or all residency programs shall maintain current contact information for all Residents. The collected information must include at minimum:

● Address
● Cellular phone number
● All other available phone numbers (e.g., home)
● Primary and alternate email addresses
● Emergency contact information

The GME Office and the Resident shall provide this information to Human Resources.

Legal and Medical- Legal Aspects of Disaster Response Activity
It is preferred that, whenever possible, notwithstanding other capacities in which they may serve, Residents also act within their LifeLong Medical Care function when they participate in disaster recovery efforts. While acting within their LifeLong Medical Care function, Residents will maintain their personal immunity to civil actions under the federal and state tort claims acts, as well as their coverage for medical liability under their LifeLong Medical Care policy.

Payroll
Residents are encouraged to be paid through electronic deposit which is performed off-site. Using this method, no compensation interruption is anticipated.

Residents are encouraged to execute personal banking with an institution that has (at least) regional offices available.

Administrative Information Redundancy and Recovery
All GME programs are responsible for maintaining sufficient protection and redundancy for their program information and Resident educational records.

Disaster Policies and Procedures
● Upon declaration of a disaster by the Chief Executive Officer, the DIO will advise Residents and the ACGME will provide information on its website and periodically update information relating to the event, including phone numbers and email addresses for emergency personnel and other communication from disaster affected institutions and residency programs.
● The Designated Institutional Official (DIO) will contact the ACGME Disaster Preparedness and Residency Policy Institutional Review Committee Executive Director with information and/or requests for information.
● Program Director(s) should call or email the appropriate Review Committee Executive Director with information and/or requests for information.
● Program Director(s) should also communicate with site directors/supervisors at affiliate institutions regarding Resident status and then communicate pertinent information to the DIO.

Residents who are out of communication with LifeLong Medical Care should call or email the appropriate Review Committee Executive Director with information and/or requests for information. On its website, the ACGME will provide instructions for changing Resident email information on WebADS.

In addition to the resources listed in this document, Residents are directed to the Accreditation Council for Graduate Medical Education (ACGME) website for important announcements (www.acgme.org) and guidance.

**Communication with the ACGME**
The LifeLong Medical Care DIO or named designee will be responsible for all communication between LifeLong Medical Care and the ACGME during a disaster situation and subsequent recovery phase.

Within ten (10) days after the declaration of a disaster, the DIO will contact the ACGME Institutional Review Committee to discuss particular concerns and possible leaves of absence or return-to-work dates for all affected programs should a need exist for:

● Program reconfigurations to the ACGME
● Residency transfer decisions

The due dates for submission will be no later than 30 days post disaster, unless other due dates are approved by the ACGME. If within ten (10) days following a disaster the ACGME has not received communication from the DIO, the ACGME will initiate communication to determine the severity of the disaster, its impact on residency training, and plans for continuation of educational activities.

The DIO, in conjunction the Program Director(s), will monitor:

● The progress of patient care activities returning to normal status
● The functional status of all training programs to fulfill their educational mission both during a disaster and the recovery phase

These individuals will work with the ACGME and respective RRCs to determine if the impacted sponsoring institution and/or its programs:

● Are able to maintain functionality and integrity
● Require a temporary transfer of Residents to alternate training sites until the home program is reinstated
● Require a permanent transfer of Residents

If more than one location is available for the temporary or permanent transfer, the preferences of the Resident must be taken into consideration by the home sponsoring institution. Residency Program Directors must make
the keep/transfer decision timely so that all affected Residents maximize the likelihood of completing training in a timely fashion.
FATIGUE MITIGATION POLICY

Purpose
The LifeLong Medical Care’s Family Medicine Residency Program is committed to promoting patient safety and resident well-being in a supportive educational environment. In compliance with ACGME requirements, the Sponsoring Institution will ensure faculty and residents appear appropriately rested and fit for duty. This policy provides guidance on methodologies available to educate faculty members and residents to recognize the signs of fatigue and sleep deprivation, alertness management and fatigue mitigation recesses, and adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

Scope
All LifeLong Medical Care administrators, faculty, staff, residents, academic affiliates, and participating sites shall understand and support this and all other policies and procedures that govern GME programs and resident appointments at LifeLong Medical Care.

Definitions
- Core Faculty: Family Medicine Physicians who have received formal assignment to teach family medicine resident physicians for a minimum of 24 hours per week.
- Fatigue mitigation: Recognition by either a resident or supervisor of a level of resident fatigue that may adversely affect patient safety and enactment of a solution to mitigate the fatigue.
- Fit for duty: Mentally and physically able to effectively perform required duties and promote patient safety.
- Resident: Any physician in an accredited graduate medical education program, including interns and residents.
- ACGME: Accreditation Council for Graduate Medical Education
- PEC: Program Evaluation Committee
- CCC: Clinical Competency Committee
- GME: Graduate Medical Education

Affected Departments and Services
- Family Medicine Residency Program
- All Residency Preceptors

Policies and Procedures
1. LifeLong Medical Care core faculty members and residents are provided information and instruction on recognizing the signs of fatigue and sleep deprivation, and information on alertness management, fatigue mitigation processes, and how to adopt these processes to avoid potential negative effects on patient care and learning. This should be accomplished using visual presentations, lectures, or any other educational resources the program may elect to use.

2. Per ACGME program requirements, residents are not permitted to work over 80 hours per week. If in a rare case this should happen, residents and preceptors are required to report this to the Coordinator and Program Director immediately. Additional requirements:
   a. one day free from clinical experience or education in seven; and,
   b. in-house call no more frequent than every third night.

3. Fatigue and fatigue mitigation is included in the annual new residents' orientation.
4. To ensure patient care is not compromised, residents are expected to come to work fit for duty. When a resident identifies himself or an attending identifies the resident/fellow as being too fatigued to perform their duties, there are several options for the resident:
   a. Call rooms/sleep quarters are available at all sites until the resident is less fatigued.
   b. Rideshare/taxi services are available. The resident will initially pay for the rideshare/taxi service. A receipt should be submitted to the program coordinator for reimbursement. This service is available to take the resident to their home only. The resident is responsible for securing his/her own transportation back to the hospital or his/her vehicle. Alternatively, if taxi vouchers are available, they will be provided to the resident to get home.

5. The program will be monitored for compliance through the GME Office. Review of program will occur as part of the Annual Institutional Review.
GRIEVANCE AND DUE PROCESS POLICY

This Grievance and Due Process Policy shall be utilized for academic or other disciplinary actions that could result in suspension, dismissal, non-renewal of contract, non-promotion to the next level of training or other action that could significantly affect a resident’s intended career development. This policy also sets forth the manner in which resident complaints related to the clinical learning environment, the program or faculty will be addressed. Any Resident serving in an ACGME accredited program at LifeLong Medical Center (“LifeLong”) may seek resolution of grievances under this Grievance and Due Process Policy.

Appealable Academic or Other Disciplinary Actions
All residents participating in an ACGME accredited program sponsored by Lifelong will be afforded the opportunity to have reviewed and appealed, in the manner set forth below, any of the following decisions:

1. Academic Probation
2. Suspension
3. Adverse annual evaluation
4. Repeat academic year
5. Denial of certificate of completion
6. Change of record
7. Non-renewal of appointment
8. Dismissal for cause

Descriptions of Appealable Academic or Other Disciplinary Actions

Academic Probation
Residents who are in jeopardy of not successfully completing the requirements of a GME training program may be placed on academic probation by the Program Director. Conditions of academic probation will be communicated to the Resident in writing and should include: a description of the reasons for the probation, any required remedial activity, and the specific time frame for the required remedial activity.

Suspension
The Program Director or DIO may suspend the Resident from part or all of the Resident’s usual and regular assignments in the GME training program, including, but not limited to, clinical and/or didactic duties, when the removal of the Resident from the clinical service is required for the best interests of patients, staff and/or Resident.

Adverse Annual Evaluation
A Resident may request a review by the Clinical Competence Committee for an annual evaluation that is adverse (overall unsatisfactory or marginal).

Repeat an Academic Year
A Resident may be required to repeat an academic year in lieu of dismissal from the Program due to unsatisfactory progress in the training program or for other problems.

Denial of Certificate of Completion
If the Program Director, in consultation with the DIO, decides not to award the Resident a Certificate of Completion, the Program Director will notify the Resident as soon as reasonably practicable of this intent and the basis therefore.
Change of Record
A Resident may seek a correction or deletion to his/her personal/employee record by submitting a written request to the Program Director for a review by the Clinical Competence Committee.

Non-Renewal of Appointment
The Resident’s appointment is for a one-year period, which is normally renewed annually. Due to the increasing level of responsibilities and increasing complexity of clinical care over the course of the Resident’s training, satisfactory completion of prior academic year(s) or rotation(s) does not ensure satisfactory proficiency in subsequent years or rotations. A Resident may have his/her appointment not renewed at any time there is a demonstrated failure to meet programmatic standards.

Dismissal for Cause
Based on the Program Director’s discretion with concurrence by the DIO, a Resident may be dismissed from a GME training program for academic deficiencies or disciplinary cause or reason. Reasons for dismissal may include but are not limited to the following:
   a. A failure to achieve or maintain programmatic standards in the GME training program;
   b. a serious or repeated act or omission compromising acceptable standards of patient care and/or patient safety including but not limited to an act which constitutes a medical disciplinary cause or reason;
   c. unprofessional, unethical or other behavior that is otherwise considered unacceptable by the GME training program;
   d. a material omission or falsification of a GME training program application, medical record, or LifeLong Medical Center or medical document, including billing records. Any allegation regarding failure to comply with LifeLong’s billing rules shall be forwarded to LifeLong’s Director of Compliance for resolution in accordance with LifeLong’s Corporate Compliance Program.

Non-appealable actions
The following actions are not appealable:

Administrative Actions:
1. Automatic suspension
2. Automatic resignation
3. Investigatory leave
4. Conditional leave

Academic Actions:
5. Counseling letter
6. Notice of concern

Automatic Suspension
The Resident will automatically be suspended from the GME training program for any of the following reasons:
   a. failure to complete and maintain medical records as required by the medical center or participating sites in accordance with the center’s/hospital’s medical staff bylaws and/or rules and regulations; or
   b. failure to comply with HIPAA requirements; or
   c. failure to comply with state licensing requirements of the California Medical Board; or
   d. failure to obtain or maintain proper visa status or to provide visa or license verification; or unexcused absence from the GME Training Program for five or more days; or
e. failure to maintain organizational training or certification requirements; or
f. failure to maintain immunization requirements; or
g. failure to meet other mandatory requirements as described in the GME or Program policies.

Automatic Resignation
Automatic resignation will follow automatic suspension from the GME training program if the problem has not been rectified. Failure of the Resident to provide verification of an appropriate and currently valid visa or verification of current compliance with state licensing requirements of the state Medical Board of California during the 10-day automatic suspension period may result in the Resident’s automatic resignation from the GME training program.

Leaves
Investigatory leave and conditional leave of absence are not intended to replace any leaves that a Resident may otherwise be entitled to under state or federal law, or LifeLong policy.

Investigatory Leave
A Program Director may place a Resident on investigatory leave in order to review or investigate allegations of deficiencies or in circumstances where, in the judgment of the Program Director, the Resident may pose a threat to public, patient or staff health or safety, in situations where the Resident’s own health or safety may be compromised, or where uncertainty exists regarding the Resident’s ability to meet program expectations. The leave will be confirmed in writing, stating the reason(s) for and the expected duration of the leave. The alleged deficiency should be of a nature that warrants removing the Resident from the GME training program. The Program Director should, as soon as practicable under the circumstances, complete an investigation and either return the Resident to the program or initiate further action under these Guidelines. The Resident will be paid for the period of investigatory leave.

Conditional Leave
A conditional leave of absence from the GME training program may be provided only under exceptional circumstances, upon the Resident’s written request, and at the Program Director’s discretion with concurrence of the DIO. At the end of the conditional leave, the Program Director will determine whether to re-admit the Resident conditionally, unconditionally, on probation, or to seek the Resident’s dismissal pursuant to the procedures contained in these Guidelines. The Resident will not be paid a stipend for the period of the conditional leave. Potential uses of conditional leave include, but are not limited to, illness beyond sick leave limitations, personal leave to care for a personal or family emergency, or pursuit of an educational opportunity not related to the training program. In granting the request for leave the Program Director will specify in writing the acceptable time frame and any conditions for return.
Non-Appealable Academic Actions

Counseling Letter
A counseling letter may be issued by the Program Director to a Resident to address an academic or professional deficiency that needs to be remedied or improved. The purpose of a counseling letter is to describe a single instance or pattern of problematic behavior or interaction and to recommend actions to rectify the behavior.

Notice of Concern
A notice of concern may be issued by the Program Director to a Resident who is not performing satisfactorily. Notices of concern should be in writing and should describe the nature of the deficiency and any necessary remedial actions required on the part of the Resident. A Letter of Concern is typically used when a pattern of problems emerge.
The process described in this document is designed to provide appropriate review of actions that may adversely affect a resident’s status while at the same time ensure patient safety, quality of care and the proper conduct within the training programs. The resident is NOT entitled to legal representation at any point in the Grievance Process.
A. Program Level Review

The following process for review of an academic or other disciplinary action shall be available to the resident:

1. Upon receipt of a decision from either the Clinical Competency Committee (CCC) or the Program Director resulting in the suspension or dismissal from the training program, non-promotion to the next level of training or the non-renewal of the Resident Agreement, the resident may request the opportunity to present, in person, to the CCC their appeal of the decision. The resident must make this request to their Program Director, in writing, within seven (7) calendar days of receiving the notice of the decision. The resident presentation to the CCC shall occur within fifteen (15) business days of receipt of the request to the Program Director unless a later date is mutually agreed to by all parties. The resident shall be provided with the opportunity to present oral and written statements in support of the appeal.

2. If the CCC upholds the initial decision and the Program Director is not a member of the CCC, the resident will have the option of making an appeal to the Program Director for the respective Program.

3. If the Program Director is a member of the CCC or, upon review, the Program Director upholds the CCC decision, and all procedural steps of the Program Level Review have been exhausted, the Program Level Review has been concluded. The resident will be notified in writing of the conclusion of the Program Level Review.

4. The Program Director shall establish a reasonable and appropriate time frame for the completion of the Program Level Review when the process is initiated by the resident.

4. The next level of appeal available to the resident is the GME Level Review (as described further in Section B). If the resident does not make a timely request for the GME Level Review, the decision resulting from the Program Level Review shall be final and binding on the resident and Program, and shall conclude the Grievance Review Process.

B. Graduate Medical Education (“GME”) Level Review

Upon the conclusion of the Program Level Review, the resident may request the initiation of the applicable GME Level Review, as set forth below. The resident must make this request to the GME Office in writing within seven (7) calendar days of the conclusion of the Program Level Review. Failure to do so shall constitute waiver of resident’s opportunity for the applicable GME Level Review. If initiated, the decision resulting from the GME Level Review shall be final and binding on the resident and Program, and shall conclude the Grievance Review Process.

1. Non-renewal of Contract or Non-promotion in the Training Program: The resident will meet with the DIO to review the grievance. Prior to this meeting, the DIO will have the opportunity to review all relevant documents, including formative and summative evaluations and other assessments of the trainee, and consult with representatives of the Program to ensure consideration of information needed for an appropriate and informed decision. In the event a mutually agreeable resolution of the grievance is not possible, within seven (7) calendar days following this meeting, the DIO will issue, in writing, his/her decision, concluding the GME Level Review and Grievance Process.

   a. In the event that the DIO has been involved in the direct evaluation of the resident in his/her training experience, an appropriate administrative designee will be determined.
b. Dismissal for Cause or Suspension from the Training Program: The resident will meet with a Graduate Medical Education Appeals Board appointed by the DIO to hear the appeal. The members of the Appeals Board may hold an appointment in the same Program as the resident in question, provided there are no conflicts of interest. The resident will be afforded the opportunity to present any relevant information in reference to the dismissal or suspension during this time frame, including oral and written statements in support of the appeal. The members of the Appeals Board will have access to all relevant documents, including formative and summative evaluations and other assessments of the trainee in question during their discussions and deliberations. The Program Director shall be responsible for presenting evidence in support of the dismissal or suspension. Specific procedures applicable to the appeal may be adopted by the Appeals Board and furnished to the resident and Program Director.

1. The decision of this GME Appeals Board will be presented, in writing, to the resident within seven (7) calendar days of the meeting, concluding the GME Level Review and Grievance Review Process.

   a. If the resident’s Appeal is upheld, the GME Appeals Board will provide direction to the Program on reinstatement, and make recommendations pertaining to focused education, remediation and continuing trainee assessment, as appropriate.

Complaints Related to the Work Environment, Program or Faculty

In the event a resident in the training program at LifeLong has concerns or complaints about their program or educational learning environment, it is recommended they first address these issues with the Program Director. If the resident believes real or perceived conflicts of interest would preclude or render unproductive such a discussion, it is recommended they engage the designated LifeLong Director of Compliance for advice and counsel on the most appropriate course of action to address their concerns (e.g., Human Resources, Graduate Medical Education Office).

If at any time the resident is uncomfortable with these discussions or unsatisfied with previous counseling or recommendations, the DIO will be available to meet with the resident, directly, to resolve the concern.
GUIDELINES FOR INTERACTIONS WITH VENDORS POLICY

Overview
The following guidelines have been developed to provide guidance on relationships with the healthcare industry and its representatives, particularly proprietary entities that produce health care and medical goods and services, and to ensure independence of clinical decision making, educational curriculum and research programs. The purpose of this policy is to establish standards for interactions, occurring in a variety of contexts and crossing a variety of educational missions within the institution, with health care product industry representatives for LifeLong personnel. Because of the integrated nature of our academic and clinical programs and the evolution of current standards and best practices in this area (see the Report of the American Association of Medical Colleges Task Force on Industry Funding of Medical Education and the Report of the Council on Ethical and Judicial Affairs on Industry Support of Professional Education in Medicine, both published in 2008), we will continue to review and update these guidelines as necessary.

LifeLong Medical Care policies understandably emphasize issues of importance to clinical decision making and patient care, and specifically relate to selection of supplies and equipment, relationships with vendors, and sample management. These guidelines address these issues and will require a coordinated approach both within LifeLong Medical Care and with our academic and clinical training partners to ensure consistency and appropriate standards for all LifeLong Medical Care faculty, students and staff.

General Principles
The LifeLong Medical Care guidelines have been developed to ensure that all interactions with industry be conducted in ways that avoid actual or perceived conflicts of interest. Should conflicts arise, they must be addressed appropriately, and all attempts must be made to minimize conflicts that affect clinical care, education or research.

All faculty, trainees, students and staff of the GME Office and residency program(s) have a responsibility to ensure, to the best of their abilities that all decisions about clinical care, research activities and educational content are independent and unbiased. Decisions should be made in the best interests of patients, students and LifeLong Medical Care and should not be based on any actual or perceived personal benefit that might be derived to the individual.

The following guidelines have been adopted to minimize the potential for real or perceived bias in clinical care, education or research. The goal of these guidelines is to ensure, to the extent possible that clinical decision making, educational program content and research activities are as free from bias and outside influence as possible and that all real or potential conflicts are disclosed and resolved. The guidelines cannot identify every potential conflict, but provide general principles upon which faculty, residents, students and staff should act. It is incumbent upon each of us to comply with the guidelines and, when real or potential conflicts are identified to disclose and eliminate them to the extent possible.

Guidelines Regarding Relationships with Industry
Compensations or Gifts
1. Personal gifts from an industry representative may not be accepted by any faculty, trainee, student or staff of the GME office or residency program(s), or at any location when participating in any LifeLong Medical Center related activity or during any clinical or other educational rotation.
2. Individuals may not accept compensation, including reimbursement for expenses associated with attending a CME or other activity in which the attendee has no other role. Reasonable honoraria and payment of expenses may be provided for speakers at accredited educational meetings, consistent with guidelines developed by the Accreditation Council for Continuing Medical Education (ACCME) and LifeLong Medical Care policy.
3. No gifts or compensation may be accepted in exchange for listening to a sales talk or similar presentation by a representative of a commercial interest that produces or distributes health care goods and services.
4. Faculty, trainees, students and staff are strongly discouraged from accepting gifts of any kind from industry as part of non-professional activities. Individuals should be aware of and comply with applicable policies, such as the:
   1. AMA Statement on Gifts to Physicians from Industry (http://www.ama-assn.org/ama/pub/category/8484.html);
5. Meals and other gifts or donations funded directly by industry may not be provided at any site where LifeLong Medical Care educational activities occur. Vendors and other industry representatives may provide unrestricted funds for educational programs. The funds will be managed according to the Standards for Commercial Support of the ACCME.
6. No gifts may be accepted in exchange for modifying patient care, such as prescribing a specific medication. Support for research and educational programs must be provided without influence on clinical decision making.
7. Free samples, supplies or equipment designated for an individual are considered a gift and are prohibited. Vendors may donate products for evaluation or for educational purposes if LifeLong Medical Care invites the donation and there is a formal evaluation process. Sample donations are restricted to the amount necessary to complete the evaluation. Other policies related to the management of samples must comply with the specific policies and procedures of each hospital or clinic. Faculty must abide by the policies developed at the clinical sites in which they practice.

Industry Support for Educational Programs
1. Commercial support for educational programs must be free of actual or perceived conflict of interest.
2. All educational programs within LifeLong Medical Center must abide by the Standards for Commercial Support established by the ACCME. This requirement applies to all undergraduate, graduate and continuing medical education programs regardless of whether continuing medical education credit is offered.
3. All funds provided by industry or an industry representative to support educational programs must be given to LifeLong Medical Care as an unrestricted grant. The funds can be provided to the Department, Program or Division, but cannot be given to an individual faculty member, trainee, student or staff. This requirement applies to all funds for meals or refreshments, speaker honoraria, or any other expense related to an educational program and includes noon conferences, grand rounds, and lectures at all LifeLong Medical Care sites. Funds that are provided by educational groups or other entities that act as “intermediaries” for industry must also be provided as unrestricted grants.
4. No gifts may be accepted in exchange for listening to a lecture or presentation by a representative of a commercial entity that produces health care or medical goods and services.
5. Vendors may provide educational activities on a LifeLong Medical Care site only if they are requested to do so by the DIO. Participants in an educational program may not be required to attend any educational session in which an industry representative disseminates information about their products or services except when such services are provided as part of a contract for in-service or other training as part of an executed purchase decision.
6. The content of all educational programs will be determined by the LifeLong Medical Care program planning group and, when appropriate, the CME office. Industry sponsors of educational programs may not determine the content or selection of speakers for educational programs.
7. These requirements do not apply to meetings governed by ACCME Standards or meetings of professional societies and other professional organizations that may receive partial industry support. Individuals who actively participate in meetings or conferences that are supported in whole or in part by industry, including lecturing, organizing the meeting or moderating sessions should abide by the following requirements:
1. Financial support should be fully disclosed by the meeting sponsor;
2. The content of the meeting or session must be determined by the speaker, not the industry sponsor;
3. The speaker must provide a fair and balanced discussion, and;
4. The speaker must make clear that the comments and content reflects the individual views of the speaker and not LifeLong Medical Care.

2. Faculty, trainees, students and staff should carefully evaluate whether it is appropriate to participate in off-campus meetings or conferences that are fully or partially sponsored by industry because of the high potential for real or perceived conflict of interest.

Provision of Scholarships or Other Educational Funds for Students and Trainees
1. Industry support for students and trainees’ participation in education programs must be free of any real or perceived conflict of interest. All educational grants or support of educational programs must be specifically for the purposes of education and must comply with the following requirements:
   1. LifeLong Medical Care must select the student(s) or trainee(s) for participation.
   2. The funds must be provided to the Program and not directly to the student or trainee.
   3. The Program determines that the education conference or program has educational merit.
   4. There is no implicit or explicit expectation that the participant must provide something in return for participation in the educational program.
1. This provision does not apply to regional, national or international merit-based awards which will be considered on a case-by-case basis.

Disclosure of Relationships with Industry
1. Faculty and staff must disclose all financial interests with outside entities in accordance with LifeLong Medical Care policy. The specific disclosure obligation and method is dependent on the activity.
   1. For research activities the relationship must be disclosed to the LifeLong Medical Care Conflict of Interest Advisory Committee.
   2. All publications should be in compliance with the guidelines of the International Committee of Medical Journal Editors (www.icmje.org).
   3. All continuing medical education activities must be disclosed and resolved as defined by the Office of Continuing Medical Education and the ACCME (http://www.accme.org).
2. Faculty or staff who serve as consultants, members of a speakers’ bureau, have an equity interest in or another relationship with industry for which they receive personal compensation or other support must recuse themselves from deliberations or decision making regarding the selection of products or services to be provided to LifeLong Medical Care by the company. Faculty with such ties to industry shall not participate in decisions regarding the purchase of related items, drugs, procedures in their department unless specifically requested to do so by the purchasing unit and after full disclosure of the faculty member’s industry relationship. Under all circumstances the financial relationship must be disclosed, and any conflict resolved prior to participation in any decision making.
3. Faculty and staff are prohibited from publishing articles that are substantially or completely “ghost” written by industry representatives. Faculty and staff who publish articles with industry representatives must participate in the preparation of the manuscript in a meaningful way to include interpretation of data and/or the writing of the manuscript and shall be listed as authors or otherwise appropriately cited for their contribution. The financial interests of all authors shall be listed in accordance with the standards of the journal.
4. Faculty with financial relationships with industry must ensure that the responsibilities to the company do not affect or appear to affect the ability to properly supervise and educate students, residents and other trainees, nor influence employment decisions for faculty and staff. All such relationships must be disclosed and resolved as defined by ACCME.
Access by Sales and Marketing Representatives to Faculty, Trainees, Staff, and Students
Faculty, trainees, and staff at LifeLong Medical Care must abide by the policies and procedures for each institution involved in LifeLong Medical Care’s program education and training. In general representatives are permitted in non-patient care areas by appointment only. Company representatives are not permitted in any patient care areas except to provide scheduled and approved in-service training on devices and other equipment for which there is an executed contract for these services. Involvement of students and trainees in such meetings should occur only for educational purposes and only under the supervision of a faculty member.

Relationship to Other LifeLong Medical Care Policies
The guidelines supplement LifeLong Medical Care and our partnering organizations’ policies on Conflict of Interest. Faculty and staff should familiarize themselves with the policies and reporting obligations. Questions about the policies should be discussed with administrative staff.
HEALTH AND DISABILITY POLICY

Benefits
Residents are eligible for health; dental; life; accidental death and dismemberment; long-term disability; and vision plans offered through LifeLong Medical Care. Residents insurance is bundled; therefore, if a trainee opts out of health insurance then he/she is not eligible for any of the other insurance types. When a trainee is enrolled in a health insurance plan, he/she is also enrolled in dental, vision, life, accidental death and dismemberment, and long-term disability. These benefits, options, and annual premiums are re-negotiated annually by LifeLong Medical Care Human Resources. These plans for Residents are different from the various plans offered to faculty and staff employees. Information regarding plan choices is available from Human Resources.

Health Insurance
Each resident must submit to his/her program coordinator the health insurance enrollment form within 30 days of the appointment date. Each year, the months of June and July are Open Enrollment for the Residents. New enrollment and/or changes in coverage must be made during this period of time; elective changes are not allowed at any other time during the academic year. Upon initial selection of coverage and enrollment, the effective date of coverage will be retroactive to the date of employment. The trainee and eligible dependents or a domestic partner must be registered. To add a domestic partner, the Declaration of Domestic Partnership form must be completed with an enrollment form. If dependents are acquired during the year, they may be added within 30 days of a marriage, birth, or adoption. Deletions of dependents can be done at any time of the year. Adding or deleting domestic partners can be done any time of the year. At the time of separation from LifeLong Medical Care, continued insurance coverage under the terms of COBRA may be elected. Information regarding this coverage is available in each home department office or from Human Resources.

Life Insurance and Accidental Death & Dismemberment
Residents enrolled in any health insurance plans have coverage under life insurance and accidental death and dismemberment insurance in the amount of $50,000. The program coordinator will give each trainee a "Designation of Beneficiary" form at the time of employment/appointment. This designation may be changed at any time by filing a new form with Human Resources.

Disability
LifeLong Medical Care supports and fully complies with the Americans with Disabilities Act (ADA) and the California Fair Employment and Housing Act (FEHA). LifeLong Medical Care will make all reasonable efforts to accommodate qualified residents with verified disabilities by providing them with the necessary auxiliary aids and services that do not fundamentally alter the measurement of the skills or knowledge that is integral to residency training or result in an undue burden or hardship. The parties will engage in the interactive process to determine what accommodations may be necessary and reasonable under the ADA and the FEHA.

LifeLong Medical Care, in the absence of applicable LifeLong Medical Care policies, will refer to the ABFM ADA Policies and Procedures if applicable with regard to special accommodations for residents with disabilities and act in accordance with the ADA, FEHA and any other applicable local, state, or federal laws and regulations.

If a resident or student wishes to receive special aids or assistance during an ABFM in-service examination or other tests and evaluation procedures due to a disability, the candidate must promptly submit to LifeLong Medical Care, at the candidate’s expense, documentation substantiating the candidate’s disability.
M A L P R A C T I C E  P O L I C Y

Malpractice Insurance Benefits
The residents of LifeLong Medical Care’s residency program(s) receive comprehensive medical malpractice insurance as an employee benefit. The insurance is provided through the Federal Tort Claims Act (“FTCA”) and Northern California Residents will receive malpractice insurance coverage on their first full day of employment with LifeLong Medical Care.

This malpractice policy does not cover residents should they ever be doing work or providing clinical services outside of the activities of the residency program.
MOONLIGHTING POLICY

Each training program must have a program-specific policy addressing moonlighting. It is the responsibility of each resident to ensure that he/she is in compliance with his/her program's policy. Each program's policy must state whether or not moonlighting is permissible (both internal and external, see below for definitions). If moonlighting is allowed, the policy must contain a method for written pre-approval, monitoring (which must include the method for tracking hours), and periodic review.

Residents must not be required to engage in moonlighting and this must be clearly stated in the policy. Each program allowing moonlighting must demonstrate ongoing compliance with clinical and educational work hours requirements as a prerequisite for GMEC approval of its policy.

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents moonlighting, both internal and external, must be counted towards the 80-hour maximum weekly hour limit and closely monitored by the program in a manner similar to other duty.

Residents are responsible for ensuring that moonlighting and other outside activities do not result in fatigue that might affect patient care or learning. It is the responsibility of the resident to obtain written permission to moonlight from his/her program director prior to beginning any internal or external moonlighting activity. The program director will monitor resident performance in the program to ensure that moonlighting activities are not adversely affecting patient care, learning, or resident fatigue. If the program director determines that resident performance does not meet expectations, permission to moonlight will be withdrawn. Any residents moonlighting without written pre-approval will be subject to disciplinary action.

Internal moonlighting is defined as extra work for extra pay performed at any LifeLong Medical Care (“LifeLong”) facility as well as any other site that participates in the resident's training program. This activity must be supervised by faculty and is not to exceed the level of clinical activity and responsibility of the resident in his/her training program. Residents may not function as independent practitioners. Internal moonlighting hours must be documented and must comply with the written policies of the ACGME, LifeLong GMEC, and the program regarding clinical and educational work hours.

External moonlighting is defined as work for pay performed at a non-LifeLong site or a site that does not participate in the resident's training program. External moonlighting hours must be documented and must comply with the written policies of the ACGME, LifeLong GMEC, and the program regarding clinical and educational work. For external moonlighting, the resident is not covered under LifeLong's professional liability insurance program as the activity is outside the scope of LifeLong employment. The resident is responsible for ensuring liability coverage from another source, DEA licensure, Medicare (or other governmental) provider number and billing training, and licensure requirements by the California Medical Board as well as any other requirements for clinical privileging at the employment site.

Please note: Senate (SB) 798 (Hill, Chapter 775) revised postgraduate training and licensing requirements for physicians and surgeons beginning January 1, 2020. Due to these policies, moonlighting may not be permitted until 36 months of ACGME-accredited postgraduate training is completed.
PROGRAM EVALUATION COMMITTEE POLICY

Purpose
LifeLong Medical Care’s Family Medicine Residency Program (FMRP) will comply with the Program Requirements for Family Medicine Residency Program Evaluation Committee (PEC) as set forth by ACGME.

The PEC is responsible for conducting a systematic evaluation of the FMRP at least annually and submitting a written report that details: resident performance; faculty development; ABFM certification examination of graduates; program quality; and a plan of action.

Annual reviews will include the participation of faculty, residents and others as specified below; and will result in the written Annual Program Evaluation (APE). This report will be shared with the Annual Institutional Review (AIR) Committee and Graduate Medical Education Committee (GMEC).

Definitions
- ABFM: American Board of Family Medicine
- ACGME: Accreditation Council for Graduate Medical Education
- AIR: Annual Institutional Review
- APE: Annual Program Evaluation
- FMRP: Family Medicine Residency Program
- GMEC: Graduate Medical Education Committee
- PEC: Program Evaluation Committee

Affected Departments/ Services
- Graduate Medical Education
- Family Medicine Residency Program
- Residency Clinic Faculty
- GMEC

Policy

Program Evaluation Committee
1. The Program Director will appoint the Program Evaluation Committee with the chair being the Director of the Family Medicine Inpatient Service. The Program Director is also responsible to appoint at least two program faculty members. The PEC will also include one resident selected by their peers.

2. The program must have written description of PEC responsibilities.

3. The PEC will meet quarterly and for an additional meeting at the end of year to produce the APE (as well as additional urgent meetings).

4. PEC role:
   a. Participate actively in planning, developing, implementing and evaluating educational activities of the program.
   b. Review curriculum and makes revisions of competency-based goals and objectives.
   c. Address areas of non-compliance with ACGME standards.

Evaluation Requirements
The PEC is responsible for reviewing the program annually using evaluations of faculty, residents, and others, as specified below.

In this annual review, the program, through the PEC, must document formal, systematic evaluation of the curriculum, and is responsible for rendering a written, annual program evaluation (APE).

The program must monitor and track each of the following areas:

Written Plan of Action
The PEC must prepare a written plan of action to document initiatives to improve performance in one or more areas below. This plan must include how improvement will be measured and monitored.

The "Action Plan" should be reviewed and approved by the teaching faculty and documented in the meeting minutes.

Procedure for Quarterly PEC Meetings

1. Documentation and Review
   a. Sign attendance sheet that documents absences, date, and time of meeting
   b. Pass out documents to review: agenda, evaluation dashboards, FAQs, PEC Manuals
   c. Note start time of meeting (typical duration is one hour)
   d. Discuss/set date and location for next PEC meetings
   e. Discuss individual documentation of evaluation requirements
   f. Review and finalize summary documentation of evaluation requirements

2. Assessments/evaluations
   a. Discuss adjustment of number of assessments and of what type that are needed for any given evaluation requirement
   b. Determine how to best aggregate/interpret data
   c. Note any challenges in the evaluation process and make improvement plan for evaluation process
      a. Identify where each item being evaluated is located in the residency program (e.g., which rotation or department or clinic etc.)
      b. Determine how/where/by whom each is assessed
      c. Identify any gaps in assessment and what are the plans for addressing them

3. Review the following with members:
   a. Define PEC process
      a. Include in FM resident’s handbook
      b. Must update process annually to make sure it is up-to-date
   b. Set time to review process with residents and faculty members by program at least annually
      a. Review process for grievances with a PEC assessment

4. Discuss educational opportunities
   a. The Program Director provides and informs members of educational opportunities required for professional development around PEC members' role on the committee
   b. Discuss attendance at state, regional or national meetings that provide continuing education about PEC evaluations at least once a year by at least one program faculty member

5. Follow up
   a. Set ("timely") date for the Coordinator to distribute minutes (hard copy and/or electronic) of the Committee meeting
   b. Discuss storage of PEC minutes in the residency program records
6. Continuous educational quality improvement
   a. Debriefing
      i. After debriefing, identify at least one (1) way to improve PEC assessment process
      ii. Identify who will do what and when the change will be implemented (assign action items)
PROFESSIONALISM POLICY

Purpose
LifeLong Medical Care is committed to fostering a professional environment in which all residents and staff exhibit the highest standards of professional behavior. Professional behavior creates an environment that cultivates learning, promotes safe and high-quality care and enables a healthy workplace for all care providers.

Scope
LifeLong Medical Care expects that all residents and staff exhibit the key attributes of compassion, integrity and respect in their clinical care, within all types of hospital environments and with everyone with whom they interact. Professional behavior is responsive and sensitive to the needs of a diverse patient population, demonstrates respect for patient autonomy and privacy, and is accountable to all stakeholders (patients, institution, and their profession). Residents and staff are expected to engage in healthy and appropriate communication at all times and resolve conflicts in an appropriate manner.

As outlined in the Resident Renewal and Promotion Policy all residents must meet the professionalism competency by demonstrating a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Standards for professionalism include:

- Personal integrity must be of the highest caliber. This demands strict avoidance of substance abuse, theft, lying, cheating, and unexplained absences. Unauthorized use of hospital and/or clinic equipment and personnel for other than education, professional, and patient care use is prohibited.

Additionally, all residents will need to demonstrate proficiency/mastery of:

- Respect, compassion, integrity and honesty
- Practice ethical decision making including end-of-life care
- Willingness to acknowledge errors
- Teach and role model responsible behavior
- Placing the needs of others above self-interest
- Provide compassionate and culturally appropriate care to diverse populations

Failure to follow/meet these standards will be grounds for corrective action and/or dismissal.

Definitions and Examples

Professional behavior (includes but is not limited to):
- Treats colleagues, healthcare professionals and patients and their families with compassion and respect.
- Maintains integrity and is honest in all verbal, written and electronic communications
- Is respectful of cultural and religious differences
- Maintains professional composure at all times
- Is collaborative
- Is timely and courteous (including answering pages/calls, meetings/appointments)
- Respects patient privacy and HIPPA
- Receptive to feedback and can negotiate differences in opinion respectfully and in the appropriate setting

Unprofessional Behavior (includes but is not limited to):
- Illegal activities
- Conduct that can be characterized as harassment or discrimination (see LMC Policy)
- Violating HIPPA in written, electronic or verbal communication(s)
- Written, electronic or verbal threats; including violence or belittling insults
- Inappropriate physical contact
- Unprofessional behavior in front of patients/families (such as arguing)
- Physical altercations involving others or objects
- Slandering/disparaging remarks about others/department/institution

**Procedure**
Residents are expected to report all disruptive and harassing behavior that is directed at them, or they observe to any of the following: The Site Medical Director or Site Operations Manager; Director of the LifeLong Medical Care GME Office; and/or Director of Human Resources or any member of the Human Resources Department. Residents who report this type of behavior will be protected from retaliation and reprisal in accordance with the Clinical Learning Environment policy.

Residents will receive feedback on their performance on the six core competencies, including professionalism, regularly through the online rotation evaluation tool on New Innovations. Other tools such as peer evaluations and 360 evaluations will also collect data on competency performance. These evaluations will be aggregated at a minimum of twice a year by the Clinical Competency Committee (CCC) and reported to the individual resident and relevant boards, as well as stored permanently in the resident training file. In the event of an adverse decision resulting from these evaluations, the resident should refer to the Grievance and Due Process policy.

If an egregious breach of professionalism occurs, such as the falsification of records and patient data or abuse of peers or patients, the outcome may result in non-promotion and/or non-completion of the residency program. In these instances, the resident should refer to the Grievance and Due Process Policy.
PROTOCOLS DEFINING COMMON CIRCUMSTANCES FOR FACULTY INVOLVEMENT POLICY

Purpose

To provide minimal standards to guide residents with a set of clinical conditions that requires immediate attending notification.

Scope

The following policy applies to all residents:
All LifeLong Medical Care administrators, faculty, staff, Residents, and academic affiliates shall understand and support this and all other policies and procedures that govern GME programs and Resident appointments at LifeLong Medical Care

Policies and Procedures

1. Escalation of Care: Any urgent patient situation should be discussed immediately with the supervising attending. This includes:
   a. In case of patient death
   b. Any time there is unexpected deterioration in patient’s medical condition
   c. Patient is in need of invasive operative procedures
   d. Instances where patient’s code status is in question and faculty intervention is needed
   e. A patient is transferred to or from a more acute care setting (floor to ICU and vice versa)
   f. A patient’s condition changes requiring Code Team activation
   g. Any other clinical concern whereby the intern or the resident feels uncertain of the appropriate clinical plan

2. Timeliness of Attending Notification: It is expected that the resident will notify the attending as soon as possible after an incident has occurred. Notification of the attending should not delay the provision of appropriate and urgent care to the patient. If despite the best efforts, the resident cannot reach the assigned attending, then they should notify the program director, medical director of the service or the chair of the department for guidance.

3. Bedside Procedures and Level of Training
   a. PGY-1 Resident: Direct supervision by upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity, this number can vary by training program.
   b. PGY-2 and Higher Resident: Direct supervision by peer upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity, this number can vary by training program.
   c. Performance of Procedure
      i. It is the policy of LifeLong Medical Care that all trainees performing a bedside procedure discuss the clinical appropriateness of the procedure with the senior resident or attending. PGY-2 and higher GME trainees should discuss the clinical appropriateness of a bedside procedure with the attending as needed.
      ii. The attending physician is responsible for determining the appropriate level of supervision required for performing a bedside procedure, the appropriate indication for the procedures, discussion of risk-benefit with residents and patients (as necessary), assessing the risk of the procedure, determining the qualification of the resident performing the procedure and providing adequate support to the trainee performing the procedure.
iii. It is expected that a resident shall inform the faculty member or upper level resident when he/she does not feel capable of performing a bedside procedure.

iv. The resident performing a procedure should make sure that there is adequate backup (such as senior resident, fellow, attending, interventional services, surgical services) before performing the procedure.

v. The resident should attempt the procedure no more than three times before stopping and re-evaluating the clinical situation and asking for a senior resident, fellow, attending, interventional service, or surgical service to take over the performance of the procedure.

vi. The resident should call the senior resident, fellow or the attending if he/she has attempted the procedure three times unsuccessfully before attempting the procedure again.

vii. The procedure should be aborted and alternate plans discussed with the attending when the risk of the procedure including discomfort to the patient outweighs the benefit of repeated attempts beyond three.

viii. In case of emergency, greater than three attempts can be made but should be justified with clear documentation of the need to do so in the procedure note.
**PROVISION OF RESIDENT AGREEMENT POLICY**

**Purpose**
To delineate the requirement of LifeLong Medical Care to provide contracts to residents/fellows and detail the required elements of the contracts.

**Contract Issuance**
Resident contracts will be reviewed and approved by the GMEC each year. Upon notification of Match results, LifeLong Medical Care’s Family Medicine Residency Coordinator will coordinate the preparation of a GMEC-approved contract for each matched resident. In situations of resident transfers, or residents outside of the match, the Family Medicine Coordinator will coordinate the preparation of a resident contract for each resident upon notification by the Program Director of the resident’s acceptance into the residency program. The resident contracts will be sent to the Program Director and then to the DIO for review and organizational signature.

Contracts will include, at a minimum, the following elements:

a. Resident Name and PGY Year
b. Resident/fellow responsibilities
c. Duration of appointment
   a. Start date of contract
   b. End date of contract (one-year duration with no guaranteed reappointment)
d. Annual salary
e. Financial support for residents/fellows
f. Conditions for reappointment and promotion to a subsequent PGY level
g. Grievance and Due Process
h. Annual benefits including:
   a. Vacation, parental, sick and other leave(s) for residents/fellows, compliant with applicable laws
   b. Disability insurance for residents
   c. Professional liability insurance, including a summary of pertinent information regarding coverage
   d. Hospital and health insurance benefits for residents and their eligible dependents
i. Conditions for beginning work (Physical, medical school, completion of USMLE II, PTAL, etc.)
j. Timely notice of the effect of leave(s) on the ability of residents/fellows to satisfy requirements for program completion
k. Information related to eligibility for specialty board examinations
l. Resident and Institutional responsibilities
m. Institutional policies and procedures regarding resident clinical and educational work hours and moonlighting
n. Link to resident handbook and policies
o. Termination

Contracts are to be executed by all parties before the resident’s first day on-site.
QUALIFICATIONS OF APPLICANT POLICY

Eligibility
In addition to ACGME requirements, the following apply.

1. Since pursuing a career in California is desired, no program shall admit a resident that the California State Medical Board will not consider for a California license.
2. Successful completion of any step of the USMLE or COMLEX in no more than 3 attempts per step
3. An applicant must be able to carry out the duties as required of the residency program.
4. An applicant must demonstrate the following English language proficiency to the satisfaction of the Program Director:
   a. Proficiency in reading and writing (printing) English text,
   b. Proficiency in understanding spoken English on conversational and medical topics, and
   c. Proficiency in speaking English on conversational and medical topics.
5. The ability to reside continuously in the U.S. for the entire length of training.
6. Other eligibility requirements may include, but are not limited to, the following:
   a. Application submitted only through the Electronic Resident Application System (ERAS).
   b. A maximum length of time elapsed since completion of medical school training.
   c. A maximum length of time elapsed since the practice of medicine as a physician.
   d. A commitment to complete the entire residency/fellowship program.
   e. A commitment to taking and passing the specialty boards.
   f. A commitment to practice within the East Bay Area of California after graduation.
   g. Fluency in language(s) spoken in the East Bay Area of California

Selection Criteria
1. The program’s written procedure will include the criteria and procedure used by the program to select residents and the length of time the program keeps the applications on file.
2. The selection process should include, at a minimum, a review of eligible applicants by a program selection committee, individual interviews, and/or written interview evaluations.
3. Commitment to pursue a career in the selected specialty within the East Bay Area of California should weigh heavily in the selection criteria.
4. Other criteria for selection may include, but is not limited to:
   a. Performance on standardized medical knowledge tests
   b. Overall academic performance in medical school
   c. Demonstrated ability to choose goals and to complete the tasks necessary to achieve those goals
   d. Maturity and emotional stability
   e. Honesty, integrity, and reliability
   f. Lack of history of drug or alcohol abuse
   g. Prior research and publication experience
   h. Verbal and written communication skills (personal statement and interviews)
   i. Letters of recommendation from faculty
   j. Dean’s letter
   k. Medical school transcript
   l. Summative evaluation from residency program or other evaluation informative of competency
   m. A commitment to complete the entire training program
   n. Fluency in languages spoken in the East Bay Area of California
RESIDENT RENEWAL AND PROMOTION POLICY

Requirements for Advancement and Graduation

The decision to promote a resident from the PGY-1 to PGY-2 year, then PGY-2 to PGY-3 year, and from PGY-3 to graduation shall be determined by the Program Director with recommendation from the PEC and the advice of the faculty using competency-based criteria.

The method of evaluation shall consist of direct observation of the resident as well as by indirect observation through videos, rotation evaluations, correspondence between departments and written examinations (USMLE, In-Training Exam). Residents will pass all rotations or complete programs of study as determined by faculty. It is expected that residents will participate in all aspects of the curriculum including attendance at conferences, behavioral science sessions, and didactic sessions.

Residents will participate in the periodic evaluation of educational experiences and teachers. It is further expected that residents will complete their administrative responsibilities, including medical records completion, licensure, credentialing, etc. in a timely fashion.

Standards for All Residents

Advancement shall be based upon demonstrated competency in the six ACGME core competencies. These core competencies are:

1. **Patient Care** – Residents must be able to participate in patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
   a. Residents are evaluated on each rotation/clinic setting. Major performance deficits are subject to a program of remediation and/or corrective action.
   b. Specific Competency Requirements include demonstration of resident competency in:
      i. Efficient assessment of patients in inpatient and outpatient settings
      ii. Appropriate differential diagnoses for the full spectrum of patient presentations
      iii. Appropriate delegation of patient care activities
      iv. Efficient and appropriate utilization of health care resources

2. **Medical Knowledge** – Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
   a. Residents must perform on the In-Training ABFM Examination at or above the z-score of a negative point five (-.5). If lower, active participation in a program of academic improvement/remediation is required.
   b. Attendance at academic didactic sessions will be monitored and is designed to fulfill needs addressing competency in this area.
   c. Contributions to the academic and scholarly mission of the department are required. Teaching, conference presentations and participation, as well as overall faculty assessment of performance serve as key components of evaluation in this area. Major performance deficits are subject to a program of remediation and/or corrective action.
   d. Specific Competency Requirements include demonstration of resident competency in:
      i. An understanding of health and disease across the life cycle.
      ii. Patient care options for patients presenting in both the inpatient and outpatient setting.
      iii. Understanding of relevant pathophysiology and evidence based care for neonates, pediatrics, adolescents, adults, and the elderly.
iv. Understanding of relevant pathophysiology and evidence base care for patients with medical, obstetrical, gynecological, surgical and psychiatric problems.

3. **Practice-Based Learning and Improvement** – Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
   a. Active participation in chart audits and providing recommendations for improving patient care is expected.
   b. Specific Competency Requirements include demonstration of resident competency in:
      i. A commitment to self-assessment
      ii. Constant evaluation of their own performance
      iii. Ability to evaluate the health care provided by themselves and other members of the health care team
      iv. Incorporate feedback into improvement activities
      v. Efficient use of technology to access and manage information

4. **Interpersonal Communication Skills** – Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families, and professional associates.
   a. Residents are evaluated through active participation in videotape reviews of patient encounters with faculty.
   b. Specific Competency Requirements include demonstration of resident competency in:
      i. Caring, accurate, and appropriate counseling of patients and families
      ii. Compassionate and empathetic care for patients from multicultural, diverse backgrounds
      iii. Supervision and teaching for junior residents and students
      iv. Effective communication of clinical care with faculty and supervisors
      v. Appropriate and professional interactions with staff

5. **Professionalism** – Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
   a. Personal integrity must be of the highest caliber. This demands strict avoidance of substance abuse, theft, lying, cheating, and unexplained absences. Unauthorized use of hospital and/or clinic equipment and personnel for other than education, professional, and patient care use is prohibited. Failure to follow this standard will be grounds for corrective action.
   b. Specific Competency Requirements include demonstration of resident competency in:
      i. Respect, compassion, integrity and honesty
      ii. Practice ethical decision making including end-of-life care
      iii. Willingness to acknowledge errors
      iv. Teach and role model responsible behavior
      v. Placing the needs of others above self-interest
      vi. Provide compassionate and culturally appropriate care to diverse populations

6. **Systems-based Practice** – Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
   a. Compliance with all hospital and departmental record keeping and documentation requirements is required. A pattern of lateness and noncompliance will be grounds for corrective action.
   b. Specific Competency Requirements include demonstration of resident competency in:
      i. Maintain high quality medical records in a timely fashion
      ii. Ability to access medical information efficiently and effectively
      iii. Efficient use of clinical pathways
iv. Work professionally with other health care providers
v. Ability to practice effectively as a member of a multidisciplinary health care team
vi. Ability to independently access and mobilize health care resources.
vii. Assist patients in dealing with health care system complexities
viii. Develop and implement health care systems improvement

**Additional Promotion Requirements from PGY-1 to PGY-2**

Criteria for advancement may include ability to demonstrate the following:

**Patient Care**
- Identify the purpose(s) for a patient visit.
- Develop appropriate bio/psychosocial hypotheses that apply to the presenting problem.
- Conduct a focused evaluation of the presenting problem (including H&P, Physical Exam, and Lab/Radiology procedures).
- Appropriately prioritize the probable and potential diagnoses to ensure that attention is given to the most likely, most serious, and most readily treatable options.
- Present a provisional and working diagnosis to the patient.
- Arrange for follow-up of the current problem that fits the guidelines of current standard of care and/or attends to the special needs of the patient.
- Document patient care encounters in the medical record in a concise and legible manner following a problem-oriented format.
- Update the bio/psychosocial problem list and medication list at each visit.

**Medical Knowledge**
- Satisfactory performance as PGY-1.
- Passage of USMLE Steps I, II, & III. Residents who have not passed USMLE III or osteopathic residents who have not passed COMLEX III may be suspended or terminated from the LifeLong Medical Care Team.
- Successful completion of the Advanced Life Support in Obstetrics (ALSO) Course.
- Recommendation by faculty to advance.

**Practice-Based Learning and Improvement**
- Competent to supervise PGY-1’s and medical students as judged by faculty.
- Documentation of the PGY-specific procedures and encounters required for program advancement as listed on the program website. Specific required procedures may change from year to year.

**Interpersonal Communication Skills**
- Conduct an interview that fosters an adequate and helpful doctor-patient relationship.

**Professionalism**
- Develop a plan of action that attends to salient medical, psychosocial, family, cultural and socioeconomic issues.

**Systems-based Practice**
- Exercise fair and appropriate billing practices for services rendered, referring those who need financial assistance to the appropriate resources.
Additional Promotion Requirements from PGY-2 TO PGY-3

Criteria for advancement may include ability to demonstrate the following:

**Patient Care**
- Implement the negotiated plan.
- Inquire into and discuss sensitive issues that may impact the execution of the negotiated management plan.
- Incorporate the principles and practice of health maintenance into each patient care encounter, where appropriate.
- Review the biopsychosocial problem list at each visit and attend to appropriate longitudinal issues.

**Medical Knowledge**
- Satisfactory performance as PGY-2.
- California licensure unless international medical school graduate.
- Recommendation by faculty to advance.

**Practice-Based Learning and Improvement**
- Demonstration of skills in teaching, supervision, and team leadership.
- Documentation of the PGY specific procedures and encounters required for program advancement as listed on the program website. Specific required procedures may change from year to year.

**Interpersonal Communication Skills**
- Conduct an encounter that recognizes the primacy of patient needs and treats the patient as an appropriately equal health care partner

**Professionalism**
- Conduct an interview in a manner consistent with the values of family medicine using appropriate verbal and non-verbal skills.

**Systems-based Practice**
- Conduct the visit in a time-efficient and professional manner.
- If indicated, assist the patient in arranging for appropriate medical and ancillary referrals that seek to resolve specific issues in the diagnostic or management arenas.

Additional Promotion Requirements for Graduation

**Patient Care**
- Complete the tasks of the patient care session so that all necessary duties (including telephone messages, charting, administrative tasks, patient care) are accomplished in a timely, organized, and professional manner.

**Medical Knowledge**
- Satisfactory performance as PGY-3.
Complete three years of Family medicine training that meets the Residency Review Committee for Family Medicine guidelines unless prior authorization for advanced credit was received from the American Board of Family Practice.

- Meet standards for attendance at noon lecture and Educational half-day activities.
- Demonstrated engagement in activities that will foster personal and professional growth as a physician.
- Recommendation of faculty to graduate.

Practice-Based Learning and Improvement
- Has engaged in continuing or delivering medical education activities that are influenced by interest, deficiency, and need.
- Documentation of the PGY specific procedures and encounters required for program advancement as listed on the program website. Specific required procedures may change from year to year.
- Anticipate and recognize new curriculum necessary for future practice and advocate for needed reform in medical education.
- Satisfactory completion of a scholarly activity project incorporating community oriented research, as determined by the LifeLong Medical Care faculty.

Interpersonal Communication Skills
- Completed exercises in videotaping and shadowing to assess future needs in this area.

Professionalism
- Demonstrate sufficient professional ability to practice effectively and responsibly.

Systems-based Practice
- Work together with clerical staff and nursing staff in a manner that fosters mutual respect and facilitates an effectively run practice.
- Work together with partners, fellow family physicians, and specialists in a manner that fosters mutual respect and facilitates the effective handling of patient care issues.
- Work together with other professionals on the health care team in a manner that fosters mutual respect and facilitates the effective handling of patient care issues.
- At each patient care encounter, present yourself and the practice in a manner that will encourage the patient to select you, the practice, and family medicine in the future.

Final Evaluation
A written final evaluation will be provided by the Program Director or his/her designee for each resident who satisfactorily completes the program. This evaluation will be based on performance during the final period of training and must verify that the resident has demonstrated sufficient professional ability to practice effectively and responsibly.

The information on which advancement and promotion is based shall be contained in the resident’s academic file. Residents are permitted and encouraged to review all aspects of their academic file when their advisor or designee is present. Residents are not permitted to review their files without their advisor or a representative of the LifeLong Medical Care team approved by their advisor in attendance.

Intent Not to Renew
LifeLong Medical Care team will provide residents with a written notice of intent not to renew a resident’s contract no later than four months prior to the end of the resident’s contract. However, if the primary reason(s) for the non-renewal occur(s) or is under evaluation less than four months prior to the end of the contract, LifeLong Medical Care team will provide residents with as much written notice of the intent not to renew as the circumstances will reasonably allow.

Procedural Competency
In addition to determining whether residents have met requirements for advancement/graduation, LifeLong Medical Care Team is often asked to comment on the competency of residents to perform various procedures. LifeLong Medical Care Team has established minimum expectations in regards to the number of supervised procedures performed during residency to obtain competency. Required procedures are logged into New Innovations.

LifeLong Medical Care team must declare the resident competent to perform the required procedures. Those residents who have met these quantitative and qualitative standards for proficiency are considered competent to perform the procedure. If residents do not meet the numeric guidelines established above, or are not considered competent and proficient by the LifeLong Medical Care team, requests for statements regarding procedure competency will be handled by referring the requesting organization to the resident’s documented procedure list.
RESIDENCY REDUCTION AND CLOSURE POLICY

The LifeLong Medical Care requires a Program Director to submit proposals for a temporary or permanent increase or decrease in resident complement to the GMEC for approval prior to submission to the ACGME/RRC. The GMEC will weigh the potential benefits of a change in program size against potential liabilities and may request justification and information on the projected impact of the proposed change. All changes should be submitted to the DIO for review in order to ensure compliance with both ACGME/RRC requirements and LifeLong Medical Care’s guidelines.

Changes in program size must also be approved per the LifeLong Medical Care’s oversight mechanism. Per the LifeLong Medical Care requirements, changes approved by the GMEC require review and approval by the LifeLong Medical Care CEO.

Residents must be notified as soon as possible regarding an intended reduction in program size or closure of their residency program. In the event of such a reduction or closure, LifeLong Medical Care will allow residents already in the program to complete their education or assist the residents in enrolling in an ACGME-accredited program in which they can continue their education.
RESIDENCY RECRUITMENT AND SELECTION POLICY

Interviewing

Selection of candidates for interviews
All applications received during the selection period will be reviewed by at least one member of the LifeLong Medical Care faculty and/or staff. LifeLong Medical Care will interview the best qualified applicants. Preference will be given to candidates who have a demonstrated commitment to working in the East Bay and with underserved populations, and with evidence of satisfactory completion of all clinical rotations. Consideration will also be given to candidates who have participated in an ACGME approved post-graduate program within the last two years or in a country with reciprocity agreements recognized by the ABFM (Canada, Britain, New Zealand and Australia). Other international medical graduates (IMGs) will also be considered. All IMGs must have applied to receive a valid letter from the Medical Board of California permitting entry into a residency training program to be granted an interview.

Criteria for Selecting Applicants for Interview
All applications are processed through ERAS (Electronic Residency Application Service). U.S. graduates apply through their medical school dean's office. International graduates apply through ECFMG. Paper applications are not accepted.

Applicants need to have graduated from medical school within 4 years of September 15, 2019, the date the ERAS portal opened.

Passage of Part 1 of the USMLE, COMLEX, or the equivalent examination from a country with reciprocity agreements recognized by the ABFM is required. Scores on each part of the USMLE, American Osteopathic Association Board or its equivalent which have been taken must be reported.

Applicants that have completed undergraduate medical education training must provide Part 2 scores prior to consideration for the Match.

If an applicant has post-graduate experience, a letter from the medical school dean’s office and the program director from the resident's training program with a copy of medical school transcript are required. A list of completed rotations from the post-graduate experience is also required. A personal statement written by the applicant that includes their reasons for choosing Family Medicine in general is required.

Three letters of recommendation from professionals who have worked with the applicant on clinical rotations in the last two years, or who currently work with the applicant in a medical setting, must be submitted.

Various, specific applicant attributes will be considered beneficial and may be granted ‘extra points’ in the selection process because there is health workforce evidence to support the claim that individuals with these attributes have a higher likelihood of being retained as practicing physicians in the East Bay or similar, region. Other attributes that will be considered include:

1. Previous experience, especially origins, in the East Bay
2. Representatives of underrepresented minority communities who indicate an interest in working in the East Bay
3. Previous experience, especially origins, in underserved populations
4. Demonstrated commitment to underserved populations
5. Communication/language skills help in caring for a large number of non-English speaking patients in our region; therefore, multi-lingual applicants, particularly those whose language(s) coincide with populations served (Spanish, indigenous Latin American languages, Southeast Asian languages, Armenian, and Punjabi), will be viewed positively
6. Other professional skills acquired beyond those learned in medical school often help in practice (e.g. advanced professional training in a field related to medicine such as public health, anthropology, computer science, etc.), and will also be viewed favorably. Granting preference to applicants with the aforementioned characteristics will help to meet our mission of providing well-trained, culturally-competent physicians to the population we serve.

**Equal Employment Opportunity**

It is the intent and resolve of LifeLong Medical Care to comply with the requirements and spirit of the law in the implementation of all facets of equal opportunity and non-discrimination. In recruitment, selection, or any other personnel action, there will be no discrimination on the basis of race, creed, color, religious belief, sex, age, national origin, ancestry, physical or mental disability, or veteran status.

**Proof of Eligibility to Work**

In compliance with the Immigration and Reform Act of 1986, all applicants must show proof of eligibility to work in the United States. Should an applicant be offered a position within the Family Medicine Residency Program, upon being hired, the applicant must complete an I-9 form, which requires verification and certification of current eligibility to work in the United States. Applicants must show proof of eligibility to work in the United States if offered a position within the LifeLong Medical Care.

Failure of a resident to begin residency training on time causes significant disruption to the program. If proof of eligibility is unavailable at the time of the match, the prospective resident must demonstrate an active pursuit of the process and cooperate with the LifeLong Medical Care to secure recommended eligibility. Failure to do so may cause LifeLong Medical Care to notify the NRMP of intent to release the employment contract based upon an anticipated breach for the forthcoming academic year and the uncooperative nature of the prospective resident.

**California Letter**

International graduates are required to submit a current evaluation status /post-graduate training authorization letter (“P-TAL”) from the State of California with their application. The letter must be dated within one year of the start of residency training. Applications received without a current letter will be considered incomplete and will not be considered until a current letter is submitted by the applicant. Per Senate (SB) 798 (Hill, Chapter 775), effective January 1, 2020, the Medical Board of California will no longer issue Postgraduate Training Authorization Letters (PTAL) to international medical school graduates. As a result, international medical school graduates applying for the 2020 residency match will not require a PTAL.

**Community Recommendations**

LifeLong Medical Care values the input and participation of physicians in our community and in residency training. In the event a physician in the community or former alumnus of the LifeLong Medical Care recommends an applicant to the LifeLong Medical Care directly by contacting the program, they will likely be offered an interview as a courtesy, if space permits. The same applies for personal contacts of current residents.

**Interviews**

LifeLong Medical Care will go over the scheduling process for interviews at least once a year. Interviews with faculty are required for all candidates. LifeLong Medical Care personnel coordinate the interview schedule, and help candidates in numerous ways to feel comfortable and informed in dealing with the interviewing process, finding directions, etc. Applicants are accompanied by LifeLong Medical Care and/or staff during their tour of LifeLong Medical Care sites. Residents may participate as tour guides and are excused from their clinical responsibilities on the half-day they provide tours. Where possible, first year residents should participate in the interview process. Two goals stand out in these interviews: to get to know each candidate better, and to introduce the residency program as a whole to each candidate. Each resident guide completes a copy of the applicant evaluation form. Residents on probation are ineligible to be tour guides.
Selection

Selection of Candidates
The LifeLong Medical Care evaluation process is designed to ensure fairness and consistency, involvement by interested faculty, and relevance to LifeLong Medical Care and community needs. Candidates will be judged based on criteria established by LifeLong Medical Care. The following factors are taken into consideration:

- Faculty Interview scores. Resident evaluation scores (Resident input is considered an important part of the selection process and residents are encouraged to complete interview forms to receive a better assessment by residents).
- Passing Board exams on first attempt
- Dean's letters
- Letters of recommendation
- Personal statements
- Other desirable applicant attributes as delineated above under “Criteria for Selecting Applicants for Interview.”

A preliminary rank list is compiled from scores in each of the domains described above. The formula used for the analysis will be modified based on feedback from faculty, administrators, and residents each year.

Fine-tuning occurs after tentative rank ordering of all candidates is available.

Advance Credit and the Match
No advance credit will be offered for first year positions filled through the Match. Applicants accepted into the residency program outside the Match may receive advance credit consistent with their training and the American Board of Family Medicine guidelines.

The Match
The NRMP Match is an “All in” or “All out” process. LifeLong Medical Care has chosen to be “All in” and thereby will not recruit outside the Match other than the SOAP Process.

Every effort will be made to fill all of the first-year positions through the National Resident Matching Program (NRMP) Match. For residents recruited by means other than ERAS (i.e. post-Match), a standard letter of inquiry should be used to verify medical school graduation, and, where applicable, previous medical licensure and/or previous residency training.

Medical licensure can be verified via letter or the Federation of State Medical Board's web site (www.fsmb.org/cryhome.htm). For international medical school graduates, possession of a valid ECFMG certificate meets the intent of this policy for verification of medical school graduation.
**Resident Transfer Policy**

Institutions offering to accept temporary or permanent transfer from LifeLong Medical Care residency programs affected by a disaster must complete the transfer form on the ACGME website.

- Upon request, the ACGME will supply information from the form to affected residency programs and Residents.
- Subject to authorization by an offering institution, the ACGME will post information from the form on its website.
- The ACGME will expedite the processing of requests for increases in Resident complement from non-disaster-affected programs to accommodate Resident transfers from disaster-affected programs. The Residency Review Committee will expeditiously review applications and communicate decisions as quickly as possible.

The ACGME will establish a fast track process for reviewing (and approving or denying) submissions by programs related to program changes to address disaster effects, including, without limitation.

- Addition or deletion of a participating site
- Change in the format of the educational program
- Change in the approved Resident complement

At the outset of a temporary Resident transfer, a program must inform each transferred Resident of the minimum duration and the estimated actual duration of his or her temporary transfer, and continue to keep each Resident informed of such durations. If and when a residency program decides that a temporary transfer will continue to or through the end of a training year, the residency program must so inform each such transferred Resident.
RESTRICTIVE COVENANT POLICY

Restrictive Covenant Policy (Non-Competition)
The policy applies to all ACGME-accredited residency programs at LifeLong Medical Care.

The ACGME specifically prohibits the use of restrictive covenants in trainee agreements. In order to ensure appropriate institutional oversight as required by the ACGME Institutional Requirements, this policy has been established.

Neither the Sponsoring Institution nor any of its ACGME-accredited training programs may require residents to sign a non-competition guarantee (restrictive covenant).
SERVICES FOR HOUSE STAFF POLICY

Resident Services
Residents can obtain the following services directly from the LifeLong Medical Care GME office:
- Processing of requests for training verification
- Information on student loan deferment and financial aid
- Training certificates
- Photo IDs
- Information regarding housing and community services and resources
- Information regarding cultural, recreational and fitness activities available to residents

Financial Aid/ Student Loan Deferment
Many trainees can defer their student loans incurred during medical school or post-graduate training. Trainees who do not qualify for a loan deferment can request loan forbearance. Interest accrues during periods of forbearance, but payment is not expected.

For more information on this, please contact the LifeLong Medical Care GME Office.

House Staff Communication Forums

 Resident’s Forum: The Resident’s Forum (RF) meets monthly to address issues related to the trainee work environment and educational experience. RF also participates in improving methods of delivering care to the patients of LifeLong Medical Care and its training partners. The members of the committee are expected to disseminate information from this committee to their colleagues, and to bring issues from their colleagues to the committee. All residents are invited to participate.

 GME Confidential Helpline: Residents may call 510-981-4175 at any time and leave a message regarding any questions or concerns. Callers do not need to leave a name or phone number, but if they do, they will receive a follow-up call from the Office of GME.

Libraries
A medical library is available to the residents at 1030 Nevin Ave. Richmond, CA.

The library is open from 8-5pm Mon-Fri and open electronically for access 24 hour a day.

Meals
Residents on duty have access to food services 24 hours/day at all participating hospitals. In addition, the resident call areas have refrigerators that are stocked with food and beverages.

Medical-Legal Assistance and Malpractice Insurance
LifeLong Medical Care holds a malpractice policy with NorCal Group and is also covered through the Federal Tort Claims Act (“FTCA”) to defend residents against any liability or malpractice claim arising out of the residents’ acts or omissions within the scope of duties for work completed during the training period. Professional liability insurance coverage is maintained to defend LifeLong Medical Care residents against any liability or malpractice claim arising out of residents’ acts within the scope of LifeLong Medical Care duties for work completed during the training period. Exceptions to such coverage are acts or omissions in the course of activities not within the scope of resident duties and acts or omissions resulting from fraud, corruption, malice or criminal negligence.
Work at affiliated or associated hospitals, clinics or elsewhere is clearly covered when it falls within the course or scope of LifeLong Medical Care employment. Residents and clinical fellows who enroll for short-term elective rotations must provide documentation of malpractice insurance from their home institution.

The Corporate Compliance Officer is available to assist residents in situations where medical decisions could include legal considerations. The Risk Management Department attempts to minimize the LifeLong Medical Care's exposure to hospital and medical malpractice liability.

Attorneys or investigators may contact residents to review and comment on the care provided to a patient. Trainees should contact the Risk Management Department before responding to any such requests.

For information or questions about risk management or medical malpractice coverage please go to the Office of GME.

**Physician Well Being Programs**

**New Resident Orientation**: All new residents attend GME Orientation where physician impairment and substance abuse are addressed. Cost free resources that are available to address these issues on an individual and confidential basis are highlighted. This is done both by live presentation and through handouts and brochures that are included in the Orientation packet for each resident and clinical fellow.

**Physician Well-Being Committee**: The LifeLong Medical Care Physician Well-Being Committee is composed of physician representatives from various clinical departments and is a subcommittee within the GMEC committee. The committee is dedicated to addressing issues such as resident burn out, resident fatigue, clinical experience and education hour adherence and overall resident well-being.

The Committee offers assistance and support to residents who have or might have problems with any of the above issues that might affect their health or well-being or impact the safeguarding of patient care.

**Employee Assistance Program (EAP)**: The Employee Assistance Program (EAP) provides voluntary, confidential, and individual counseling services to the employees of LifeLong Medical Care. This includes all LifeLong Medical Care residents regardless of their current hospital rotation site. The EAP team consists of licensed counselors who provide consultation and counseling services. For more information regarding EAP, please contact Human Resources.

**GME Grand Rounds**: The Office of GME holds monthly Grand Rounds where well-being topics and other all-program curricular issues are often covered. The GME Grand Rounds series is designed for all residents. All presentations are available on the Office of GME website.

**Workers’ Compensation**
If a trainee sustains a work-related injury or illness, he/she is eligible to receive benefits under workers' compensation law. This program is designed to guarantee medical attention for the injury or illness and to ensure regular monetary benefits as a means of financial support while medically unable to return to work. LifeLong Medical Care pays the premiums for this program. Information regarding workers' compensation and its activation process is available upon request from your program coordinator.

If an injury, exposure to blood or body fluids or a needle stick occurs while at work, the resident should immediately notify the Site Medical Director or Site Operations Manager. If emergency treatment is required, 911 should be called. In all cases a report must be made to the Human Resources Department. The LifeLong Medical Care
Care Policy on Exposure to Blood Borne Pathogens can be found on the Lifelong Sharepoint Staff Page under Policies and Procedures.

**Harassment**

LifeLong Medical Care is committed to providing and maintaining a healthy learning environment and educational culture for all house staff, faculty and other members of the LifeLong Medical Care community including patients and employees of affiliated educational institutions and medical facilities. The commitment includes maintaining an educational environment that is free of unlawful discrimination and harassment on the basis of any legally protected status. In accordance with LifeLong Medical Care educational goals and mission, and applicable law, LifeLong Medical Care does not discriminate or tolerate harassment based on sexual, racial, national origin or any protected group status. LifeLong Medical Care will not tolerate any form of harassment including sexual harassment in violation of this policy by or against any house staff involving anyone in the LifeLong Medical Care community, including other house staff, faculty, medical staff, patients, vendors, employees or affiliated medical institutions and/or any other third party.

The conduct prohibited by this policy includes unwelcome conduct, whether verbal, physical or visual, that is based upon a characteristic protected by law, such as sex, race, color, religion, ancestry or national origin, age, disability, marital status, parental status, sexual orientation, gender identity, veteran status, citizenship status, or other protected group status as defined by law. LifeLong Medical Care will not tolerate harassing conduct that unreasonably interferes with an individual's education or that creates an intimidating, hostile, or offensive educational environment. Such harassment may include, for example, jokes or epithets about another person's protected status or teasing or practical jokes directed at a person based on his or her protected status. It may also include the display or circulation of written materials or pictures that are degrading to a person or group described above or verbal abuse or insults about, directed at, or made in the presence of an individual or group of individuals in a protected class. Conduct of this sort is prohibited by this policy without regard to whether the conduct would violate applicable laws.

It is the policy of LifeLong Medical Care not to discriminate against any individual on the basis of sex, race, color, religion, ancestry or national origin, age, disability, marital status, parental status, sexual orientation, sexual identification, political views, veteran status, citizenship status, or other protected group status as defined by law in matters of admission, services or educational programs or activities in accordance with the requirements of all applicable laws.

**Definition of Sexual Harassment**

Prohibited sexual harassment is defined to include unwelcome sexual advances, requests for sexual favors, and other verbal, physical or visual conduct based on sex when: (1) submission to such conduct becomes an implicit or explicit term or condition of any individuals education including any training, advancement, continuation in the program or other academic decision relating to the graduate medical educational program; (2) submission to or rejection of the conduct is used as the basis for any educational decision including training, advancement, continuation in the program or other academic decision, or (3) the conduct has the purpose or effect of unreasonably interfering with an individual's educational or training performance or creating an intimidating, hostile or offensive educational environment. Sexual harassment is not limited to explicit demands for sexual favors. It may include other unwelcome conduct based on sexual favors. It may include other unwelcome conduct based on sex, whether directed toward a person of the opposite or same sex and also may include such actions as: (1) sex-oriented verbal kidding, teasing or jokes; (2) repeated sexual flirtations, advances or propositions; (3) continued or repeated verbal abuse of a sexual nature; (4) graphic or degrading sexually-oriented comments about an individual or his or her appearance or sexual activity; (5) visual conduct, including leering, making sexual gestures, or the display of sexually suggestive objects or pictures, cartoons or posters; (6) pressure for sexual activity; (7) suggestive or obscene letters, notes or invitations; or (8) offensive physical contact such as patting, grabbing, pinching or brushing against another's body.
Reporting Procedures
Everyone at LifeLong Medical Care is responsible to help assure that our educational environment is free from all forms of prohibited discrimination or harassment. If you believe you have experienced or witnessed any conduct that may be inconsistent with this policy, you are to immediately notify any of the following:
1. The Site Medical Director or Site Operations Manager.
2. Director of the LifeLong Medical Care GME Office
3. Director of Human Resources or any member of the Human Resources Department.

All reports describing conduct that is inconsistent with this policy will be investigated. It is the obligation of every member of the LifeLong Medical Care community to cooperate in any investigation of alleged or suspected harassment or retaliation. If an investigation confirms that a violation of this policy or inappropriate conduct has occurred, LifeLong Medical Care will take corrective action as is appropriate under the circumstances. In the event of harassment by an individual other than a member of the house staff, LifeLong Medical Care shall immediately contact the appropriate designated representative of the affiliated institution and/or take other action as deemed appropriate. Such affiliated institution and LifeLong Medical Care shall then work jointly to reach a resolution to the issue.

Prohibition of Retaliation
LifeLong Medical Care forbids retaliation against anyone for reporting harassment, registering a complaint pursuant to this policy, assisting in making a harassment complaint, participating in an investigation, filing a charge of discrimination, or otherwise pursuing his/her rights under applicable municipal, county, state and federal laws. Anyone experiencing or witnessing any conduct he or she believes to be retaliatory should immediately report it to any of the individuals named above.

Confidentiality
LifeLong Medical Care is committed to balancing the interests of all parties involved in harassment complaints. LifeLong Medical Care will attempt to keep the name of the complainant confidential consistent with its need to investigate complaints and to respect the rights of the accused harasser. Moreover, when credible information received through an investigation indicates that there may be violations of other LifeLong Medical Care or affiliated institution policies, appropriate officials will be notified. Information related to complaints and investigations will be shared only with those representatives of the interested parties who have a need to know in order to investigate and resolve the matter.

Investigation Process
The Director of Human Resources or designee shall be responsible for investigating all reported complaints of harassment within the LifeLong Medical Care community by working with appropriate LifeLong Medical Care officials and officials of affiliated LifeLong Medical Care entities. Once the initial investigation is completed, including notice of the allegations and an opportunity to be heard, any house staff members found in violation of this policy will be subjected to corrective or disciplinary action including but not limited to reprimands, academic probation, termination or expulsion from the program. If the alleged violation of this policy involves individuals who are not LifeLong Medical Care house staff members, the Director of Human Resources shall immediately contact the appropriate designated representative of the affiliated institution and/or take other action as deemed appropriate. Such affiliated institution and LifeLong Medical Care shall then work jointly to reach a solution to the issue.

Complaint Procedure
This Complaint Procedure is intended to encourage and enable employees and others to raise serious concerns internally so that LifeLong can address and correct inappropriate conduct and actions. It is the responsibility of all board members, officers, employees and volunteers to report concerns about violations of LifeLong’s standards of conduct or suspected violations of law or regulations that govern LifeLong operations.
No Retaliation
It is contrary to the values of LifeLong for anyone to retaliate against any board member, officer, and employee or volunteer who in good faith reports an ethics violation, or a suspected violation of law, such as a complaint of discrimination, or suspected fraud, or suspected violation of any regulation governing the operations of LifeLong. An employee who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.

Reporting Procedure
LifeLong has an open door policy and suggests that employees share their questions, concerns, suggestions or complaints with their supervisor. If you are not comfortable speaking with your supervisor or you are not satisfied with your supervisor’s response, you are encouraged to speak with the LifeLong Privacy Officer. Supervisors and managers are required to report complaints or concerns about suspected ethical and legal violations in writing to Health Center Counsel and Compliance Director who has the responsibility to investigate all reported complaints. Employees with concerns or complaints may also submit their concerns in writing directly to their supervisor.

Acting in Good Faith
Anyone filing a written complaint concerning a violation or suspected violation must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

Confidentiality
Violations or suspected violations may be submitted by the complainant on a confidential basis by calling the LifeLong confidential hotline at 510-981-4175. This hotline may only be accessed by the Health Center Counsel and Compliance Director and requires a security code to do so. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

Handling of Reported Violations
LifeLong’s Compliance Director will notify the person who submitted a complaint and acknowledge receipt of the reported violation or suspected violation. All reports will be promptly investigated and appropriate corrective action will be taken if warranted by the investigation.

Accommodations for Disabilities
LifeLong Medical Care is committed to providing reasonable accommodations to qualified residents with disabilities. This policy describes the process by which residents with a disability may request reasonable accommodations. This policy does not address the selection of residents who have applied for a position in a training program. Such selection is based upon, among other things, an applicant’s ability to achieve the requisite competencies in the particular specialty or subspecialty training program to which the applicant has applied, as defined by the relevant ACGME Program Requirements. An applicant will not be disqualified from consideration because of a disability or be required to disclose the existence or nature of any disability during the application process, but all applicants and residents must be able to satisfy the technical standards listed below, with or without reasonable accommodation. Applicants and residents who cannot meet the technical standards outlined below will not be able to fulfill the essential requirements of the training program and may be denied admission to or excluded from their program on that basis.

Qualified residents who have a disability will not be excluded from participation in, denied the benefits of, or be subjected to discrimination in connection with the training programs or other services offered by LifeLong Medical Care. In response to a request made by a qualified resident with a disability, LifeLong Medical Care will arrange for the provision of reasonable accommodations necessary to afford such resident the full opportunity to participate in his or her training program. LifeLong Medical Care is not required to provide an accommodation that compromises the essential requirements of the relevant training program, imposes an undue financial burden.
based on LifeLong Medical Care overall institutional budget, or poses a direct threat to the health or safety of the resident or others.

All applicants and residents, regardless of whether they have a disability or have received any reasonable accommodations, must be able to meet the following technical standards unless a particular program has determined that one or more of the following technical standards do not apply to a particular specialty. These standards are essential requirements of LifeLong Medical Care training programs and are designed to qualify graduates for the competent and independent practice of their specialty.

Observation
Applicants and residents must be able to:
1. observe demonstrations and participate in clinical care; and
2. accurately observe patients.

Communication
Applicants and residents must be able to:
1. speak intelligibly, communicate adequately, observe patients to elicit and transmit information, describe changes in mood, activity, and posture, and perceive non-verbal communications
2. communicate effectively and efficiently both orally and in writing in English with all members of the health care team
3. possess English reading skills at a level sufficient to accomplish curricular requirements and provide clinical care; and
4. complete appropriate medical records and other documents in an efficient and timely manner.

Sensory and Motor Skills
Applicants and residents must:
1. possess sufficient sensory and motor function to elicit information using various diagnostic procedures
2. be able to execute motor movements reasonably required to provide care and treatment to patients; and
3. be able to coordinate both gross and fine muscular movements and maintain equilibrium.

Intellectual, Conceptual, Integrative, and Quantitative Abilities
Applicants and residents must:
1. be able to identify significant findings from, and make recommendations based upon, a patient’s history, physical examination, and laboratory data in an efficient and timely manner
2. possess the ability to incorporate new information from peers, supervisors, and medical literature in formulating diagnoses and plans; and
3. possess good judgment in patient assessment and in diagnostic and therapeutic planning.

Behavioral and Social Attributes
Applicants and residents must:
1. possess the emotional health required for full use of their intellectual abilities, the exercise of good judgment, and the prompt completion of all responsibilities attendant to the diagnosis and care of patients
2. exhibit the development of mature, sensitive, and effective relationships with patients, colleagues, clinical and administrative staff, and all others in the professional or academic setting
3. be able to tolerate taxing workloads and function effectively under stressful conditions
4. be able to adapt to changing environments, display flexibility, and learn to function in the face of uncertainties inherent in the care of many patients; and
5. be able to accept appropriate suggestions and criticism and, if necessary, respond by modification of behavior.
Requesting Accommodations
Residents who wish to seek reasonable accommodation must submit to the DIO current documentation from a qualified professional that (1) verifies the existence of a disability by articulating a diagnosis, (2) describes the nature and severity of any functional limitations that result from the disability, including in particular how the disability affects the resident’s ability to comply with the technical standards applicable to their program (3) describes the duration for which any such functional limitations are expected to continue, and (4) suggests any possible reasonable accommodations that he or she may consider appropriate in light of the technical standards needed to competently and independently practice their specialty.

To familiarize themselves with the range of reasonable accommodations that may be available for persons with a disability and other information regarding disability resources, residents are encouraged to contact LifeLong Medical Care Office of Graduate Medical Education. It is the resident’s responsibility to arrange for the required documentation, and LifeLong Medical Care is not required to pay for any required diagnosis or testing. The type, nature, and extent of documentation required may vary depending on the disability at issue. Periodically, residents may have to update or augment documentation to ensure that LifeLong Medical Care has all of the information necessary to evaluate a request for reasonable accommodation.

To determine whether the required documentation is adequate or an accommodation is reasonable, LifeLong Medical Care may seek input on a confidential basis from outside service providers.

Investigation of Complaints
Residents who believe that they have been discriminated against because of their disability may pursue a complaint as provided under LifeLong Medical Care Anti-Discrimination and Harassment Policy.
SPECIAL REVIEW POLICY

Purpose
This Special Program Review Policy outlines the Graduate Medical Education Committee ("GMEC")'s responsibilities for the oversight, review, and monitoring of the Lifelong Medical Care ("LifeLong")'s residency program. LifeLong’s GMEC is responsible for reviewing and revising this policy. The purpose of this policy is to outline the process for identifying underperforming programs, developing a report that describes the quality improvement goals, corrective actions, and monitoring of outcomes.

LifeLong’s GMEC has authorized a Subcommittee on Internal Review which is comprised of the DIO, the Director of Quality Improvement, one faculty member and a resident selected by his/her peers.

Process
The GMEC Subcommittee for Internal Review will review the Annual Program Evaluation (APE) materials and Annual Program Evaluation Minutes & Action Plan for each LifeLong residency program and either:

- Accept
- Ask for clarification/additional documentation
- Determine the need for a Special Program Review (SPR)

If the need for a Special Program Review ("SPR") is identified, a proposal for a SPR will be presented to the GMEC. The GMEC will either:

- Accept the proposal
- Modify the proposal
- Reject the proposal

If the SPR proposal is modified or accepted, the SPR will be scheduled. If the SPR proposal is rejected, oversight of the program reverts to the standard APE process.

The SPR will be scheduled within 45 days of the GMEC's approval.

The SPR will be conducted and a Special Program Review Report generated.

The GMEC Subcommittee for Internal Review will review the Special Program Review Report and either:

- Accept and create an action plan
- Ask for clarification/additional documentation and create an action plan

The Special Program Review Report and Special Program Review Action Plan created by the Subcommittee for Internal Review are presented to the GMEC.

The Special Program Review Action Plan developed by the GMEC Subcommittee for Internal Review will be sent to the PD within 30 days of the SPR being approved by the GMEC. Progress on action plans will accessed at the time of the next APE.

Criteria for Identifying Underperformance
- Potential triggers for an SPR include but are not limited to:
  - Negative communication from the ACGME
  - Resident complaint to ACGME
  - Clinical and Educational Work Hours non-compliance
  - Negative ACGME Faculty Survey trends
  - Negative ACGME Resident Survey trends
  - Significant concerns from APE

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- Match issues
- Resident attrition
- Scholarly activity deficiencies (either resident or faculty)
- Negative Milestones trends
- Failure to adequately address action plan items from a previous SPR or APE
- Other at the discretion of 010

**SPR Materials**
Materials requested for the SPR will be determined by the Subcommittee for Internal Review and referenced in the proposal to the GMEC. The materials will be selected based on the deficits identified.

**SPR Program Participants**
Program representatives to be interviewed during the SPR will be determined based on the deficits identified. If the program being reviewed is a dependent subspecialty, the Program Director for the respective core program will be interviewed with the program leadership.

**The SPR Meeting**
The SPR will be chaired by the chair of the GMEC Subcommittee for Internal Review. Panel members from other external Family Medicine programs may include one additional faculty, two peer-selected residents, one program coordinator and others as deemed necessary by the panel co-chairs.

**SPR Report and Action Plan**
- **Report:** The chair of the panel will compose a Special Program Review Report detailing the findings of the panel. The report will outline specific areas of underperformance, if and how corrective actions are to be implemented, and outcomes monitoring. The report will be submitted to the Subcommittee for Internal Review. The Subcommittee for Internal Review will develop a Special Program Review Action Plan based on the report. Both the Special Program Review Report and Special Program Review Action Plan will be submitted to the GMEC.

- **Action Plan:** The Special Program Review Action Plan developed by the Subcommittee for Internal Review will be sent to the Program Director within 30 days of the GMEC's approval of the SPR. Progress on action plans will be accessed at the time of the next APE.

**GMEC Monitoring of Outcomes**
GMEC monitoring of outcomes is operationalized in the Subcommittee for Internal Review with reports to the GMEC.
SUPERVISION OF RESIDENTS POLICY

Supervision of Residents
The Accreditation Council for Graduate Medical Education Institutional Requirements requires that the GMEC ensure that Graduate Medical Education programs provide appropriate supervision for all residents, as well as a duty hour schedule and a work environment, which is consistent with proper patient care, the educational needs of residents, and the applicable program requirements. Resident supervision will be reviewed during the internal review process.

Residents must be appropriately supervised at all times and in all settings in which graduate medical education occurs. This includes both inpatient and outpatient settings, as well as any rotation away. In these clinical learning environments, each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient’s care. This information should be available to residents, other faculty members, and patients. Residents and faculty members should inform patients of their respective roles in each patient’s care.

Each program will develop mechanisms for supervision of residents that are appropriate to the specialty, Residency Review Committee (RRC) requirements, and consistent with appropriate educational development as may be determined by progress in educational milestones.

Levels of Supervision
To ensure oversight of resident supervision, each program must use the following classification of supervision:

1. Direct Supervision: The supervising physician is physically present with the resident and the patient.
2. Indirect Supervision:
   a. 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.
   b. 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.
3. Oversight: The supervising physician is available to provide review of procedures / encounters with feedback provided after care is delivered.

Progressive Authority and Responsibility
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. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility. The program is responsible for developing descriptions of the level of responsibility accorded to each resident by rotation and year level and should have these available for each internal review. These descriptions must be provided to the residents and medical staff. These descriptions must include identification of the mechanisms by which the participant’s supervisor(s) and graduate education program director make decisions about each participant’s progressive involvement and independence in specific patient care activities.

Specifically:
1. The Program Director must evaluate each resident’s abilities based on specific criteria established by the faculty of the training program, which in turn are based on ACGME milestones.
2. Supervising faculty members will delegate patient care activities to residents based on the needs of the patient and the demonstrated abilities of the resident.
3. Senior residents or fellows should serve in a supervisory role of junior residents with appropriate patients, provided their demonstrated progress in the training program justifies this role.
4. In each training program, there will be circumstances in which ALL residents, regardless of level of training and experience, must communicate with appropriate supervising faculty. Programs must identify and set guidelines for these circumstances – for example – unexpected escalation of care to an ICU, and these guidelines must be available in writing for all residents and discussed at the beginning of each rotation, as applicable.

5. In addition, each program must define level specific circumstances in which all residents at the level must communicate with their attending physician. Each resident must know the limits of his / her scope of authority to make decisions, and the circumstances under which he/ she is permitted to act with conditional independence. Specifically, PGY-1 resident supervision should be either direct or indirect with direct supervision immediately available. If indirect supervision is provided, such supervision must be consistent with RRC policies, and PGY-1 residents must meet established criteria in order to be eligible for indirect supervision.

Resident supervision must also be consistent with current billing practice regulations.

On-call and clinical assignment schedules must be available at all clinical service locations (that includes contact information) so that residents as well as ancillary personnel can easily identify faculty responsible for providing supervision, 24- hours a day 7-days a week.
TRANSITIONS OF CARE POLICY

Purpose
This policy aims to define a safe, effective, and structured process for conveying important information about a patient’s care during transfer of responsibility from one resident physician to another. The intent is to ensure and facilitate continuity of care and patient safety at all participating site. This includes arrangements that extend beyond the inpatient setting into the community and the home.

Background

A handoff is the active process of transferring information, authority and responsibility for a patient during transitions of care. Transitions include changes in providers, whether from shift to shift, service to service, or hospital or clinic to home. Transitions also occur when a patient is moved from one location or level of service to another. In providing patient care that is compassionate, appropriate, and effective residents must demonstrate the ability to provide transfer of care that ensures seamless transitions.

Both written and verbal handoffs are important, and each has a different purpose. Written handoffs provide detailed information that serves as a reference for the receiving provider. Verbal handoffs provide “big picture” communication about the patient and should include discussion and cross-checking with the receiving provider to be certain that he/she has understood the information being provided.

Expectations
Although clinical assignments are made to minimize the number of transitions in patient care there will be routine and special circumstances where transitions will have to occur and standardization of this process optimizes safety and efficacy.

All interns are required to attend the “transitions of care” training session during orientation.

1. **Handoff Mechanics**
   - Handoffs should take place in a location that minimizes distractions and interruptions
   - All needed resources must be available and accessible
   - Handoffs should be both verbal and written in all settings. The handoff process must allow the receiving physician to ask questions
   - Face-to-face verbal handoffs are required for
     - shift change handoff (day to night and night to day)
     - change in level of service handoff (Floor to ICU and vice versa)
   - Verbal handoff in addition to written format is allowed for change of team handoff

2. **Structures for handoffs** – Structured hand-over processes facilitate both continuity of care and patient safety.
   - **Verbal handoffs** should follow a predictable structure using the IPASS Mnemonic found in Appendix A.
     - The “watcher” or “unstable” patients should be noted.
     - The “Action List” and “Situation Awareness & Contingency Planning” should be explicitly discussed as should the rationale behind the tasks.
     - The “receiving” resident must have the opportunity to summarize and prioritize received information.
Time for questions must be a part of all verbal handoffs.
Handoff length will vary based on the complexity and severity of illness for each patient as well as the extent of the resident’s prior knowledge of the patient.

Written handoffs must be structured and organized so that information is provided in a predictable format for each patient following the same IPASS Format. The information must be updated at least daily and be current at time of handoff. Written information should include the following:

- Identifying information --Name, age, weight, location
- Diagnosis and condition (particularly if unstable or evolving). Code status.
- Recent important events
- Problem list (active/chronic)
- Medications and other pertinent treatments
- Pertinent laboratory results
- Pending laboratory / studies that the “receiving” resident will need to review
- Important contact information- providers/subspecialist
- To do tasks
- Anticipated problems/guidance

3. **Handoffs are always supervised by senior or supervisory residents.**

“Transferring” interns will provide handoff on their own patients to either the “receiving” intern or upper level assuming care of the patient. A senior resident will be present to oversee this handoff (i.e. intern to intern handoff alone is not permissible). If no senior resident is available, a faculty member will oversee the handoff.

Senior residents are expected to give feedback to interns on their handoff skills at least monthly.

4. **A formal handoff must take place for all patients for which the resident is assuming responsibility.**

5. **A formal handoff must take place whenever a new resident assumed responsibility for a patient.**

6. **Rotation-specific attendings must make sure that residents are competent in communicating with team members in the hand-over process.** Handoffs are supervised by faculty or fellows at regular intervals (at least 2-3 times/week) on inpatient services. Supervisors are expected to provide feedback, ensure adherence to policy and format, and offer modeled behaviors.

**Other Transitions of Service**

**Transfers**

Except for transfers in emergency situations, a transfer note must be provided by the “sending” resident when a patient is transferred to a different level of care or to a different service. No transfer note is required if a patient is being relocated but will be cared for by the same service. A “transfer acceptance note” must be documented by the receiving service.

**Change of team**

An “off-service” note must be written by the responsible resident when the entire resident care team rotates off service on the same day and the team has cared for the patient for more than 48 hours (24 hours for ICU care). This note should provide a sufficient summary of the patient’s hospitalization and proposed plans so that the next resident(s) can assume knowledgeable care of the patient in an efficient manner.

**Discharges**
• The discharging resident must ensure that the discharge note/summary and orders are completed and accurate.
• The discharging resident is responsible to ensure that the receiving physician (PCP, subspecialist or accepting physician at another location) is updated verbally and given the opportunity to ask questions.
• The discharging resident is responsible for ensuring that information about clinically important laboratory, radiologic, or other results that come to a prescriber after a patient is discharged are conveyed either to the patient, his/her primary care provider, or any appropriate provider. This contact should be documented in the medical record.

**Fatigue**

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. While rotational and call schedules are constructed to mitigate issues of fatigue and residents are educated on and encouraged to use alertness management strategies, it is true 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. It is the expectation that residents will sign out their clinical duties when they cannot perform them in a safe and effective manner, and available residents or faculty will assist them in this handover of care while adhering to the following maximum duty period of length guidelines:

• Duty periods of PGY-1 residents must not exceed 24 hours in duration.
• Duty periods of PGY-2/3 may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
• Residents may be allowed to remain on-site in order to accomplish these tasks for a maximum additional period of four hours.
• In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient for reasons limited to required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Further information on annual faculty, intern and resident development opportunities around issues of sleep and fatigue can be reviewed in the “Fatigue Management” policy.
## Appendix A.

**I-PASS**

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<th>Illness Severity</th>
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<td>Patient Summary</td>
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<td>• Time line and ownership</td>
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<td>• Receiver summarizes what</td>
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Essentials of Team Function

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<th>BARRIERS</th>
<th>TOOLS &amp; STRATEGIES</th>
<th>OUTCOMES</th>
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<tbody>
<tr>
<td>Organizational Culture</td>
<td>Brief Huddle Debrief Cross monitor Advocate &amp; Assert Check-back Feedback Handoffs</td>
<td>Team Performance Shared Mental Model Patient Safety!!</td>
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I-PASS Handoff Essentials

Structured Verbal Handoff
- Begin with overview of entire service
- Need proper environment – limit interruptions
- Use IPASS mnemonic
- Employ closed loop communication

Printed Handoff Document
- Supplements verbal handoff
- May import elements from EMR
- Keeps information current with updates

High Level Skills
Patient Summary
- Be concise and focused
- Establish working diagnosis
- Include semantic qualifiers
- Ensure check-back with receiver

Contingency Plans – “If this happens, then…”
- Problem solve before things go wrong
- Know potential therapies or interventions
- Identify most worrisome patients
- Articulate chain of command

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Verbal Handoff Assessment – Faculty Observation and Feedback Tool for Giver

I-PASS STUDY

Verbal Handoff Assessment: Faculty Observation and Feedback Tool for Giver

Observer Information

Name: __________________ Date: / / (mm/dd/yy)  Obs. Start Time: : am/pm  Obs. End Time: : am/pm

How well do you know the patients whose handoff you are evaluating?  Very well  Somewhat well  Not at all

Resident Information

Name: __________________ PGY Level: ______  Total number of patients discussed during the handoff: ______

Type of Handoff

1. Please indicate the type of handoff you observed (circle one)  Individual  Team

Situational Overview (Big Picture)

2. Was a situational overview provided by the resident giving the handoff (e.g. description of the “big picture” of what will need to be prioritized by the receivers of the handoff):  Yes  No

Indicate the frequency that the specific element of the mnemonic was used throughout the handoff.

<table>
<thead>
<tr>
<th>Verbal Mnemonic</th>
<th>Description</th>
<th>Never</th>
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Rate the frequency with which the resident who gave the handoff did the following:

| 8. Actively engages receiver to ensure shared understanding of patients (encouraged questions, asked questions, considers learning style of receiver) | Never | Rarely | Sometimes | Usually | Always |
| 9. Appropriately prioritizes key information, concerns, or actions |       |        |           |         |        |
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I-PASS STUDY

Verbal Handoff Assessment: Faculty Observation and Feedback Tool for Giver

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VACATION AND LEAVE POLICY

Leave
Leave with compensation shall be 20 days per academic year. Vacation time does not accrue from year to year and must be scheduled and taken in the same academic year the vacation is earned. Under special circumstances, departments may make a discretionary allowance for carry over beyond that year. Vacation leave shall be scheduled by mutual agreement with the program and given as leave depending upon the mode of scheduling of a given service. Procedures for requesting and assigning vacation schedules must be written policy and be in compliance with each program’s ACGME Program Requirements, which concern the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program and on qualifying for Board Eligibility. It is the responsibility of the resident to make sure they satisfy the leave requirements of their Specialty Board. The Program Director will determine which blocks residents may take vacation time.

Administrative Holidays
Administrative holidays for residents will be consistent with the schedule at the institution to which the resident is assigned and with the policies of the program.

Sick Leave
Sick leave with compensation is given at the rate of twelve (12) days per academic year (one day per month). Sick leave is credited to the year of appointment and does not carry over from year to year. In addition, vacation leave may be used to cover sick leave which exceeds twelve (12) days. The total length of sick leave (paid and unpaid) may not exceed twelve (12) work weeks in a calendar year (see “Family and Medical Leave” section below). Additional sick leave may be granted at the discretion of the program. Makeup time may be required to meet educational objectives and be in compliance with ACGME Program Requirements and Specialty Board Eligibility Requirements.

Personal Leave
Personal leave to attend to personal matters of a serious, time consuming nature may be taken by mutual agreement with the program. Personal leave in excess of vacation and sick leave is uncompensated. Makeup time may be required to meet educational objectives and be in compliance with ACGME Program Requirements and Specialty Board Eligibility Requirements. It is the responsibility of the resident to make sure they satisfy the leave requirements of their Specialty Board.

Attendance at Educational Meetings and Activities
Attendance at educational, scholarly, and professional activities is scheduled by mutual agreement with the program and/or department.

New Parent Leave
Compensated leave is a minimum of two (2) work weeks. Time taken in addition to this exceeding vacation leave and sick leave will be uncompensated. In accordance with the Family and Medical Leave Act (FMLA), leave can extend to twelve (12) work weeks.

The resident must give written notice to the program and/or department of his/her intention to take leave prior to the expected birth or adoption.

Makeup time may be required to meet educational objectives and be in compliance with ACGME Program Requirements and Specialty Board Eligibility Requirements. It is the responsibility of the resident to make sure they satisfy the leave requirements of their Specialty Board.

Family and Medical Leave
Family and medical leave is provided for an eligible resident’s serious health condition, or the serious health condition of the person’s child, spouse or parent. Medical leave may be requested for a medical condition affecting his/her ability to continue in a training program or provide patient care. These leaves must include the use of vacation leave and sick leave at the onset of the leave. The duration of the leave must conform to the program and the American Board requirements together with the applicable state and federal law, including the federal Family and Medical Leave Act (FMLA) of 1993.

**FMLA:** FMLA allows for qualified employees to take leave of up to twelve (12) workweeks in a calendar year, continuance of health plan coverage, and employment reinstatement rights due to:
- Employee’s own serious health condition;
- Care for child, parent, spouse, or domestic partner (same sex or opposite sex) with a serious health condition; or
- Care for a newborn child or a newly placed adopted/foster child (applicable for both maternity and paternity leave).

In order to qualify for FMLA, a resident must meet the following two criteria:
- Provided at least 12 months of LifeLong Medical Care services (does not need to be continuous) AND
- Worked at least 1,250 hours in the 12 months immediately preceding the leave (these are actual hours worked – including overtime – and do not include time on vacation, sick leave, or other paid leave).

**Benefit and Pay Status:** FMLA does not require residents be paid during leave, only that benefit coverage continues during the Family and Medical Leave. However, in accordance with LifeLong Medical Care policy, vacation leave and sick leave may be used towards pay during the FMLA leave period. Once vacation leave and sick leave have been used, unless otherwise negotiated with the training program, leave will be unpaid.

While on unpaid leave (other than FMLA leave), the resident will be eligible to maintain insurance coverage for the remainder of the leave and may be required to reimburse LifeLong Medical Care for the cost of the insurance. In accordance with federal law, the program will continue its contribution to health insurance benefits for up to twelve (12) workweeks per year of FMLA leave.

Moonlighting while on Family and Medical Leave is not allowed and may be cause to terminate leave.

**Qualifying Time for American Board Requirements:** The duration of Family and Medical Leave must be in compliance with each program’s requirements, which concern the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the training program (see “American Board Requirements” below).

**Leave for Military Service**
Residents are eligible for up to thirty (30) days of military leave with pay while engaged in the performance of military duty. All benefit coverage will continue during paid military leave. Absence from the training program to meet military service obligations must be with the approval of the program director and/or department.

**Leave for Jury Duty**
A resident or clinical fellow called to Jury Duty will receive regular compensation for time served. The program director and/or department must be notified as soon as a jury summons is received. Only the court, pursuant to the procedure outlined in the Jury Summons Notice, can grant deferment or excused absence from jury service.

**Other**
**Disability Benefits:** Please note that residents and clinical fellows are not eligible for, nor covered by the state of California for short-term disability insurance. However, residents and clinical fellows enrolled in the LifeLong
Medical Care Housestaff Benefits Plan are entitled to disability coverage following 30 consecutive days of “total disability.” For more information, please contact Human Resources.

**American Board Requirements:** It is the responsibility of the resident to be in compliance with the Program Requirements concerning the effect of leaves of absence on satisfying the criteria for completion of the training program, and guaranteeing eligibility for certification by the relevant certifying Board. Prior to granting leave, American Board requirements should be reviewed by the program director and resident to assure that the resident is familiar with the possibility of having to make up time away from training. If extended leave results in the requirement for additional training in order to satisfy American Board requirements, financial support for the additional training time must be determined when arrangements are made for the leave and the makeup activity.
WRITTEN OR ELECTRONIC INFORMATION POLICY

The National Resident Matching Program ("NRMP") requires that applicants for residency positions through the NRMP who are invited to interview must be given complete and accurate information regarding the policies and procedures governing their training programs.

This must include:
- A sample contract
- All institutional policies regarding eligibility for appointment to a residency program

It is the policy of LifeLong Medical Care that at a minimum, programs provide to applicants who are invited to interview for residency positions the information above, in either electronic or hard copy format, and to document that the information has been shared. The program director will be responsible for maintaining this documentation. If they wish, programs may share more information with the interviewees, including printed copies of the material listed above.
SUMMARY OF KEY POLICIES

RESIDENT PAY & BENEFITS SUMMARY

The LifeLong Medical Care Family Medicine Program residents will receive salaries, stipends and benefits listed as the following:

<table>
<thead>
<tr>
<th>Resident Year</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Year</td>
<td>$65,000</td>
</tr>
<tr>
<td>Second Year</td>
<td>$68,000</td>
</tr>
<tr>
<td>Third Year</td>
<td>$71,000</td>
</tr>
</tbody>
</table>

The salary may exceed the amounts shown above in the case of salary increases across the entire residency class. Payment of this training stipend shall be contingent upon satisfactory performance in all training duties by the Resident during the training program.

Residents are eligible for health, dental, life, accidental death and dismemberment, long-term disability, and vision plans offered through LifeLong Medical Care. Residents insurance is bundled; therefore, if a trainee opts out of health insurance then he/she is not eligible for any of the other insurance types. When a trainee is enrolled in a health insurance plan, he/she is also enrolled in dental, vision, life, accidental death and dismemberment, and long-term disability. Please refer to the Health and Disability policy for more detailed information on insurance policies.

PROGRAM LEAVE PROCESS

Participating LifeLong residents may be dismissed from the Residency Program for academic deficiencies or disciplinary causes or reason. This will be based on the Program Director’s discretion along with the DIO. Depending on the occurrence, the resident may be placed under investigatory or conditional leave. Under investigatory leave, the resident will be reviewed and investigated if he/she poses as a threat to the health or safety of the public, patients, faculty and staff. The resident will be paid for the period of investigatory leave.

Conditional leave may be provided under exceptional circumstances, upon resident’s written request, or under the Program Director’s discretion alongside with the DIO. Some uses for conditional leave include: illness beyond sick leave limitations, personal leave to care for a personal or family emergency, or pursuit of an educational opportunity not related to the training program. The resident will not be paid under conditional leave. For further information on program leave, please refer to the Grievance and Due Process Policy.

JURY DUTY

For any resident or clinical fellow who is called to Jury Duty, he/she will be compensated for the time served. Once the jury duty summons is received, it is the recipient’s responsibility to notify the Program Director immediately. An excused absence or deferment from service can only be granted by the court. You may refer to the Vacation and Leave Policy for any further information.
PROFESSIONALISM POLICY

We expect all residents, healthcare professionals, and staff to adhere to the highest forms of professional behavior to foster a safe and healthy learning environment where high quality patient care is achieved. During this program, LifeLong Medical Care’s professionalism standards must be carried out by exhibiting compassion, integrity and respect while interacting amongst faculty, staff, and most importantly patients. Professional and ethical behavior must be practiced consistently due to the sensitivity and complexities of our diverse patient population. Violation of this policy will result in protocols listed in the official Professionalism Policy.

QUALITY IMPROVEMENT

As a physician in the LifeLong Medical Care Family Medicine Residency Program, residents will have the opportunity to practice team-based quality improvement (QI) from day one. LMC’s goal is to provide clinical and didactic experiences to prepare resident to utilize the QI process throughout the duration of their medical practice. The first year of training is primarily focused on learning QI tools and processes. During the second and third year of training, residents will be expected to take on a leadership role and help direct the team through project creation, developing SMART goals, and implementing successive Plan-Do-Study-Act (PDSA) cycles. Residents will have the opportunity to present their QI work as one of the required scholarly activities for residency or potentially at a local/national conference.

In their PG1 year residents will receive a lecture on the basics of scholarly writing and statistics to ensure that they have the skills to critically evaluate journal articles along with an introduction to scholarship types and resources. In their one-on-one biannual meetings with the Program Director or mentor, all residents will be individually mentored on additional methods and opportunities for scholarly work as well as completing an academic plan for scholarship. Biannual meetings with the PD will continue in PGY2 and PGY3 in order to specifically focus on resident scholarly development.

The Family Medicine outpatient (FMOP) rotations in PGY1, 2, and 3 will include structured, supported QI projects that will qualify for scholarly work as posters, presentations, or publications, as well as qualify for ABFM Part 4 Maintenance of Certification requirements for the PGY3 Board Certification exam.

RESEARCH/SCHOLARLY ACTIVITY

All residents are expected to complete two scholarly activities by the end of residency; one must be a QI/QA project. Scholarly activity can take a variety of forms and includes: presenting a poster/case study/original research locally or at a regional/national conference; publishing original research; publishing an op-ed in a local/state newspaper (explaining the meaning and significance of a current public health concern); and publishing a letter to the editor of a national medical journal that analyzes/critiques a paper authored by others. Scholarly activity also includes leading local/state patient education conferences, serving as the chair of a local/state medical society or committee (with a published report of accomplishments) and even preparing a curriculum or QI/QA activity for use in the residency program. The above list is not comprehensive and when considering activity that can be used to fulfill the scholarly activity requirement there are two main tenets:

1. The work must be shared with peers.
2. The work must be subject to peer review.

Progress on scholarly activity will be monitored in meetings with your advisor/mentor and also on your bi-annual progress report. Failure to complete scholarly work will hinder graduation.
To promote scholarly activity and collegial interaction LMC FMRP encourages presentation of research and/or contributions at professional meetings. Subject to availability of funds, LMC FMRP will cover the first $1,000 in expenses including registration, travel, lodging and meals to such forums and will allow up to 5 days of excused absence to attend.

**PROGRAM DUTY HOUR MONITORING PROCESS**

All residents are limited to work a maximum of 80 clinical and educational hours per week and must be scheduled one-day-off-in-seven free of clinical work and required education, averaged over a four-week period. This includes all hours worked in-house, clinical work done at home, and any moonlighting. Residents will have eight hours off between scheduled clinical work and education periods. Under any circumstances when residents choose to stay to care for patients or return on site fewer than the eight hour off period, this must only occur within the context of the 80 hour and one-day-off-in-seven requirements.

Residents must be scheduled for in-house call no more than every third night over a four-week period. For 24 hours of in-house call, residents must have at least 14 hours free of clinical work and education. Please refer to the Clinical Experience and Education policy for more details regarding clinical education and experience hours. Further information may be found in the Clinical Experience and Education Policy.

**LOGGING CLINICAL EDUCATION & EXPERIENCE HOURS**

All residents are limited to work a maximum of 80 clinical and educational hours per week and must be scheduled one-day-off-in-seven free of clinical work and required education, averaged over a four-week period. This includes all hours worked in-house, clinical work done at home, and any moonlighting. Residents will have eight hours off between scheduled clinical work and education periods. Under any circumstances when residents choose to stay to care for patients or return on site fewer than the eight hour off period, this must only occur within the context of the 80 hour and one-day-off-in-seven requirements.

Residents must be scheduled for in-house call no more than every third night over a four-week period. For 24 hours of in-house call, residents must have at least 14 hours free of clinical work and education. Please refer to the Clinical Experience and Education policy for more details regarding clinical education and experience hours. Further information may be found in the Clinical Experience and Education Policy.
# Rotation Information

## Block Rotation Schedule

<table>
<thead>
<tr>
<th>PGY-1</th>
<th>Rotation</th>
<th>Pediatrics</th>
<th>BH</th>
<th>ER</th>
<th>NIC</th>
<th>LMC</th>
<th>LMC</th>
<th>OBG</th>
<th>CCRM</th>
<th>CCRM</th>
<th>ORC</th>
<th>ER</th>
<th>ASK</th>
<th>OB</th>
<th>Electives</th>
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<tbody>
<tr>
<td>Site</td>
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<td>100</td>
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<td>0</td>
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<tr>
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<table>
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<th>CCRM</th>
<th>CCRM</th>
<th>ORC</th>
<th>ER</th>
<th>ASK</th>
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<th>Electives</th>
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<table>
<thead>
<tr>
<th>PGY-3</th>
<th>Rotation</th>
<th>Pediatrics</th>
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<th>CCRM</th>
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</tbody>
</table>

Possible Electives: Addiction Medicine, Obstetrics, Gynecology, Allergy and Immunology, Otolaryngology, Behavioral Medicine, Reproductive Medicine, Palliative Medicine.
**ROTATION TRAVEL**

*All directions originate from LifeLong William Jenkins Health Center.*

**Alta Bates Summit Medical Center**

![Map of Alta Bates Summit Medical Center](image1)

**Bay Area Orthopaedics /Dr. Rakesh Donthineni, MD, Inc.**

![Map of Bay Area Orthopaedics](image2)
Contra Costa Regional Medical Center

<table>
<thead>
<tr>
<th>150 Harbour Way S, Richmond, CA 94801, USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.4 mi. About 28 mins</td>
</tr>
<tr>
<td>1. Head north on Harbour Way toward Bissell Ave</td>
</tr>
<tr>
<td>2. Turn right onto Barrett Ave</td>
</tr>
<tr>
<td>3. Sharp left onto San Pablo Ave</td>
</tr>
<tr>
<td>4. Slight right onto the Interstate 80 E ramp to Sacramento</td>
</tr>
<tr>
<td>5. Merge onto I-80 E</td>
</tr>
<tr>
<td>6. Take exit 23 to merge onto CA-4 E toward Stockton</td>
</tr>
<tr>
<td>7. Take exit 9 for Alhambra Ave toward Martinez</td>
</tr>
<tr>
<td>8. Sharp left onto Alhambra Ave</td>
</tr>
<tr>
<td>9. Turn left onto B St</td>
</tr>
<tr>
<td>Destination will be on the right</td>
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</tbody>
</table>

| 2500 Alhambra Ave, Martinez, CA 94553, USA |

Children's Hospital Oakland

<table>
<thead>
<tr>
<th>150 Harbour Way S, Richmond, CA 94801, USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.9 mi. About 17 mins</td>
</tr>
<tr>
<td>1. Head south on Harbour Way toward Chambers Ave</td>
</tr>
<tr>
<td>2. Merge onto I-580 E via the ramp to Oakland</td>
</tr>
<tr>
<td>3. Take the exit onto I-580 E/I-80 W toward Oakland/San Francisco</td>
</tr>
<tr>
<td>4. Take exit 88 on the left for I-580 E toward Downtown Oakland/Hayward/Stockton</td>
</tr>
<tr>
<td>5. Continue onto I-580 E</td>
</tr>
<tr>
<td>6. Take the CA-24 exit toward Berkeley/Walnut Creek</td>
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<tr>
<td>7. Keep right, follow signs for Martin Luther King Jr. Way and merge onto Martin Luther King Jr. Way</td>
</tr>
<tr>
<td>8. Turn right onto 32nd St</td>
</tr>
<tr>
<td>9. Turn right</td>
</tr>
<tr>
<td>Partial restricted usage road</td>
</tr>
<tr>
<td>Destination will be on the left</td>
</tr>
</tbody>
</table>

| 747 52nd St, Oakland, CA 94609, USA |
Kaiser Permanente Richmond

1. Head north on Harbour Way toward Bissell Ave.
2. Turn left at the 3rd cross street onto Nevin Ave. Destination will be on the right.

Kaiser Pediatrics Oakland

- Get on I-580 E
  - 3 min (0.9 mi)
- Continue on I-580 E. Take I-80 W to 34th St in Oakland. Take the exit toward Broadway Auto Row/Webster St from I-580 E
  - 12 min (10.2 mi)
- Continue on 34th St. Take Broadway to Kaiser Hospital
  - 3 min (0.3 mi)
MILEAGE REIMBURSEMENT

Residents who wish to be reimbursed for travel from different sites may submit a mileage/travel reimbursement claim form. This form is located on the Sharepoint main page (https://staff.lifelongmedical.org) under LifeLong Documents and Forms. Select “Form Type: General Forms” and use the bottom right arrow to scroll until you find the Excel document labeled “Mileage Reimbursement Form.”

Please fill out the form and include any documents needed (receipts, map showing travel, etc.) and have your supervisor sign. Upon completion, please have your designated residency staff sign and submit the form to the Program Coordinator for final approval. A check will be processed and mailed.

Please note: Do not fill in the grant number section. Parking may be reimbursed, but lodging, meals, taxi, and tolls are not reimbursable.
**Rotation Goals & Objectives**

In addition to program goals and objectives, each rotation has a detailed description, specific goals and objectives that align with the six core competencies, and an evaluation tool. Residents can access rotation descriptions, goals and objectives, and evaluations using New Innovations.

**Electives**

LifeLong is committed to providing residents with opportunities to complete electives in areas that are not traditionally covered in the core rotations. Electives allow the resident to pursue complementary educational experiences which are both relevant to the resident’s future practice of family medicine and to their professional and personal growth. Electives might be specialty areas within the current training hospital on which the resident doesn’t traditionally rotate, off-campus, out of state, or even in different countries.

Residents in good standing may schedule a maximum of 1 block (4 weeks) of elective rotations during their PGY2 year and a maximum of 2 blocks (8 weeks) of elective rotations during their PGY3 year. Offsite electives are a privilege given to PGY3 residents in good standing.

**Requesting Electives**

Requests for electives need to be made a minimum of three months in advance to the resident’s Program Director and is a two-step process.

**Step 1:** An initial request needs to be made in writing and must include a description of the rotation (including anticipated dates) and justification for the educational experience. Initial requests need to be signed by the resident advisor/mentor and submitted to the Program Director. If the Program Director determines that the applicant is in good standing and feels that the experience would likely benefit the applicant, they will be asked to complete the second step. Approval of step 1 will be made within 1 week. If initial approval is granted the resident may move on to step 2.

**Step 2:** For the second step of the approval process, the resident must:

1. Complete a written curriculum (with the help of their advisor and program director) to develop goals and objectives for their elective that fit within their overall goals for residency and their eventual career.

2. The resident (with the help of their advisor and program director) should also designate a rotation supervisor at the site, who will be required to complete an evaluation of his/her elective rotation performance.

Once these two steps are completed, the resident must submit the materials/information to the Program Director for final approval. Final approval is granted when the resident, rotation supervisor, and program director sign the written curriculum.

All elective rotations must include:

A. Four half-day clinics during their elective experience (residents may request a lesser number of clinics for electives subject to program and clinic approval, and at the discretion of the program director).

B. A written evaluation based on the curricular objectives to be completed by the rotation supervisor. Credit for the elective is not granted until the evaluation is completed by the rotation supervisor.

**Resident Responsibilities During Electives**
● All residents must maintain good communication with the program director, rotation supervisor and/or any faculty member associated with the elective process. Changes to the curriculum and/or structure must be communicated with all parties as soon as possible.

● Residents must arrange for/pay for their own travel, room, board and incidental expenses during their electives.

● If a resident is on an elective outside of the LifeLong Medical Center system, they need to familiarize themselves with the policies and procedures of the institution in which they are rotating.

Residents Who Do Not Select Independent Electives
Residents who do not propose and develop their own elective at least three months (90 days) prior to the first day of their scheduled elective rotation(s) may select from a menu of structured electives; an updated list of these electives is available for review through the residency coordinator. If a resident does not choose a structured elective between 89-31 days before assigned elective date start, one will be assigned to them at the discretion of the LifeLong Residency Program.

SCHEDULE CHANGES
Rotation schedules are set prior to each academic year and residents will have the opportunity to make requests prior to schedule finalization. Once the schedule is released for the academic year requests for changes will be made on a case by case basis. Requests for rotation schedule changes should be made a minimum of 3 months in advance in writing to the program director and copied to the program coordinator.

Clinic schedules are set many months in advance and take into account site workload and production flow, patients’ service needs, and the efficient management of personnel resources; Therefore, it is the policy of LifeLong Medical Center to not modify work schedules once the schedule is distributed. Given the complexity of coordinating schedule changes for the various residents and other medical providers, alternative work schedules will not be considered, unless there are extenuating patient circumstances and the change can be accommodated easily.

LIFELONG WILLIAM JENKINS HEALTH CENTER HOURS

<table>
<thead>
<tr>
<th>William Jenkins Health Center</th>
<th>Address:</th>
<th>Clinic Hours:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>150 Harbour Way, Richmond, CA 94801</td>
<td>Monday-Friday 8:00 am-5:00 pm</td>
</tr>
</tbody>
</table>

CHANGES TO HOME CALL ASSIGNMENTS
Time spent on patient care activities by residents on at-home calls count toward the 80-hour maximum weekly limit. At-home calls are 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 calls must not be so frequent so it interferes with rest or reasonable personal time for each resident.

Residents must return to the hospital while on at-home call to provide direct patient care for new and existing patients. These hours of inpatient care must be reflected in the 80-hour maximum weekly limit.
**CHANGES TO NIGHT FLOAT ASSIGNMENTS**

Each resident may be assigned night float annually and the schedule will be available for the academic year at the start of the year. Night float assignment takes into account the block rotation schedule and individual resident vacation requests and therefore it is very difficult to make changes once night float is assigned for the year. If a resident wishes to change an assigned week of night float they must speak to the Program Coordinator with their request ASAP; however, changes cannot be guaranteed.

**CONTINUITY OF CARE**

Continuity of care is central to the LifeLong Medical Care FMRP training for residents. LifeLong Medical Care is the site of the FMRP continuity clinic for all 3 years of the residency program. Residents spend 1 to 4 sessions each week in the FMP for a total of 44 weeks in continuity clinic. When schedules allow, residents may attend to their continuity patients when admitted to the hospital, communicate with the inpatient team, see patients for rounds as often as possible, and accept sign out of the patient at discharge. Residents are also responsible for communication and follow up with specialists for their continuity patients.

Each resident is assigned a panel of patients that is demographically balanced. At least ten percent of continuity patients are pediatric patients and at least ten percent of patients are geriatric patients. The approximate panel sizes are as follows:

- PGY1: 125 patients
- PGY2: 250 patients
- PGY3: 325 patients

Residents will complete over 1,900 continuity visits. The number of continuity patient visits is tracked for each resident. The goal number of visits per session per PGY for each resident is as follows:

- PGY1: 3 visits per session, increasing to 5 visits per session by the end of the year
- PGY2: 6 visits per session, increasing to 8 visits per session by the end of the year
- PGY3: 9 visits per session

More patients scheduled per session than goal numbers (listed above) may be scheduled depending on show rates per resident. Resident and patient continuity will be tracked with targets that are national benchmarks for high performing teaching clinics. In order to ensure success, corrective action plans will be generated on a quarterly basis for residents who do not meet targets.

**RESIDENT SCHOLARLY PROJECT AND SUPPORT FOR SCHOLARLY ACTIVITY**

All Family Medicine Residents are expected to complete two scholarly activities by the end of residency with one being a QI/QA project. Scholarly activity can take a variety of forms and includes presenting a poster/case study/original research locally or at a regional/national conference; Publishing original research, publishing an Op-Ed in a local/state newspaper (explaining the meaning and significance of a current public health concern), or publishing a letter to the editor of a national medical journal that analyzes/critiques a paper authored by others. Scholarly activity also includes leading local/state patient education conferences, serving as the chair of a local/state medical society or committee (with a published report of accomplishments) and even preparing a curriculum, or QI/QA activity for use in the residency program. The above list is not comprehensive and when considering activity that can be used to fulfill the scholarly activity requirement there are two main tenets: 1) the work must be shared with peers and 2) be subject to peer review.
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CORE COMPETENCIES AND MILESTONES

CORE COMPETENCIES

Patient care and procedures: Provide primary care for all ages and genders including problem-based and preventive care, cognitive and procedural care, and office, hospital, home, and long-term residence based care.

Medical knowledge: Maintain a working knowledge of current best evidence-based practice of Family Medicine, achieving and maintaining Board certification in Family Medicine.

Practice-based learning and improvement: Life-long learning, self-evaluation and professional improvement; accessing and utilizing current evidence to improve care; application of quality improvement tools to improve practice; adoption of new information technology; educating medical students, residents, and other health professionals.

Interpersonal and communication skills: Build collaborative relationships with patients, their families, colleagues, and other health professionals to provide patient-centered team-based care.

Professionalism: Respect the rights, values, needs, and autonomy of all patients, colleagues, co-workers, and students; respecting the unique perspectives of people diverse in age, gender, ethnicity, religion, physical abilities, and sexual orientation; and contributing to the improvement of the profession.

Systems-based practice: Function effectively as a member and leader of health care teams and systems, and contributing to improvements in the value of health care at the systems level.

MILESTONES

1. Health Promotion and Wellness (PC1)
2. Care of the Acutely Ill Patient (PC2)
3. Care of Patients with Chronic Illness (PC3)
4. Ongoing Care of Patients with Undifferentiated Signs, Symptoms, or Health Concerns (PC4)
5. Management of Procedural Care (PC5)
6. Demonstrates MK of Sufficient Breadth and Depth to Practice Family Medicine (MK1)
7. Critical Thinking and Decision Making (MK2)
8. Patient Safety and Quality Improvement (SBP1)
9. System Navigation for Patient-Centered Care (SBP2)
10. Physician Role in Health Care Systems (SBP3)
11. Advocacy (SBP4)
12. Evidence-Based and Informed Practice (PBLI1)
13. Reflective Practice and Commitment to Personal Growth (PBLI2)
14. Improves Systems in Which the Physician Provides Care. (PBLI3)
15. Professional Behavior and Ethical Principles (PROF1)
16. Accountability/Conscientiousness (PROF2)
17. Self-Awareness and Help-Seeking Behaviors (PROF3)
18. Patient- and Family-Centered Communication (ICS1)
19. Interprofessional and Team Communication (ICS2)
20. Communication within Health Care Systems (ICS3)
DOCUMENTATION

COMPLETING CHART NOTES

Residents must abide by the following procedures when documenting and completing chart notes in patients’ electronic medical records and for review of outside clinical information sent to the record.

1. Clinic staff are not permitted to take physical copies of protected health information out of the office for review.
2. All orders must be completed and signed at the time of the visit.
3. Chart notes must be completed and signed within two business days of the visit.
4. After charts are locked at the end of this two (2) day period; any late entries to the encounter must be posted in the form of an addendum to the locked entry.
5. Staff’s direct edits of the chart beyond the permitted time frame without specifically noting the edit as a “late entry” or “addendum” will be deemed tampering with the chart and will be subject to the appropriate course of disciplinary action.
6. For outside clinical information that comes to the patient’s electronic record (e.g. lab and imaging results, consult reports, hospital records, etc.), results of high importance must be reviewed within one (1) business day and those of low importance within four (4) business days.
7. Reports are run by designated staff on a regular basis to monitor staff compliance with this rule.
EVALUATION AND PROMOTION

FORMATIVE EVALUATIONS

The ACGME Common Requirements state that “The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. The program must: provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); (3) document progressive resident performance improvement appropriate to educational level; and, (4) provide each resident with documented semiannual evaluation of performance with feedback. The evaluations of resident performance are accessible for review by the resident. In order to review an evaluation, the resident must schedule an appointment with the Program Director and meet with the Program Director.” (ACGME Common Requirements, Section V.A.2.)

RESIDENT ROTATION EVALUATIONS

During each rotation, the resident will be evaluated by their supervising attending via direct observation and evaluated monthly by global assessments via the computerized formative evaluation tools in New Innovations. LifeLong Medical Care is committed to promoting a culture in which the reporting of deficiencies in ability is not seen in a negative light but rather as a positive means for continual improvement and this culture will be cultivated in the LifeLong residency program. Feedback will be given formally and directly to the resident every two weeks by the supervising attending for each rotation. At the Clinical Competency Committee, which meets bi-annually, formative evaluations will be reviewed, group discussion will occur, and consensus decisions will be made about which residents are appropriate for advancement in progressive authority and responsibility including conditional independence and supervisory roles in patient care.
Residents will be evaluated at the end of each rotation. Evaluation specific rotations will be available on New Innovations for residents to access as needed.
PROGRAM AND FACULTY EVALUATION PROCESS

The Program Director will be evaluated on an annual basis. Evaluators will measure the Program Director’s ability to commit to his duties, setting priorities for the residency program, meeting expectations or responsibilities, maintaining communication between faculty and residents on any pressing issues or developments, ability to effectively oversee the residency program, availability and support for faculty and residents, and other metrics as detailed in the Program Director Annual Review evaluation tool. Evaluators will be able to provide any additional comments/feedback pertaining to the performance of the Program Director. Program Director evaluations will be done using the Program Director Annual Review form and will be submitted anonymously.

Residents will have the opportunity to submit anonymous faculty evaluations during each rotation. Faculty evaluations will measure their supervision, teaching skills, encouragement on self-directed learning, commitment to the educational program, clinical knowledge, professionalism, scholarly activities, and clinical efficiency with teaching rounds. Evaluators will be given the chance to provide any additional feedback pertaining to the overall performance of faculty. Faculty evaluations will be completed using the Resident Evaluation of Faculty form. To ensure confidentiality any information identifying the evaluator will be removed and evaluations will be released to faculty when 3 evaluations have been completed by residents, or at the end of the academic year.

All data collected and program regarding the faculty will be utilized to enhance the Residency Program through review by the PEC and the GMEC’s Sub-committee for Institutional Review.

SEMI-ANNUAL REVIEW

A comprehensive semi-annual review will be conducted by either the resident’s advisor or program director and will include a review of compliance with rotation curricula requirements, conference attendance, duty hour compliance and violations, procedure log to date, aggregate comments from individual rotation evaluations, information on certification status, test scores, overall average scores on competencies by rotations completed, and milestone progress on your 22 milestones and finally overall aggregate competency progress. This information will be reviewed between the resident and advisor at their semi-annual face to face.

MULTI-SOURCE/360 EVALUATION

As referenced above, the ACGME Common Requirements call for a Multi-source or 360 evaluation that includes a resident’s evaluation by his/her faculty, peers, patients, self, and other professional staff. With the exception of patient evaluations and monthly rotation evaluations, all other faculty/advisee, peer and staff evaluations will occur semi-annually. Individual evaluations will be compiled in the resident’s individual portfolio and will be reviewed during the semi-annual clinical competency committee. The resident and his/her advisor will review the compilation of evaluation information together during their semi-annual face-to-face evaluation meeting.

SUMMATIVE EVALUATION

The Family Medicine Milestones will be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program.

The program director will provide a summative evaluation for each resident upon completion of the program. This evaluation will (1) become part of the resident’s permanent record maintained by LifeLong and will be accessible for review by the individual resident upon scheduling an appointment and meeting with the Program Director. The Summative Evaluation documents the resident’s performance during the final period of education; and, verifies that the resident has demonstrated sufficient competence to enter practice without direct supervision. (V.A.3)
**Residents and Faculty ACGME Surveys**

ACGME conducts an annual survey of all faculty and residents. That results of these two surveys are compiled and stripped of any respondent names. The compilation is provided to the Program Director and DIO for review. The PEC and the GMEC will review the outcomes and, if necessary call for a Special Review of the program. Any negative outcomes will result in the Program Director developing a corrective action plan which is then approved and monitor by the GMEC.

**Evaluation of Didactics**

At the conclusion of every didactic session each resident will complete an evaluation on the topic, speaker, and the extent to which the objectives of the lecture were fulfilled. This information will be used to provide feedback to the Program Director and individual lecturer in order to continuously improve our didactics.

**Evaluation Forms**

All evaluations are available in New Innovations.

**In-Training Examinations (ITE)**

Each October, all residents in the LifeLong Family Medicine Residency will be required to take the In-Training Examination (ITE). The ITE is a computer-based examination with 240 multiple-choice questions with content that mirrors the ABFM Certification examination. The purpose of the examination is to provide norm-based PGY year assessment of each resident's progress, while also providing programs with comparative data about the program as a whole.

Scores on the ITE will be used for formative feedback for self-evaluation and as part of programmatic evaluation. Low ITE scores that corroborate an overall pattern of deficient performance may adversely affect resident advancement. Remediation, or remedial instruction, may be required for scores which are significantly below expected performance.

(Click here to download the ITE content outline.) The examination includes 4–8 pictorial items, which may be radiographs, EKGs, pictures of dermatologic conditions, or other images.

**Residency Evaluation Management System**

All residents will be required to use New Innovations to log duty hours and procedures, review rotation curriculum, view rotation and vacation schedules, to evaluate didactics and faculty and to review competency based evaluations of their performance. Information on how to access New Innovations and how to use specific portals will be provided during orientation. Faculty will have access to New Innovations to view schedules and to evaluate residents as well as view anonymous evaluations of their teaching by residents. If you have problems accessing New Innovations, please contact the Program Coordinator.

**Requirements for Program Advancement, Promotion, and Graduation**

The Program Director, with recommendation from the PEC and advice of faculty, determines the decision to promote or graduate each resident.

Advancement is based upon demonstrated competency in the six ACGME core competencies:
1. Patient care
2. Medical knowledge
3. Practice-based learning
4. Interpersonal communication skills
5. Professionalism
6. Systems-based practice

Detailed information, as well as additional promotion requirements for each year and for graduation, can be viewed in the *Resident Renewal and Promotion Policy* as well as New Innovations.

The Program Director provides a written final or summative evaluation for each resident. This evaluation is based on performance during the final period of training and verifies that the resident demonstrated sufficient professional ability to practice effectively and responsibly based on the residents academic file.

**PROCEDURE LOGS AND DUTY HOURS TRACKING**

Residents are expected to log duty hours and procedures online using New Innovations. Residents must log in a timely fashion and duty hour or procedure logs that are significantly in arrears will be flagged for review by the Program Director. Residents with out of date logs will not be promoted to the next year of training.

**PROGRAM EVALUATION COMMITTEE (PEC)**

The Program Evaluation Committee will be chaired by the Program Director. The committee will be responsible for conducting evaluations at least annually while complying with the Program Requirements set by ACGME. The PEC will monitor and track resident performance, faculty development, ABFM certification examination of graduates, program quality, plan of action, and will produce a written report including these details. The PEC will meet quarterly and once additionally at the end of year to produce the APE. PEC will meet for any urgent meetings as well. For any additional information regarding PEC, please refer to the Program Evaluation Committee policy.

**CLINICAL COMPETENCY COMMITTEE (CCC)**

The Clinical Competency Committee will consist of the Program Director, Practice Director, In-patient Services Director as well as any additional physician faculty members appointed by the Program Director. The CCC will be responsible for performing semi-annual reviews on all residents, reporting extensive Milestones evaluations on residents semi-annually to ACGME, and advising the Program Director on resident progress, including promotion, remediation and dismissal. For further details on the CCC and evaluations process, please refer to the Clinical Competency Committee policy.
RESIDENT MENTORSHIP & RESIDENT FORUM

RESIDENT MENTORSHIP

Each resident is assigned a faculty advisor whom they are required to meet with. The faculty advisor is a mentor for the resident in their professional career as well as a sounding board for concerns and support. Each faculty advisor provides feedback to the Clinical Competency Committee twice per year and is responsible for discussion on individual academic achievements and the academic plans.

Twice a year, residents meet one on one with the Program Director for individual mentorship on methods and opportunities for scholarly work as well as create an academic plan for scholarship. In the second and third years, residents will focus on scholarly development in their meetings with the Program Director.

THE RESIDENT FORUM

The Resident Forum meets monthly to address issues related to the resident work environment and education experience. The Resident Forum also participates in improving methods of delivering care to patients. Committee members are expected to disseminate information from the committee to their colleagues and to bring issues from their colleagues to the committee. All residents are invited to participate.
LIBRARY & ELECTRONIC RESOURCES

COMPUTER RESOURCES

All residents must have access to adequate communication technologies and technological support to complete their daily work and fulfill their residency documentation requirements (duty hours, procedure logs etc.). Computers will be available on site for documentation of residency activity using the software New Innovations. Ask individuals on site for directions of which computer to use at each location.

LIBRARY RESOURCES

To complement clinical training residents will have access to a large system of online e-resources to enhance their education including Up-To-Date, Dynamed, Clinical Online Library, the Natural Medicine Database, and a wide selection of Family Medicine journals and textbooks. Use of e-resources is subject to copyright laws and individual software regulations.

To complement electronic resources, The Medical Library has specific Family Medicine reference materials and participating sites (UCSF Benioff Children’s Hospital of Oakland, Contra Costa Medical Center and Kaiser Permanente East Bay) have onsite librarians skilled at assisting residents in accessing literature searches and reference materials for all specialties including Family Medicine.
SITE INFORMATION

LIFE LONG MEDICAL CARE, WILLIAM JENKINS HEALTH CENTER

The LifeLong Medical Care William Jenkins Health Center is located at 150 Harbour Way, Richmond, CA 94801. This is the primary site of the residency program, the family medicine outpatient rotations, and continuity clinic. All residents will receive badges to enter the building. The residency is located on the third floor of the building. Each resident will have a desk of their own in the resident work room. Faculty, program administrators, and staff have offices adjacent to the resident work room. Didactics will occur in the conference room located across from the resident work room. The outpatient clinic where residents and faculty will work is also located on the third floor. Parking is on the street and free. There is no call room but there is a lactation room available. Residents have access to a lounge and outdoor balcony on the third floor. For any onsite assistance, please contact the Program Coordinator.
Alta Bates is located at 2450 Ashby Ave, Berkeley, CA 94705. Please park in the garage on the first day by taking a ticket, but then exit with your badge at the end of the day. Once you get your ID, you will be able to enter and exit without paying. Prior to rotation, you will receive an email from the Medical Staff office at Alta Bates for anything needed for your credentialing process. You will have a brief orientation with a credentialing specialist in the Medical Staff office on the first floor of the hospital, followed by a 3-hour EHR orientation with a physician liaison specialist.

L&D is located on the 3rd floor, which can be reached via elevator or stairs. If you take the stairs, ID badge access is required to open the door. This will be automatically activated for you. Touch base with your preceptors before the first morning of each week to set a meeting place. Sign-out happens in the CNM/MD lounge on the 3rd floor, in the call room, or on the 3rd floor of the hospital. There is a doctors’ lounge in the cafeteria that serves breakfast and lunch. Locker rooms are on the 3rd floor to leave belongings and get scrubs from the machine. Your ID gives you access to this.

On the nights you are on call, you will need to sign up for a call room located on the 6th floor of the hospital. You use your ID badge to enter the hallway. Find an open room and add your name to the sign-up sheet on the door. One of your weekday preceptors can orient you to all of the above locations and share any necessary access codes or combinations. For any onsite assistance, please contact site director, Dr. Katarina Lanner-Cusin.
The Children’s Hospital Oakland main campus is located at 747 52nd Street, Oakland, CA 95609 and the Summit Street campus is located at 3100 Summit Street, Oakland, CA 95609. There is free parking right across the street from the main hospital. At the main campus, call rooms are located on the same floor as the patients and are accessed by badge or key. There is a resident lounge on the third floor of the main campus.

At Summit, there are multiple conference rooms available for resident work, educational purposes, and meals. Additionally, there is one shared lounge for all staff. Parking is to be covered by GME. At both sites, the parking structure is across the street from the hospital. For any onsite assistance, please contact site director, Dr. Pamela Simms-Mackey.
The Contra Costa Regional Medical Center is located at 2500 Alhambra Avenue, Martinez, CA 114553-1495. Residents may park in the employee or patient/visitor parking at no cost. Additionally, there is a free valet service available. The resident lounge is located on the fifth floor, Room 5535. The phone number for the resident lounge is 925-370-5620 or 925-370-5621. The call room is located on the third floor in the hallway to the left of the IMCU waiting room. The code for the call room is 2450. There is another call room on the fifth floor in the corner of the back hallway (between the pediatrics office/nursery and L&D). The code is 9055. Residents may use the lounge on the fifth floor in the corner on the right past the security desk for L&D. The code for the lounge is 5355#. For any onsite assistance, please contact site director, Kristin Moeller.
The Kaiser Permanente Medical Center, Richmond, is located at 901 Nevin Street, Richmond, CA 94801. The main phone number is 510-307-1722. There is a physician’s call room in the Emergency Department for residents to use. Residents may park in the Kaiser Permanente parking garage or the lot adjacent to the medical center. For any onsite assistance, please contact your site director based on rotation: Steven Bailey, affiliate site director, Emergency Medicine; Rosa Valadao, affiliate site director, Gastroenterology; Tova Mannis, affiliate site director, Ophthalmology; Peter Le, affiliate site director, Pulmonary; Ciana Leatherwood, affiliate site director, Rheumatology; and David Aaronson, affiliate site director, Urology.
The Kaiser Permanente Medical Center, Oakland, is located at 3600 Broadway, Oakland, CA 94611. The main phone number is 510-752-1000. The Pediatrics department is located in the Mosswood Building at 3505 Broadway, Oakland, CA 94611.

There is a physician’s call room for residents to use. Residents may park in the Kaiser Permanente parking garage or the lot adjacent to the medical center. For any onsite assistance, please contact Jeana Radosevich, MD.
Bay Area Orthopaedics is located at 5700 Telegraph Ave, Suite 100, Oakland, CA 94509. This office is a private, outpatient clinic. There are no call rooms or resident lounge at this location. Parking is located behind the office, but it highly suggested for residents to park on the street as the lot is mainly for patient use. There is ample street parking for residents to use. For any onsite assistance, please connect with site director, Dr. David Chang.
Dr. Rakesh Donthineni MD, Inc. is located at 5700 Telegraph Ave, Suite 100, Oakland, CA 94509. This office is a private, outpatient clinic. There are no call rooms or resident lounge at this location. Parking is located behind the office, but it highly suggested for residents to park on the street as the lot is mainly for patient use. There is ample street parking for residents to use. For any onsite assistance, please connect with site director, Dr. Rakesh Donthineni.
LIFELONG MEDICAL CARE
Job Description

POSITION: Resident, LifeLong Medical Care Family Medicine Residency Program

REPORTS TO: Director, LifeLong Medical Care Family Medicine Residency Program

POSITION SUMMARY: The LifeLong Family Medicine resident position entails provision of patient care matching with the individual physician's level of advancement and competence. A resident physician's responsibilities include patient care activities and educational activities within the scope of their clinical privileges commensurate with the level of training. Expectations include attendance at clinical rounds and didactics, timely completion of medical records, compliance with all educational and record keeping responsibilities, and demonstration of proficiency on the core competencies.

FLSA Classification: Exempt

Overall Description
The LifeLong Family Medicine resident position entails provision of patient care matching with the individual physician's level of advancement and competence. A resident physician's responsibilities include patient care activities and educational activities within the scope of their clinical privileges commensurate with the level of training. Expectations include attendance at clinical rounds and didactics, timely completion of medical records, compliance with all educational and record keeping responsibilities, and demonstration of proficiency on the core competencies.

All residents in the LifeLong Family Medicine Residency Program are employees of LifeLong Medical Center and must abide by their policies and procedures.

Residents are taught and evaluated according to the six (6) core competencies established by the Accreditation Council of Graduate Medical Education (ACGME): Medical Knowledge, Patient Care, Professionalism, Practice Based Learning, Systems-Based Practice, and Interpersonal Communication.

Residents are expected to complete evaluations for each rotation for which they participate, for faculty and peers with whom they work, and of the program.

Essential Functions
1. Provide responsible, safe, efficient, and compassionate physician practice activities and progressive acquisition of clinical skills consistent with the practice of Family Medicine.
2. Participate fully in assigned educational activities, including conferences, rotations, workshops, simulation and journal clubs.
3. Provide patient care under the supervision of a member of the Family Medicine faculty or other supervising licensed independent practitioner, as assigned by the Resident Program Director. Practice at a level commensurate with experience and skills; seek supervision when care demands.
4. Treat each patient encountered and all other persons with whom you interact with respect, dignity and compassion.
5. Recognize own role as a learner and participate in available opportunities to enhance learning.
6. Ensure timely attendance and deadline management for all clinical and educational activities.
7. Be receptive to feedback and opportunities for personal and professional growth.
8. Be a team player; recognize role and limitations in/to team.
9. Practice cost effective care.
10. Maintain certification in ACLS, PALS, NRP, ALSO, and BLS protocol where required during patient care.
11. Log required procedures, duty house, and complete evaluations as outlined in LifeLong Policies.
12. Complete timely and comprehensive medical records.
13. While on duty, wear white lab coat and hospital-issued identification badge.

Primary Duties and Responsibilities
In addition to the essential functions outlined above, residents will be responsible for the following based on their PGY training year:

PGY-I
- Under direction of attending or senior resident, see a broad spectrum of patients with an emphasis on quality of patient evaluation and care.
- Perform the initial patient assessment and actively participate in all aspects of patient care, including history and physical, diagnostic and therapeutic planning, procedures, writing orders, and family interactions.
- Conduct an in-depth discussion of all cases with the attending prior to all diagnostic studies or therapeutic interventions.
- PGY1 residents can have no conduct no supervision or direction of decisions of other residents or medical students.
- All procedures must be done under direct approval and supervision of attending.

PGY-II
- Must be familiar with patients and serve as the attendings’ principal resource for day-by-day patient data.
- May supervise junior trainees and/or medical students.
- Must seek and gain experience with full spectrum of procedures; working to increase proficiency, efficiency, and quality of patient evaluation and care.
- Initiate common diagnostic studies and therapeutic interventions in straight forward patients, prior to attending presentation.
- Make decisions regarding invasive procedures, change in plans, discharge or problems are discussed in-depth with the attending. Specialized diagnostic studies, uncommon therapeutic interventions, and use of consultants, must be discussed with the attending prior to initiation.
- All procedures must be completed with attending supervision and approval.

PGY-III
- Play supervisory role with increased teaching, consultative and research activities.
- While seeing a broad spectrum of patients, ensure emphasis is on those with highest acuity or greatest critical illness.
- Manage time and resources efficiently. Work within multiple systems to ensure effective patient flow and coordination of teams.
- Be proficient in a full range of medical procedures as required for graduation.
While PGY3 residents must discuss all cases with the attending they may initiate common diagnostic studies and therapeutic interventions prior to attending discussion. With attending approval, a PGY3 resident may also initiate more sophisticated diagnostic studies and therapeutic interventions.

With attending approval, a PGY3 may take presentations from Jr. residents and/or medical students and assist in their patient care management.

With attending approval, the PGY3 may attempt or initiate procedures.

May assist with the attempt, or initiation of, procedures by more junior level house staff, with attending approval (and if so certified by the residency training program, as appropriate.)

Responsible for running “board rounds” at change of shift.

**Qualifications**

Applicants must meet the qualifications as outlined in the LifeLong GMEC Qualifications of Applicants Policy. In addition, all applicants must meet the following ACGME standards:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME) and successful completion of any pre-requisite accredited training specified by ACGME Residency Review Committees.
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA) and successful completion of any pre-requisite accredited training specified by ACGME Residency Review Committees.
3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
   a) graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or,
   b) graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association (AOA); or,
   c) graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:
      1. holds a currently-valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or,
      2. holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in his or her current ACGME specialty/subspecialty program; or,
      3. has graduated from a medical school outside the United States and has completed a Fifth Pathway** program provided by an LCME-accredited medical school

The resident physician must be in possession of a CA training or unrestricted license, a valid DEA number and current BLS certificate plus other advanced competencies as deemed necessary for their level of training, (ACLS, ATLS, PALS, etc.) to become involved in direct patient care.

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My signature below confirms I have reviewed and received a copy of this job description. I understand and can perform the duties described herein:

_________________________________________  ______________________
Signature         Date
LifeLong Medical Care Family Medicine Residency Program
Resident Training Agreement

Academic Year July 1, 2020 to June 30, 2021

I. This Training Agreement made and entered into this ____ day of ____, 2020 by and between
LifeLong Medical Care ("LMC", also referred to in this Agreement as "the Program") and
______________________________ _____________________________ ("the Resident").
This Agreement shall begin on July 1, 2020 and terminate June 30, 2021 for the PGY ____ year
of training.

II. Background: The LMC Family Medicine Residency Program is a Residency Program
accredited by the Accreditation Council for Graduate Medical Education (ACGME). Residents
are typically selected through the National Residency Match Program following an application
and interview process. All of the Residents in the Program must sign this Agreement and
comply with its terms. It is understood that the Program reserves the right to dismiss the
Resident at any time during the period of training stipulated in this Agreement for just cause.
Renewal of this one-year Agreement is dependent upon satisfactory performance of each year
of training, as determined by the Residency Program Director and the Family Medicine Clinical
Competency Committee. This Resident Training Agreement supersedes any other employment
or training contract or agreement.

III. Terms and Conditions of Appointment to the Educational Program: By entering into this
Agreement, LMC and the Resident assume certain responsibilities and obligations, as outlined
below.

A. Resident’s Responsibilities and Obligations:

1. The Resident shall perform such assignments and duties of the Program,
conscientiously, to the best of his or her ability, and under the highest personal
bond of professional morals and ethics and in accordance with Medical Staff
Bylaws and Rules and Regulations of the participating institutions, and the State
of California Business and Professions Code.

2. The Resident shall develop and adhere to a personal program of self-study and
professional growth.

3. The Resident shall participate fully in the educational and scholarly activities of
the Program, including, but not limited to, the clinical, administrative, didactic,
and academic portions of the Program and curriculum.

4. The Resident shall assume responsibility for teaching and supervising other
Residents and students, as assigned.

5. The Resident shall participate in institutional programs and activities involving
medical staff at the assigned institutions and adhere to established practices,
procedures, and policies of those institutions.
6. The Resident shall further adhere to established practices, procedures, and policies of the institutions that provide the Resident's clinical training. Discipline, however, regardless of which institution provides the Resident's salary line, shall be governed by the LMC policies and procedures.

7. The Resident shall participate in institutional committees and councils, as assigned, especially those that relate to patient care review activities.

8. The Resident shall participate in the Resident Evaluation process. The Resident's duties in this process include, but are not limited to, making appointments to receive and discuss the semi-annual Quality Assurance/Peer Review Letters of Evaluation, acting upon the areas identified in the semi-annual Quality Assurance/Peer Review Letters of Evaluation as warranting improvement, receiving the periodic rotation evaluations, and acting upon areas identified in the periodic rotation evaluations as warranting improvement.

9. The Resident shall participate in evaluation of the quality of education provided by the Program through the formal process by which the LMC faculty, rotations, and the Program are evaluated at least annually.

10. The Resident shall develop an understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education and of how to apply cost containment measures in the provision of patient care.

11. The Resident shall keep charts, records, and/or reports up to date and signed at all times.

12. The Resident shall conduct himself or herself, at all times, in a professional manner consistent with the behavior customarily expected of physicians.

13. The Resident shall cooperate with and participate in quality management, utilization review, and risk management activities.

14. Health Insurance Portability and Accountability Act Of 1996 (HIPAA). The Resident shall: (i) not use or further disclose information other than as permitted or required by this Agreement; (ii) not use or further disclose information in a manner that would violate the requirements of the HIPAA regulations; (iii) use appropriate safeguards to prevent use or disclosure other than as provided in this Agreement; (iv) report to LMC any use or disclosure not provided by this Agreement; (v) ensure that any subcontractors and agents to which the Resident may provide protected health information agree to the same restrictions and conditions as apply to the Resident; (vi) make appropriate health information available upon individual request as appropriate; (vii) make its practices, books, and records relating to the use and disclosure of protected health information available to the U.S. Department of Health and Human Services; (viii) return or destroy all protected health information at the termination of this Agreement; and (ix) authorize the LMC to terminate this Agreement if the Resident has violated a
15. The Resident shall provide services as defined in this Agreement within the scope of the current Joint Commission on Accreditation of Hospital Organizations (JCAHO) and NCQA standards. LMC expects and demands that the aforementioned services shall be performed in a manner consistent with LMC’s policies and procedures and applicable professional standards. Non-compliance upon Resident’s part shall provide LMC with the right to terminate this Agreement for cause. LMC requires that Resident maintain evidence of current clinical competence, which shall be provided to LMC upon request. The Resident shall conduct and document that each individual providing services under this Agreement meets pre-service orientation requirements outlined by JCAHO; e.g., cardiopulmonary resuscitation (CPR), infection control measures, fire, and electrical safety, among others.

16. Attached to this agreement is the Job Description for the particular level of training that applies to the individual resident. By signing this agreement, the resident acknowledges receipt and understanding of that Job Description. Additional copies of the Job Descriptions are available in the Residency Office, the Office of GME, and/or the Human Resources Office.

17. Resident represents and warrants to LMC that: (a) Resident is a student in good standing of an accredited college of medicine or medical school in the United States; (b) Resident has not been the subject of, or otherwise materially involved in, any government investigation or any suit, action or other legal proceeding arising out of Resident's business practices or the provision of professional services; (c) Resident has not been subject to disciplinary proceedings or action before any academic institution or any state's medical board or similar agency responsible for professional standards or behavior; (d) Resident’s license to practice medicine (if any) in the State of California has not been restricted, suspended or terminated; (e) Resident has not been charged with or convicted of a criminal offense related to healthcare; and (f) Resident has not been debarred, suspended or otherwise made ineligible to participate in the Medicare, Medicaid or any other federal or state healthcare program.

18. Throughout the duration of employment in the LMC the resident shall demonstrate the following:

A. **Patient care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;

B. **Medical knowledge** about established and evolving biomedical, clinical, and cognitive (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care;

C. **Practice-based learning** and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care;

D. **Interpersonal and communication skills** that result in effective information exchange and teaming with patients, their families, and other health professionals;
E. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population; and

F. **Systems-based practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.

B. **The LifeLong Medical Care Family Medicine Residency Program's Responsibilities and Obligations:**

1. LMC shall maintain a training program in Family Medicine in accordance with the rules of the Residency Review Committee for Family Medicine of the Accreditation Council for Graduate Medical Education. Successful completion of this Program and the endorsement of the Residency Program Director will satisfy the training requirements of the American Board of Family Medicine to apply to take the board certification examination. Such an endorsement by the Residency Program Director, however, is not guaranteed through this Training Agreement.

2. LMC shall provide an annual stipend for the Resident of at least:

   - $65,000.00 for FM1 Residents
   - $68,000.00 for FM2 Residents
   - $71,000.00 for FM3 Residents

   The salary may exceed the amounts shown above in the case of salary increases across the entire residency class. Payment of this training stipend shall be contingent upon satisfactory performance in all training duties by the Resident during the training program.

3. LifeLong Medical Care shall provide twenty (20) days of paid leave per year for the Resident. The Resident must make known vacation/leave requests to the scheduling Chief Family Medicine Residents by May 1 of the applicable Agreement year. There shall be no guarantee that the specifically requested dates for vacation will be accommodated. It is the resident’s responsibility to not take more leave than is allowed by the American Board of Family Medicine. Resident acknowledges that doing so will jeopardize the ability of the resident to sit for their specialty boards.

4. LMC does not guarantee to provide professional leave (protected time free from clinical duties) nor stipend to attend meetings.

5. LMC shall provide up to twelve (12) weeks of unpaid parental or family leave, if the Resident qualifies and in accordance with the Family Medical Leave Act. Such leave from the residency shall not be credited towards the advancement and graduation requirements. The Residency Program Director, however, will make efforts to accommodate the special needs of the Resident through flexibility in the curriculum, such as scheduling arrangements and creative use of elective
time. The Resident is obligated to notify the Residency Program Director as soon as practical of his or her special needs and to work with the Residency Program Director and the Chief Family Medicine Residents to meet those special needs and the obligations of the Program as well as to insure the leave does not negatively impact the Resident's ability to sit for their Board Exam. It is the resident’s responsibility to not take more leave than is allowed by the American Board of Family Medicine. Resident acknowledges that doing so will jeopardize the ability of the resident to sit for their specialty boards.

6. LMC shall provide the necessary shift coverage for the Resident in the case of an illness in accordance with the Vacation and Leave Policy.

7. LMC shall provide professional liability insurance ("malpractice insurance") for all clinical activities that are a part of the residency curriculum, including electives. The liability insurance will not cover clinical activities outside of the residency curriculum, whether these activities are compensated or not.

8. LMC shall provide health insurance for the Resident.

9. LMC shall provide disability insurance for the Resident.

10. LMC shall provide two (2) pair of surgical scrub garments (pants and shirts) and two (2) white lab coats for the Residents.

11. LMC is not obligated to provide any other insurance benefits for the Resident and/or the Resident's family.

12. LMC is not obligated to provide living quarters, meals, nor laundry services for the Resident.

13. If clinically indicated, LMC shall facilitate the Resident's access to appropriate and confidential counseling, medical, and psychological services.

14. Policies that must be followed include, but are not limited to, Sexual Harassment, Physician Impairment and Substance Abuse, HIPAA compliance and pre-employment drug screening.

IV. Residency Closure and Reduction Policy: If LMC decides to reduce the number of residents in the Program or to close the Program, the Resident will be notified as soon as possible.

LMC and its affiliated institutions agree to provide the support, as outlined in this agreement, until the Resident separates from the Program through graduation, resignation, dismissal, or non-renewal. Reduction in the total number of residents in the Program shall not constitute grounds for the dismissal or non-renewal of the Resident. Any such reductions shall be phased in so as to not affect the salary lines of the residents already in the Program. Program size reductions must be made in accordance with the rules of the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Family Medicine of the
Accreditation Council for Graduate Medical Education.

Residency closure shall be managed in a similar fashion as for program reduction. LMC and its affiliated institutions agree to provide the support, as outlined in this agreement, until the Resident separates from the Program through graduation, resignation, dismissal, or non-renewal. Closure of the residency program shall not constitute grounds for the dismissal or non-renewal of the Resident. Closure of the residency program shall be phased in, to the extent possible, so as to not affect the salary lines of the residents already in the Program. The procedure for program closure must be made in accordance with the rules of the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Family Medicine of the Accreditation Council for Graduate Medical Education.

If the Program loses accreditation and must be closed more precipitously than will allow the Resident currently in the Program to continue until separation as described above or if the Program must be closed precipitously for some other reason outside the Program's control, the Program will do the following:

1. inform the Resident as soon as possible;
2. make an effort to allow the residents already in the program to complete their education;
3. make an effort to assist the Resident in identifying programs in which they can continue their education.

V. Duration of Appointment and Conditions for Reappointment: The duration of this Agreement shall be as outlined above in Paragraph I and subject to Paragraph VI ("Automatic Termination of this Agreement") and any other such applicable passages in this Agreement. If the Resident successfully completes the academic year, as stipulated in LMC's Criteria for Advancement, the Resident may apply for renewal of this Agreement on an annual basis until LMC's Criteria for Graduation are fulfilled and the Resident graduates from the Program. Failure to comply fully with the Responsibilities and Obligations as outlined here on the part of the Resident can be sufficient grounds for LMC to refuse to offer another Agreement term without further due process. If the Program decides to exercise its option not to renew this agreement, the resident will be notified of that intent no later than four (4) months prior to the end of the resident's current agreement. With advancement in the LMC Family Medicine Program, the Resident will be provided with the appropriate salary level. The Resident may resign from this Agreement by giving sixty (60) days written notice of intent to resign.

VI. Automatic Termination of this Agreement: This Agreement shall automatically terminate upon the occurrence of any of the following:

1. death of the Resident; or,
2. disability of the Resident for a period in excess of ninety (90) days, which disability shall be defined as a state of mental or physical illness of such degree that, even with reasonable accommodation, the Resident is unable to carry out his or her essential services under this Agreement.

No payments beyond the date of termination shall be due the Resident in the event of automatic
termination of this Agreement.

VII. **Policies Regarding Professional Activities Outside the Educational Program**: Clinical activities outside the residency curriculum ("moonlighting"), whether for compensation or not, are governed by LMC’s Policy on Moonlighting. Residents must apply to the Residency Program Director for permission to engage in outside clinical activity. Permission may be granted at the discretion of the Residency Program Director and shall be for specific dates and times only, and must adhere to all the policies and procedures of the residency. The Resident may not engage in outside clinical activities if he or she is on Academic Probation, or if the outside clinical activity would interfere in any way with the Resident's full participation in the Residency Program. If the Resident performs outside clinical activity while on Academic Probation or if the performance of outside clinical activity by the Resident (whether on Academic Probation or not) interferes in any way with the Resident's full participation in the Residency Program, it shall be viewed as grounds for dismissal from the Program. The professional liability insurance provided by LMC will not cover clinical activities outside the residency curriculum.

VIII. **Procedures for Discipline and Redress of Grievances**: The procedures for discipline and the redress of Grievances may be found in LMC’s Policies and Procedures (Grievance and Due Process Policy). These procedures constitute the due process that is afforded the Resident.

IX. **Policies and Procedures Whereby Complaints of Sexual Harassment and Exploitation may be Addressed in a Manner Consistent with the Law and Due Process**: Each of the participating hospitals and institutions have policies whereby complaints of sexual harassment and exploitation may be addressed in a manner consistent with the law and due process. If such an accusation is made, it will be addressed by the policy in place at the institution in which the alleged offense took place. If the allegation of sexual harassment or exploitation cannot be addressed by such a policy, the policy in place at LMC shall be used.

X. **Assignment**: The Resident shall not have the right to assign his or her duties under this Agreement.

XI. **Venue and Governing Law**: This Agreement shall be construed and enforced in accordance with the laws of the State of California without regard to the choice of law thereof. Venue for any legal action relating to this Agreement shall lie in Alameda County, California.
**Resident’s Signature:** I accept the appointment outlined above and agree to all rules and regulations of the LifeLong Medical Care Family Medicine Residency Program and the affiliated institutions to which I am assigned. I also agree to discharge all the duties of a trainee as determined jointly by the affiliated institutions, as represented by the Program Advisory Committee, and the Residency Program Director of the LMC Family Medicine Residency Program.

______________________________
Resident Printed Name

______________________________
Resident Signature

______________________________
Resident’s Social Security Number       Date

______________________________
Residency Program Director, for LifeLong Medical Care Family Medicine Residency Program

______________________________
Designated Institutional Official, for LifeLong Medical Care Graduate Medical Education