OSTEOPATHIC NEUROMUSCULOSKELETAL MEDICINE RESIDENT MANUAL

LUCOM GRADUATE MEDICAL EDUCATION SERVICES

COLLABORATIVE HEALTH PARTNERS - SPECIALTY SERVICES

2024-2025

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Mission Statement

The Osteopathic Neuromusculoskeletal Medicine (ONMM) Program sponsored by Liberty University College of Osteopathic Medicine Graduate Medical Education Services (LUCOM GMES) equips physicians to become leaders in clinical practice in the specialty, medical education, and scholarship and is thereby building a value-chain pipeline of highly skilled physicians for Central Virginia. Program leadership works closely with the Sponsoring Institution, LUCOM GMES, in building and developing the ONMM program to prepare physicians for their careers in academic medicine or community based ONMM specialty practice.

Program Aims

1. Equip physicians to become leaders in the specialty of ONMM, medical education, and scholarship during and following graduate medical education
2. Educate physicians using evidence-based approaches to the clinical practice of Osteopathic Neuromusculoskeletal Medicine (ONMM) as a specialty
3. Effectively promote the career development of residents and faculty physicians as medical educators
4. Enhance collaboration in academic and clinical inquiry to promote the development of additional clinical and educational scholarship in academic medicine
5. Effectuate change in healthcare delivery using principles of continuous improvement science applied by faculty and residents
6. Develop and grow the program in ONMM as a value-chain pipeline of physicians to the underserved regions of Virginia experiencing significant physician shortages

Collaborative Health Specialty Services

Collaborative Health Specialty Services is a multispecialty academic medical practice housing sports medicine, endocrinology, osteopathic neuromusculoskeletal medicine, physical medicine and rehab, and adult behavioral health services, including psychiatry and psychology. The practice is affiliated with Liberty University College of Osteopathic Medicine (LUCOM). It serves as a clinical rotation site for LUCOM students and is home of the LUCOM GMES ONMM Residency. Together with its incredible team of nurses and allied health staff, the practice fosters a collaborative approach to holistic patient-centered medical care while also advancing medical student and post-graduate resident physician education. An X-Ray machine, ultrasound suite, and lab are

accessible on site and allow physicians to offer convenient access to necessary testing for patients.

Recruitment and Retention

Liberty University does not engage in unlawful discrimination or harassment because of race, color, ancestry, religion, age, sex, national origin, pregnancy or childbirth, disability, or military veteran status in its educational programs and activities. Liberty University maintains its Christian mission and reserves its right to discriminate based on religion to the extent that applicable law respects its right to act in furtherance of its religious objectives. The following persons have been designated to coordinate Liberty University's compliance with certain anti-discrimination laws: Coordinator of LU Online Disability Accommodation Support at (434) 592-5417 or luoodas@liberty.edu; Director of Disability Accommodation Support (Residential) at (434) 582-2159 or odas@liberty.edu; Executive Director of Title IX at (434) 592-4999 or TitleIX@liberty.edu.

Liberty has the right under federal law to apply religious criteria to employment decisions regarding its staff and faculty.

Diversity is integrated as a core value of the College of Osteopathic Medicine. Biblical based diversity, equity, and inclusion efforts are critical to Liberty University, and as such, to the College of Osteopathic Medicine. Furthermore, the College of Osteopathic Medicine's Diversity, Equity, and Inclusion Committee works to provide training, support, and community-building opportunities for LUCOM's faculty, staff, post-graduate residents, and students. This committee works to increase student engagement and retention, faculty/staff research and publication, and leadership awareness and responsiveness - programming that is available to LUCOM GMES' clinical faculty and Resident physicians. The committee promotes diversity in LUCOM's academic and professional community. LUCOM follows all guidelines, policies, and corresponding procedures set forth by the Office of Equity and Inclusion.

The ONMM Program at LUCOM GMES works in conjunction with Liberty University College of Osteopathic Medicine (LUCOM) and Collaborative Health Partners (CHP) to achieve and ensure diversity in recruitment, selection, and retention of incoming residents. This is important as part of our Mission includes the ONMM Program serving as a pipeline for the development of our students into ONMM specialty physicians, who will serve in clinical and private practice in Central VA. The ONMM Program will continue to recruit medical school graduates from across the country in addition to our own LUCOM graduates as we seek a diverse group of talented physicians who will help us solve the significant doctor shortage in underserved areas of Virginia. A clear example of this is our participation in the ERAS platform for receiving applications to our program during the past four recruiting cycles and participation in the NRMP service in 2021, 2022, 2023, and 2024. Our recruitment strategies also include involvement in the American Academy of Osteopathy's Resident Information Session

and virtual information sessions throughout the academic year held by other national organizations. In this way, we can connect with a diverse prospective resident population outside of our local, regional scope.

Ensuring a diverse clinical faculty and program administrative staff has been accomplished in conjunction with LUCOM GMES. LUCOM GMES has fostered a culture where all clinical staff, clinical faculty, administrative personnel, and leaders recognize the accomplishments that have been achieved through diversity of thought, educational backgrounds, faith beliefs, and professional training. This atmosphere in post-graduate medical education has facilitated continuing excitement around recruiting staff, faculty, and leaders to our organization from all backgrounds to ensure the diversity of perspectives in individuals who participate as part of our cohesive team. Methods utilized to achieve this include job advertisements in the local community, professional search firms, professional society organizations including the American Academy of Osteopathy, and the American Osteopathic Academy of Sports Medicine, the utilization of Indeed for both dissemination of opportunities and to review interested applicants, and the evaluation of a candidate by at minimum, five different organization personnel and faculty along their interview process. Collaborative Health - Specialty Services (CH-SS), which serves as the site of the Resident-Faculty ONMM continuity clinic, continues to grow in scope and specialty. Not only is it the site of the ONMM continuity clinic, but it also provides specialty medical care of Endocrinology and Diabetes, Psychiatry and Young Adult Behavioral Health, Physical Medicine and Rehabilitation, and Sports Medicine. Placing a variety of specialties in the same clinical space encourages collaborative care of the patient. This growing healthcare delivery system contributes to the ONMM Program's success by ensuring diversity among colleagues within the educational clinical environment. Additionally, the program benefits from collaboration with faculty and administrators from various off-site rotations through partnerships such as Centra Health Services, VA Salem Healthcare, McLaren Greater Lansing, Michigan State University, and Arthritis Consultants of Tidewater in Virginia Beach. Working with individuals from these environments adds another measure of exposure to diversity within our program that is facilitated by the unique regional, institutional, and patient population considerations of these host sites.

Various retention strategies have been implemented to demonstrate appreciation for all faculty and personnel and to promote happiness, inclusion, and wellbeing in the workplace. Faculty and staff receive Diversity, Equity, and Inclusion training to ensure that our practices and behaviors as individuals and as an organization maintain an inclusive work environment. An annual Equal Employment Opportunity report is compiled which highlights the breakdown of demographics among clinical faculty and staff. Leadership reviews benefit packages yearly and adjusts, as necessary. The current market salaries are reviewed every other year to ensure compensation is commensurate with the region. Examples of team member engagement initiatives include an annual physician meeting to actively engage clinical faculty and residents in improvements of the clinical environment and allows for a platform where concerns or needs can be directly shared with the business leaders; annual all faculty and staff summit to review the EPIC-T (Excellence, Professionalism, Integrity, Communication,

Teamwork) model of care in the clinical practice - a unique approach by our healthcare delivery system, quarterly fun team-member engagement activities, and physician and staff discretionary incentives. These activities have played a role in the successful retention and new acquisition of clinical faculty and staff involved with the ONMM program.

Program Leadership Responsibility

Accountability and Responsibility in the ONMM Residency

The ACGME common program requirements and specialty specific requirements for ONMM, as defined by the ACGME's Residency Review Committee (RRC) for ONMM, will be adhered to by the ONMM Program. Oversight will be provided by LUCOM GMES as the Sponsoring Institution for GME Programs.

LUCOM GMES requires faculty physicians to supervise residents in accordance with the ACGME's framework for faculty supervision.

Residents will have limited licensure status as resident physicians in training and must be supervised by faculty in their decision-making in GME. Although residents may obtain independent medical/osteopathic licensure in the state, the ONMM Program will continue to expect residents and faculty in the program to abide by these requirements and the ONMM Faculty Supervisory Policy for Residents.

Per ACGME core requirements, the privilege of progressive authority and responsibility in patient care and the Resident's role in supervising other learners must be assigned by the Program Director and faculty. Faculty must delegate portions of care to residents based on the needs of the patient and the skills of each resident. As clinical faculty observe that the resident has progressed in their skill level, the resident will be assigned more responsibility and autonomy. Likewise, the assignment of medical students to be supervised by Residents will be determined by the Program Director in collaboration with the clinical faculty. The Program Director must consult the DIO of the Sponsoring Institution when issues arise for the program, faculty, or residents related to resident supervision issues.

Program Director

The Program Director (PD) has the duty and responsibility to structure faculty supervision assignments 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 PD will provide the residents with a clear means of identifying supervising physicians who share responsibility for patient care and supervision of residents on each rotation. Schedules will be clearly defined noting which faculty are responsible for supervision. The PD reports to the DIO, and any issues or challenges that arise in the context of faculty supervision will be reviewed with the DIO and the Graduate Medical Education Committee (GMEC) of the Sponsoring Institution.

Advancing residents to higher levels of responsibility (including supervisory roles for senior residents) in patient care settings are graduated, conditional responsibilities that must always be aligned with the appropriate level of faculty supervision. The PD is responsible for ensuring the appropriate faculty supervision for individual residents and groups of residents is present in all clinical settings. The PD must also ensure that Sponsoring Institution policies and procedures and common and specialty specific requirements of the ACGME are followed.

The PD will be informed by deliberations and discussions of the Clinical Competency Committee (CCC). The CCC reviews the assessment of specialty specific competencies and milestones as established for the ONMM residents by the ACGME Residency Review Committee for ONMM. The CCC provides recommendations on the progress of the resident including attainment of specialty specific milestones and progression and advancement through competency-based training.

The Program Director will evaluate Resident physician's performance with the supervising faculty regularly to accomplish ongoing academic and professional development of the Resident Physician. The PD will review the Resident Physician's performance at least twice annually with the Resident Physician directly per ACGME requirements for graduate medical education programs. These summary evaluations summarizing the Resident Physician's performance and evaluations in multiple settings from multiple faculty and healthcare professionals will be documented by the Program Director as per requirements for residency programs accredited by the ACGME. These evaluations are intended to guide the Resident Physician toward successful completion of all residency program requirements by the end of the training program in graduate medical education. Should Resident performance not be progressing satisfactorily in the Residency program of the specialty, as determined by the Program Director and documented by the Program Director, the Program Director will utilize the policies and procedures of the ONMM Residency program and Sponsoring Institution for residency programs in GME to: address inadequate and/or unsatisfactory Residency Physician performance or failure to progress in residency training and education in multiple domains of Resident Physician competency, as set out by the Program Director and in

alignment with expectations for residency programs and Resident Physicians in training through residency programs accredited by the ACGME.

Resident Physician's performance, if deemed to be inadequate and/or unsatisfactory by the Program Director, will be remediated according to standard operating policies and procedures used by the Residency Program Director to remediate Resident performance. These policies and procedures are in alignment with expectations of the ONMM residency program and Resident Physicians in training through ACGME accreditation. The remediation plan (Personal Improvement Plan [PIP]) will engage the resident with a documented individual improvement plan including a timeline for expected improvements to be developed and overseen by the Program Director. This plan will be developed in the context of the policies and procedures of the residency program for expected improvement in Resident Physician performance within the timeline developed and documented in the remediation plan outlined by the Program Director.

Please see the GME Counseling and Remediation Template on p. 161-162

Residents in ONMM:

Individual ONMM Residents will be assigned a faculty supervisor(s) for each rotation or clinical experience in the ONMM Program by the Program Director in advance of the rotational experience. It will be communicated to the resident by the program director that these faculty supervisors will be responsible for supervision of all resident activities including clinical care oversight of resident patient care activities and the timely completion of written evaluations of the resident(s) under faculty supervision.

Each resident must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with the appropriate classification of faculty supervision toward graduation with, increasing degrees of responsibility in patient care as communicated by the program director. The program director is responsible for identifying supervising physicians, including faculty supervisor schedules, so that residents can identify their faculty supervisors. Residents are to communicate directly with the supervising faculty when they are unable to care for the patient safely or effectively. Whether the attending is offering direct or indirect supervision, it is the responsibility of the Resident to contact the attending directly to make the attending aware of the situation and communicate their needs.

Continuity Clinic Faculty

As per ACGME requirements, all faculty members who teach ONMM residents in the ambulatory continuity of care clinic or in the inpatient ONMM consult service setting must be AOBNMM-certified, AOBSPOMM-certified, or AOBNMM board-eligible, or possess qualifications acceptable to the Review Committee.
Should the faculty have any concerns about the resident's individual performance during the rotation, the faculty member agrees that he or she must contact the program director immediately to discuss the resident's performance and the faculty member's concerns. Faculty members functioning as supervising physicians will be accountable to assign portions of care to Residents based on the needs of the patient and the skills of the resident that they directly observe and evaluate in patient care settings.

The faculty supervisor must always provide to the program director a timely, summative written evaluation of each resident's performance during the period that the resident was under his or her direct supervision. This evaluation is due within one week of the completion of the resident experience.

Rotation Faculty

Additionally, faculty members who teach osteopathic neuromusculoskeletal medicine residents in specialties other than Osteopathic Neuromusculoskeletal Medicine must have current certification by an American Osteopathic Association (AOA) certifying board or an American Board of Medical Specialties (ABMS) board or possess qualifications acceptable to the review committee.

Should the faculty have any concerns about the resident's individual performance during the rotation, the faculty member agrees that he or she must contact the program director immediately to discuss the resident's performance and the faculty member's concerns. Faculty members functioning as supervising physicians will be accountable to assign portions of care to Residents based on the needs of the patient and the skills of the resident that they directly observe and evaluate in patient care settings.

The Faculty supervisor must always provide to the program director a timely, summative written evaluation of each residence performance During the period that the resident was under his or her direct supervision. This evaluation is due within one week of the completion of the resident experience.

The Clinical Competency Committee (CCC)

The CCC will serve to review all aspects of Resident performance to provide recommendations to the program director regarding assessment of progress and achievement of Milestones for the ONMM resident; strengths and areas for improvement; and readiness to be advanced into higher levels of training. The CCC also has a responsibility to discuss and review the resident's progression on Milestones so that the program can report the specialty specific Milestones to the ACGME.

For residents who are not progressing as expected in the specialty or are not demonstrating progression in competency-based education, the CCC will recommend action steps and the development of a monitoring plan by the program director (through use of a Performance Improvement Plan) relevant to the resident's current level of performance and expected improvement outlined.

Supervision Policy

The ONMM Program has developed a faculty supervision policy to ensure residents have the appropriate degree of supervision, can carry out their duties, and progress through their responsibilities appropriately within each level of training.

Supervision shall be structured to provide residents with progressively increasing responsibility commensurate with their level of education, ability, attainment of ONMM defined specialty Milestones and according to PGY-1, PGY-2, and PGY-3 ONMM program educational goals and objectives in the ONMM Residency Program curriculum.

Residents will be educated to communicate as complexity and acuity increase in patient care settings. When precepting the ONMM residents, if the ratio is three residents to one attending, the attending will have no other clinical duties during the clinic session. All patients will be presented to or be seen/treated by the attending before being discharged.

The ONMM program director will use the following classifications of supervision as outlined by ACGME requirements in GME:

1. Direct Supervision: The supervising physician is physically present with the resident during the key portions of the patient interaction.
2. Indirect Supervision: The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

3. Oversight: The supervising faculty physician will be available to provide review of procedures/encounters with feedback provided after care is delivered.

Based on the same criteria and in recognition of their progress toward graduated responsibility and greater degrees of independence toward anticipated completion of the ONMM Program, senior residents in ONMM may serve a supervisory role of Junior residents and medical students, but still with the continual oversight of supervising faculty.

The program director will make determinations on advancement of residents to positions of higher responsibility and patient care settings and align the appropriate classification of Faculty supervision required. The program director must always consider the performance level of the resident and competency-based medical education and Milestones achieved.

Continuity Clinic

ONMM 1 Year

Direct supervision of all aspects of patient care with progression to indirect supervision within the first month for the aspects of attaining the HPI and the PE. The procedure of OMM will be supervised with direct supervision for the first three quarters of the year, with progression to indirect as the resident advances into the fourth quarter and there is evidence of appropriate growth in procedure skill level. All patients are seen/treated by the attending faculty prior to the end of the encounter; the attending faculty is always available, on-site to assist the resident in patient care as necessary.

> Example: ONMM resident and attending care for the patient together, faculty can observe the resident's performance of obtaining an HPI, physical exam directly, with discussion of management and plan led by the resident and redirected by the faculty if necessary. Direct observation by the attending faculty ensures that they are aware of any difficulties the resident may be encountering. As the resident progresses in skill level, the attending will provide indirect supervision while being on site and readily available should the resident need assistance. During this first year, the resident will advance in their skill of efficiently gathering information, assimilating a differential and management plan to present to the attending prior to discussion with the patient. Should the resident encounter difficulties, such as ineffective muscle energy to the innominate while performing the procedure of osteopathic manipulation, the attending physician is on-site, and the resident will directly communicate their need for assistance with the attending.

ONMM 2 Year

Indirect supervision for all aspects of patient care with the attending immediately available to assist the resident in the ONMM-2 year. Patients new to the ONMM clinic will be presented to the attending after acquiring the HPI and PE and before any interventions are applied. Patients being seen in follow-up can be seen and as indicated, treated with OMM prior to the presentation to the attending. All patients are seen/treated by the attending faculty prior to the end of the encounter; the attending faculty is always available, on-site to assist the resident in patient care as necessary.

> Example: During the second year, the resident will continue to advance in their skill of efficiently gathering information, assimilating a differential, and management plan to present to the attending prior to discussion with the patient as well as progress to having the discussion with the patient and treating the patient prior to a discussion with the attending. The resident is aware that should they encounter difficulties, such as ineffective muscle energy to the innominate while performing the procedure of osteopathic manipulation, or the patient presents with a problem the resident is not comfortable managing, the attending physician is physically on-site and available. The resident will directly communicate with the attending their need for assistance.

ONMM 3 Year

Indirect supervision is immediately available for all aspects of patient care with growth to Oversight supervision as the resident enters the last three to six months of training. Patients new to the ONMM clinic will be presented to the attending after acquiring the HPI and PE and before any interventions are applied. Patients being seen in follow-up can be seen and treated with OMM prior to presentation to the attending. All patients are seen/treated by the attending faculty prior to the end of the encounter; the attending faculty is always available, on-site to assist the resident in patient care as is necessary.

> Example: The resident is caring for a patient, who is established at the ONMM clinic. The patient presents with a new complaint of right shoulder pain which the resident attributes to somatic dysfunction found on exam. The resident attempts to treat these findings with an articulatory approach, followed by strain-counterstrain, but the patient's pain level remains unchanged. The resident is aware that they are to directly communicate to the attending the difficulty they are encountering with patient care. The attending is on-site and can readily offer assistance.

Rotation Sites

ONMM 1 Year

Outpatient Service: Direct supervision of all aspects of patient care with progression to Indirect supervision within the first month for the aspects of attaining HPI and PE. Any procedures will be directly supervised during the ONMM 1 Year until the attending feels comfortable progressing to Indirect supervision.

> Example: Resident is completing their required Family Medicine rotation. The patient needs a cortisol shot to the shoulder. The resident will make the attending aware that the patient needs this procedure, and that the resident needs assistance from the attending. The attending is on-site and assists the resident accordingly.

Inpatient Service: Direct supervision of all aspects of patient care with progression to indirect supervision immediately available within the first month for the aspects of attaining HPI and PE. Any procedures will be directly supervised during the ONMM 1 Year, until the attending feels comfortable progressing to Indirect supervision.

Example: Resident is completing their required Internal Medicine rotation. A patient under their care begins to decline rapidly and the resident is unsure of how to proceed. The resident ensures the safety of the patient, then contacts the attending, who is on-site and directly available, communicating that they need the Attending's assistance.

ONMM 2 Year

Outpatient Service: Indirect supervision of all aspects of patient care in the ONMM 2 Year.

> Example: Resident is caring for a patient on a required selective Neurology rotation. The patient begins to show an acute change in mentation. The resident ensures the patient's safety and leaves the patient to alert the attending of the need for assistance in patient care. The attending is on-site, and the resident directly communicates the need for assistance; the attending takes over the management of the patient.

Inpatient Service: Indirect supervision of the resident in the ONMM2 Year.

> Example: The resident is performing an inpatient ONMM consult on a patient who is status-post lower abdominal surgery. The resident attempts to correct somatic dysfunction identified in the thoracic cage that is contributing to the patient's symptoms. Upon recheck after the procedure, the resident finds that the somatic dysfunction remains. The resident directly communicates to the

attending, who is on-site, that the resident requires assistance in effectively caring for the patient.

ONMM 3 Year

Outpatient Service: The resident will be supervised with Indirect supervision with expected progression to Oversight in the last three to six months of their ONMM training for all aspects of patient care.

Example: Resident is completing their required orthopedic surgery rotation. The patient needs a cortisol shot to the right carpal region and the resident has not performed this independently yet. The resident will make the attending aware that the patient needs this procedure, but that the resident has not yet completed one independently and needs assistance from the attending. The attending is on-site and assists the resident accordingly.

Inpatient Services: The resident will be supervised with Indirect supervision with expected progression to Oversight in the last three to six months of their ONMM training for all aspects of patient care.

Example: The resident is performing an inpatient ONMM consultation on a patient who is status-post left knee replacement with complications during surgery. The resident attempts to correct somatic dysfunction identified in the pelvis that is contributing to the patient's pain symptoms. Upon recheck after the procedure, the resident finds that the somatic dysfunction remains. The resident directly communicates to the attending, who is on-site, that the resident requires assistance in effectively caring for the patient.

Didactics

Residents will be supervised by ONMM clinical faculty during the protected didactic seminar time. The didactic curriculum is designed by the ONMM program director and implemented in an intercollegiate fashion with all members present actively participating. Faculty involvement and supervision is encouraged and supported by the Sponsoring Institution to ensure high-quality education and preparation for ONMM Board certification.

Purpose:

Provide residents with educational experiences to support their development in providing excellent patient care and above-optimal preparation for ONMM board

certification exams, which is a 3-part exam inclusive of written, oral, and practical examinations.

Format:

Residents and clinical faculty cycle through topics, largely based on region each week, with additional ACGME requirements added in the overall rotation. Each week there is specific region covered with the following categories captured:

1. Anatomy and/or radiology of the region
2. Clinical application as it applies to the region
3. OMM application review
4. Written practice questions

Additional topics include monthly journal club, monthly study of osteopathic philosophy, systems-based practice topics including a radiology series, billing and coding, documentation, quality improvement, wellbeing, practice-based learning, special populations (neurology, pediatrics, OB, sports med), scholarly work, mock oral exams, mock practical exams, and MSK U/S.

Expectations:

All presentations will be prepared in such a way as to enhance the education of colleagues and all those in attendance with the primary impact being on resident education. These presentations are to assist co-residents in developing the medical knowledge and skills for excellent patient care and board certification exams. Information should be up to date, from reputable sources, and to include a list of references used to prepare the presentation. While medical students may be in attendance, the audience the discussion is geared to is the ONMM residents.

Categories:

1. Anatomy and/or radiology presentation should be approximately 30 to 45 minutes in duration and should involve a review of the anatomy related to muscular, vascular, neural, lymphatic, and bony structure, or as directed in the didactic schedule.

2. Clinical application is to cover typical presenting symptoms, presenting signs on exam, management including medicinal, diagnostic work-up, diagnostic interventions, therapeutic interventions. This presentation should last between 30 and 45 minutes.

3. ONMM application: This is intended to encourage a review of various ONMM techniques and share this information with co-residents. A variety of texts are available in the resident room for use. This presentation should last approximately 60 minutes and should include residents practicing the techniques on one another including

structural exam diagnosis first followed by appropriate treatment based on which application is being reviewed that day.

4. Written practice questions: These are provided by the program director. At times they are to be performed on an individual basis, at other times as a group working together to review the questions and answers utilizing a variety of sources. The didactic conference schedule will delineate whether the written questions are performed individually or as a group.

5. Monthly Journal club: This is an ACGME requirement geared towards ensuring that residents are exposed to osteopathic literature, that they understand how to analyze scientific literature including application of results into the clinic as a form of quality and patient care improvement. Resident is responsible for discussing 2 articles and utilizing the framework shared with the group by Dr. Unger. At least one of the articles needs to be of osteopathic origin. These discussions generally last between 30 to 45 minutes.

6. Monthly study of osteopathic philosophy: Assigned readings and associated discussion sheet are distributed at the start of the academic year. The leading resident is expected to read the assigned pages, complete the questionnaire at minimum to enhance leading the discussion with peers. It is expected that all residents whether they are leading the discussion or not, will have read the required assignment and complete the discussion sheet in preparation to actively participate in the discussion. Leading of this discussion generally lasts between 30 to 40 minutes.

7. Systems-based practice: This can include anything from billing and coding discussions, documentation, radiology series, quality improvement. These will generally be presented by an invited guest, or sometimes by the residents with detailed instructions on the conference schedule as to what is expected. These presentations last between 30 and 60 minutes.

8. Practice based learning: This can include presentations from invited guests on community resources, processes performed within the clinic, and other related topics. These generally last 45-60 minutes.

9. Wellbeing: This includes topics on all things related to wellbeing which may include self-survey, fatigue mitigation, balance in the workplace, quality of life. These presentations generally last from 30 to 45 minutes.

10. Special populations: These can include topics unique to pediatrics, geriatrics, OB, neurology, hospitalized patients, system-based pathologies. These presentations will last from 30 to 45 minutes.

11. Mock oral exams and mock practical exams are put on by the program director several times throughout the academic year. They are designed to prepare residents for the required in-training exam and board certification exams.

12. MSK U/S: Resident assigned will lead fellow residents through anatomy seen with MSK U/S, how to access the anatomy, and any clinical correlations. At times, clinical faculty may be available to answer additional questions. There are several on-line resources attached to this curriculum for use during the afternoon in addition to the U/S machine.

13. Radiology Series: This is completed twice monthly. The Resident leading the discussion will access the films through the “LMMG Shared drive”. The films are placed on screen for viewing by all; 2-3 minutes is given by the lead to review and document on worksheets located in the Conference room. The lead will share the corresponding report on the screen for review and/or discussion as time permits. This report is emailed to the Residents by the PC/PD prior to the start of didactics.

Osteopathic Philosophy Discussion Questions

1. Please list three highlights from the reading. These can be phrases that caught your attention, ideas that came to mind while you were reading, and/or themes you pulled from the reading that you would like to discuss.

    a. _____
    b. _____
    c. _____

2. Please share two ways that the reading can be applied to your current clinical practice.

    a. _____
    b. _____

3. Please share two ways that the reading has augmented your growth in osteopathic understanding and/or curiosity.

    a. _____
    b. _____

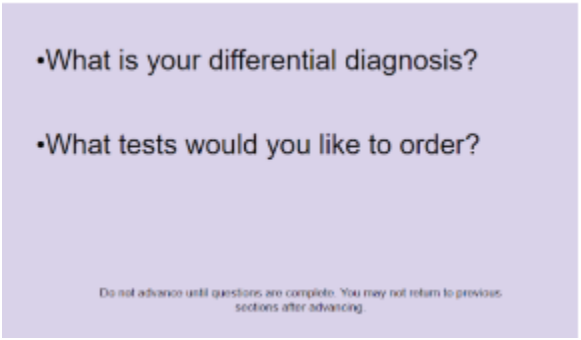
4. How does the reading relate to anatomy or physiology of the human body?

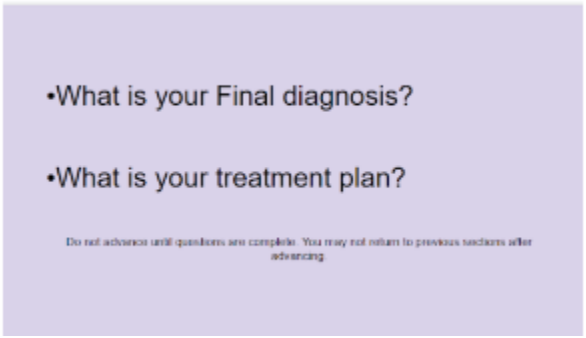
5. Other thoughts or considerations?

LUCOM GMES ONMM Residency: Mock Oral Board Exam Exercise: Instructions

Description of Activity: In order to receive board certification, ONMM Residents must pass the three-part AOBNMM Board Exam which consists of oral, practical, and written portions. This mock oral exam exercise has been created to help you understand the flow of the exam, timing, and spectrum of medical and specialty specific knowledge that will be required for successful completion of the oral portion of your Board Exam. During this mock oral exam, you will be presented with three cases. A total of 25 minutes time will be allotted for your completion of these cases. Please review the instructions presented below, as well as the description of the exam as provided by the AOBNMM at:
https://certification.osteopathic.org/neuromusculoskeletal-medicine/certification-process/specialty-certification-process/initial-certification-exams/

How to complete the exam: Three patient cases will be presented to you on slides. Embedded within each case are two slides with exam questions that you must naser aloud for your examiners. In this mock oral exam, the questions appear similar to these:





During your exam, it is ok to take notes. It is ok to read back through the slides unless explicitly stated otherwise. It is ok to talk through your reasoning as you work. You will be scored according to the AOBNMM's rubric for your responses which evaluate your understanding of standards of general medical care, expertise and application of specialty specific knowledge, professionalism, and timely completion of the exam.

Here is a list of recommendations for putting your best foot forward during the exam:

1. Provide a summary of the case prior to answering the case questions.
2. Differential Diagnosis: Give at least three- two medical and one or two somatic dysfunction diagnoses.
3. Tests: List additional clinical exam findings you would look for or maneuvers you would perform, blood work, or imaging tests you would like to order. For extra thoroughness- explain what you are ruling out with these.

4. Results: Summarize the data presented by the results, blood work or imaging. Describe what imaging modality has been presented and what the observable findings are. If there are other tests that would be helpful for you to make a diagnosis, state what other tests you would have considered ordering.
5. Final Diagnosis: List the most likely diagnosis given the results that were presented in the case. It is ok to talk through your reasoning. If you aren't certain of your diagnosis, state what additional information would help you make your diagnosis. Somatic dysfunction is also appropriate to list here if SD was listed in the physical exam. Of note, SD is usually not the primary diagnosis but is often an appropriate secondary diagnosis.
6. Treatment Plan: List referrals, tests or treatments for the diagnosed condition. Is OMT indicated/contraindicated? Would you perform OMT during this visit as part of the plan? If so, modalities including ice, rest, splinting, analgesics, etc.
7. Good Luck!

Interprofessional Communication
How to Send a Letter to Another Provider by the Resident

1. Once the encounter documentation is signed off by the attending and closed, the attending will make you aware that the letter can now be drafted.
2. Select the patient chart either through the MRN or clicking on their name on the day that you saw them.
3. Click on the menu bar and select "orders".
4. Change the rendering provider to the attending's name.
5. Select letters (you should be on the "Sign-off tab")
6. Click the plus sign.
7. In the search bar type: "Consult New patient", select "Consult New Patient Detailed".
8. In the box of who to send it to, type in the name of the physician to receive the letter, select the name.
9. Click add.
10. Click on "View".
11. Click on the body of the letter.
12. Click "Ok" to edit.
13. Make revisions including adding your name for ownership of working alongside the attending.
14. Below the attending's E-signature, please type in your name including your post-graduate year of training.
15. Click "save".
16. Click "view actions".
17. There is a box on the "Leave in REVIEW to:" line. Please put the attending's name in the box.

18. Click save.
19. The attending will review and send to the front staff for distribution.

Emailing Patient Data

When emailing patient information, it is safe to email within our domain, but if you email anyone outside of these domains you must encrypt your email. Our domains include CVFP.net, CollaborativeHP.com, and WalkinCares.com. If you are emailing outside of this, please put SECURE first in your subject line then a space and your actual subject. This will send the patient information securely.

LUCOM GMES ONMM RESIDENCY PROGRAM

Well-being Policy for Residents and Faculty

Purpose and Intent

This document will attempt to define the ways in which residents, faculty, and staff will be supported by the ONMM Program with oversight by and support from the Sponsoring Institution, LUCOM GMES, during graduate medical education (GME) in the domain of well being. The contemporary times in which healthcare delivery, medical education and graduate medical education are carried out by physician-led teams remain very challenging.

If/when residents are individually expressing concerns related to not being well, the Program Director must be made aware of these concerns in graduate medical education programs to effectively address the concerns and bring the resources and assistance to the individual residents. The Program Director will then facilitate the deployment of resources to individuals and/or groups of residents to meet their needs and to promote or restore wellness.

The Program Director will be responsible for promoting wellness in the ONMM Program and attending to the individual needs of the residents while working collaboratively with the entire team in GME including faculty, the Program Coordinator, Associate Program Director(s), Residents, staff, and the Sponsoring Institution.

Wellness and Well-being refer to the state of being healthy in mind, body and spirit and cultivating joy in work and life while seeking meaning and balance in professional life and personal/family activities.

Background: The Importance of Wellness and Foundational Principles

Residents' physical, psychological, emotional, and spiritual well-being are of paramount importance. Residents, and faculty are encouraged to lead healthy lives and make healthy choices that support them in their personal, family, and professional growth trajectories over the short-term and hopefully throughout the duration of their careers in medicine. The foundation for wellness across a physician's career can be solidly created and structured to support a future medical career where wellness is prioritized beginning in undergraduate and graduate medical education. Well-being is multifaceted. Physical, mental - psychological, emotional, and spiritual well-being are critical in the development of competent, caring, and resilient physicians. Caring for oneself and family are important components of living a balanced life. These skill sets must be developed intentionally by young physicians and strategically nurtured with their faculty mentors in the context of other competing aspects of residency and education. The ONMM Program, in partnership with LUCOM GMES, has the same responsibility to support, encourage and ensure well-being as it does the other very important aspects of GME.

Program Implementation of Solutions to Improve Wellness

In the development of the ONMM Program, the residency program is dedicated to implementing effective solutions to promote health and wellness for all individuals engaged in GME. The program recognizes it will be most effective in promoting wellness when collaborating with the Sponsoring Institution and broader university community. The synopsis presented below highlights the strategies that have been implemented by the ONMM Program to support health, well-being, and resilience, and it provides an overview of the many avenues and opportunities that exist for promotion of the health and wellness of the LU Campus Community including residents, faculty, staff, and students.

Synopsis of ONMM Program Support for Wellness and Solutions Implemented at the Program Level

Resident well-being is a main topic covered by the ONMM Program during new resident orientation.

Residents participate in an annual burn-out survey.

Residents participate in an annual self-evaluation survey.

Beginning with orientation, fostering situational awareness, and encouraging residents and faculty to alert the program director or DIO and/or other designated personnel if concerned that another resident or fellow, or faculty may be displaying signs of burnout, depression, substance abuse, or suicidal ideation.

The program provides education on how residents can access the Employee Assistance Program, including access to behavioral health services.

All residents have access to and are encouraged to participate in VITAL WorkLife and faculty have access to Safe Haven – both offer behavioral and professional life consulting inclusive of various domains such as mental health and burn-out, financial health, peer coaching.

The Program Director conducts monthly wellness check-ins with first-year resident physicians and bi-monthly with PGY-2 and 3 resident physician to address any issues as they arise

Discussion of wellness is a standard topic covered every two months in the weekly didactic seminar.

Semi-annual faculty development programs to foster physician well-being.

Active monitoring of clinical educational work hours reported to ensure there is compliance to requirements.

Developing physicians as leaders who will promote the concept of wellness to many others over the course of their careers in medicine.

Enhancing professional relationships among students, faculty, residents, and staff

Creating solutions that go beyond honoring clinical education work hours including attention to scheduling, work intensity, and work compression that impact faculty, and resident, wellbeing.

Developing formal and informal professional programming and leadership development sessions that encourage optimal resident and faculty member wellness.

Providing educational resources on burnout and depression including the identification of the symptoms and signs of burnout and depression.

Increasing awareness of appropriate web-based tools for self-screening for lack of wellness and levels of burnout in healthcare.

Encouraging residents to attend medical, mental health, vision, and dental care appointments, including those scheduled during their working hours.

Ensure faculty understand that residents may be unable to attend work due to illness, fatigue, bereavement, and personal/family emergencies.

Ensuring faculty understand the program's standard administrative procedures and processes that seek to provide optimal coverage of patient care if a resident may be unable to perform his/her patient care responsibilities without fear of or experiencing negative consequences for the resident who is unable to provide the clinical work in these types of situations.

Educating resident and faculty on procedure to follow when they are unable to come in to work: Program director and Clinic lead are made aware of a group text, Clinic schedules are modified with patients being cared for by other available Resident-Faculty care teams. If on an Inpatient

rotation, resident will notify the Program director and the Lead clinical faculty for the service and appropriate coverage is arranged through other available Resident-Faculty care teams.

Time away from work is encouraged for completion of medical (mental health, dental and vision) appointments. Clinical Faculty will continue to set individual examples in this regard and remove any barriers that exist for residents.

Ensuring residents will easily be able to use transportation services to and from clinical settings if they are too fatigued to drive home after a clinical shift. These expenses will be uniformly and readily reimbursed by all GME programs.

Synopsis of Institutional Support for Wellness and Solutions Implemented at Liberty University

Liberty University provides employees and their families with resources and services that motivate, encourage, and promote healthy lifestyles and foster resilience to achieve greater levels of wellness for individuals and the university community.

Health insurance programs that promote access to medical services that are effective and affordable (Day One coverage for residents).

Dental insurance programs that optimize dental health and prevention as well as treatment (Day One coverage for residents).

Vision programs to promote eye care and vision correction including glasses and contact lenses (Day One coverage for residents).

Direct primary care services to create value-added services (in addition to standard health insurance coverage) for residents, staff, and faculty at minimal expense to ensure ready access to primary care physicians in the community.

Day One health, life insurance, retirement vesting, and disability coverages are provided for residents, just as they are for faculty.

Numerous outdoor activities are promoted at Liberty including mountain hiking and trail running on many miles of trails around the scenic LU campus in the Blue Ridge Mountains.

Division I athletic events and Club Sports are discounted for the university community.

Music, theater, and arts programming is plentiful on campus and in the community.

Vacation time is generous in our university culture.

New residents are welcomed with celebratory events sponsored by LUCOM GMES.

Generous time and funding for CME activities/meetings and professional development seminars have been very well received by residents, faculty, and staff.

Honoring and adhering to all LUCOM GMES policies and procedures in wellness.

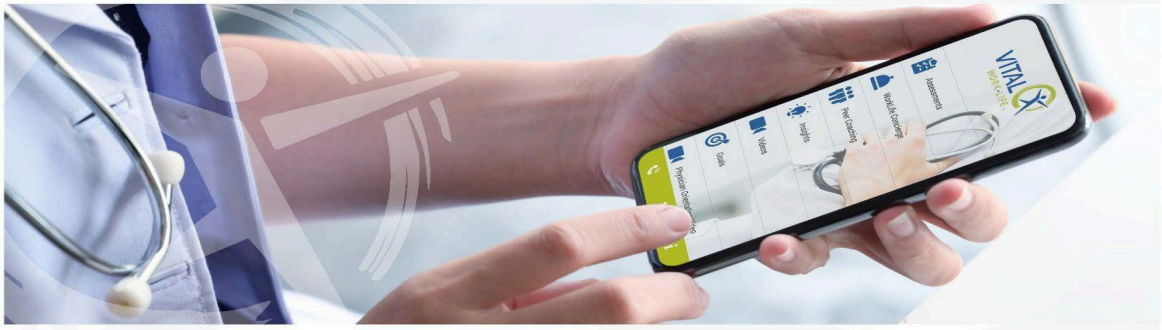
Respecting the absolute necessity of strict adherence to clinical education work hours by residents per LUCOM GMES policies and ACGME requirements.

Expecting all residency programs in graduate medical education to develop a zero tolerance for any clinical educational work hours violations and deal with these immediately at the level of the Program Director working with LUCOM GMES leadership including the DIO.

Safe Haven

VITAL WorkLife App

Your Well Being Resources, wherever you need them



As a busy physician or provider, you are challenged with unique demands that impact your well being and your work/life balance. Take charge with the VITAL WorkLife App, designed to help you assess and improve your well being and easily access your VITAL WorkLife resources whenever you need them.

The VITAL WorkLife App helps you:

Connect with your program resources

- Connect directly to the ***WorkLife Concierge*** site
- Tap to call or email VITAL WorkLife
- Learn more about ***Peer Coaching*** and how to use it
- Review information about the breadth of well being resources available to you and your family members

Take Assessments to Evaluate your Well Being

- ***Assessments*** for each of the six dimensions of well being (professional, physical, financial/legal, spiritual, emotional, relational)
- The ***Well-Being Index***, invented by the Mayo Clinic
- Maslach Burnout Inventory (MBI)
- Mindfulness Attention Awareness Scale (MAAS)
- After completing each assessment, receive recommendations based on your results

Access Insights and Videos By Experts

- View Insights by dimension of well being
- Watch relevant videos from VITAL WorkLife's channel
- Watch the orientation video for a 5-minute overview of your VITAL WorkLife Well Being Resources

Set Personal Goals

Establish personal goals and set reminders to stay on track.

What is the Well-Being Index?

The ***Well-Being Index*** is a brief online self-assessment invented by the Mayo Clinic. The index helps you better understand your overall well being and areas of risk compared to other healthcare professionals across the nation. This nine-question confidential survey provides you with immediate individualized feedback including tools and resources to address well being.

Setting up an account and completing the assessment is fast and easy:

- Open the VITAL WorkLife App and tap "Assessments"
- Tap "Well-Being Index" and the registration page will open
- Register (approximately two minutes)
- Take the assessment (approximately two minutes)

Registration & Login for VITAL WorkLife Mobile App

First time use:

Download the VITAL WorkLife App from your app store.

Select "register" to create your new profile and enter:

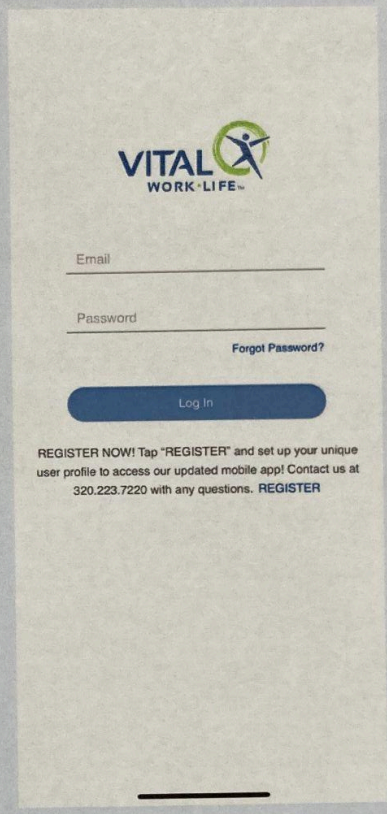
- Name
- Preferred email
- Password of your choosing
- Company Username: chp

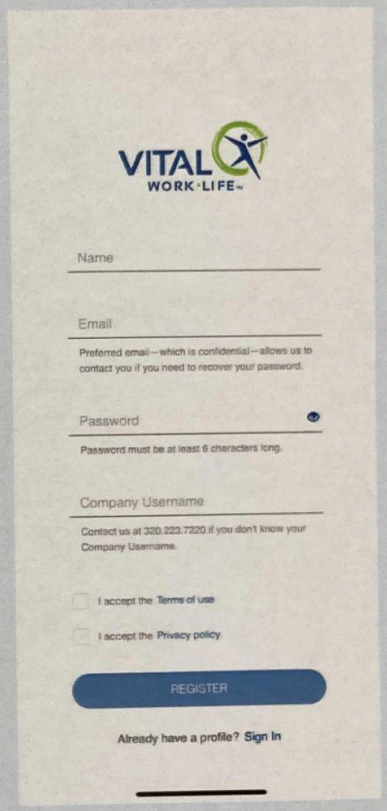
Download the App

Troubleshooting:

Contact us at 320.223.7220 for help.

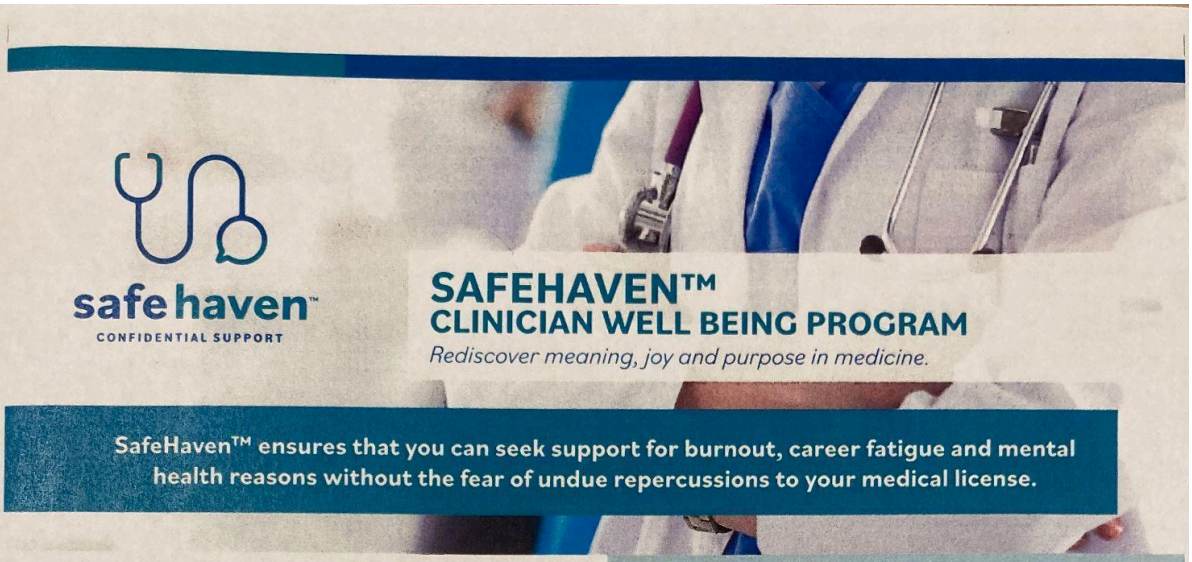
Make sure to enter your Company Username exactly as it's provided to you, with no spaces between words.





safe haven™

VITAL



safe haven™
CONFIDENTIAL SUPPORT

SAFEHAVEN™ CLINICIAN WELL BEING PROGRAM

Rediscover meaning, joy and purpose in medicine.

SafeHaven™ ensures that you can seek support for burnout, career fatigue and mental health reasons without the fear of undue repercussions to your medical license.

RESOURCES FOR YOU AND YOUR FAMILY MEMBERS

SafeHaven™ includes Clinician Well Being Resources from VITAL WorkLife—confidential and discreet resources designed to reduce stress and burnout, promote work/life integration and support well being for you and your family. These resources include:

- **Clinician Peer Coaching** — talk with someone like you who can help you grow both personally and professionally
- **Counseling** — available in either face-to-face or virtual sessions
- In-the-moment **telephonic support** — available 24/7
- **Legal and financial consultations** and resources
- **WorkLife Concierge** — a virtual assistant to help with every day and special occasion tasks
- **VITAL WorkLife App** — mobile access to resources, well being assessments, Insights, videos and more

WE PROTECT PHYSICIANS AND PAs

SafeHaven™ was launched in 2020 after recognizing a greater need to provide physicians and PAs the support needed to stay well and prevent burnout. It was established when MSV introduced and successfully passed legislation in the 2020 and 2021 Virginia General Assembly sessions. **The SafeHaven legal protections provides:**

INDEPENDENCE.

The bill establishes, in the Virginia Code, legal protections for a professional program which addresses issues related to burnout by doctors of medicine or osteopathic medicine and PAs.

IMMUNITY.

Amendments give more professional discretion to the provider on when to report to the board a belief that a physician or PA is in danger to themselves or others. All participants of SafeHaven™ are immune from reporting unless they are a danger to themselves or others.

PRIVILEGED COMMUNICATIONS.

Consultations under SafeHaven™ are considered privileged communications and do not pose a risk to a clinician's medical license, except in the case of extraordinary circumstances.

To Access Resources via **Your Member Site:**

Visit **VITALWorkLife.com**

Username: ~~Imms~~ CHP

Password: vitalworklife

You can also call anytime for support: **877.731.3949**

To Access Resources via **the VITAL WorkLife App:**

SCAN ME

Scan the QR code with your smartphone's camera to download the mobile app.

Company Username: CHP

MSV™ MEDICAL SOCIETY OF VIRGINIA

VITAL WORK·LIFE

To support the needs of replace with healthcare professionalsstruggling with stress, burnout and the effects of COVID-19, the Medical Society of Virginia (MSV) and VITAL WorkLife have partnered to offer physicians and PAs a comprehensive set of well being resources they can use without risk to their medical license, SafeHaven™.

15 Ways to Use the VITAL WorkLife App:

1. Take the Well-Being Index assessment
2. Use mindfulness resources to support your well being and help reduce stress
3. Make travel arrangements with WorkLife Concierge
4. Take the Maslach Burnout Inventory
5. Read Insights written by industry experts to help in your well-being journey
6. Evaluate your relational depth
7. Assess your mindfulness with the Mindfulness Attention Awareness Scale
8. Take inventory of your financial and legal health
9. Contact us to schedule financial consultation
10. Watch videos to improve your emotional intelligence
11. Set goals to improve your physical well-being
12. Learn more about your resources by watching the orientation video
13. Make dinner reservations or purchase tickets with WorkLife Concierge
14. Connect with your Peer Coaching resources
15. Contact a VITAL WorkLife Well-Being Coordinator

Take Control Today!

Download the VITAL WorkLife App and register with your Company Username to access your Well-Being Resources.

Bereavement Leave

A team member who wishes to take time off due to the death of an immediate family member should notify his/her Care Center Leader immediately. Bereavement leave will be granted unless there are unusual business needs or staffing requirements.

Paid bereavement leave is granted according to the following schedule:

- Team members are allowed five days of paid leave in the event of the death of the team member's spouse, child, father, father-in-law, mother, mother-in-law, brother, sister, stepfather, stepmother, stepbrother, stepsister, stepson or stepdaughter.
- Team members are allowed three days of paid leave in the event of death of the team member's brother-in-law, sister-in-law, son-in-law, daughter-in-law, aunt, uncle, grandparent, grandchild or spouse's grandparent.
- Team members are allowed up to four hours of bereavement leave to attend the funeral of a team member or retiree of the company upon approval of the Department Manager or Care Center Leader.

Long-Term/Medical Leave

The Resident Physician will follow policies and processes in graduate medical education to request a leave(s) and is expected to give as much advance notice as possible when submitting a request for leave from the program. All requests for leave from the program will be reviewed by the Program Director, the Resident Physician's immediate supervisor. It is recognized that time-sensitive requests (such as military service duty or medical emergencies) will be addressed in a time-sensitive manner by the Program Director. All applicable policies of the employer related to federal workplace requirements and guidelines for employee leave will be followed.

LUCOM GMES will provide residents/fellows will a minimum of six weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program, starting the day the resident/fellow is required to report. The leave does not include vacation or sick days.

Please contact CHP Human Resource department to further discuss your short-term/long-term benefits and for further questions.

Robin Hammer - rhammer@collaborativehp.com
434-382-1118
Elyse Douglas - edouglas@collaborativehp.com
434-534-6720

LUCOM GMES ONMM Residency Clinical Educational Work Hours Policy

Accountabilities and Responsibilities in the ONMM Residency

The issue of limits on work hours for physicians in graduate medical education programs has become an increasingly visible national issue over the past decade.

The ACGME continues to update a uniform set of work hour requirements for all accredited training programs that are designed to increase quality of life, improve the educational environment in training programs, and to maintain a safe environment for patient care.

Some individual RRC's may add additional requirements to the ACGME's Common Requirements in this area that provide clarification or additional direction.

1. This work hours policy is derived from the ACGME clinical and education work hours requirements. The ONMM program, overseen by the Graduate Medical Education Committee (GMEC) must, at minimum, follow this policy regarding work hours.

2. Trainees may often have different titles, this policy covers all trainees. The generic term "Resident" will be used to include all Residents.

3. The educational goals of the program and learning objectives of Residents must not be compromised by excessive reliance on trainees to fulfill departmental coverage needs. Work hours, however, must reflect the fact that responsibilities for continuity of patient care are not to be automatically discharged at specific times.

4. Resident work hours and on-call time periods must not be excessive. The structuring of work hours inclusive of on-call schedules must focus on the needs of the patient, continuity of care, as well as the educational opportunities and reasonable opportunities for Resident rest and personal well-being. The Program must ensure that trainees are provided appropriate back-up support when patient care responsibilities are especially difficult or prolonged and that patient care is not jeopardized during or following assigned periods of work.

5. It is the responsibility of the Program Director and faculty to ensure that work hours completed by Residents in the program are in accordance with this policy and any other specialty-specific accreditation requirements.

Specific Clinical and Education Work Hour Requirements:

Note: The Program Director will work with the DIO and GMEC to ensure that any ACGME changes in the clinical and education work hour requirements are updated and implemented into the program upon announcement from the ACGME.

The program and Program Director will insist on absolute and strict adherence to the ACGME clinical and education work hour requirements.

1. Clinical and Education Work hours are defined as all clinical and academic activities related to the training program including patient care (both inpatient and outpatient), administrative duties (i.e., completion of patient care related paperwork or dictation of charts), the provision for transfer of patient care (i.e., check-in and check-out), time spent providing clinical care while on call, and scheduled academic activities (i.e., required academic conferences). Work hours also include any research activity that is part of the required curriculum for the training program when completed in designated "Scholarly work hours".

2. Clinical and education work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and education activities, clinical work done from home and all moonlighting.

3. The 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.

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

5. 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.

6. Clinical and education work periods for the Resident must not exceed 24 hours of continuous scheduled clinical assignments.

7. Clinical work done from home must be counted toward the 80-hour weekly maximum. Clinical work periods for all Residents must not exceed 24 hours of continuous scheduled clinical assignments.

8. Clinical work hour exceptions may be granted by the Review Committee. The Program Director is responsible for justifying any exceptions to the DIO and GMEC and documenting and tracking them.

Home Call Activities:

1. Home call is defined as call taken from outside the assigned institution.

2. When a trainee is on home call, the time the trainee spends on clinical activities are to be counted toward the 80-hour work limit.
3. Time spent at the institution while on home call and clinical activities from home must not be excessive or so frequent or taxing as to preclude rest and reasonable personal time for each trainee or to approximate in-house call. The Program Director and the faculty must monitor the demands of home call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

Moonlighting:

1. The program has developed a separate policy on Moonlighting in the context of GME. Moonlighting is defined for the purposes of this policy as clinical work done outside the scope of a training program's required obligations and responsibilities by a trainee.

2. The Program Director has the responsibility to ensure that moonlighting does not interfere with the ability of each trainee to achieve the goals and objectives of their educational program.

3. Moonlighting which occurs at any inpatient or outpatient site must be counted toward the 80-hour weekly limit on work hours.

4. All moonlighting hours must be routinely reported to the Program Director in order to ensure that time spent moonlighting is not adversely impacting the trainee's progress in the educational program.

5. For additional policies regarding moonlighting that are not related to work hours, please refer to the moonlighting policy.

6. PGY-1 Residents in their first year of GME after medical school are not permitted to moonlight.

Monitoring of Clinical and Education Work Hours:

1. Actual work hours should be monitored for all trainees. The Program Director is responsible for *actively monitoring* all Residents' work hours using a variety of methods including but not limited to the electronic reporting system, direct discussion, interactions and interviews with Residents for information seeking and clarification.

2. The Program Director is responsible for ensuring that work hours are being monitored and that this policy is also being adhered to on all off-service rotations and at affiliated

training sites. If an issue arises related to work hours on one of these rotations that cannot be solved by the Program Director and the rotation leadership, then the DIO should be notified.

3. Actual hours spent at the assigned institution for trainees on home call should be monitored routinely by the Program Director to ensure that home call rotations do not exceed the averaged 80 hours per week standard and to ensure that home call responsibilities do not become excessive. Documentation of this monitoring of time spent at the institution on home call should be done by the Program Director.

4. One day in seven free of clinical and education responsibilities must be monitored and documented for all trainees in all programs. It is recommended that this be monitored and documented by trainees using the electronic tracking system.
5. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create trainee fatigue sufficient to jeopardize patient care.

6. The DIO and GMEC may request to review the documentation of work hours for any program.

7. Monitoring of work hours by the DIO and GMEC will be done through the following means:
    - For cause internal reviews (e.g. recurrent violations, non-compliant trainee responses on ACGME surveys, new program leadership) of training programs
    - Annual LUCOM GMES Work Hours Survey
    - Program-level work hours surveys
    - Communication with the members of the Resident Forum
    - Results of RRC accreditation site visits

8. Trainees must comply with requests from the Program Director to report work hours as required by the program's work hours policy. Reporting should be done using the work hour tracking system. If a Resident does not report work hours as required by the program's policy, the Program Director may take the following actions:
    a. First occurrence: provide a warning in writing to the trainee
    b. Second occurrence: provide a second warning in writing to the trainee
    c. Subsequent occurrence: the Program Director may discipline the Resident by one or more of the following actions:
        i. Formally place the trainee on probation.
        ii. Pull the trainee from service until the work hours documentation is complete.
        iii. Other disciplinary actions as proposed by the program and approved by the DIO and GMEC.
    d. Recurrent written warnings and discipline may be documented in the trainee's file as a deficiency in professionalism.

Clinical and Education Work Hours Exceptions:

1. Exceptions will be true exceptions and will be carefully reviewed by the DIO and GMEC for the Program to be congruent with ACGME defined exceptions. The DIO and GMEC expect the Program and Program Director to operate well within the ACGME Requirements.

2. Resident input and information will always be sought in the instance of a Program noting exceptions as defined by the ACGME.

LUCOM GMES ONMM Residency Moonlighting Policy

Accountabilities and Responsibilities in the ONMM Residency

Moonlighting is defined for the purposes of this policy as clinical work done outside the scope of a training program by a Resident hereafter known as a "trainee."

Trainees are not required to moonlight. Moonlighting is permitted only if the following points are satisfactorily met in the opinion of the residency Program Director who has the authority to grant and revoke moonlighting privileges under the oversight of the DIO at LUCOM GMES.

1) State license: The trainee must obtain a full Medical License from the State Medical Board from the state in which the trainee is moonlighting. Trainees may not practice medicine outside of their training program in the State of Virginia. It is the responsibility of the institution hiring the trainee to moonlight to determine whether such licensure is in place, adequate liability coverage is provided, and whether the trainee has the appropriate training and skills to carry out the assigned obligations.

2) DEA certificate/number: The trainee must obtain a personal DEA certificate/number if the moonlighting includes the potential for prescribing medications on an inpatient or outpatient basis.

3) Malpractice insurance: The trainee must secure his/her own malpractice insurance. The trainee can either pay for this malpractice personally or it can be provided by the entity employing the trainee for the moonlighting. The LUCOM GMES malpractice insurance policy which covers a trainee within a GME training program will not cover any activities outside of a training program when performed outside of the trainee's responsibilities in the LUCOM GMES GME activities of the GME program.

4) Approval of Moonlighting: Any trainee wishing to moonlight must first have the approval of the Program Director. The trainee must complete a copy of the Moonlighting Approval Form that is attached as an addendum to this policy. The Program Director may add any stipulations or restrictions on the moonlighting activity to the form. The form must be signed by the trainee, the Program Director and DIO noting these approvals from GME

leadership prior to beginning any moonlighting activities. The Program Director and DIO are not in any way obligated to provide approval for moonlighting activities after their individual reviews of the circumstances of the request(s) from a Resident and the program and Resident issues pertinent to the request(s). All ACGME Requirements will be adhered to including the requirements for reporting and honoring clinical education work hours in GME.

5) Interference with education/training: Moonlighting must not adversely affect the education and training of any trainee. The Program Director may limit or prohibit moonlighting by an individual trainee at any time in the context of the GME program if they indicate upon review that the amount of time spent moonlighting is adversely affecting the professional development of that trainee. The DIO is integrally involved in these discussions and will provide guidance to the Program Director

6) Monitoring of moonlighting hours: Moonlighting which occurs at any inpatient or outpatient site must be counted toward the 80-hour weekly limit on clinical education work hours of the ACGME and MUST be recorded in clinical education work hours reporting that is reviewed by the Program Director with oversight of the DIO. If it is brought to the attention of GME leadership, either the Program Director or DIO, that a trainee is found to not be reporting moonlighting activities, there will be immediate suspension of all moonlighting privileges.

   All other moonlighting hours at sites outside of the activities of the GME program must be routinely reported to and tracked by the Program Director in order to ensure that time spent moonlighting is not adversely impacting the trainee's progress in the educational program.

7) Other clinical obligations: Trainees are prohibited from moonlighting if they are on in-house call, home call, or during any assigned clinical obligations within their training program that might overlap with the moonlighting shift. Trainees may not moonlight while on family, medical, or paternity/maternity leave.

8) Program-specific specialty issues: The Program Director is responsible for reviewing all issues related to moonlighting requests and clinical education work hours monitoring. Failure to report moonlighting hours to the Program Director may result in one or more of the following adverse actions for the trainee in accordance with the nature and frequency of the violation: 1) prohibition from future moonlighting for a prescribed period of time, 2) probation, 3) suspension, 4) dismissal.

9) RRC Program Requirements: Any future program requirements for the ONMM specialty training program of the RRC which are more explicit or limiting with regard to moonlighting will be adhered to by the Program Director, should requirements change and be communicated by the RRC

LUCOM GMES

Moonlighting Approval Request Form

This form should be completed prior to the trainee beginning any moonlighting activities. The Program Director and the trainee must sign the form and a copy of this form will be kept in the trainee's file.

Trainee Name: _____

Training Program: _____

Year in Training Program: _____

Description of moonlighting request and activities:

Maximum number of moonlighting hours per week:_____

Other restrictions on moonlighting activity:

Program Director Review and Summary Comments to be Reviewed with the DIO:

By signing this form, the Trainee notes his/her requirements to report all moonlighting hours worked to the Program Director and understands the consequences described in this policy for not accurately reporting moonlighting hours in his/her clinical education work hours. The trainee also understands that he/she must obtain individual professional liability insurance coverage for moonlighting activities.

Trainee Signature:

Date: _____

Program Director Signature:

Date: _____

DIO Signature:

Date: _____ P

Please see the form in the Appendix (p.120).

Didactic Attendance Policy

Attendance to the weekly Didactic Seminar, which is protected time, is mandatory for all LUCOM GMES ONMM Residents. Participation will occur in person at CH-SS Wards Road in the conference room (unless otherwise noted) or via Microsoft Teams. Microsoft Teams can only be utilized if a resident is at a required away rotation site or has received prior approval from the Program Director. Site directors at other locations are aware of your protected didactic time when schedules are coordinated.

Timeliness

Residents will arrive in a timely fashion as this is a core element in professional behavior, where unpacking computers, textbooks, changing into the appropriate dress, etc., do not interfere with the timely start of the session. Residents will also be prepared to engage in the planned education activities that are listed on the Conference Schedule.

Absences

The following scenarios are approved excused absences:

1. Scheduled time away that has already been approved by the Program Director utilizing the Time Away request form.
2. Scheduled time away for other required educational activities such as the ITE and associated travel days.
3. If a resident is on an inpatient service and completed an on-call service, or overnight work with the attending, they are excused from participating in CEWH after 12 noon the day following.
    a. EX: If the resident completed an overnight or on-call service, they will have completed their entire workday by noon the next day. Therefore, they would not be required to attend Didactics.
4. Unexpected illness that results in the use of a personal day.

Active Monitoring of Attendance

Residents will attest to being present at didactics by documenting their attendance on MedHub.
The following procedure is how to document attendance:

1. Login to MedHub.
2. Select Conferences in the Toolbar.
3. Find the corresponding Didactics session.
4. Select Attendance.
5. Place your initials next to your name.

A 90% attendance rate is expected of all Residents. If a Resident falls below this number, the Program director will address it with a verbal conversation. If over a period of 6 months the Resident fails to improve their attendance, the Program Director will send them a written notification of their non-compliance with the verbal request for correction. A third offense will merit a formal in-person meeting with the Program Director and establishment of a Performance Improvement Plan.

Conflict Resolution

This policy is intended to provide clinical trainees with the opportunity to raise and resolve issues in their training program without fear of intimidation or retaliation. When a trainee experiences a problem such as perceived harassment, unfair treatment, concerns regarding work environment, program noncompliance with ACGME, RC or LUCOM GMES requirements or procedural discrepancies/inequities, it is best handled within the program whenever possible.

Trainees are encouraged to engage the Program Director, Clinical faculty mentor, or other designated individuals in the training program in resolving issues or complaints. Occasionally, these issues are unable to be resolved at the program level, in which case the clinical trainee is encouraged to contact Graduate Medical Education to arrange a meeting. The trainee will be scheduled to meet with the DIO or a designee to discuss the issue or complaint. Every attempt will be made by GME leadership to investigate and resolve the reported issues/complaints.

If a workable solution is not reached by GME, the clinical trainee may choose to bring the matter before the Graduate Medical Education Committee. Findings and action taken by the Graduate Medical Education Committee are considered final and binding on all parties involved.

Drug and Alcohol Free Workplace

Collaborative Health Partners (CHP) has a longstanding commitment to provide a safe and productive work environment. Alcohol and drug abuse pose a threat to the health and safety of team members and to the security of our equipment and facilities. For these reasons, CHP is committed to the elimination of illegal drug and/or alcohol use and abuse in the workplace.

This policy outlines the practices and procedures designed to correct instances of identified illegal drug and/or alcohol use and abuse in the workplace. This policy applies to all team members and all applicants for employment of CHP.

Employee Assistance and Drug-Free Awareness

Illegal drug use and alcohol misuse have a number of adverse health and safety consequences. Information about those consequences and sources of help for drug and/or alcohol problems is available from the Human Resources Department. CHP provides

additional resources for drug and/or alcohol problems through the employee assistance program (EAP). Additional details about the EAP are provided later in this handbook or can be obtained from the Human Resources Department.

CHP will assist and support team members who voluntarily seek help for such problems before becoming subject to discipline and/or termination under this or other policies. Such team members may be allowed to use accrued paid time off, placed on leaves of absence, referred to treatment providers and otherwise accommodated as required by law. Such team members may be required to document that they are successfully following prescribed treatment and to take and pass follow-up tests if they hold jobs that are safety sensitive or that require driving or if they have violated this policy previously.

Team members should report to work fit for duty and free of any adverse effects of illegal drugs or alcohol. This policy does not prohibit team members from the lawful use and possession of prescribed medications. Team members must, however, consult with their doctors about the medications' effect on their fitness for duty and ability to work safely and promptly disclose any work restrictions to their Care Center Leader or other member of management. Team members should not, however, disclose underlying medical conditions unless directed to do so.

Work Rules

The following work rules apply to all team members:

- Whenever team members are working, are operating any company vehicle, are present on company premises, or are conducting related work off-site, they are prohibited from:
    - Using, possessing, buying, selling, manufacturing or dispensing an illegal drug (to include possession of drug paraphernalia).
    - Being under the influence of alcohol or an illegal drug as defined in this policy.
- The presence of any detectable amount of any illegal drug or illegal controlled substance in a team member's body while performing company business or while in a company facility is prohibited.
- CHP will not allow any team member to perform their duties while taking prescribed drugs that are adversely affecting the team member's ability to safely and effectively perform their job duties. Team members taking a prescribed medication must carry it in the container labeled by a licensed pharmacist or be prepared to produce it if asked.
- Any illegal drugs or drug paraphernalia will be turned over to an appropriate law enforcement agency and may result in criminal prosecution.

Required Testing

The company retains the right to require the following tests:

- Reasonable suspicion: Team members are subject to testing based on observations by a Care Center Leader or other member of management of apparent workplace use, possession or impairment. The Human Resources Department must be consulted before sending a team member for reasonable suspicion testing.
- Post-accident: Team members are subject to testing when they cause or contribute to accidents that seriously damage a company vehicle, machinery, equipment or property and/or result in an injury to themselves or another team member requiring off-site medical attention. In any of these instances, the investigation and subsequent testing must take place immediately following or within the same day of the accident.

Follow-up

Team members who have tested positive, or otherwise violated this policy, are subject to discipline, up to and including termination of employment. Depending on the circumstances and the team member's work history or record, CHP may offer a team member who violates this policy or tests positive the opportunity to return to work on a last chance basis pursuant to mutually agreeable terms, which could include follow-up drug testing at times and frequencies for a minimum of one (1) year or referral to a rehabilitation program. If the team member either does not complete a rehabilitation program or tests positive after completing a rehabilitation program, the team member may be subject to immediate disciplinary action, up to and including termination of employment.

Consequences

Team members who test positive for alcohol or illegal drug use under this policy, refuse to cooperate in required tests or who use, possess, buy, sell, manufacture or dispense an illegal drug in violation of this policy may be subject to disciplinary action, up to and including termination of employment.

Team members will be paid for time spent in alcohol or drug testing. Suspension may apply depending on the results of the drug or alcohol test. After the results of the test are received, a date and time will be scheduled to discuss the results of the test; this meeting will include a member of management and a member of the Human Resources Department.

In the event a team member disputes the results of a drug and/or alcohol test, the sample will be sent to an outside lab not affiliated with CHP for a second test.

Confidentiality

Information and records relating to positive test results, drug and alcohol dependencies and legitimate medical explanations provided to the medical review officer (MRO) shall be kept confidential to the extent required by law and maintained in secure files separate from normal personnel files.

Inspections

CHP and/or its operational partners reserves the right to inspect all portions of its premises for drugs, alcohol or other contraband. All team members and visitors may be asked to cooperate in inspections of their persons, work areas and property that might conceal a drug, alcohol or other contraband. Team members who possess such contraband or refuse to cooperate in such inspections may be subject to appropriate disciplinary action, up to and including termination of employment.

Crimes Involving Drugs

CHP prohibits all team members from manufacturing, distributing, dispensing, possessing or using an illegal drug in or on company premises or while conducting company business. Team members are also prohibited from misusing legally prescribed or over-the-counter (OTC) drugs. Law enforcement personnel shall be notified, as appropriate, when criminal activity is suspected.

Office Disruption/Workplace Violence

Purpose:

This policy is intended to provide guidance to all team members if a colleague or patient is threatened or being threatened with intimidation, harassment or actual violence while onsite or offsite during a work-related activity.

Policy:

It is the policy of the organization to provide a safe workplace for all team members. To ensure a safe workplace and to reduce the risk of violence, all team members should review and understand all provisions of this office disruption/workplace violence policy.

Prohibited Conduct

The organization does not tolerate any type of workplace violence committed by or against team members. Team members are prohibited from making threats or engaging in violent activities. This list of behaviors provides examples of conduct that is prohibited:

- Causing physical injury to another person.
- Making threatening remarks.
- Displaying aggressive or hostile behavior that creates a reasonable fear of injury to another person or subjects another individual to emotional distress.
- Intentionally damaging employer property or property of another team member.
- Possessing a weapon while on company property or while on company business.
- Committing acts motivated by, or related to, sexual harassment or domestic violence.

Dangerous/Emergency Situations

In the event of a disturbance or disruption by patients, visitors and/or staff, action should be taken to prevent physical injuries to all personnel. Such situations may include an individual raising his/her tone of voice and/or making threats which cause a team member or patient to become uncomfortable, and the disrupting individual refuses to calm down.

Team members who confront or encounter an armed or dangerous person should not attempt to challenge or disarm the individual. Team members should remain calm, make constant eye contact, and talk to the individual. If a Care Center Leader or

Clinical Team Lead can be safely notified of the need for assistance without endangering the safety of the team members or others, such notice should be given. Otherwise, team members should cooperate and follow the instructions given.

If a team member believes an individual may resort to violence and/or if the situation becomes life threatening, they should remove himself/herself from the situation and immediately call 911.

If a team member believes an individual is acting in a manner to vent frustration, remove the individual from the location where the incident is taking place and allow the individual to calm down in an area away from patients and visitors.

In all cases of disruption, team members should immediately report the incident to the Care Center Leader.

If an individual causes a disruption, the Care Center Leader should communicate with the individual to determine how to best resolve the problem.

Reporting Procedures

Reporting workplace concerns can be made anonymously, and all reported incidents will be investigated. Reports or incidents warranting confidentiality will be handled appropriately, and information will be disclosed to others only on a need-to-know basis. All parties involved in a situation will be counseled, and the results of investigations will be discussed with them. The organization will actively intervene at any indication of a hostile or violent situation.

A detailed record of the event must be documented and, if necessary, sent to the Threat Assessment Team.

Hiring

The HR department takes reasonable measures to conduct background investigations to review candidates' backgrounds and to reduce the risk of hiring individuals with a history of violent behavior.

Individual situations

Although the organization does not expect team members to be skilled at identifying potentially dangerous persons, they are expected to exercise good judgment and to inform the HR department if any team member exhibits behavior that could be a sign of a potentially dangerous situation. Such behavior includes:

- Discussing weapons or bringing them to the workplace
- Displaying overt signs of extreme stress, resentment, hostility, or anger
- Making threatening remarks
- Showing sudden or significant deterioration of performance
- Displaying irrational or inappropriate behavior

Enforcement

Threats, threatening conduct, or any other acts of aggression or violence in the workplace will not be tolerated. Any team member determined to have committed such acts will be subject to disciplinary action, up to and including termination. Non-employees engaged in violent acts on the employer's premises will be reported to the proper authorities and fully prosecuted.

Threat Assessment Reporting

To report a threat or concern:

1. Send an email to the "Threat Assessment Team" using the group located in your Outlook address list. This group consists of Lauren Bennett, Brandi Kenney, Robin Hammer, and Lindy Mason.
2. The concern will be evaluated by the Threat Assessment Team to determine what actions need to be taken.
3. The Threat Assessment Team will follow up with the team member who files a concern to gather additional information and/or to provide a conclusion once an investigation has been conducted.
4. For life threatening or urgent issues, promptly contact one of the CTA team members or your Care Center Leader directly:

   Lauren Bennett – lbennett@collaborativehp.com; 434-660-9696

   Brandi Kenney – bkenney@collaborativehp.com ; 434-660-8611

   Robin Hammer – rhammer@collaborativehp.com; 434-660-0492

   Lindy Mason – lmason@collaborativehp.com; 434-401-3027

Active Shooter

Purpose:

This policy is intended to provide guidance in the event an individual is shooting persons at the workplace and to comply with applicable regulations of the Occupational Safety and Health Administration (OSHA).

Policy:

It is the policy of the organization to provide an active shooter emergency response plan to alert team members that an active shooter is actively engaged in killing or attempting to kill people at the workplace.

Definitions:

An **active shooter** is defined as a person or persons who are actively engaged in killing or attempting to kill people at any of our organization's locations. In most cases active shooters use firearms and display no pattern or method for selection of their victims.

In some cases, active shooters use other weapons and/or improvised explosive devices to cause additional harm and act as an impediment to police and emergency responders. These improvised explosive devices may detonate immediately, have delayed detonation fuses, or detonate on contact.

Procedures:

1. The first team member to identify an active shooter situation:
    a. Announce Code "Active Shooter" (with the location of the incident) and a physical description of the person(s) with the weapon, and type of weapon, if known.
2. The Care Center Leader (or designee) will:
    a. Provide a page announcement "Code Active Shooter (and the location)" by accessing the emergency page group on the phone system. This will include the administrative team at each location.
    b. The designated administrative staff, who is at a location distant from the active shooter, will contact 911.
    c. A phone call to 911 (from the area where the caller is safely concealed) should provide the following information to the police:
        i. Number and types of weapons.
        ii. Suspect's direction of travel.
        iii. Location and condition of any victims.

Potential Responses:

1. In response to an active shooter event, there are three potential courses of action:

a**. Get out** b**. Get ready** c. **Get aggressive**

Get out:

1. If there is an accessible escape path, attempt to evacuate the premises. Follow these recommendations:
    a. Have an escape route and plan in mind.
    b. Evacuate regardless of whether others agree to follow.
    c. Leave your belongings behind.
    d. Help others (patients) escape, if possible.
    e. Prevent individuals from entering an area where the active shooter may be.
    f. Always keep your hands visible.
    g. Follow the instructions of any police officers.
    h. Do not attempt to move wounded people until advised that it is safe to do so.
    i. call 911 when you are safe.

Get ready:

1. If you cannot evacuate, hide where the shooter is less likely to find you.
    a. Be inconspicuous.
    b. Be out of the active shooter's view.
    c. Provide physical protection if shots are fired in your direction (e.g., locate into a bathroom and lock the door, stay as low to the floor as possible and remain quiet and motionless). In care centers that have x-ray, the x-ray room is a good location if unable to
    safely evacuate.
    d. Do not trap yourself or restrict your options for movement.
2. To prevent an active shooter from entering the hiding place:
    a. Lock the door.
    b. Blockade the door with heavy furniture.
    c. If the active shooter is nearby:
        i. Lock the door.
        ii. Silence cell phone and/or pagers.
        iii. Turn off any source of noise (i.e., radios, televisions).
        iv. Hide behind large items (i.e., cabinets, desks).
        v. Remain quiet and motionless.

Get aggressive:

1. If it is not possible to evacuate or hide, then consider self-defense, with these recommendations:
    a. Remain calm.
    b. Dial 911, if possible, to alert police to the active shooter's location.
    c. **If you cannot speak, leave the line open and allow the 911 dispatcher to listen.**
2. Act against the active shooter only when you believe your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter as follows:
    a. Act as aggressively as possible against him/her.
    b. Throw items and improvised weapons.
    c. Yell!

d. Commit yourself to defensive physical actions.

Law Enforcement Response:

1. The police will arrive to respond to the emergency, follow these recommendations:
    a. Comply with all police instructions. The first responding officers will be focused on stopping the active shooter and creating a safe environment for medical assistance to be brought in to aid the injured.
    b. Remain calm and follow officers' instructions.
    c. Put down any items in your hands (i.e., bags, jackets).
    d. Quickly raise your hands and spread your fingers.
    e. Always keep your hands visible.
    f. Avoid making quick movements toward officers such as attempting to hold on to them for safety.
    g. Avoid pointing, screaming and/or yelling.
    h. Do not stop to ask officers for help or direction when evacuating, just proceed in the direction from which officers are entering the area or to an area to which they direct you.
2. When the police arrive, the following information should be available:
    a. Number of shooters.
    b. Number of individual victims and any hostages.
    c. The type of problem causing the situation.
    d. Type and number of weapons in the possession of the shooter.
    e. All necessary Company representatives are still in the area as part of the organization's emergency management response plan.
    f. Identify and describe the participants, if possible.
    g. Keys to all involved areas as well as floor plans.
    h. Locations and phone numbers in the affected area.

Post Incident Response:

When the police have determined the active shooter emergency is under control, the Care Center Leader (or designee) will provide a public announcement that the emergency is over by paging Code Active Shooter "All Clear" over the phone page group.

Police Investigation:

After the police have secured the premises, designated administrative staff will participate in the law enforcement investigation of the incident, including identifying witnesses and providing requested documents.

Medical Assistance:

The Company will designate administrative representatives to engage with emergency responders who provide medical assistance to injured team members. This includes ensuring all required medical benefits and insurance documentation are provided.

Notification of Relatives:

The CHP Administrative team will work with the Care Center Leader (or designee) to notify relatives of any injured team members in a timely fashion.

OSHA:

If there is a fatality, or a team member is hospitalized for treatment, OSHA must be notified. If there is a fatality, OSHA must be notified within eight (8) hours. In the event of a hospitalization of a team member for treatment, OSHA must be notified within twenty-four (24) hours. In addition, if the fatality or injury is work-related, the Company may have to record the incident on its OSHA 300 Log within seven (7) calendar days.

Media:

The CHP Administrative Team will respond to any media requests for information. Such representatives will carefully consider the nature of any such requests to avoid disclosing information about any person that is confidential and protected by Federal and state privacy and medical information laws and regulations and interfering with any ongoing police or internal Company investigation. Unless authorized by a CHP Administrative Team Member, no comments or information should be disclosed to the media.

Lockdown Policy

Purpose

This policy is intended to provide guidance in the event of an emergency where a lockdown is necessary to provide preventative measures against any external threats, and to comply with applicable regulations of the Occupational Safety and Health Administration (OSHA).

Policy/Procedure/Protocol

It is the policy of CHP to alert team members of a facility lockdown, and to provide procedures for a lockdown scenario:

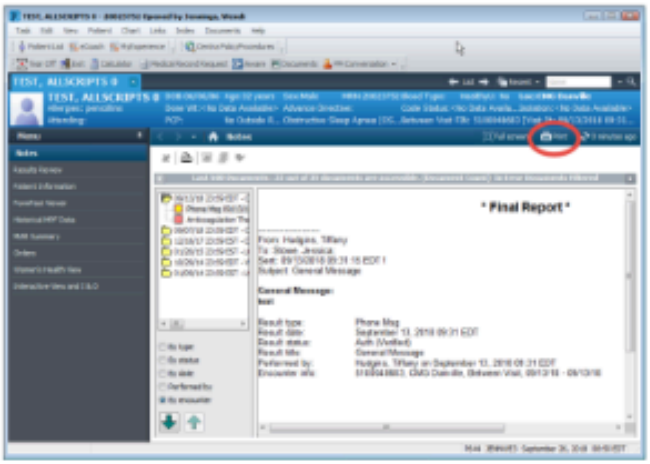
1. The Compliance Officer/designee or Care Center Leader/designee is notified of a local emergency by a patient, staff member, or local alert system.
   If notified of an emergency <u>requiring lockdown directly by police</u>, skip to procedure 4.
2. The Compliance Officer/designee or Care Center Leader/designee calls the local non-emergency police line to confirm the emergency and discuss any immediate threats.
    a. Non-emergent police telephone numbers are located locally in each office's "Lockdown Folder," as well as, digitally via the "Safety Procedures" folder under "All Resources" on CHP's network.

3. Based on the information received from the local police, the type of emergency, and the proximity to the building(s), the Compliance Officer/designee or Care Center Leader/designee decides if the building(s) will enter a lockdown.
4. The Compliance Officer/designee or Care Center Leader/designee sends out a Lockdown alert via the RedFlag alert system to appropriate office groups.
5. On-site leadership/designee notifies a staff designee to stand to the side of the practice's innermost eternal door to allow patients that wish to leave to exit the facility.
6. Front office staff call patients, scheduled within the next hour, to set up virtual appointments or reschedule. If the lockdown persists for over an hour, front office staff will call patients, scheduled for the next hour, to set up virtual appointments or reschedule. **Repeat as necessary.**

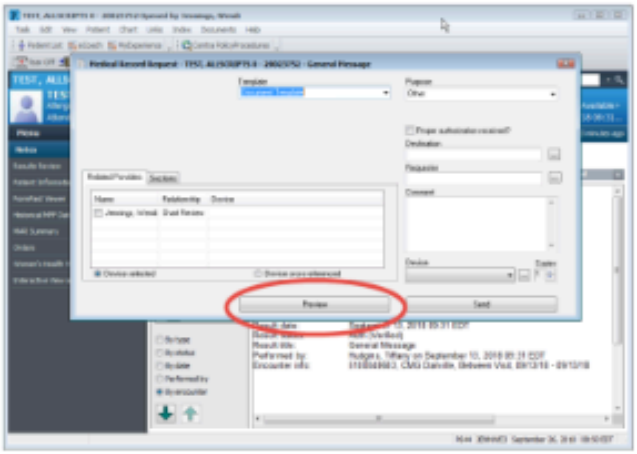
Cerner Printing Workflow

The computer's default printer will automatically populate in centra portal:	
Change computer default printer: Computer Desktop > Privia Tools > Devices and Printers or Printers & Scanners Devices and Printers > Right click printer change to default Printers & Scanners Click Printer > Mange change to default	One time printer change: Blue Centra Portal Screen > Right Click Screen > Choose Print > Right Click Printer and Choose "Set as default printer" > Choose "Apply" > Close popup

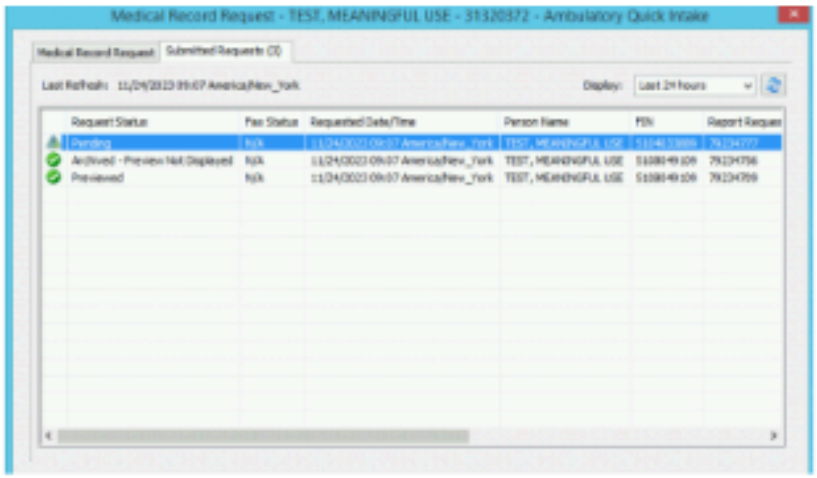
1. Search patient and find desired document
2. Click **"Print"**



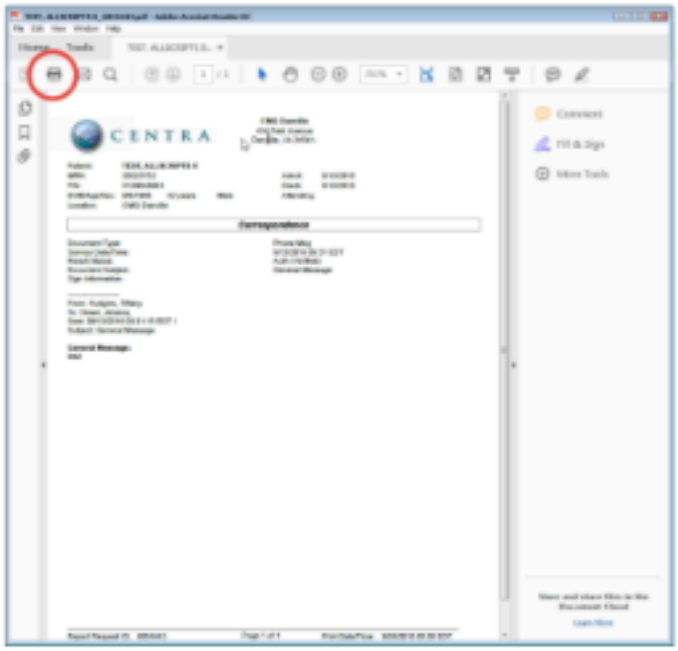
3. Click **"Preview"**
   **Template dropdown must be document template



4. Submitted Request Popup Appears
   Once request turns into green checkbox icon (Use refresh icon)
   Double click document



5. Click printer icon



6. Choose "print"

Support Request

There is a support request icon on your desktop. This icon is to be used to submit any IT needs, training requests, report requests, quality assistance, etc.

For urgent requests please contact 434-382-1117.

Microsoft Teams Recording

1. Once the meeting is started, select the “...” and “start recording” in the toolbar.
2. After the meeting is complete, select the “...” and “end recording” in the toolbar.
3. The recording will automatically save and will appear in the chat.
4. Open the chat, select the “...” on the video once it appears and select “link.”
5. Copy the link.
6. Paste in an email or a document, to be pulled later.

Locker and Lock Agreement

Purpose

To provide a facility where GME trainees can secure their belongings. Lockers will be provided to trainees and trainees can bring in their own lock to secure their belongings. Trainee will notify the Program Coordinator which locker they have selected.

Procedure/Policy

1. Lockers are owned by GME and considered property of LUCOM GMES in its clinical settings.
2. Use of a locker by a person other than whom it is assigned is forbidden. Misuse of a locker may lead to the termination of locker privileges. Personal locks are permitted.
3. GME and the LUCOM GMES retain the right to conduct routine and random locker inspections at any time and without warning or approval. The lock may be removed without warning or approval to conduct such an inspection. Misuse of these facilities may be the cause for corrective action.
4. GME and the LUCOM GMES are not responsible for personal property that is lost or stolen. All trainees are encouraged to leave valuables at home, secure their locker, and refrain from giving their key or lock code to other individuals.
5. All personal property must be stored completely within the locker or shelf. All items left outside of a locker or shelf, whether secured or not, will be removed and disposed of accordingly.
6. Flammable materials, dangerous chemicals, explosives or weapons of any kind are strictly prohibited inside of the lockers and locker rooms.
7. It is each trainee's responsibility to always keep his/her locker neat and clean. Perishable items (food and beverages) and illegal or controlled substances such

as drugs and alcohol are prohibited inside of the lockers and locker rooms.

8. Upon assignment and during use, trainees are responsible for reporting any damage or needed repairs to the GME office. Trainees will assume the cost of any unreported damage.

Adverse Event Reporting

Patient Safety

Patient Safety is a core value that cannot be compromised and is the responsibility of every physician and caregiver. The Patient Safety Plan and Program are designed to support and promote the mission, vision and values of the ONMM Program with a systematic, coordinated approach to continuously improving patient safety and reducing risk. The ONMM Program's safety initiatives are supported by leadership and executed through the integration and coordination of patient safety initiatives.

Safety provides the foundation for a systematic and coordinated approach to integrating patient safety priorities into the design and redesign of all relevant organizational processes, functions, and services to create an accountable culture of safety. Patient safety is determined in part by each clinical setting's leadership, but the culture of patient safety builds a framework for the delivery of safe care, perpetuates a culture of safety and improves patient outcomes through reducing variability in care processes, increasing reporting of safety events and overall reduction of preventable adverse events.

The patient safety plan of each clinical setting must be honored.

The goals and objectives of the Patient Safety Plan are:

- Promote High-Reliability Principles
- Support a Culture of Safety
- Enhance Education and Training in Patient Safety
- Continuously improve Patient Safety Measurement and Reporting

Culture of Safety in Clinical Care Settings

The ONMM Program supports a Culture of Safety. The elements of our program include:

- Functioning in teams led by attending physicians and acting as a unit.

- Striving for high reliability: doing the same thing for our patients every time.
- Activating patients and their families: enlisting the patient and/or family as part of the healthcare team.
- Listening to the needs of the patient and concerns of the family members present
- Ensuring accountability: establishing expectations and accountability for expected safety behaviors.
- Encouraging ‘speaking up’ through event reporting, with processes that help all involved understand why errors occur.
- Learning as a community of learners and teachers: full cycle learning from reported events.

Speak Up

The ONMM Program supports a safe culture by establishing expected safety behaviors which include stopping the line when something does not seem right and reporting actual or potential safety events. Residents should support and encourage the caregiver to report and share lessons about safety events, so others are able to learn.

Safety and Quality Improvement Education

The ONMM Program facilitates projects and resources providing opportunities for clinical trainees to become involved in-patient safety and quality improvement. Residents are required to complete a continuous quality improvement and safety project, while in the training program. All projects will be approved in advance by the Program Director prior to implementation in any educational or clinical setting. Prior to submission of any results of such work to any venue for dissemination (such as, including but not limited to, local/regional/national/international meeting, professional organization meeting, journal submission, poster, or abstract submission) all faculty mentors, all student and resident collaborators, and the Program Director must sign-off on the scholarly work. Depending on the project, application to the LU Institutional Review Board for exemption or approval prior to initiation may be necessary.

Safety Event Reporting

Reporting a safety event when it occurs provides an opportunity to identify and learn about system failures, hazards, and risks. It is critical to note that safety events are not limited to those events that cause a patient harm. Often, we have the most to learn from near-miss events and no-harm events. Learning about these events can help safeguard our patients from future-harm events. The safety event can provide information as to

where processes are breaking down and therefore reduce the likelihood of recurrence. This review and analysis process will lead to improvements in the quality of patient care.

Any LUCOM GMES affiliated hospital or facility caregiver, who is involved in, observes or otherwise becomes aware of a safety event, is responsible for promptly reporting the event in the electronic system or telephonic reporting system of the healthcare delivery setting.

When on rotation at Collaborative Health Specialty Services (CHSS), the resident will report all events to the attending faculty, Program Director, and Care Center Leader. Appropriate next steps to ensure patient safety will be performed. All events are reported to the GMEC.

Reports may be submitted in an identifiable or anonymous manner via the following hotlines:

1. Confidential reporting hotline, Ronny Smith at MidState, 1-844-382-5067
2. Employee Assistance for stress or reporting adverse events, VITAL Worklife-Safehaven, 1-888-316-6616 or email at Service@VITALWorkLifeConcierge.com

Events should be reported as soon as possible within 24 hours of occurrence. Residents are assured that they can report safety events without fear of retribution. Event reporting is a mechanism for organizational learning, not a disciplinary pathway.

Our response to events is centered on being "systems-oriented" with a focus on understanding the context in which errors occur. All events will be reviewed by the Patient and Faculty Safety Committee. The ONMM Program is committed to supporting an environment which is neither purely punitive nor blame-free. Of critical importance in determining a "just" response to an event is understanding that while all caregivers bring expected behaviors to work (avoiding reckless behavior, gross neglect, or intentional acts of harm), we do work within complex and imperfect systems. Learning from these events allows us to improve the systems that all caregivers work within.

Reportable events fall into the following categories:

- **Adverse Event:** Any injury (undesirable clinical outcome) caused by the omission or commission of medical care.
- **Event:** Any happening that is not consistent with the routine care of a patient, or an occupational injury/illness of an ONMM resident or any happening that is not consistent with normal operations of a clinical care setting. An event may involve a patient, resident, visitor or the physical environment within a LUCOM GMES

affiliated clinical partner facility and is associated with actual or potential for harm, loss or damage. An event may involve an error, but the term 'event' is not synonymous with 'error'.

- **Near Miss:** Circumstances or events that have the capacity to cause error and did NOT reach the patient.
- **Sentinel Event:** A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: Death, Permanent Harm or Severe Temporary Harm. Severe Temporary Harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition or additional major surgery, procedure or treatment to resolve the condition.

Professionalism and Personal Appearance

LUCOM GMES recognizes the importance of the professional appearance of its staff in maintaining an atmosphere conducive to the delivery of quality health care services. To promote such an atmosphere, clinical trainees are expected to dress in a manner appropriate to the jobs that they perform and the professional level they represent. Although it is not necessary to recount all the components in the employee policy, the following tenets are set forth for clinical trainees:

1. Clinical trainees must present themselves in appropriate attire to reflect their position. When caring for patients, male trainees should be dressed in dress shirts and slacks with appropriate footwear and LUCOM GMES administered lab coat. Male trainees are encouraged to wear ties with their white coats. Female trainees should be dressed in appropriate business attire which would include suits, dresses or appropriate blouse and slacks, with appropriate footwear and lab coat.
2. Clothing should be neat, clean and in good condition. Clinical trainees should be dressed in a fashion that represents their professional level. Hair should be clean and well groomed (including facial hair).
3. Furnished LUCOM GMES uniforms or other garments are expected to be kept clean, pressed and in good repair. Scrubs are to be worn within LUCOM GMES only, not worn to and from work. Caps, booties, and masks should be removed when outside of the operating room.
4. When responding to after-hours or weekend calls, appropriate business casual attire may be worn. Business casual attire includes casual slacks, shirts without ties, polo shirts and shirts or blouses with collars.
5. The employee ID Badge must be worn above the waist.
6. The scrub personnel responsibility information listed here is to encourage hygiene, ensure OSHA compliance, promote compliance with infection control and preserve our public image.
    1. No surgical attire can be worn outside of the hospital/facility or to and from work. Staff and employees must change into scrubs or surgical attire once

they enter their work locations in surgical/procedural areas and change again before leaving work. When leaving the surgical or procedure rooms, scrubs and surgical attire must be covered with white buttoned lab coats while inside the hospital (i.e., during a lunch break in the cafeteria, running an errand outside of the surgical department). However, this attire cannot be worn when traveling to and from work.

2. Completely change out of scrubs or surgical attire with or without a lab coat before leaving the premises. Disposable hats, masks, gowns, gloves, and shoe coverings must be removed when leaving surgical departments. Discard these items prior to leaving the surgical department areas or procedural suites.
3. Residents will be held accountable for compliance in clinical settings. Clinical supervisors will obviously enforce compliance in procedural and surgical areas. Program Directors will be notified of offenses. Please help remind colleagues of this policy, and do your part to encourage hygiene, ensure OSHA compliance, promote compliance with infection control and preserve our public image.

HOW TO

Enter Clinical Education Work Hours

***Note: this information can be found in this manual under the section titled: “MedHub Resident and Fellow Quick Start Guide”

Complete ADS Logs for ONMM Cases and Procedure Counts

Residents in the LUCOM GMES ONMM residency will track patient procedures completed during their time in residency via the online ACGME Resident's Case Log system accessible through the Accreditation Data System (ADS). Data that will be logged includes:

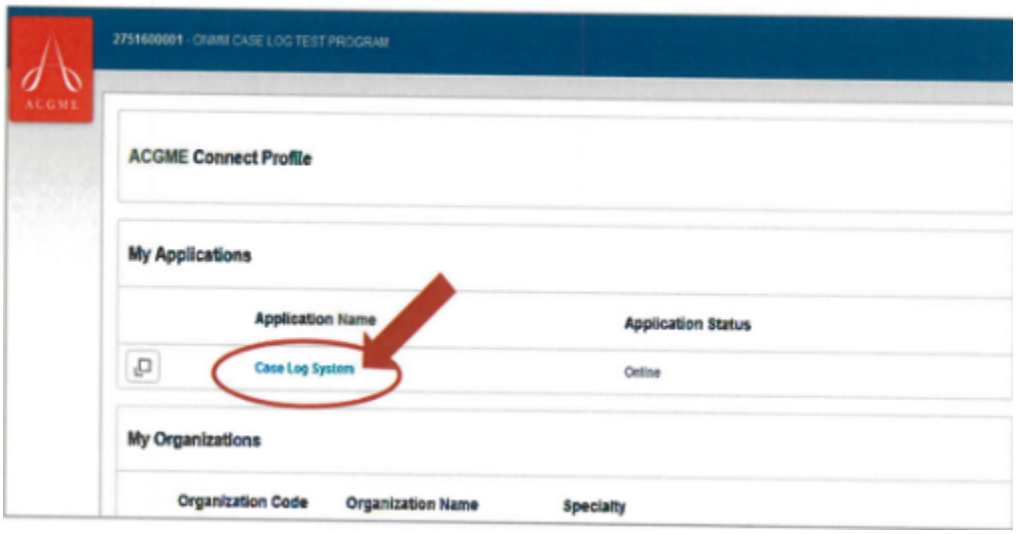
- All Osteopathic manipulative medicine procedures supervised by **ONMM board certified** attending physicians.
- Any musculoskeletal therapeutic injection (CPT 20550, 20552, 20553) or arthrocentesis, aspiration/injection (CPT 20600, 20605, 20610) procedures performed by **any board certified** attending physician.

These logs shall be entered at the end of each workday and will be monitored by the ONMM program team regularly to ensure appropriate progress is being made towards achieving required patient minimums. These logs will also be reviewed by the ACGME Review committee to ensure that residents are achieving patient encounters and procedures appropriate to their level of training.

Instructions on how to log cases on ADS are provided below. This information has been taken from the ACGME website:
https://www.acgme.org/globalassets/pfassets/programresources/onmm_case_log_instructions_guide_final.pdf

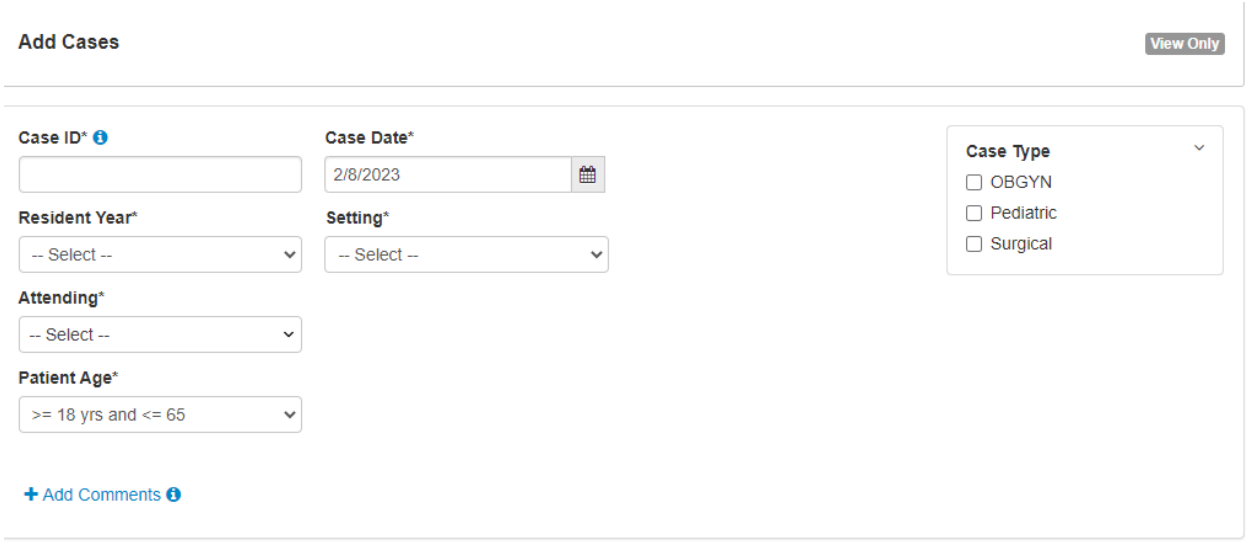
1. Case Log System Access

Programs and residents access the Case Log System through the Accreditation Data System (ADS). Programs must grant residents access before they can log patient encounters.
Residents only have access to the system while actively training in an ACGME-accredited program.
Access the system at www.acgme.org/connect. Once logged in, click on the "Case Log System" link.



2. Entering Patient Encounters - Basic Information

All logged patient encounters should include the following basic information: case ID; the resident's year in the program; the supervising attending physician; the date patient was seen; setting (inpatient/outpatient); the patient's age; and patient type if applicable (continuity clinic panel patient, OB, pediatric, surgical).



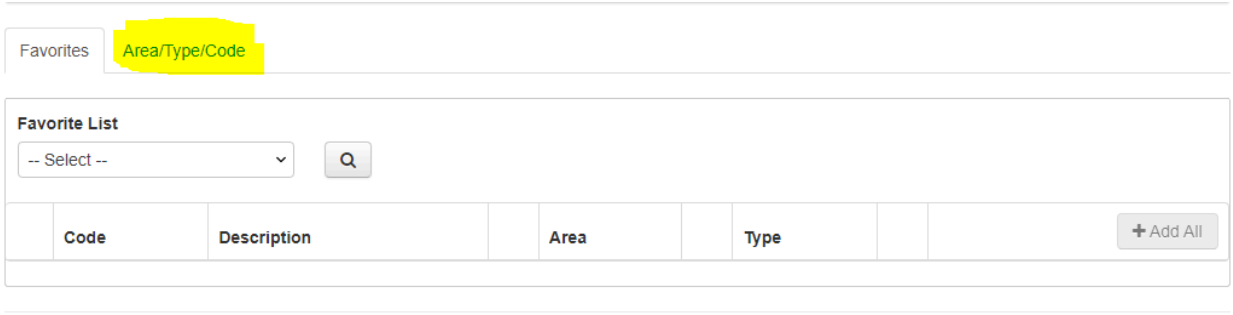
- Resident: The system will autofill the resident's name. If the name in this field is incorrect, log out of the system and log back in with the correct credentials.
- Case ID: The Case ID should be a unique patient identifier but must not be patient identifiable information such as a patient name or Social Security Number.
- Resident Year: The system will autofill the resident's current year in the program. If the patient encounter occurred in a prior year of the program, select the correct year from the drop-down menu.

Note: residents who enter the program at the ONMM 2 level will only log patient encounters at “resident year 2” in the Case Log System.

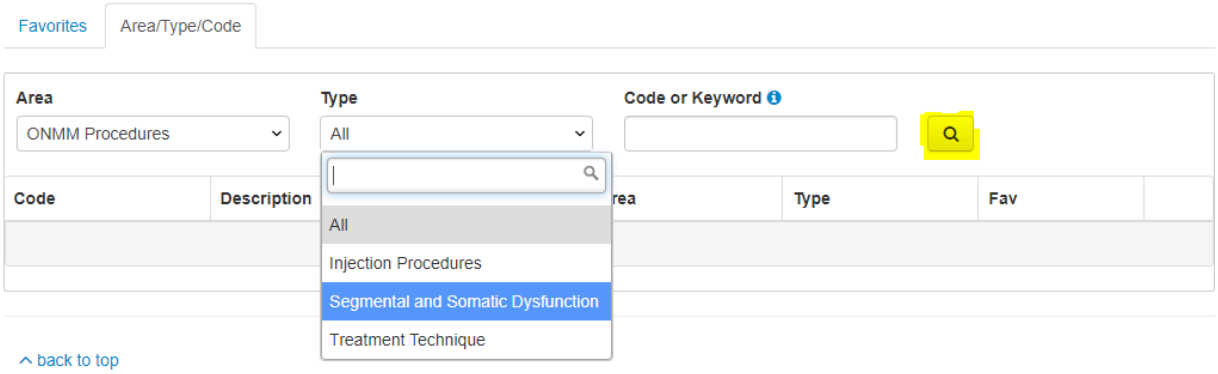
- Attending: Select the name of the attending physician who supervised the osteopathic neuromusculoskeletal medicine patient encounter from the drop-down menu. If this encounter included an injection procedure and was supervised by a physician who is not a neuromusculoskeletal medicine specialist, select “Attending, Not NMM Board Certified” from the drop-down menu. Contact the program to add physician faculty members if they are board certified in neuromusculoskeletal medicine and do not appear in the drop-down menu.
- Date Patient Seen: The system will autofill to the date of entry (not the date of the patient encounter) and will need to be changed if the patient encounter occurred previously.
- Setting: Select the setting, inpatient or outpatient, in which the patient was seen.
- Patient Age: Select the age range (>= 18 years and <=65; or >65) for the patient at the time of the encounter being logged.
- Patient/Class Type: check all applicable patient types for the patient encounter. Skip this step if none apply.
- Comments: Enter any additional basic patient information for the encounter. This field is optional, and comments will only be visible in the “Full Detail Report”

3. <u>Entry of Patient Encounters - Segmental and Somatic Dysfunction</u>

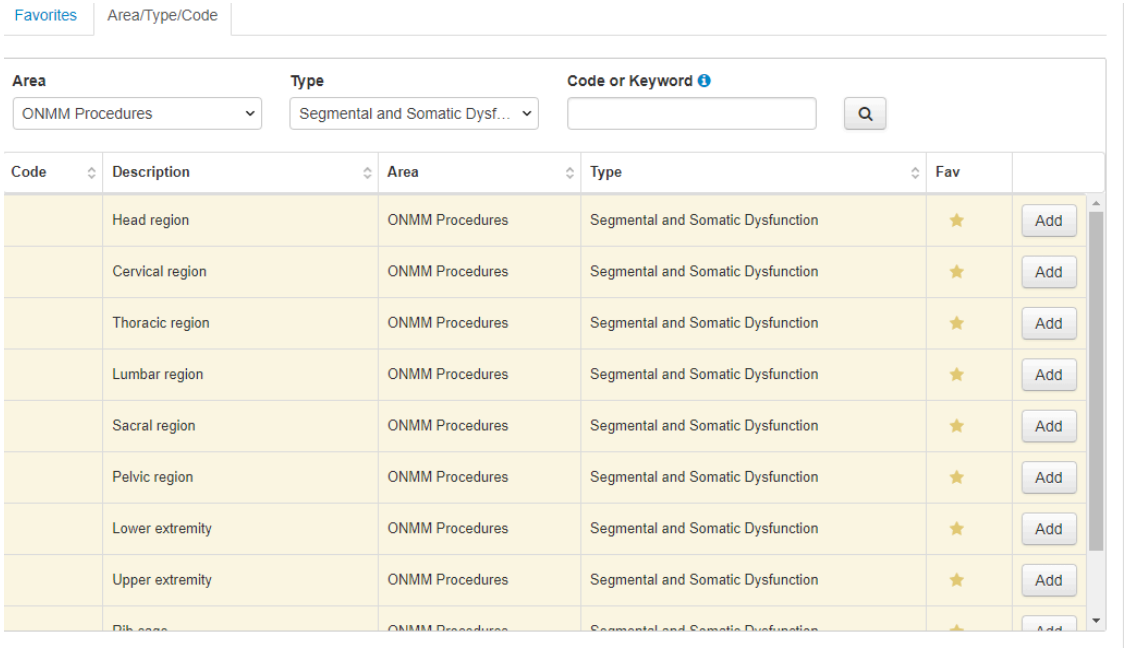
To enter segmental and somatic dysfunction, click on the “Area/Type/Code” Tab.



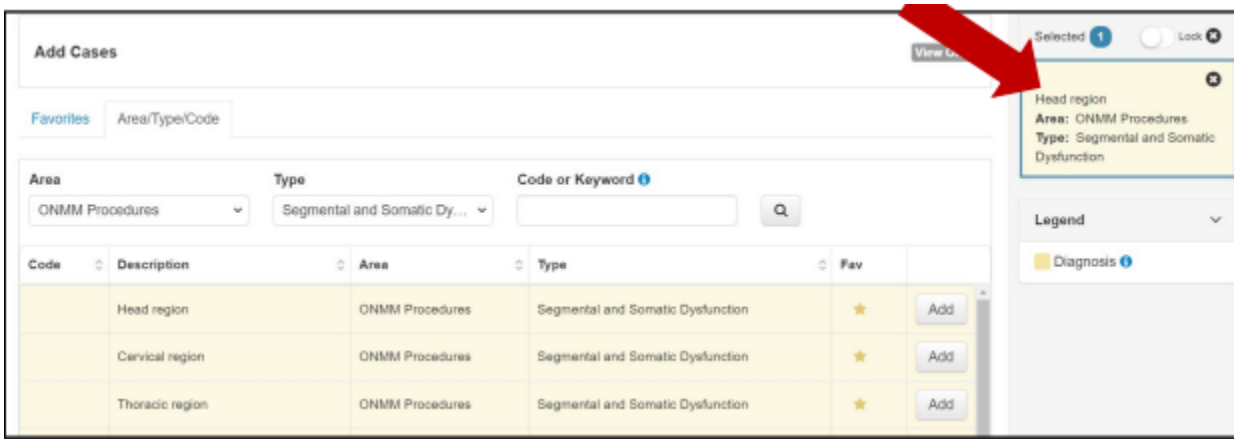
Select “Segmental and Somatic Dysfunction” from the drop-down menu under “Type” and Click the search icon.



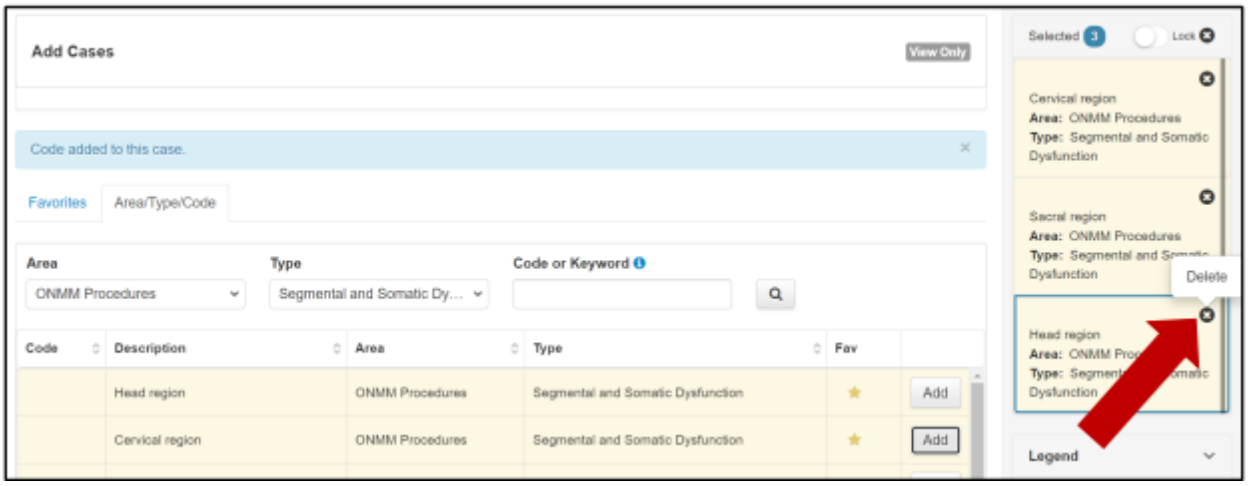
Click “Add” next to each relevant region for the patient encounter.



After each region is added, a box will appear on the right-hand side of the window confirming the selection.

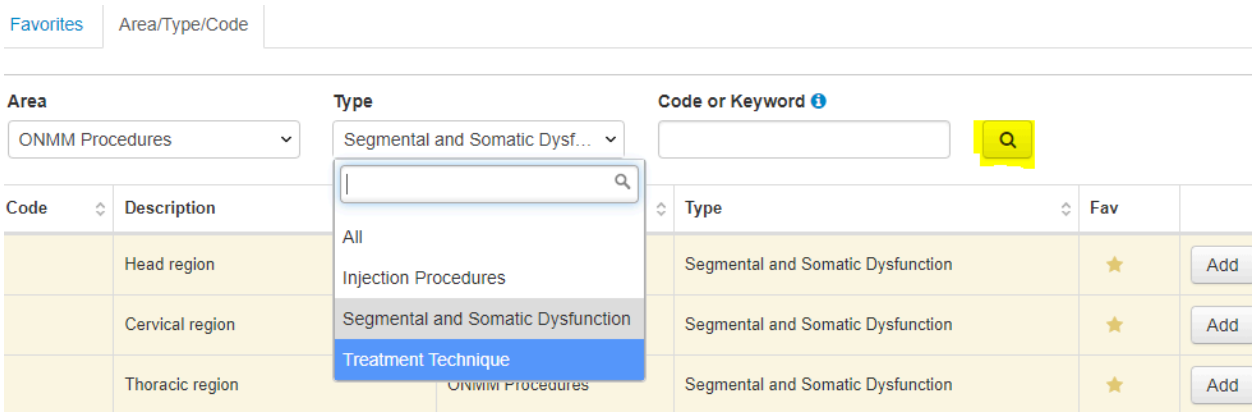


If a region should be deleted, click the “X” in the right corner of the region’s box.

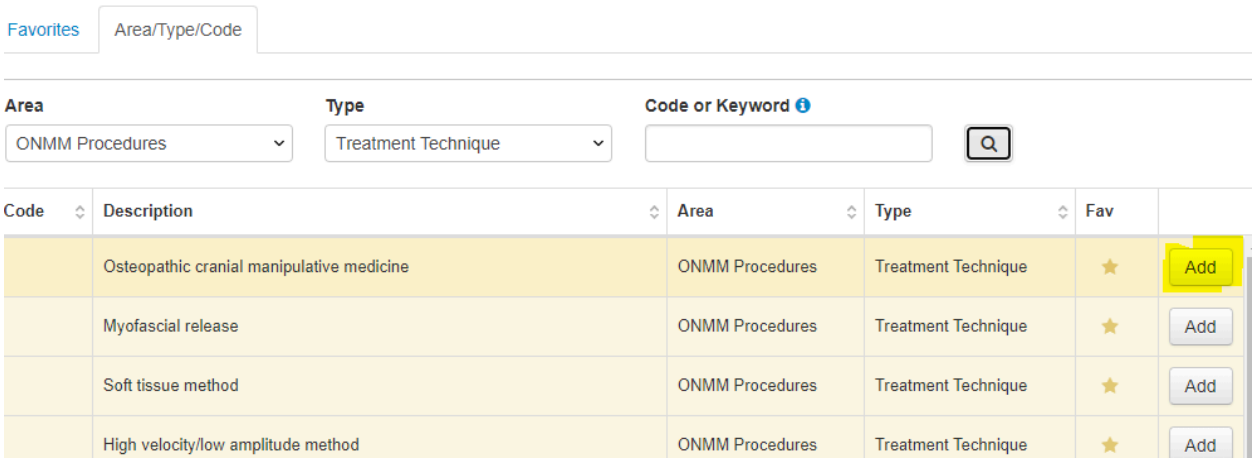


4. Entering Patient Encounters - Treatment Technique

Select “Treatment Technique” from the drop-down menu under “Type” and click the search icon.



Click “Add” next to each relevant technique for the patient encounter.



As above, a confirmation message will appear in a box on the right-hand side.

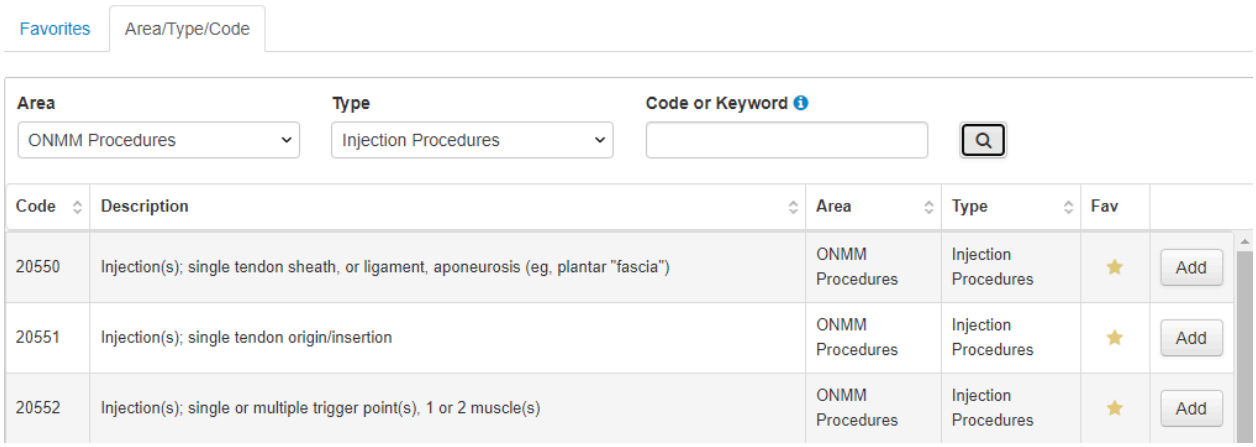
To verify what has been logged for the encounter, view the right-hand side bar and to remove a selection, click the “X” next to the description.

5. Entering Patient Encounters - Procedures

If an additional procedure is performed it should be entered as one patient encounter with the "Segmental and Somatic Dysfunction and Treatment Technique." The Review Committee will only track injection procedures as outlined in Osteopathic Neuromusculoskeletal Medicine Case Log Announcement (available on the Documents and Resources page of the **ONMM** section of the ACGME website). For instructions on how to log procedures other than those being tracked by the **Review** Committee, refer to the "Resident User Guide" in **ADS.**

To log tracked procedures, select “Injection Procedures” from the drop-down menu under “Type” menu and click the search icon.

Click “Add” next to each procedure relevant to the patient encounter.



As above, to verify what has been logged for the encounter, view the right-hand side bar and remove any items by selecting the “X” next to the description.

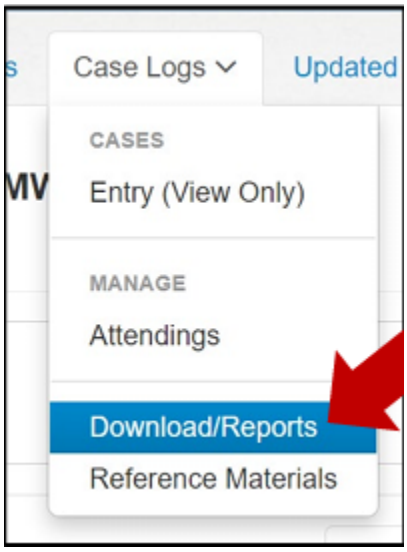
6. Submission of Patient Encounter and Procedures

Prior to saving the patient encounter, thoroughly review the information entered. Each logged patient encounter should include a segmental and somatic dysfunction and a treatment technique. If a procedure other than a treatment technique is performed, it must be entered at the same time. It should not be entered separately. The patient encounter and procedures are only logged and saved once the "Submit” button is clicked.

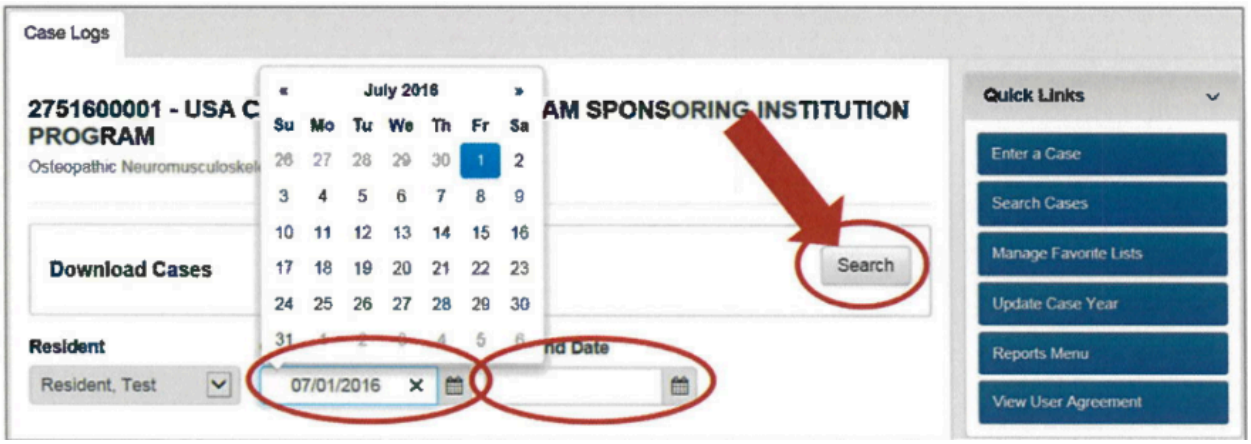
The Basic Patient Encounter Information should also be reviewed. Once all information has been reviewed, click "Submit" to log and save the patient encounter and procedure(s).

7. <u>Case Log System - Downloading Logged Cases</u>

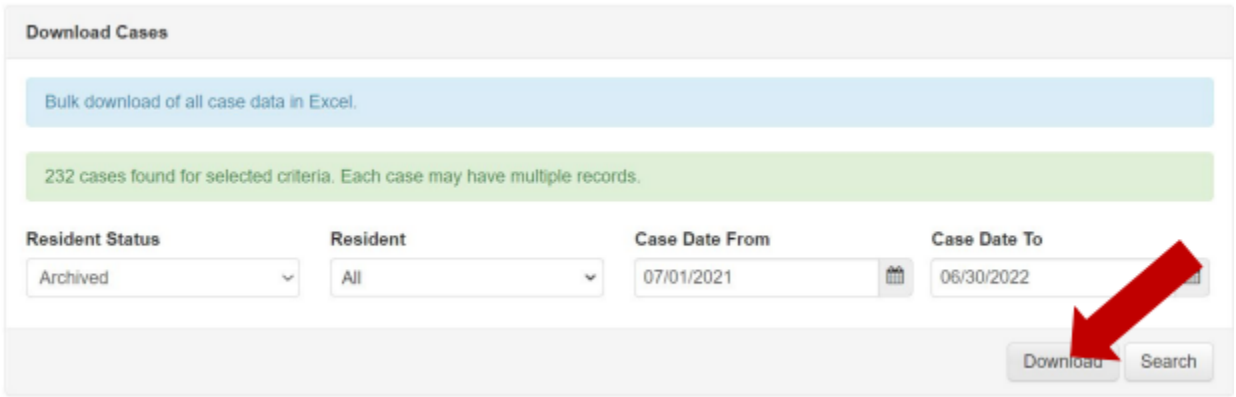
Download cases logged in the system by clicking “Download Cases” from the “Case log” tab.



Enter the Start and End Dates for the cases you want to download and click “Search.”

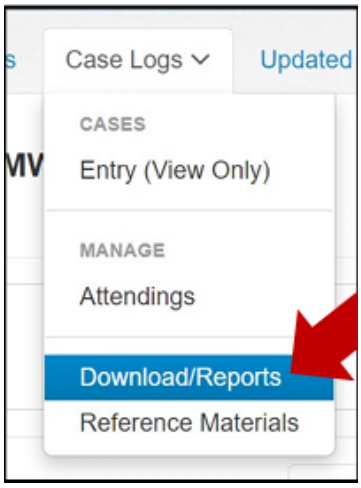


A message will appear identifying how many cases were found in the system for the date range selected. Click “Download” to download the case data to a spreadsheet.

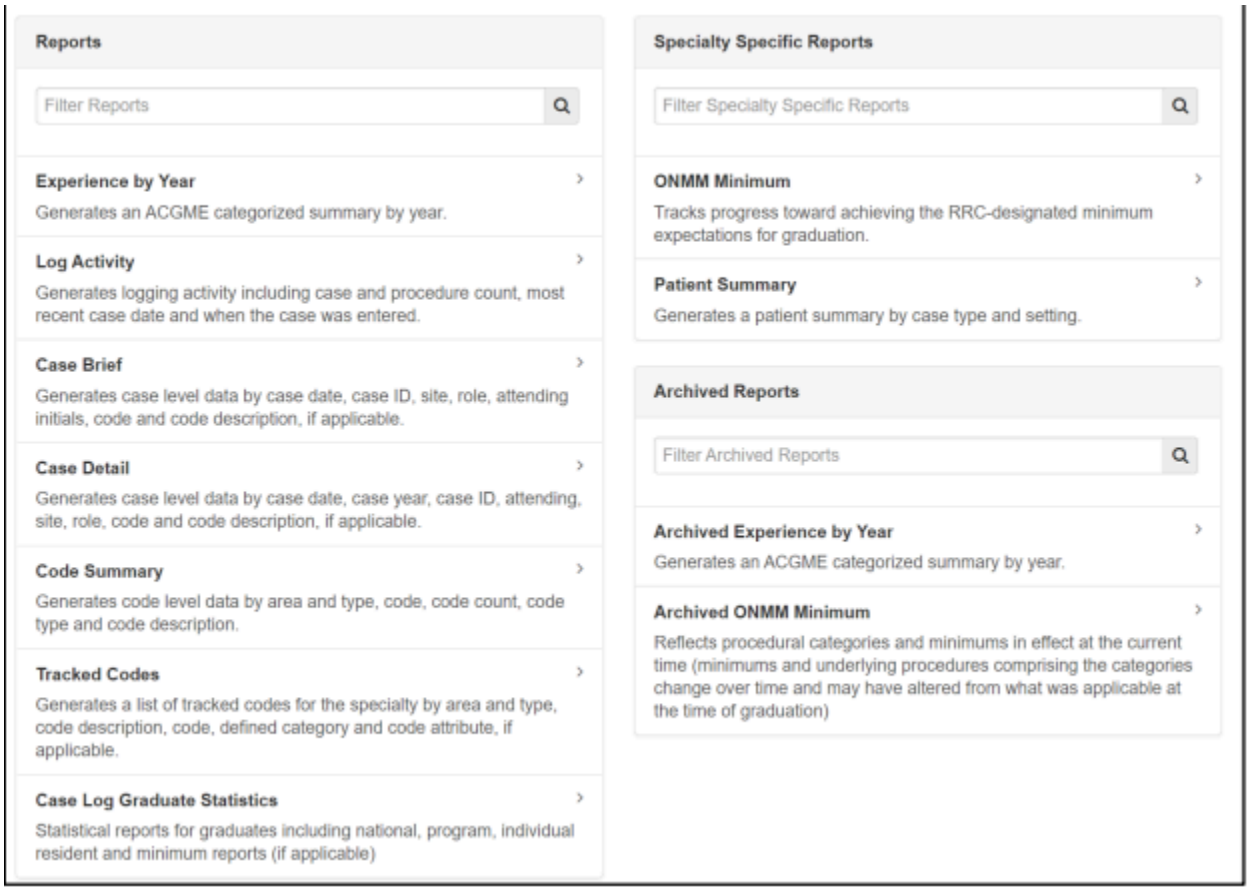


8. Case Log System - Reports

A number of reports are available in the “Reports Menu,” accessible under “Case Logs” tab.



Additional parameters can be set to customize available reports.



Direct questions about Case Log requirements can be directed to the Program coordinator, Ashton Pack or Program Director, Dr. Joy Palmer. Direct questions specific

to the system itself to ADS@acgme.org.

Request Time Away

Resident physicians are granted 20 days (40 half-days) for vacation time away and 5 days (10 half-days) for personal time away. If presenting scholarly work at a conference, you are granted up to 5 days for travel to and from and participation in the conference. Time away must be approved by the Program Director. To honor patient scheduling and clinical faculty schedules, please submit requests for time-away 90 days in advance. Please work with your fellow residents to ensure appropriate coverage of patient care during and around the holiday seasons. Please refer to your contract for paid holidays off from clinical responsibilities. Paid holidays in the Collaborative Health-Specialty Services outpatient setting include:

- Memorial Day (5/29)
- Independence Day (7/4)
- Labor Day (9/4)
- Thanksgiving (11/23)
- Christmas (12/25)

If you are ill and cannot make it to work, please submit the Time Away form as soon as you are feeling well enough. When you are away from work due to illness, these days will fall under the "Personal Time" heading. Medical and dental appointments are encouraged to be planned and requests for time away may be taken in half-day increments from "Personal" or "Vacation" time.

Forms are submitted to the Program Director for review and approval, with a cc to the Program Coordinator.

Please see the form in the Appendix (p.121)

Holiday and Vacation Policy

Purpose:
This policy is intended to provide guidance on vacation requests and expected holiday coverage as it pertains to the Osteopathic Neuromusculoskeletal Medicine (ONMM) Residency Program for both inpatient and outpatient settings. This policy is to ensure that there is a fair and equitable system to regulate resident's leave, to optimize resident education, and to ensure safe patient care.

Holidays Recognized by Collaborative Health Partners (CHP):
The following are recognized by CHP as paid holidays within a CHP outpatient office:

1. New Year's Day
2. Thanksgiving Day
3. Labor Day
4. Independence Day
5. Memorial Day
6. Christmas Day

Should a holiday fall on a weekend, the holiday will be observed on the workday closest to the holiday within a CHP outpatient office.

ONMM Holiday Coverage:
Residents within the ONMM program will be required to cover four (4) holidays per academic year out of the six (6) listed above. PGY-3's will have the opportunity to select which holiday they would prefer first, followed by PGY-2's, and then PGY-1's.

However, if a resident is assigned to an inpatient rotation during the month in which a holiday occurs, then the resident will be responsible for reporting to the rotation site on the holiday per the hospital's pre-determined schedule. This schedule will be made in correspondence with the Program Coordinator.

Policy/Procedure:

I. All residents must submit any time away request forms to the Program Director and Program Coordinator for approval and schedule adjustments at least 3 months in advance.
II. Outpatient Setting
    A. The following offices used by the residency program are deemed to fall within CHP's outpatient offices: Specialty Services, Pediatrics, and Central Virginia Family Physicians.

1. Therefore, when a holiday occurs while the resident is within one of these facilities for a rotation, they will be guaranteed the specific holiday or next business day off, per CHP policy, due to office closures. This will not count towards their requested holiday time off.
2. However, they may be required to cover the days leading up or following the holiday as required by the ONMM Holiday Coverage expectation listed above.

B. Residents will receive a copy of their block diagram for the upcoming Academic Year by March 15 with the current status of each rotation, pending further communication from other preceptors.

C. Residents should submit their time away requests for holidays by the predetermined date depending on their upcoming PGY status:
    1. Upcoming PGY-3's must request holidays by April 1 of the previous academic year.
    2. Upcoming PGY-2's must request holidays by April 22 of the previous academic year.
    3. Incoming PGY-1's must request holidays by early May, prior to the start of their training.
        a) Residents in the PGY-2 and PGY-1 classes will be made aware of remaining holidays available 1 week prior to their submission deadline.
        b) For example: If an upcoming PGY-3 resident would like to take the week of Thanksgiving off in 2024 (academic year 2024-2025), then the resident will need to request this time off by April 1, 2024 (academic year 2023-2024).

D. Residents will be made aware of approval or denials of these requests within 2 weeks of the request.

E. All other non-holiday time off requests should follow the requirements outlined in the "Request Time Away" policy of the ONMM Resident Manual.

III. Inpatient Setting or Centra Locations

A. For all rotations that occur within Centra in the Outpatient or Inpatient services including: Inpatient Family Medicine, Inpatient Internal Medicine, OB/Gyn, General Surgery, Inpatient ONMM Consult service (once finalized), Neurology, and Emergency Medicine, must follow Centra guidelines. For rotations that occur at McLaren Greater Lansing including the Inpatient ONMM consult service, must follow this hospital's guidelines.

B. Residents will receive a copy of their block diagram for the upcoming Academic Year by March 15 with the current status of each rotation, pending further communication from other preceptors.
    1. If a resident is assigned to an inpatient rotation, holiday time away will not be automatically approved, as the hospital will require coverage on such days, including weekend coverage. Time away can be requested, and the Program will check with the preceptor on the Resident's behalf.

Promotion and Dismissal

All appointments for residents of LUCOM GMES will be for a period not to exceed one year and may be renewed by the LUCOM GMES DIO in writing, upon recommendation by the Program Director.

Reappointments are generated during the second half of each academic year, well in advance of July 1 which marks the new academic year and the starting point for the next level of training in GME programs. Since these offers are generated in advance of the conclusion of the academic year, such a letter of appointment is issued contingent upon the resident finishing to satisfactory completion in the current academic year, as determined by the Program Director. Therefore, in the event a resident is dismissed at any time during the academic year or if for any reason fails to satisfactorily complete the academic year, any previously issued reappointment letter shall be considered null and void.

Criteria for Promotion and/or Renewal

To be reappointed to the residency program by the Program Director, the resident physician must be in good professional standing with qualifications as a resident physician as outlined below. The employer will require that resident physician will have the following resident physician qualifications:

- Be duly licensed to practice medicine in the Commonwealth of Virginia, and that such resident physician will maintain such license in the Commonwealth of Virginia in good standing. Resident physicians must apply for and receive the

resident physician license prior to commencing care for patients on or around July 1.

- Be in good standing with all legislative, regulatory or licensing agencies; certify and represent and warrant that there are no criminal charges pending against the resident physician.
- Adhere to the professional standards to which resident physicians employed by the employer are subject.
- Be in possession of all required registrations for prescribing narcotics and controlled substances appropriate to the resident's licensure and level of training in graduate medical education.
- Take clinical duties, acute care duties, emergency call duties, and on call responsibilities demonstrating professionalism in all aspects for these duties on a rotating basis with other resident physician colleagues with appropriate faculty supervision as developed by schedules established and assigned to resident physician by the Program Director.
- Not be excluded, debarred, sanctioned or otherwise deemed or determined by any authority with legal jurisdiction, to be ineligible to participate in any federal or state health-care programs, including Medicare and Medicaid.

In addition, to be promoted to the next level of training by the Program Director, the resident physician must be in good educational and professional standing in graduate medical education in the residency program, as determined by the Program Director through sequential review of resident physician evaluations that will be reviewed with the resident physician at least twice annually by the Program Director, including review of Milestones and based on recommendations by the Clinical Competency Committee. The resident physician's performance, evaluations, and the summary evaluations reviewed twice annually must demonstrate continued progress in the residency program in the context of the expectations and requirements for the resident physician as outlined by: the Sponsoring Institution for Graduate Medical Education Programs; the residency program; the Program Director as the resident physician's supervisor; and the ACGME requirements for the specialty and graduate medical education.

Potential Non-Renewal or Non-Promotion

The Residency Program Director will evaluate the resident physician's performance with the supervising faculty regularly to accomplish ongoing academic and professional development of resident physicians during the program of graduate medical education. The Program Director will review the resident physician's performance at least twice annually with the resident physician directly per ACGME requirements for graduate medical education programs. These summary evaluations summarizing the resident physician's performance and evaluations in multiple settings from multiple faculty and

healthcare professionals will be documented by the Program Director as per ACGME requirements. These evaluations are intended to guide the resident physician toward successful completion of all residency program requirements by the end of the training program in graduate medical education. Should resident performance not be progressing satisfactorily, as determined by the Program Director and documented by the Program Director, the Program Director will utilize the policies and procedures of the residency program and sponsoring institution for residency programs in GME to: address inadequate and/or unsatisfactory residency physician performance or failure to progress in residency training and education in multiple domains of resident physician competency, as set out by the Program Director and in alignment with expectations for residency programs and resident physicians in training through residency programs accredited by the ACGME.

Resident physician's performance, if deemed to be inadequate and/or unsatisfactory by the Program Director, will be remediated according to standard operating policies and procedures used by the Residency Program Director to remediate resident performance in multiple domains of physician competency, as set out by the Program Director and in alignment with expectations for residency programs and resident physicians in training through residency programs accredited by the ACGME. The remediation plan will engage the resident with a documented individualized improvement plan including a timeline for expected improvements to be developed and overseen by the Program Director. This plan will be developed in the context of the policies and procedures of the residency program for expected improvement in resident physician performance within the timeline developed and documented in the remediation plan outlined by the Program Director.

If the Program Director has informed the resident physician, per the policies and procedures in graduate medical education, that the resident will not be promoted to the next level of training, the Program Director will provide written notice of intent not to promote the resident physician to the next level of training not later than four months prior to the end of the current Employment Agreement. If the Program Director has informed the resident physician, per the policies and procedures in graduate medical education, that the resident physician current Employment Agreement will not be renewed, the Program Director will provide written notice of intent not to renew the Employment Agreement not later than four months prior to the end of the current Employment Agreement. Should the primary reason for non-renewal or non-promotion to the next level of training occur in the last four months of the Employment Agreement, then as much written notice as possible as circumstances

allow will be provided to resident physicians by the Program Director. The resident physician would be directed to the institution's grievance procedures in graduate medical education if they receive a written notice either of intent not to renew the current Employment Agreement(s} or of intent to renew their current Employment Agreement but not promote them to the next level of training in the residency program in graduate medical education.

If the resident physician elects to voluntarily depart the residency program the resident physician shall provide the Program Director with written notice of the intent to depart the residency program no later than six months prior to the departure date. If the resident physician is unable to provide six months' notice of the intent to depart the residency program due to extenuating circumstances, the Resident Physician will endeavor to provide as much notice as possible to the Program Director of the intent to depart the Residency Program.

When a Resident Physician has been away from the graduate medical education training program for an approved extended leave of absence (including, but not limited to, a leave granted by the Program Director for military duty, medical, personal, or other program directed administrative leave time), the Program Director will work with the Resident Physician to create an individualized plan to complete all remaining and outstanding requirements that remain due to the leave of absence and which must be completed and satisfied to graduate from the GME program. This individualized plan will constitute an "off-cycle" set of remaining outstanding GME program requirements that the Resident Physician must complete and fully satisfy to finish the graduate medical education program of training and graduate from the program. This individualized plan overseen by the Program Director will direct the Resident Physician toward meeting all the remaining local GME program requirements, ACGME Program Requirements of the Specialty Review Committee, and the specialty's board eligibility requirements for individual Resident Physician. The individualized plan overseen by the Program Director for the Resident Physician will assist in guiding the Resident Physician to the completion of the GME program.

The amount of time the Resident Physician spent away from the program on an approved leave of absence will, therefore, be accounted for by the Program Director, and all remaining requirements that have not been completed (due to time away on leave) will be accounted for and made up in the individualized plan developed and overseen by the Program Director.

The Program Director will work with the Resident Physician to ensure that the

Resident Physician is provided the opportunity to complete all the requirements for program completion and board eligibility as an individual candidate in the specialty discipline.

The Resident Physician will follow policies and processes in graduate medical education to request leave(s) and is expected to give as much advance notice as possible when submitting a request for leave from the program. All requests for leave from the program will be reviewed by the Program Director, the Resident Physicians immediate supervisor. It is recognized that time-sensitive requests (such as military service duty or medical emergencies) will be addressed in a time-sensitive manner by the Program Director. All applicable policies of the employer related to federal workplace requirements and guidelines for employee leave will be followed.

Upon satisfactory completion of the requirements of the graduate medical education program, as delineated by the graduate medical education program, the Sponsoring Institution, and the ACGME Review Committee for the Specialty, and as ultimately determined solely by the Program Director, the Resident Physician will be determined by the Program Director to be "board eligible" as a Resident Physician to take the individual steps to register for, enroll in, and sit as an examinee for the specialty board examination in the specialty field of medical or surgical practice. The Program Director will only provide this determination upon satisfactory completion of all the graduate medical education program requirements of the specialty program in which the Resident Physician is engaged, and all graduation requirements are satisfactorily completed as determined by the Program Director and the Sponsoring Institution for graduate medical education programs.

Resident Physicians are required to follow all the Clinical and Educational Work Hours Policies and Procedures and all the Moonlighting Policies and Procedures of the Sponsoring Institution and its graduate medical education programs. This includes timely, accurate, and honest reporting using the standard processes for reporting this information to the graduate medical education program and the Resident Physicians immediate supervisor, the Program Director. All Clinical and Educational Work Hours in all clinical and educational settings and all hours and activities the Resident Physician spent in approved moonlighting activities must be reported according to the policies and procedures of the Sponsoring Institution and the graduate medical education program in which the Resident Physician is engaged.

In the event a decision is made not to reappoint or not to promote to the next

graduate level, the resident or fellow should be advised of such decision in writing by the Program Director at least four months prior to the end of the appointment. If the primary reason(s) for the non-reappointment or non-promotion occur(s) within the four months prior to the end of the contract, the Program Director must provide the resident or fellow with as much written notice as possible of the intent not to reappoint or not to promote, as the circumstances will reasonably allow, prior to the end of the current appointment. Non-promotion includes any extension of training in the final year of the program. The resident or fellow may appeal non-reappointment or non-promotion by submitting a written request within two weeks of the meeting with the DIO per the Policy for Due Process for Residents and that outlines the Appeal and Grievance process.

Grievance Procedure

LUCOM GMES believes that it is in the best interest of the Institution and a resident physician, whether full-time or part-time, to resolve grievances as quickly as possible. These procedures are intended to assure fair consideration for the grievance and a means of review and appeal to higher levels of authority that is fair, objective, and without prejudice. Grievances subject to this review procedure shall be limited to those problems which directly affect a resident physician's performance of his/her assigned learning obligations.

This document is intended to provide clinical trainees with the opportunity to raise and resolve issues in their training program without fear of intimidation or retaliation. When a trainee experiences a problem such as perceived harassment, unfair treatment, concerns regarding work environment, program noncompliance with ACGME, the ONMM Review Committee or LUCOM GMES requirements or procedural discrepancies/inequities, it is best handled within the program whenever possible. The levels of review are Program Director, first level, Designated Institutional Officer (DIO), second level, and LUCOM GMES Graduate Medical Education Committee (GMEC), third level. A decision at levels one or two may be accepted or appealed by the resident physician. However, a decision by the LUCOM GMES GMEC shall be final. Any appeal not submitted within the required time limit may be denied (and considered an acceptance of the decision) automatically and without any further review or opportunity to appeal required.

The grievance procedure involves an informal and a formal aspect. The resident physician should first attempt to address the grievance informally by discussing it at the lowest appropriate level. This would be the Program Director. Such informal discussion must begin within seven (7) days of the resident physician's knowledge or awareness of the issue, which is the basis for the grievance. The Program Director must give the resident a fair opportunity to discuss the grievance and attempt to achieve a mutually satisfactory resolution. The Program Director will seek to notify the resident physician of a decision within five (5) calendar days. If the matter is not addressed to the resident physician's satisfaction by the Program Director, the formal grievance procedure may proceed.

The formal grievance must be sent by the resident physician in writing, which includes email, to the resident physician's DIO. Submission of a formal grievance must occur not later than five (5) calendar days following the Program Director's decision at the informal level. The DIO must give the resident physician a fair opportunity to discuss the grievance and attempt to achieve a mutually satisfactory resolution. The DIO will seek to send written notice of a decision to the resident physician within ten (10) calendar days.

If the grievance is still not resolved following formal appeal to the DIO, the grievance may be appealed in writing to the LUCOM GMES GMEC. Submission of a formal grievance must occur not later than five (5) calendar days following the DIO's decision. The LUCOM GMES GMEC must give the resident physician a fair opportunity to discuss the grievance and attempt to achieve a mutually satisfactory resolution. The Chair of the GMEC will seek to send written notice of a decision to the resident physician within fourteen (14) calendar days. The decision of the LUCOM GMES GMEC shall be final.

If the above grievance process is not suited for the situation and the Resident would like to have the information remain confidential, the Resident can follow the procedure below instead:

<u>Confidential Reporting</u>

To ensure a learning and working environment in which residents can raise. concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation, the residents are given access to:

1. Confidential reporting hotline, Ronny Smith at MidState, 1-844-382-5067

2. Employee Assistance for stress or reporting adverse events, VITAL Worklife-Safehaven, 1-888-316-6616 or email at Service@VITALWorkLifeConcierge.com
3. Grievance concerns, Robin Hammer at 434-382-1118, or rhammer@collaborativehp.com and Elyse Douglas at 434-534-6720, or edouglas@collaborativehp.com

Concerns can be, but not limited to, patient care oriented, regarding clinical faculty, or professional behavior by resident colleagues, other learners, clinical staff, clinical faculty, and other leadership.

Scholarship Opportunities and Expectations

Residents are given several opportunities to participate in scholarly work. They are required to complete a specialty specific scholarly project. Per the ACGME reference, Program Requirements of ONMM Residency Programs, this requirement is defined as:

- Residents must participate in scholarship.
    - Residents must demonstrate one of the following forms of scholarship and/or academic productivity prior to completion of the program:
        - An original paper on a neuromusculoskeletal medicine topic suitable for publication or
        - A presented scholarly project, within the scope of neuromusculoskeletal medicine, such as a quality assurance or practice improvement project or
        - Preparation and presentation of a neuromusculoskeletal medicine related topic at a state, regional, or national meeting.
    - Residents must participate in local, state, and/or national professional organizations.

During ONMM residency training, ONMM Residents are required to complete a scholarly work project. Projects that satisfy the requirements include a continuous quality improvement project (CQI), eliminating health inequities, safety project, case report or another scholarly project approved by the program director. Progress towards

completion of this scholarly project is expected to be continuous throughout the three years and will culminate with its completion by January of the expected graduation year.

Specific requirements for the ONMM scholarly project by year are defined below:

PGY-1 Requirements

- Complete CITI training
    - https://about.citiprogram.org/landing-page-gcp/?gad=1&gclid=EAIaIQobChMIgteGsp78_gIVig-zAB2mawEnEAAYASAAEgKjMvD_BwE
- Identify a scholarly project (CQI, case report, safety project, etc.)
- Significant work towards completion of Specific Aims and Project Outline

PGY-2 Requirements

- Rough draft of scholarly project completed by June prior to end of PGY-2 Year

PGY-3 Requirements

- Complete scholarly work submitted to PD by January of PGY-3 Year

Additionally, each class will be assigned a Safety Project and a Continuous Quality Improvement Project to complete over the 3 years they are training with LUCOM GMES.

Leadership Opportunities and Expectations

Residents have several opportunities to grow in their leadership skills through a variety of experiences. There will be one representative from each class serving on the Graduate Medical Education Committee (GMEC). The GMEC meets once monthly, provides a forum for transparency in patient safety, clinical learning environment, quality improvement projects, resident progression through the program, and advancement of ONMM Program needs. A resident will be peer-selected from each class and assigned to the committee for 12 successive months of their 3 years in the ONMM Program. The resident may repeat their term up to two times.

There will be one representative from each class, beginning in the PGY-2 year, serving on the ONMM Program Evaluation Committee (PEC). This committee meets 4-times per year. The roles and duties of the PEC include: acting as an advisor to the program director, through program oversight; review of the program's self-determined goals and progress toward meeting them; guiding ongoing program improvement, including development of new goals, based upon outcomes; review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. The resident will be assigned to this committee for 18 successive months and may continue for another 18 months if they so choose.

There will be at least one resident representative per ONMM class on the Clinical Learning Environment Review (CLER) committee. This committee meets quarterly.

Residents are encouraged to participate in local, regional, and national organizations, including committee work.

Clinical Opportunities and Expectations

Residents will enjoy a variety of rotation assignments and electives over the three years of training. A block schedule outlining the rotations across the years follows. Elective options are included on this grid. Residents will work as a team with clinic colleagues, clinic staff, the patient and at times the patient's family members to ensure the best, most effective, high-quality, patient centered delivery of health care.

With each rotation assignment, the resident will receive from the GME office a half-day calendar outlining their clinical and educational responsibilities for the rotation, a syllabus detailing location, contacts, and expectations of the rotation, and an evaluation to be completed within the first week of completing the rotation.

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	Site 2	Site 1	Site 1	Site 1	Site 1	Site 1	Site 2	Site 2	Site 2	Site 2,8		
Rotation Name	Emergency Medicine	Psychiatry	Pediatric and Adolescent Medicine	Family Medicine	ONMM Outpatient	ONMM Outpatient	Inpatient Internal Medicine	Inpatient Family Medicine	General Surgery	OB/ GYN	Elective	Elective
# of half-day clinic sessions per week	1	1	1	1	1	1	1	1	1	1	1	1

ONMM 2

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	Site 1	Site 2	Site 3,4	Site 3,4	Site 5							
Rotation Name	Sports Medicine	Neurology	ONMM Inpatient	ONMM Inpatient	Rheumatology	Elective	Elective	Elective	Elective	Elective	Elective	Elective
# of half-day clinic sessions per week	4	4	4	4	4	4	4	4	4	4	4	4

ONMM 3

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	Site 3,4	Site 3,4	Site 10	Site 10								
Rotation Name	ONMM Inpatient	ONMM Inpatient	Ortho Surg	Radiology	Elective	Elective	Elective	Elective	Elective	Elective	Elective	Elective
# of half-day clinic sessions per week	4	4	4	4	4	4	4	4	4	4	4	4

Electives:

Academic Medicine
Endocrinology and Diabetes Care
Family Medicine
Internal Medicine
Neurology
ONMM Outpatient
Pediatrics and Young Adult Medicine
Physical Medicine and Rehab
Psychiatry and Adult Behavioral Health
Sports Medicine
Urgent Care

Evaluations and Milestones

Evaluation and Assessment of Residents

Timely feedback is important to clinical trainees to help them recognize areas of their performance that require improvement and areas in which performance meets or exceeds expectations. Verbal feedback in real time is the most valuable for a clinical trainee to reflect on their behaviors, actions and determine what modifications need to be made. In addition, formal assessments need to be completed on clinical trainees at the completion of each rotation by faculty that they worked with. These assessments will be available (individually and in aggregate) for the clinical trainee's review in MedHub. Faculty should be available for discussion of the clinical trainee's performance and assessment.

Clinical trainees are expected to provide feedback to others such as peers, faculty and the program. Feedback should be constructive in nature and help in further development of the person or program being evaluated.

Formative Assessment

Frequent formative assessment (assessment designed to help clinical trainees improve their performance), is a critical feature of all competency-based educational programs. While formative assessment is often verbal (e.g., feedback to clinical trainees after an observation), written formative assessment should be offered by faculty and can be collected independently to show improvement of performance over time. Formative assessment drives learning and helps our clinical trainees reach both program and individual goals. We encourage programs to increase the use of formative assessment.

Teaching faculty are required to provide an assessment of the performance of clinical trainees they supervise at the end of each rotation, or at least every three months for rotations longer than three months. These assessments are completed in MedHub,

LUCOM GMES' institutional residency management system. The number of assessments that each faculty member is required to complete varies with their individual service assignment and/or number of clinical trainees in a program. MedHub will assign performance assessments to faculty by matching their service dates to the program's rotation schedule, or as queued by the Program Coordinator.

MedHub notifies faculty via e-mail that they have assessments to complete. Upon logging into MedHub, faculty can view a list of their assigned assessments; MedHub will continue to send weekly reminders until assigned assessments have been completed. Those faculty who had limited or no teaching contact with the clinical trainee may remove the evaluation from their listing by denoting insufficient contact to evaluate. Nonetheless, faculty are encouraged to provide feedback based on their observations of single encounters.
Frequent formative assessment (assessment designed to help clinical trainees improve their performance), is a critical feature of all competency based educational programs. While formative assessment is often verbal (e.g., feedback to clinical trainees after an observation), written formative assessment should be offered by faculty and can be collected independently to show improvement of performance over time. Formative assessment drives learning and helps our clinical trainees reach both program and individual goals. As required by the ACGME, Milestone-based assessments must be utilized. Assessments in MedHub can be linked to both the Milestones and the six ACGME competency areas (Patient Care, Systems-Based Practice, Interpersonal & Communication Skills, Practice-Based Learning and Improvement, Medical Knowledge, and Professionalism). These assessments frequently incorporate numerical rating scales with behavioral anchors to assess progress. Teaching faculty are strongly encouraged to include specific, narrative feedback on the assessment form, as these comments can be used formatively by clinical trainees and provide important data for the Clinical Competency Committee's (CCC) semi-annual review.

Additional Evidence Used

In addition to the formative assessments completed by faculty, the ONMM program uses 360-degree from clinic staff and self-assessments. 360-degree assessments are extremely helpful to the CCC (Clinical Competence Committee}, due to the variety of stakeholders who have an opportunity to participate. The forms for these assessments will be developed, deployed and determined by individual programs.

Summative Evaluation

Summative assessments are used to evaluate resident/fellow learning, skill acquisition, and milestone achievement at the conclusion of each six months of training. It reflects

progress over a period; what has been achieved, and what areas may be an opportunity for growth and development. Many different components make up the summative assessments, not only is it a summary of the formative assessments received during that period, but an incorporation of feedback from other sources, such as procedural accomplishments during the period, peer feedback, patient feedback, test scores and scholarly accomplishments.

Faculty also receive summative assessments of their teaching skills using anonymous resident feedback. Faculty can use this feedback to further hone their teaching skills, thus creating a robust learning community which encourages continual growth and development. All assessment data should be considered by the program for the overall assessment of a clinical trainee's performance. Documentation must be completed by the Program Director and shared with the clinical trainee using the Summative Evaluation of Resident/Fellow Performance assessment. This documentation should indicate if the clinical trainee is achieving level appropriate specialty-specific competency Milestones and thereby is ready to progress to the next level of training or graduate from the program. Summative assessments are required for a clinical trainee's permanent education file at least twice per year.

For ACGME accredited programs, CCC's are tasked with synthesizing assessment data to advise Program Directors regarding clinical trainees' progress on competency based Milestones. Program Directors are required to review the CCC's recommendations, make determinations regarding the clinical trainee's current level of competency and provide their objective assessments of progress to the ACGME at 6-month intervals. The Program Director must complete the LUCOM GMES Verification of Residency Training assessment for each clinical trainee at the completion of the program. This final assessment must be accessible for review by the clinical trainee and will document his/her performance during the final period of training and verify that the graduating resident demonstrates the knowledge, skills, and behaviors necessary to enter autonomous practice.

Teaching Faculty Engaged in GME with LUCOM GMES

Clinical trainees are required to complete anonymous assessments of their supervising teaching faculty at the end of each rotation; these assessments are administered via MedHub. MedHub will assign performance assessments to clinical trainees by matching their service dates to the program’s faculty rotation schedule, or as queued by the Program Coordinator.

At the end of each rotation, MedHub notifies clinical trainees via e-mail that they have assessments to complete. Upon logging into MedHub, clinical trainees can view a list of their assigned assessments; MedHub will send weekly reminders until all assigned assessments have been completed.

Clinical trainees are not able to view their assessments until the assessments of faculty are submitted. Included in each teaching assessment are items which assess a range of teaching domains, including: the ability of a faculty member to establish a safe learning environment, provide specific, actionable feedback, and to teach effectively in a variety of settings. Clinical trainees are encouraged to provide narrative feedback highlighting areas of strength and targeted areas for improvement to aid in faculty development. Each program is required to use the standard form provided by the GME Office.

To assure timely feedback to teaching faculty, the anonymous staff teaching assessments completed by clinical trainees will be available in an aggregate form to not jeopardize the confidentiality of the online system in MedHub as faculty will be unable to review individual assessments completed on them. Access to the aggregate staff teaching assessments is intended to afford each staff physician the opportunity to make improvements to their methodology for teaching clinical trainees.

Residency Program Evaluation in GME

Clinical trainees and faculty are required to complete an annual survey (the Resident/Fellow Annual Evaluation of a Clinical Training Program and the Faculty Annual Evaluation of a Clinical Training Program) in MedHub that anonymously evaluates the strengths and targeted areas for improvement of the training program. Trainees and Faculty members have an opportunity to answer questions about a number of factors that contribute to the overall effectiveness of their respective programs.

The confidentiality of program assessment data is strictly ensured via an aggregate report including as many years as necessary. Information gathered from program assessments is helpful in measuring the effectiveness of the training program and is considered in future planning. The results are also used during the ACGME required Annual Program Evaluation (APE) process, which is monitored by the GMEC. Each clinical training program must undergo an APE yearly. At this meeting clinical trainees and faculty discuss the quality of the training program, a variety of assessments, graduate performance on board examinations, as well as faculty development opportunities. Upon completion of the APE the program prepares a written plan of action to document initiatives to improve performance. The action plan ought to be

reviewed and approved by the teaching faculty and documented in meeting minutes, which also includes attendance by program leaders, faculty and clinical trainee representatives. During the APE meeting the following year, discussion will focus on how successful the program was in executing the action plan of the prior year.

Compensation and Benefits

Salary and Benefits

LUCOM GMES provides a fair and equitable salary and benefit package for all trainees. Clinical trainees being paid by LUCOM GMES are to be paid at the graduate level required to enter the program; additional compensation is not provided to those who have completed training above and beyond those requirements.

Day One Benefits

Like incoming clinical faculty, ONMM resident physicians receive vacation time, personal time, and all fringe benefits on Day One of employment. Health insurance is offered to the employee as well as dependents. Medical insurance, dental insurance, life insurance, disability insurance, and retirement investing all take effect at the onset of employment.

The 2023-2024 benefits package can be reviewed on MedHub or in the appendix of this manual. Residents are allotted 20 business days of vacation time (40 half-days), to be taken 1- week at a time. Residents are allotted 5 personal days (10 half-days) and up to 5 days for Continuing Medical Education if they are presenting scholarly work.

Educational Benefits

Members of CVFP, CHP, and CHP have the opportunity to continue their education and enhance their skills and abilities at Liberty University (LU). Due to the affiliate agreement, this can be completed through LU’s online programs at a discount. Benefits include 15% tuition discount, additional discounts for First Responders and Military, life experience credit, professional credit for previous work experience, certificate and

licensure credit, on-the-job training credit, and credit for military experience. When enrolling in a class, please let your admissions counselor know the name of your employer and that there is a corporate affiliation with LU.

CHP Summary of Benefits

Medical Insurance:
Anthem Blue Cross Blue Shield-2 health plans offered
KeyCare HDHP PPO (High Deductible Health Plan)

- Calendar year deductible: $1,600 individual; $3,200 employee +1 or more members
- Plan pays 100% for in-network providers after deductible
- Pharmacy: $10, $30, $50 (20% co-insurance not to exceed $200 per script) after deductible has been satisfied
- Total out of pocket max: $2,500 individual; $5,000 employee +1 or more members
- Can opt into the Health Savings Plan (HSA) through Health Equity.
    - Pre-tax dollars
    - Maximum contributions 2022 $3,600 individual; $7,200 employee +1 or more members
- Wellness/Preventative services for adults and children covered with no deductible or copay
- Eligible for DPC program

KeyCare 400 PPO

- $40 copay for PCP and specialist visits
- Calendar year deductible: $400 individual; $800 employee +1 or more members
- Pharmacy: $10, $30, $50 (20% co-insurance not to exceed $200 per script) deductible does not apply
- Medical pays 80% after deductible is met
- Total out of pocket max: $5,500 individual; $9,000 employee +1 or more members
- Wellness/Preventative services for adults and children covered with no deductible or copay
- Eligible for DPC program

Vision-Both health plans offer the following vision coverage:

- $15 copay for eye exam

- $130 allowance per year for contacts or $130 every other year for glasses
- Additional discounts for lenses and frames

Dental Insurance:
Anthem Blue Cross Blue Shield-2 dental plans offered
Dental Clean

- Maximum Annual Benefit $1500 per covered member
- Calendar year deductible: $50 individual; $150 family
- Cleanings/Diagnostics: covered at 100% (2 cleanings per year per covered member)
- Basic Restorative: Anthem pays 80% after deductible
- Major Restorative: Anthem pays 50% after deductible
- Orthodontics: Anthem pays 50% to a max of $1000 per covered child under the age of 18

Dental Care

- Maximum Annual Benefit $4000 per covered member
- Calendar year deductible: $0
- Cleanings/Diagnostics: not covered under the Dental Care plan
- Basic Restorative: Anthem pays 80% until max benefit is met
- Major Restorative: Anthem pays 80% until max benefit is met
- Orthodontics: not covered under the Dental Care plan

Group Life and Disability:

- Offered through Hartford
- Bundle of Life/ADD/Short Term Disability (STD)/Long Term Disability (LTD)
- Salary driven program

Supplement Life Insurance:

- Offered through Hartford
- Age based
- Employee coverage amounts up to $100,000
- Spouse coverage amounts up to $30,000 (or ½ of spouse's coverage)
- Child coverage $10,000

403(b) Retirement Program:

- TransAmerica
- Liberty University matches up to 5% of what the employee contributes (Pre-tax or Roth)

Requesting Reimbursement: Prof Development Fund and Required Educational Expenses

Please submit the form to the Program Coordinator, with receipts/invoices paid and a credit card or bank statement with blackened out sections not relevant to the requested reimbursement. The Program Coordinator will then send it to the Program Director for their sign off after review. Once approved, it will be sent up the chain to the DIO and appropriate business offices. You are responsible for keeping track of your requests.

MedHub Resident Quick Start Guide

******Please note: there are many functions accessible on MedHub. We are currently utilizing this platform for:***

1. ***Clinical Education Work Hours submission by the Resident and tracking by Program Leadership to ensure compliance with ACGME***
2. ***Announcement of Didactic schedule***
3. ***Sharing of documents under Resources tab***
4. ***Syllabus and Objectives under Curriculum Objectives/Goals***
5. ***Evaluations***
6. ***Block schedule tracking under Rotation Scheduled***

MedHub is a web-based application designed to house, document, track and monitor residency requirements and educational experiences. This system will allow you to review your rotation, clinic and call schedule, submit work hours, complete evaluations, log procedures, review your conference schedule and set up your learning portfolio.

Getting Started

To log-in, navigate to your MedHub URL. If you are unsure what this is, contact your program coordinator. Log-in information is sent through an automated message from MedHub. The e-mail will contain a username and a temporary password. Upon log-in, you will be asked to change your password. Residents all have a user type of RESIDENT to indicate that the user is a trainee. Residents are identified as either a

resident or fellow from their "review records" link on the portal page as part of their training history.

Home

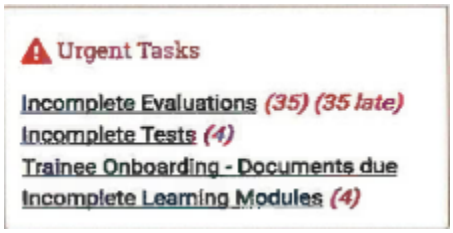
The Home page is the central or portal page for each user. This page is a communication channel where the GME Office or the residency program may post pertinent information. This page is also where you can navigate between functionality components (i.e. schedules, evaluations, etc.} or view tasks that may need to be completed. The portal page is also a location where specific resources or documents are provided for your viewing.

Tasks

Under the Tasks section, is where you will have the ability to log the current week's work hours, review your own records, and update your contact information, among other potential tasks pertinent for your training program. Reviewing your records allows you to see your basic demographic information as well as see any files that have been shared with you by the GME Office or your training program. You may have the ability to update your contact information as needed as well as record your work hours.

Urgent Tasks

Adjacent to the Tasks section are urgent tasks. This box will appear in red if you have any items that need to be completed (i.e., evaluations, incomplete work hours, etc.).



Personal Calendar

You can keep a personal calendar in MedHub and synchronize it to either an Outlook or Google email account or through an iPhone or Android. By selecting the "View myCalendar" button, it will allow you to add any appointments, meetings, etc. for each day within each month. If your training program has created a conference schedule, these conferences will also appear on your personal calendar automatically.

Curriculum Objectives

The Curriculum Objectives provides you the ability to review the list of objectives specific to rotations or services for which you are scheduled. These objectives will only

appear IF your training program has uploaded them to the system.

Messaging

Messaging allows you to send and receive messages through the MedHub system. When sending a message through MedHub, this does not go to the recipient's email unless you designate that the message you are sending should go to their email as well. If you have been sent a message, it will appear in this Messaging section where you can select the message to review the content. Residents also have the capability to send anonymous messages to their D10 or Program Director.

Announcements

Any announcements posted by either the GME Office or your training program may be visible here.

Resources/Documents

There are various directory links that are available to you in case you need to find a particular individual's contact information. The GME Office or your training program may also add other information to this section that you will have access and can review.

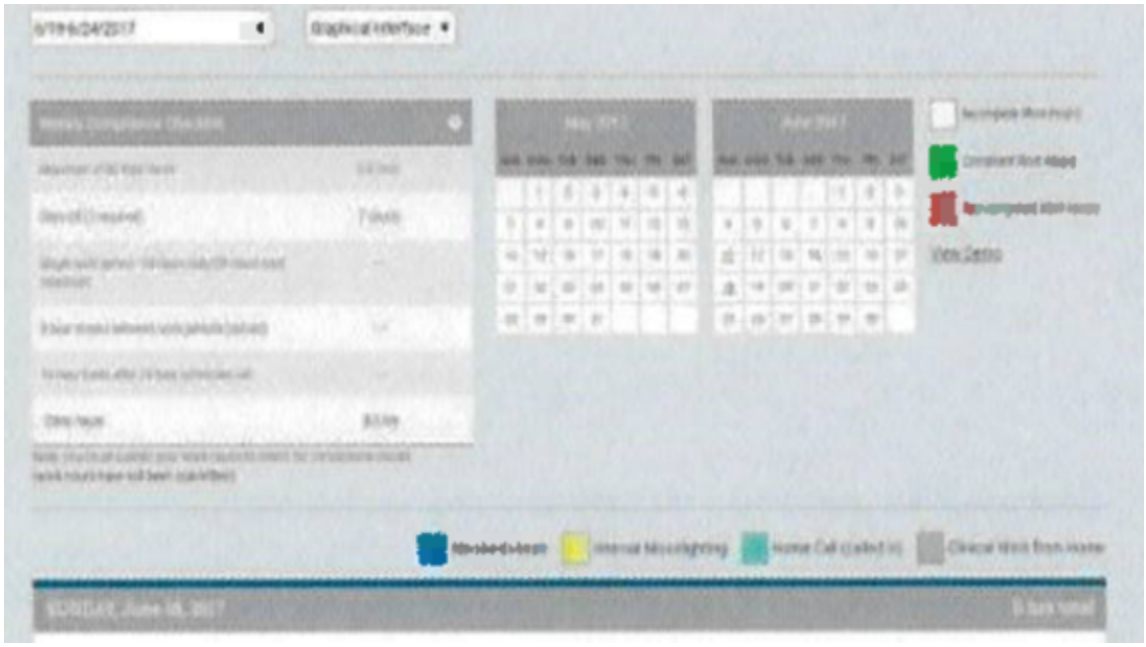
Within this location, resident physicians can view their specific rotation schedules and syllabus/objectives. It will be within a folder titled “AY 2023-2024” under the residents specific name.

Add New Channel

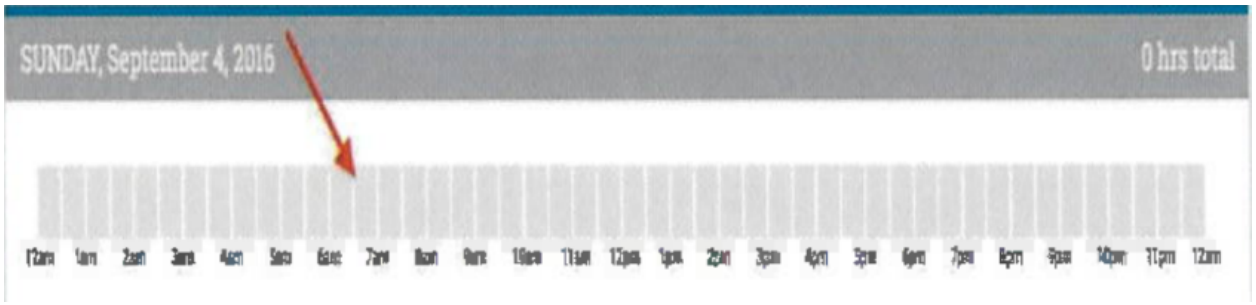
You can customize your homepage when it comes to various news feeds you may want to appear automatically when you log-in. The “Add New Channel” button allows you to add various feeds from a variety of news sources.

Work Hours

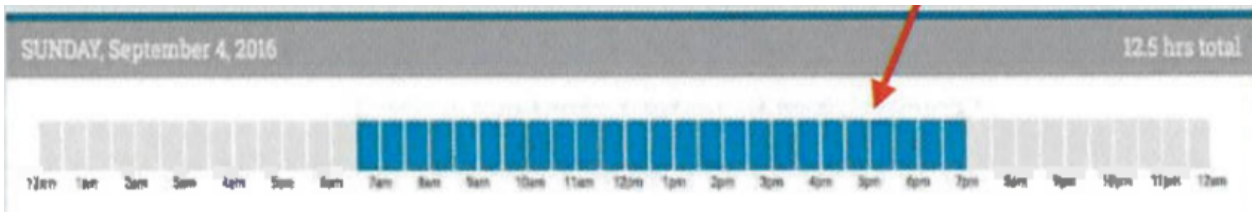
To add each week’s work hours, select the “This week’s work hours” link located in the Tasks section from your homepage. This will take you directly to the timesheet where you can begin to enter your hours.



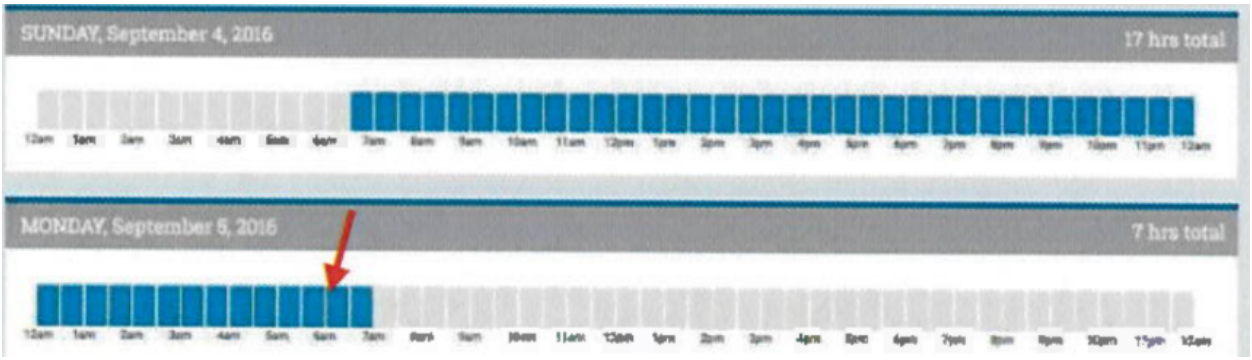
To add your hours for each day, select the start time you begin your day,



and select the end time of either that same day,

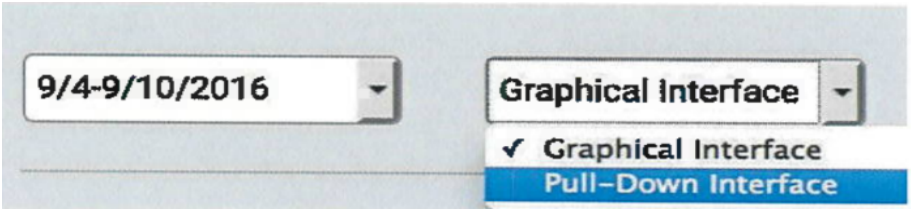


…. or the next day

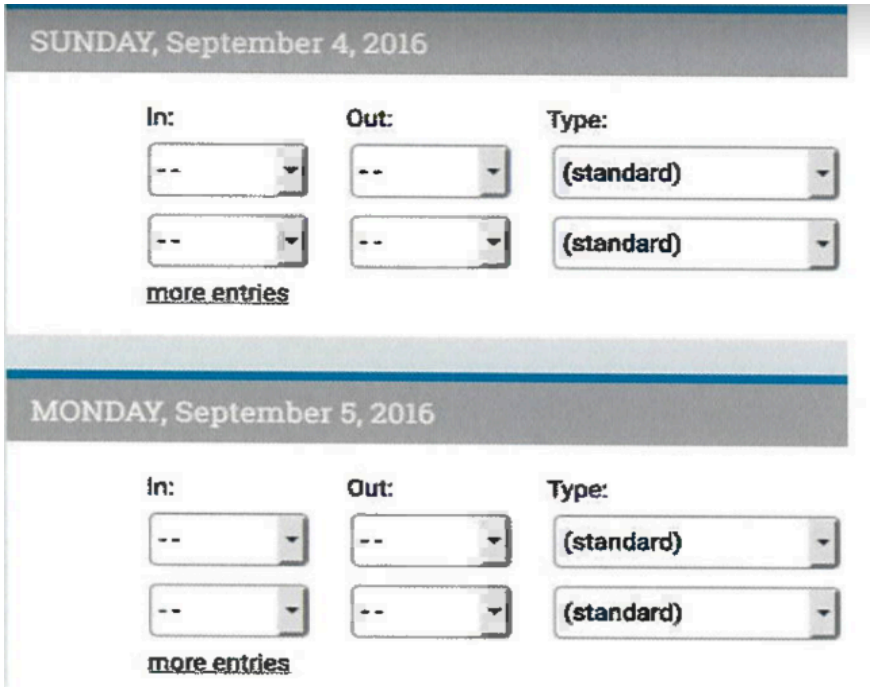


A bar will appear that totals the amount of time you worked based on your start and end times. This is called the graphical interface view. At the bottom of the timesheet, you will have an ability to save and/or submit your hours. **NOTE: Saving your hours simply saves your hours; it does not submit your hours for reporting purposes.**

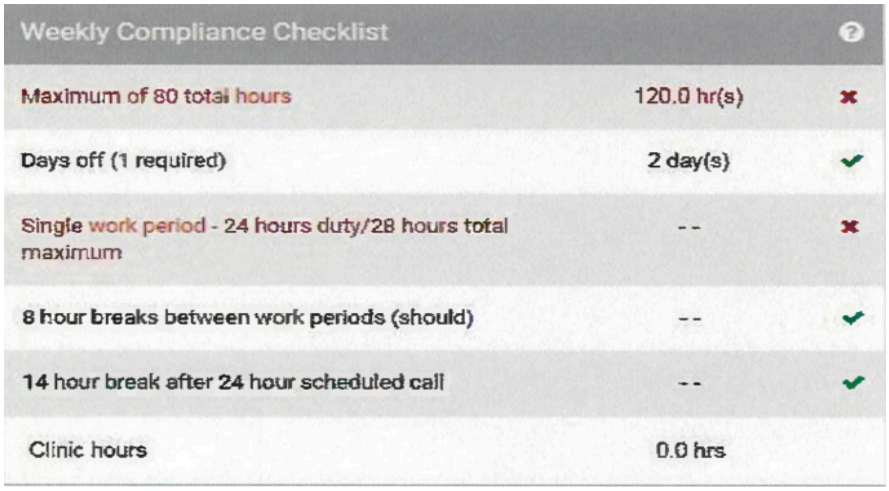
You also have the ability to switch to another view of the work hour timesheet. This is called the pull-down interface view.



The pull-down interface allows you to log hours using a drop-down format vs. a graphical representation of hours. In this format, you would also log your start and end times. The "more entries" link below the designated dropdowns provide additional dropdowns, in case you have multiple in and out times throughout the day. The term "standard" in the drop down refers to your daily schedule which encompasses all activities (rotations, clinics, etc.} that occur within a given day.



Once you have submitted your hours, and all associated work hour rules have met compliance, the compliance checklist identified at the top of the timesheet will indicate the rules where you have met compliance with a green checkmark. If you submit a non-compliant work hour timesheet, the compliance checklist will indicate what rules are not in compliance with a red x.



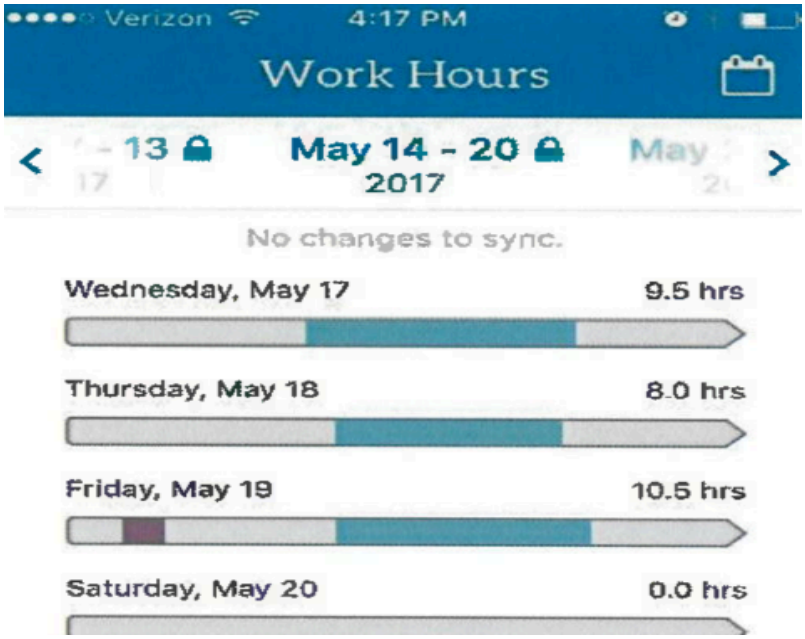
The compliant week you have submitted will show up in green on the monthly calendar located adjacent to your timesheet.

You may be required to submit rationale regarding the potentially non-compliant submission (i.e. patient volume). To review past work hour submissions, select the link called, “Work Hour History Report” located adjacent to the monthly calendars.

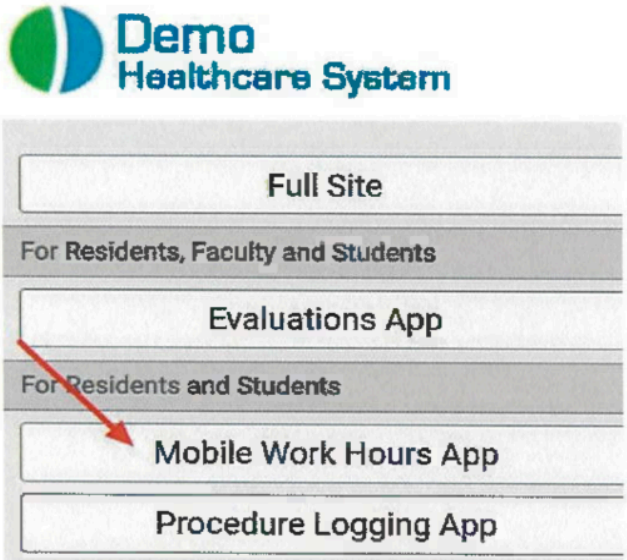
This report provides you with a listing of each week that has been submitted along with the total number of hours for that week, days off, and any compliance rationale based on a non-compliant week.

Mobile Work Hour App

The MedHub Mobile Work Hour App is available for iPhone users and may be accessed via the App Store.



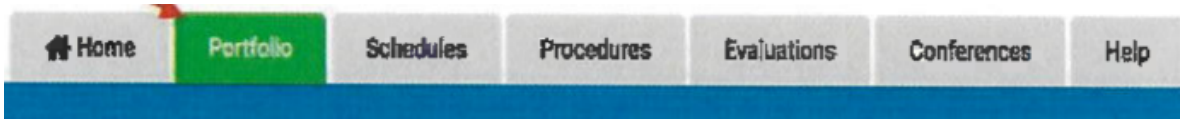
For those using an Android device, the mobile Work Hour App may be accessed by entering the institution's site with a mobile device. You will be asked if you wish to access the "Full Site" or the "Mobile Work Hours App."



Portfolios

You could manage and track your own portfolio information. Faculty who are identified as mentors or the Program Director can also view your portfolio, along with your program coordinator.

There are several portfolio entry options which you can choose from. Each portfolio entry option has its own specific fields related to that entry. To access the portfolio functionality, you will select the Portfolio tab located at the top right-hand side of the home page, also known as the navigation bar.



You can select a portfolio entry type by choosing an option from the drop-down list that describes the type of entry you would like to include in your portfolio.

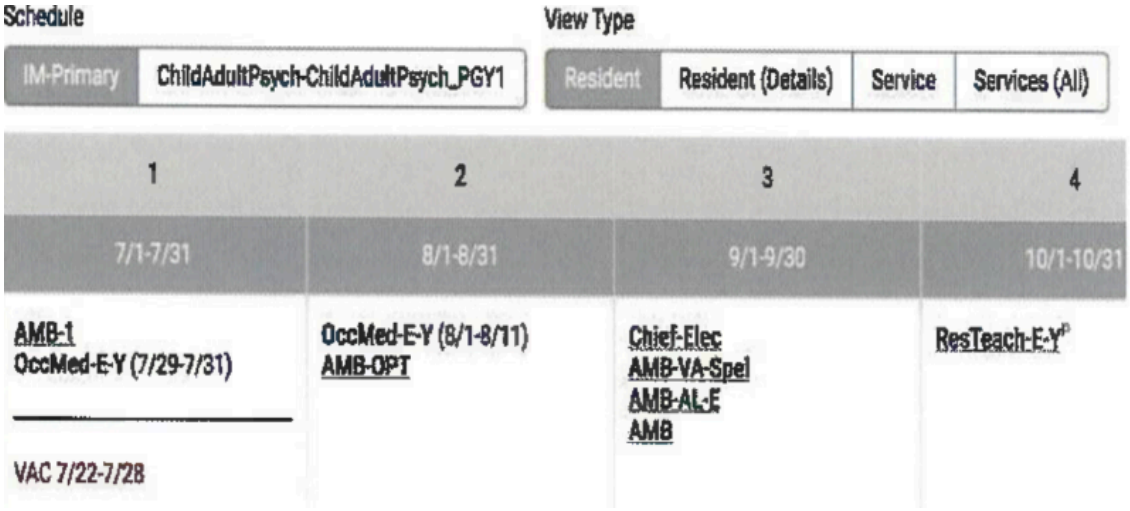
When adding a portfolio entry, you also could share this entry with the faculty members who have been added as your mentor. Some of these portfolio entry types also allow you to create a CV that will display these entries which you can manage.

Schedules

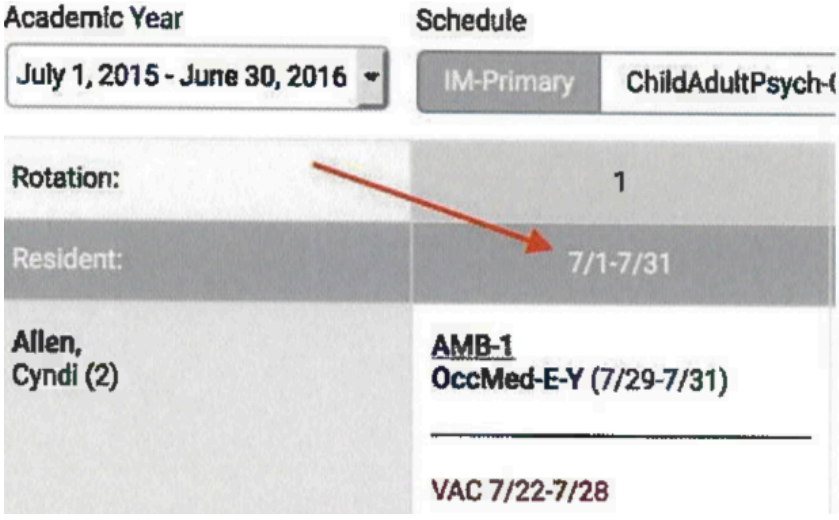
The schedule allows you to view the services or rotations that you have been assigned as well as clinics and specific calls. To access the schedule, select the Schedules tab

located at the top right-hand side of the home page.

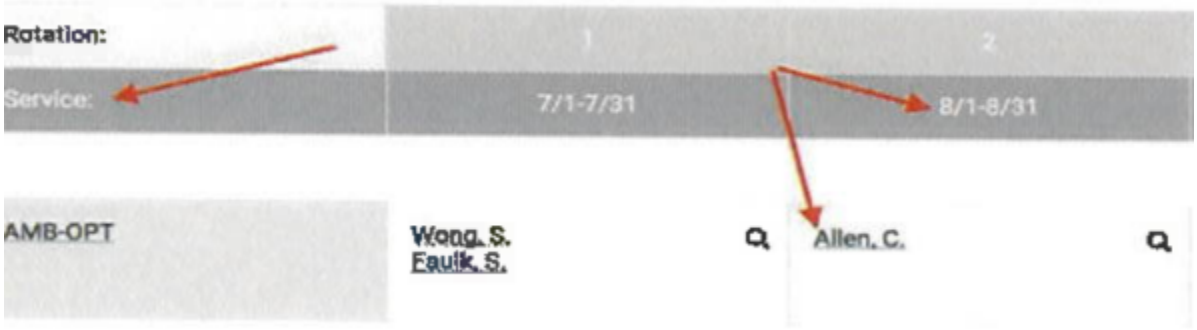
You can review the schedule for all rotations you are assigned. You can view the schedule by resident (resident or listed on the left-hand side of the schedule) or by service (rotations/services listed on the left-hand side of the schedule).



The dates at the top of the rotation schedule indicate the dates of that specific rotation block as identified by your training program.

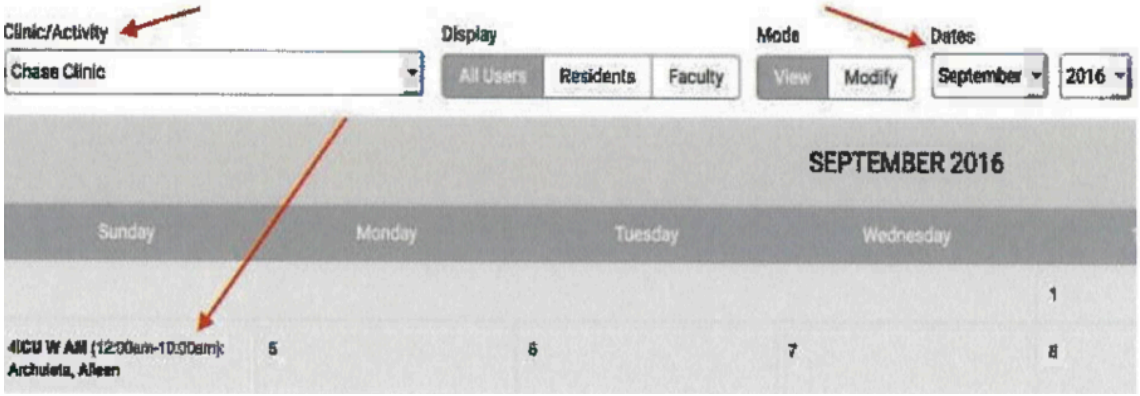


The name of the service or rotation you are scheduled for will appear in the rotation block in the resident view. In the by service view, your name will appear in the block of that service.

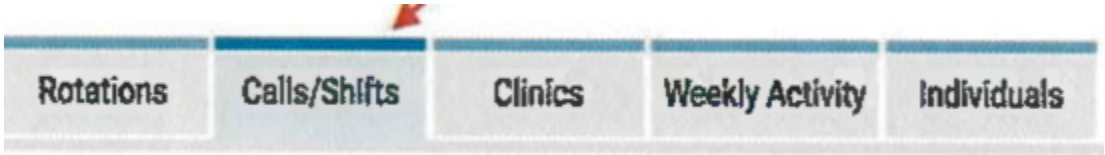


You may also see other residents, and faculty members scheduled to that same service or rotation, so you will know who is rotating with you. To see your clinic schedule, select the Clinics tab located at the top of the rotation schedule.

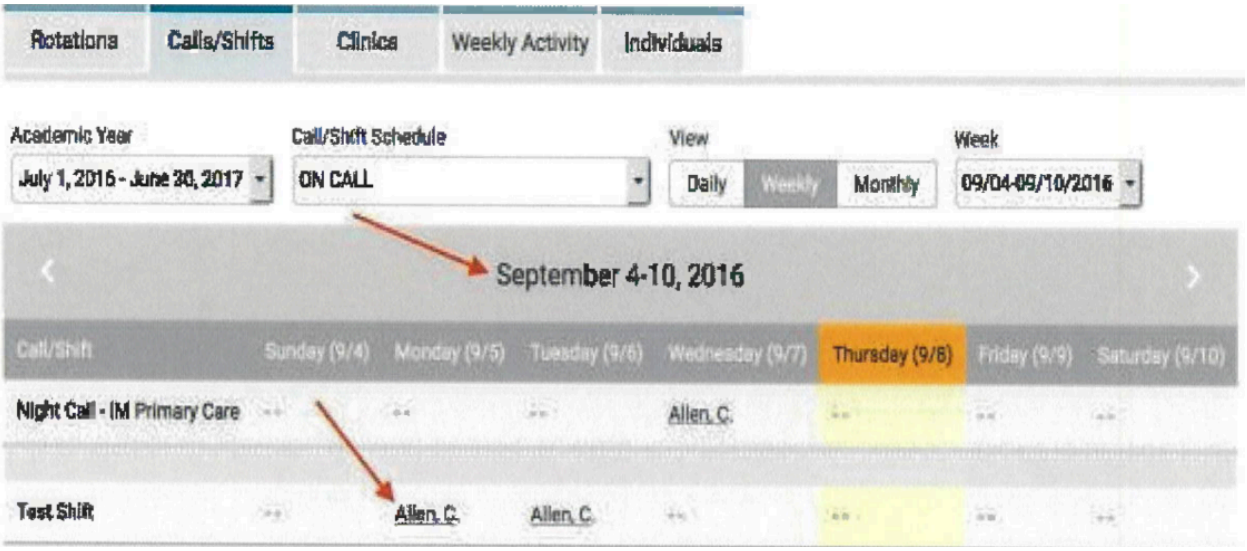
You can filter the information based on the clinic to see who is or has been assigned to a specific clinic.



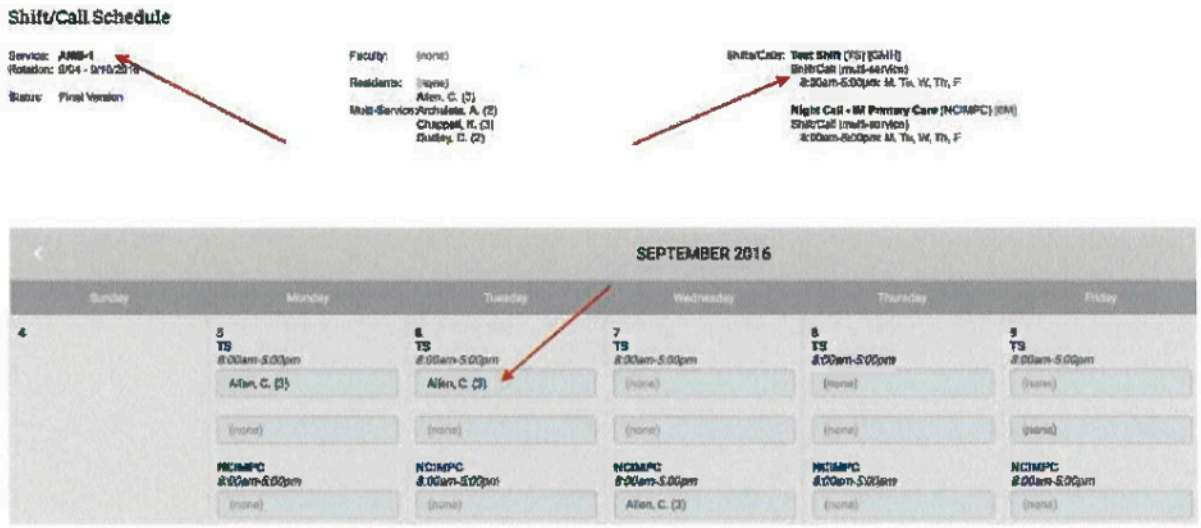
To see your call schedule, select the Calls/Shifts tab located at the top of the rotation schedule.



This will show you the view of the current call schedule for the day, week, or month.



You can also filter the call schedule by selecting the “Call/Shift Schedule” drop down to select a specific rotation or service to view the call assigned for that rotation block.



Procedures - ***Please note, you will not be logging your procedures on MedHub***

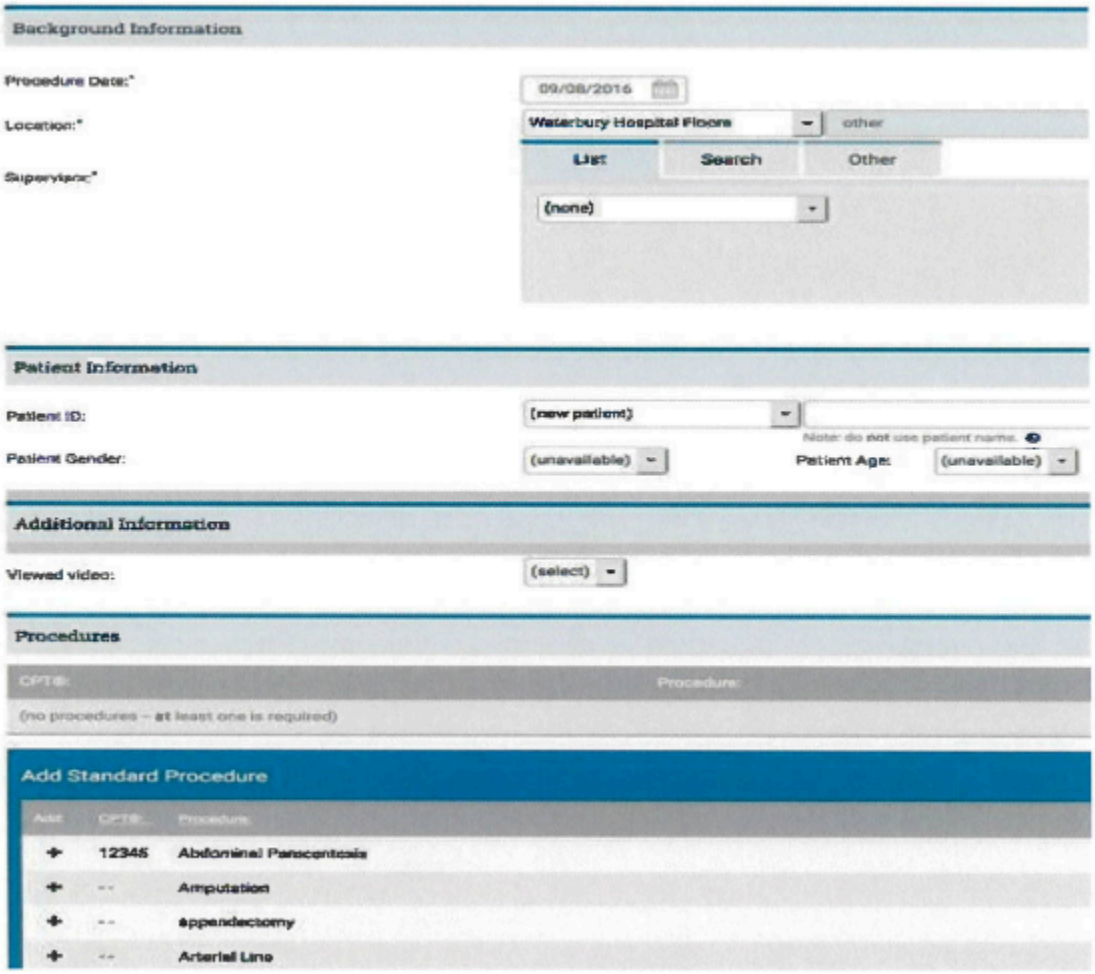
Procedure allows you to log procedure or case encounters within MedHub as well as review various reports of your submitted logs. To access procedures, select the Procedures tab located at the top right-hand side of the home page.

There are four links that you will have access to. They include:

1. Log New Procedure/Case
    a. Use this form to record new procedure/case logs. You can later review all your logs by selecting the option below.
2. View Recorded Procedure/Cases
    a. Review all your recorded procedures. This page also provides access for modifying and deleting procedure logs.
3. Procedure/Case Summary Reports
    a. Overview of procedure requirements, diagnosis requirements, procedure certifications, continuity of care and visit types.
4. Procedure/Case Demographic Breakdown
    a. Charts of procedures according to patient demographics.

You will have the ability to:

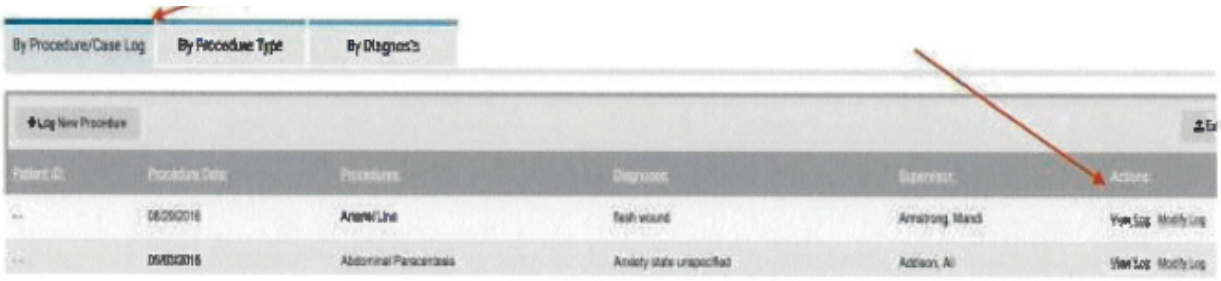
1. Identify the date of the procedure, case, or diagnosis.
2. Choose the location you performed, assisted, observed, simulated, etc. the procedure, case or diagnosis.
3. Identify the supervisor that observed you if necessary or required by your training program.
4. Choose the patient ID, gender and age if needed or as you wish in case you want to have an idea of the demographic breakdown of your patients.
5. Select the procedure, case or diagnosis from a list (defined by your training program) and classify your role or level of responsibility associated with that procedure, case or diagnosis.
6. Log Procedure.
7. Based on your training program's settings, you may be prompted to send an evaluation for a particular procedure that you performed.



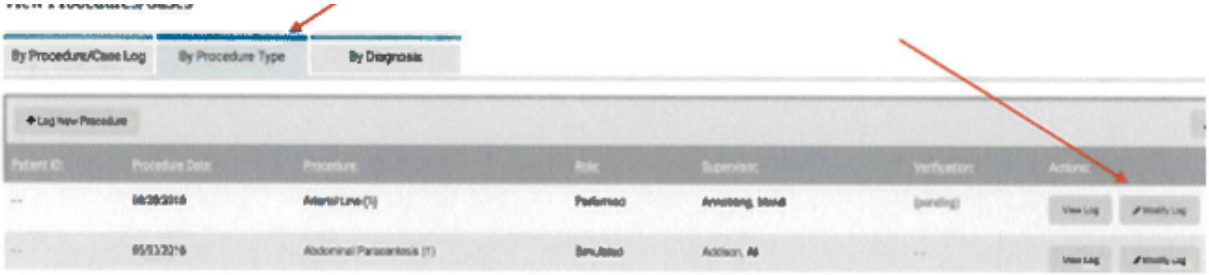
View Recorded Procedures/Case

After each submission of procedures, cases or diagnoses, you have the ability to view what has been recorded. You will view:

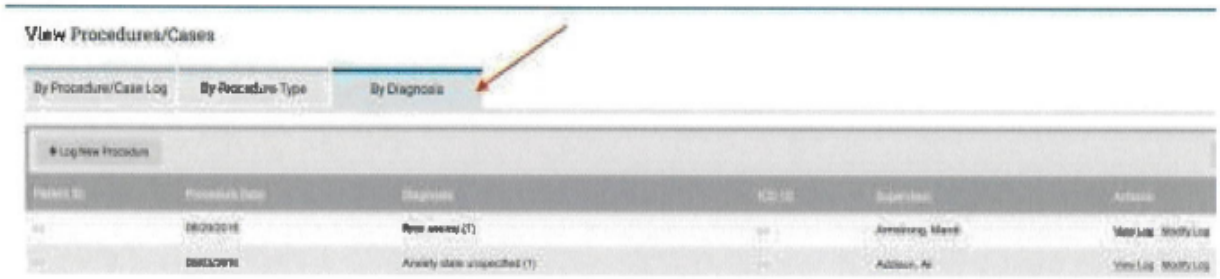
1. By Procedure/Case Logs allows you to view all your logs that you have submitted. You will also be able to view the details of the log as well as modify it if needed. You can delete the log if there is an error within that particular log and you need to re-submit.



2. By Procedure Type allows you to view the procedures or cases you have submitted along with the chosen level of responsibility (i.e., role) of each procedure or case. You can also view, modify and delete the log as needed. You will also be able to view if the supervisor has verified your procedure as well.



3. By Diagnosis allows you to view the diagnoses you have submitted as well as view, modify or delete the log associated with the diagnosis. You may see this tab or log diagnosis IF your program has enabled this information.



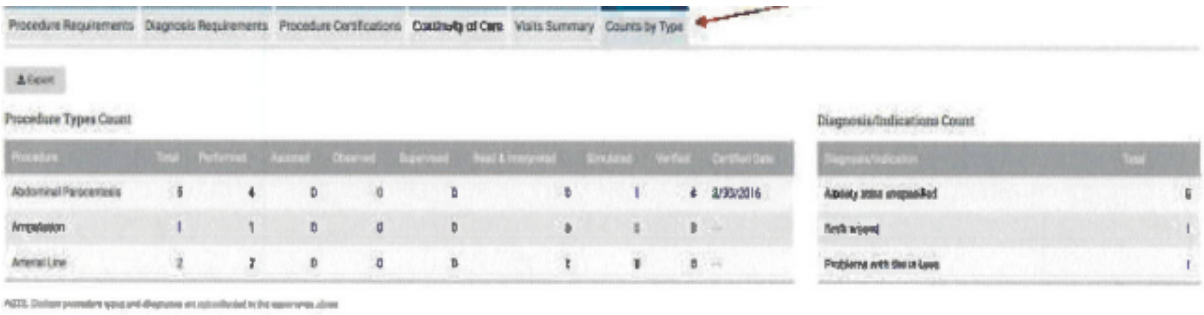
Procedure/Case Summary Reports

This provides you with the ability to review the requirements assigned to each procedure/case or diagnosis as well as audit your own performance regarding the requirements. You can review:

1. Procedure Requirements provides you an outline of the requirements you have completed at that time.
2. Diagnosis Requirements provides you with an outline of the requirements (if any are defined) you have completed at that time.
3. Procedure Certifications provides you with a list of all the procedures for which you have been certified.
4. Continuity of Care statistics on each patient if a patient ID has been designated. The patient ID field may or may not be listed in the log as this is dependent on a setting determined by your program. If you do not see the ability to log a patient ID, you will not see any data on this particular tab. The patient ID field allows you

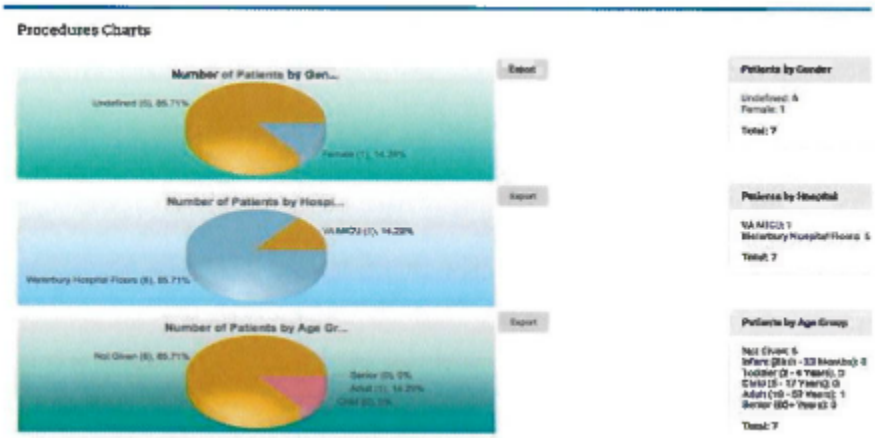
to see the number of visits by patient as well as the specific procedures/cases or diagnoses completed on that patient.

5. Visits Summary provides you with the ability to review the number of visits that were recorded for each rotation or clinic.
6. Counts by Type provides you with an ability to review the total counts of procedures or cases and your level or role of responsibility. The Diagnosis count provides a total that you may have performed, observed, etc., but does not designate the count by level of responsibility.



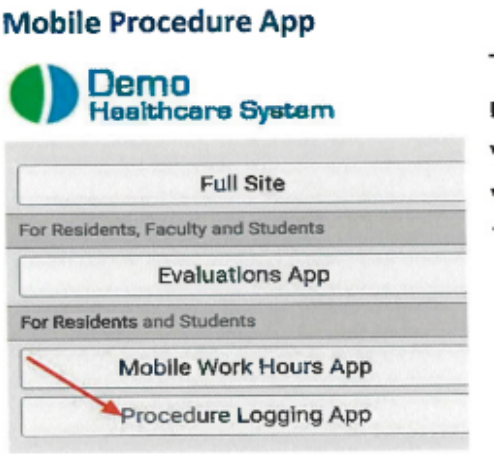
Procedure Demographic Breakdown

This provides you with the ability to see demographic breakdowns of your patients based on the information submitted in your procedure/case log. Any gender, age, or location information entered in the log, will appear in a pie graph based on the entries submitted by you.



Mobile Procedure App

The MedHub Mobile Procedure App can be accessed via a mobile device. It is not available from the App Store. When you log into your institution's site with a mobile device you will be asked if you wish to access the "Full Site" or the "Mobile Procedure App."



The Mobile Procedure App may be used to log new procedures, view recorded procedures, procedure/diagnosis requirements and track statistics for procedures logged.

Evaluations

To access evaluations, select the Evaluations tab located at the top right-hand side of the home page.

This section will allow you to:

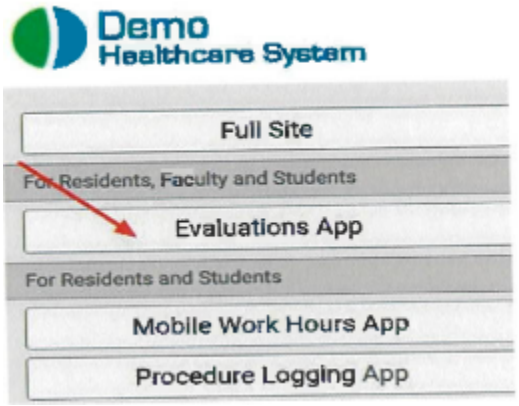
1. Complete evaluations that you have been requested to complete as well as review all evaluations you have completed in the past.
2. Review your individual performance evaluations that have been completed on you.
3. See an aggregate or summary information of evaluations that have been

completed on you.

4. Review competency summary or milestone summary data.
5. Assess trend data compared with peers by overall average or across various competencies.

Mobile Evaluation App

The MedHub Mobile Evaluation App can be accessed via a mobile device. It is not available from the App Store. When you log into the institution's site with a mobile device you will be asked if you wish to access the "Full Site" or the "Mobile Evaluation App."



When you log into the Mobile Evaluations App a list of pending evaluations will be displayed. When an evaluation is selected you will be able to complete the form on the mobile device.

For answer types that include comments the user may use the mobile device's microphone to dictate the text by clicking inside the comment area.

Conferences

If conferences have been set up by your training program, you will be able to view a conference schedule under the Conferences tab. To access conferences, select the Conferences tab located at the top right hand side of the home page.

This allows you to see an upcoming conference schedule, as well as review the complete conference schedule for the academic year and view your own conference attendance (if conference attendance was taken). Scheduled conferences may also appear on the personal calendar found on your portal or home page. You can also run

your own conference attendance report that identifies how you have attended based on the requirements set up by your program. This is found at the bottom of the list of scheduled conferences.

Help

The Help tab, located in the navigation bar provides you with the ability to search for specific topics in case you have questions about functionality.

Aside from searching for help topics, you can also send support tickets either to your program coordinator/administrator or the MedHub support team if you have a question regarding functionality.

Important Contact Information

1. Employee Assistance for stress or report of adverse events
    - VITAL Worklife – Safehaven
        - Phone: 888-316-6616
        - Email: Service@VITALWorkLifeConcierge.com
2. Report of a never event
    - Dr. Palmer : jpalmer@collaborativehp.com
        - Phone: 207-205-1967
    - Erica Spencer: espencer@collaborativehp.com
        - Phone: 540-580-5950
3. Report any issue of safety
    - Dr. Palmer : jpalmer@collaborativehp.com
        - Phone: 207-205-1967
    - Erica Spencer: espencer@collaborativehp.com
        - Phone: 540-580-5950
    - Crystal Krantz: ckrantz@collaborativehp.com
        - Phone: 434-382-1115
4. Quality Improvement personnel
    - Wendi Jennings: wjennings@collaborativehp.com
        - Phone: 434-382-1101
5. EMR issues
    - Nickie Floyd: sfloyd@collaborativehp.com
        - Phone: 434-290-3443
    - Ashley Gray agray@collaborativehp.com
        - Phone: 434-426-5229
    - IT ticket via short-cut on your CHP administered laptop
6. Grievance
    - Robin Hammer: rhammer@collaborativehp.com
        - Phone: 434-382-1118
    - Elyse Douglas: edouglas@collaborativehp.com
        - Phone: 434-534-6720
7. Confidential Reporting Line: **1-844-382-5067**
    1. Third Party: Ronny Smith with MidState
8. CHP IT Support Request:
    1. Please utilize the shortcut on your desktop- “Support Request” for IT related requests.
    2. For urgent or time sensitive requests, please call: 434-382-1117 for Kat or Josh.

Appendix

Moonlighting Form

LUCOM GMES

Moonlighting Approval Form

This form should be completed prior to the trainee beginning any moonlighting activities. The program director and the trainee must sign the form and a copy of this form will be kept in the trainee's file.

Trainee Name: _____

Training Program: _____ Year in Training Program: _____

Description of moonlighting request and activities:

Maximum number of moonlighting hours per week: _____

Other restrictions on moonlighting activity:

_____

_____

_____

_____

Program Director Comments:

_____

_____

_____

By signing this form, the Trainee notes his/her requirements to report all moonlighting hours worked to the Program Director and understands the consequences described in this policy for not accurately reporting moonlighting hours in his/her duty hours reporting to the program at LUCOM GMES.

Trainee Signature:

_____ Date: _____

Program Director Signature:

_____ Date: _____

Time Away Request

LIBERTY UNIVERSITY | COLLEGE of OSTEOPATHIC MEDICINE

GRADUATE MEDICAL EDUCATION SERVICES

LUCOM GMES Time Away from Half-Day Commitments

Date: _____ Physician: _____

Month: _____

Vacation Time: Requested by Half-Days (List dates all inclusive, 20 days provided per CALENDAR year Jan 1 to Dec 31 = 40 half-days).

Personal Time: Requested by Half-Days (List dates all inclusive, 5 days provided per CALENDAR year Jan 1 to Dec 31 = 10 half-days).

CME Time Requested for Selected Presentation: Requested by Half-Days (List Meeting and Dates all inclusive.

Presentation of Scholarly Work: _____

Course Attendance: _____

Other Requests, Special Exceptions: (List dates all inclusive) Requested and Rationale for request.

Reviewed with Program Director / Date: _____

Resident Signature/ Date: _____

LUCOM GMES DIO Approval / Date: _____

Requesting Reimbursement: Prof Development Fund and Required Educational Expenses

LIBERTY UNIVERSITY | COLLEGE of OSTEOPATHIC MEDICINE

GRADUATE MEDICAL EDUCATION SERVICES

Physician: _____

Academic Year Allotment: $1000 for Professional Development and $2000 for CME if presenting. Please submit to the Program Coordinator for processing.

Professional Development (additional courses, certifications, textbooks, journal subscription, memberships)

Required Educational Expenses/Covered by GME (Required course expenses, registration, licenses, mileage)

- ☐ Travel Date To Meeting: _____
- ☐ Travel Date From Meeting: _____

CME Expense (if presenting research – accommodations, registration) up to $2000 total with 5 business days provided by CHSS per Academic Year July 1 to June 30.

- ☐ Please list website for Meeting: _____
- ☐ Published Conference Meeting Dates that will be attended: _____
- ☐ Travel Date To Meeting: _____
- ☐ Travel Date From Meeting: _____
- ☐ Any additional leave days requested: _____

Physician/Date: _____

Program Director/Date: _____

Evaluations and Milestones Sample

Faculty Evaluation of Residents

UCOM GMES Faculty Evaluation of Resident - ONMM 2

Insufficient contact to evaluate (delete evaluation)

We appreciate your time in evaluating this resident's performance on this rotation. Your feedback is critical to the development of our residents and provides our program with a good measure of their performance. Your comments are particularly valuable and help us obtain insight into your individual assessment of the resident. For each of the following areas, please provide your responses and comments to evaluate the resident physician that you worked with during the rotation. In the "Comments" sections, please be as specific as possible. This evaluation will be anonymous once submitted and data will be released in a de-identified aggregated summary.

Patient Care

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
1. Did the resident demonstrate effective history-taking skills including considerations of biomechanical and viscero-somatic influences on symptom presentation and disease pathophysiology?*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
2. Did the resident physician gather and synthesize essential information to accurately define each patient's clinical problem(s)?*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
3. Did the resident demonstrate effective physical examination skills including an Osteopathic Structural Exam in multiple clinical settings?*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
4. Did the resident physician demonstrate effective evaluation of patients using a team-based approach to patient care, including cost-effective diagnostic evaluation?*	○	○	○	○	○	○

5. Did the resident incorporate discussion of the principles, indications, and contraindications of providing osteopathic manipulation treatment (OMT) as an approach to address the patient's presenting complaint?*	○	○	○	○	○	○

Medical Knowledge

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
6. Does the resident physician demonstrate the ability to apply and communicate knowledge in the specialty and leadership in the development and dissemination of scholarship in the specialty?*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
7. Did the resident physician demonstrate an excellent breadth and depth of specialty-specific knowledge, inclusive of anatomy, viscero-somatic reflex patterns, and pathophysiology associated with postural strain, and the five physiologic models of Osteopathic Manipulative Treatment?*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
8. Did the resident demonstrate a commitment to lifelong learning? (As evidenced by curiosity, independent study, asking and exploring questions in the context of patient care, applying current literature to patient care, and guiding learning by the healthcare team, including students, peers, and staff.)*	○	○	○	○	○	○

Interpersonal Communication

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
9. Did the resident physician communicate effectively with the healthcare team including students, staff, peers, and attendings, (including discussions on indications and contraindications of OMT, and the five physiologic models associated with OMT and patient care)?*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
10. Did the resident physician provide frequent and constructive feedback to students, staff, and peers (appropriate to their individual level of education and experience) during the clinical experience?*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
11. Did the resident physician request appropriate and well informed consultative care? (Delineated a well thought out question/reason for referral and provided concise documentation for the referral.)*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
12. Please evaluate the resident physician as a role model in providing bedside care and patient-family interactions (including how to explain OMM to the patient while acquiring informed consent for the procedure of OMM)?*	○	○	○	○	○	○

Professionalism

	Yes	No
13. Did the resident physician uniformly honor clinical education work hours (resident/fellow duty hours)?*	○	○

	Yes	No
14. Did you review the goals, objectives, expectations, and responsibilities for this rotation with the resident physician prior to beginning the rotation and/or on day one of the rotation? *	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
15. Did the resident physician demonstrate respectful interactions with the healthcare team including students, peers, staff, and attending physicians?*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
16. Did the resident physician role model bedside care and patient-family interactions worthy of being emulated?*	○	○	○	○	○	○

17. Did the resident physician contribute to a professional learning environment of growth, progress, and excellence in patient care and medical education consistent with Osteopathic Manipulative Medicine principles and practices?*

Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
0	1	2	3	4	5

18. Did the resident physician accept responsibilities and reliably follow-through on tasks in the context of physician ownership of patient care?*

Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
0	1	2	3	4	5

19. Did the resident physician respond to the patient's unique individual needs? (Patient/family-centered care)*

Practice Based Learning and Improvement

Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
0	1	2	3	4	5

20. Did the resident physician provide and apply up-to-date, evidenced-based literature (including osteopathic neuromusculoskeletal medicine focused journals and publications) to support medical decision-making for patients and families and advice provided to the health care team?*

Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
0	1	2	3	4	5

21. Did the resident physician point the team to up-to-date resources with greatest impact on improving individual and team performance in patient care and healthcare delivery?*

Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
0	1	2	3	4	5

22. Did the resident physician demonstrate that he/she could incorporate feedback from multiple individuals on the healthcare team to improve his/her performance as a resident physician (including discussions on choice(s) of Osteopathic Manipulative Medicine technique(s) utilized)?*

	0	1	2	3	4	5
23. Did the resident physician seek to collaboratively improve the delivery of specialty care and medical education in the context of the broader healthcare system?*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
24. Did the resident physician demonstrate the ability to coach the healthcare team including students, staff and peers on developing a programmatic understanding of how to use the healthcare delivery system to improve patient care and medical education?*	○	○	○	○	○	○

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
25. Did the resident physician identify forces that impact the cost of healthcare, and then advocate for, practice and deliver cost-effective healthcare?*	○	○	○	○	○	○

Medical Education

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
26. Did the resident physician help advance your own individual ability to apply knowledge to patient care in this specialty?*	○	○	○	○	○	○

	1	2	3	4	5
27. Please rate the resident physician as a teacher in medical education.*	○	○	○	○	○

Other

	Yes	No
28. Is the resident physician capable of functioning in his/her assigned role at the current level of training?*	○	○

	Yes	No
29. Did you provide mid-rotation feedback to the resident in a face-to-face session?*	○	○

	Yes	No
30. Did you lead an end of the rotation session to discuss your own summative evaluation	○	○

31. Based on your work with the resident as a faculty member on this rotation, please outline three resident strengths with brief comments. *

32. Based on your work as a faculty member with this resident on this rotation, please outline three areas for the resident to improve over the next 6 to 12 months during residency. (Please provide brief comments with your suggestions including techniques, opportunities, and recommendations.) *

General Comments *

Resident Evaluation of Faculty Member

Patient Care

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
1. Did the attending physician demonstrate effective history-taking skills?*	☐	☐	☐	☐	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
2. Did the attending physician role model effective physical examination skills?*	☐	☐	☐	☐	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
3. Did the attending physician demonstrate effective evaluation of patients using a team-based approach to patient care, including cost-effective diagnostic evaluation?*	☐	☐	☐	☐	☐	☐

Comments:

4. Did the attending physician demonstrate and implement effective evidence-based management and treatment plans for patients?*	☐	☐	☐	☐	☐	☐

Comments:

Medical Knowledge

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
5. Did the attending physician demonstrate an excellent breadth and depth of specialty-specific knowledge?*	☐	☐	☐	☐	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
6. Does the attending physician demonstrate the ability to apply and communicate knowledge in the specialty and leadership in the development and dissemination of scholarship in the specialty?*	☐	☐	☐	☐	☐	☐

Comments:

Interpersonal and Communication Skills

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
7. Did the attending physician communicate effectively with the healthcare team including students, residents, and fellows?*	☐	☐	☐	☐	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
8. Did the attending physician provide frequent and constructive feedback appropriate to my level of education during the clinical experience?*	☐	☐	☐	☐	☐	☐

Comments:

	Yes	No
9. Did you review the goals, objectives, expectations, and responsibilities for this rotation with the attending physician prior to beginning the rotation and/or on day one of the rotation?*	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
10. Did the attending physician uniformly honor clinical education work hours (duty hours) for residents and fellows?*	☐	☐	☐	☐	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
11. Did the attending physician demonstrate respectful interactions with the healthcare team including students, residents, and fellows?*	☐	☐	☐	☐	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
12. Did the attending physician role-model bedside care and patient-family interactions worthy of being emulated?*	☐	☐	☐	☐	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
13. Did the attending physician create and contribute to a learning environment for growth, progress, and excellence in patient care and medical education?*	☐	☐	☐	☐	☐	☐

Comments:

14. Did the attending physician provide and apply up-to-date, evidence-based literature to support medical decision-making and advice provided to residents/fellows and patients and families?*	☐	☐	☐	☐	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
15. Did the attending physician point the team to up-to-date resources with greatest impact on improving individual and team performance in patient care and healthcare delivery?*	☐	☐	☐	☐	☐	☐

Comments:

Systems-Based Practice

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
16. Did the attending physician seek to collaboratively improve the delivery of specialty care and medical education in the context of the broader healthcare system?*	☐	☐	☐	☐	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
17. Did the attending physician demonstrate the ability to coach the healthcare team including students, residents, and fellows on developing a programmatic understanding of how to use the healthcare delivery system to improve patient care and medical education? *	☐	☐	☐	☐	☐	☐

Comments:

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
18. Did the attending physician identify forces that impact the cost of healthcare, and then advocate for, practice and deliver cost-effective healthcare?**	☐	☐	☐	☐	☐	☐

Comments:

Summary Evaluation as a Medical Educator

	Not Applic... Contact	Fails to meet expec...	Margi...	Meets expec...	Excee... expec...	Signifi... excee... expec...
	0	1	2	3	4	5
19. Did the attending physician advance your ability to apply knowledge to patient care in this specialty?*	☐	☐	☐	☐	☐	☐

Comments:

	1	2	3	4	5
20. Please rate the attending physician as a teacher in medical education.*	☐	☐	☐	☐	☐

Comments:

Please list the three most instructive aspects of this experience while working with this attending physician. *

_____

_____

_____

_____

_____

Evaluation of Program by Residents

LUCOM GMES Evaluation of Program by ONMM Resident vs 2.0

Insufficient contact to evaluate (delete evaluation)

It is REQUIRED by the ACGME, and our Program for the training program to be evaluated at least annually by Residents, Fellows, and Faculty. Evaluations must be collected and an official meeting held with current Residents, Fellows, and Faculty, prior to completion of the academic year. Resident, Fellow, and Faculty evaluations are integral to continuously improve GME programs and healthcare delivery.

Please indicate how well the PROGRAM DIRECTOR demonstrated the following qualities or met the roles below.

	Unable to Evaluate	Unsatisfactory	Below Average	Average	Above Average	Excellent
	0	1	2	3	4	5
1. Commitment to Medical Education*	○	○	○	○	○	○
2. Level of Engagement as a Leader with the Residents and Fellows*	○	○	○	○	○	○
3. Leadership of the Program Faculty and Faculty Engaged in Teaching in the Program.*	○	○	○	○	○	○
4. Accessibility*	○	○	○	○	○	○
5. Advocate*	○	○	○	○	○	○
6. Mentor*	○	○	○	○	○	○
7. Responsive to Feedback*	○	○	○	○	○	○
8. Provides Effective Feedback*	○	○	○	○	○	○

Please indicate how well the following PROGRAM PERSONNEL supported you.

	Unable to Evaluate	Unsatisfactory	Below Average	Average	Above Average	Excellent
	0	1	2	3	4	5
9. LUCOM Graduate Medical Education Services Including Dean's Suite Leadership**	○	○	○	○	○	○
10. Program Director*	○	○	○	○	○	○
11. Program Coordinator*	○	○	○	○	○	○

	Unable to Evaluate	Unsatisfactory	Below Average	Average	Above Average	Excellent
	0	1	2	3	4	5
12. Clinical Faculty*	○	○	○	○	○	○
13. Allied Health Staff in the ONMM Clinical Setting*	○	○	○	○	○	○
14. Nursing Staff in the ONMM Clinical Setting*	○	○	○	○	○	○

Please rate the following RESOURCES.

	Unable to Evaluate	Unsatisfactory	Below Average	Average	Above Average	Excellent
	0	1	2	3	4	5
15. Online and Library Resources in Medical Education*	○	○	○	○	○	○
16. Information Technology Including Hardware and Software*	○	○	○	○	○	○
17. Facilities and Education Space for the Residency Program*	○	○	○	○	○	○
18. Inpatient Facilities with Hospital Partners*	○	○	○	○	○	○
19. Outpatient Facilities*	○	○	○	○	○	○

Please rate the quality and effectiveness of the following CONFERENCES.

	Unable to Evaluate	Unsatisfactory	Below Average	Average	Above Average	Excellent
	0	1	2	3	4	5
20. Thursday Afternoon ONMM Didactic Series (weekly)*	○	○	○	○	○	○
21. Grand Rounds*	○	○	○	○	○	○
22. Biomedical Frontiers Monthly Series at LUCOM*	○	○	○	○	○	○
23. Inter-disciplinary didactic seminars with Lynchburg Family Medicine residency program*	○	○	○	○	○	○

GOALS AND OBJECTIVES

	N/A	Yes	No
24. Are you receiving competency-based goals and objectives for each rotation at each year of residency (educational level specific)?*	○	○	○

Please indicate how well the program prepares residents/fellows to become COMPETENT in the following areas:

	Unable to Evaluate	Unsatisfactory	Below Average	Average	Above Average	Excellent
	0	1	2	3	4	5
25. PATIENT CARE that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.*	○	○	○	○	○	○
26. MEDICAL 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.*	○	○	○	○	○	○
27. INTERPERSONAL AND COMMUNICATION SKILLS that result in effective information exchange and teaming with patients, their families, and other health professionals.*	○	○	○	○	○	○
28. PROFESSIONALISM as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.*	○	○	○	○	○	○
29. 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.*	○	○	○	○	○	○
30. SYSTEMS-BASED PRACTICE as manifested by actions that 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.*	○	○	○	○	○	○
31. OMT SKILLS that focus on the development, implementation, and refinement of these skills in clinical practice settings.*	○	○	○	○	○	○

Please indicate FIVE (5) STRENGTHS for the GME program being evaluated.

32. Program Strength #1	
33. Program Strength #2	
34. Program Strength #3	
35. Program Strength #4	
36. Program Strength #5	

Please indicate FIVE (5) AREAS OF CONTINUOUS IMPROVEMENT of the GME program being evaluated:

37. Program AREA OF CONTINUOUS IMPROVEMENT #1

38. Program AREA OF CONTINUOUS IMPROVEMENT #2

39. Program AREA OF CONTINUOUS IMPROVEMENT #3

40. Program AREA OF CONTINUOUS IMPROVEMENT #4

41. Program AREA OF CONTINUOUS IMPROVEMENT #5

42. What is one area that could be improved in this GME program that would potentially have the most measurable impact on improving patient care?

43. What is one area that could be improved in this GME program that could potentially have the highest measurable impact on teaching and learning?

44. What is one area that could be improved in this GME program that could potentially have the highest measurable impact on resident/fellow wellness?

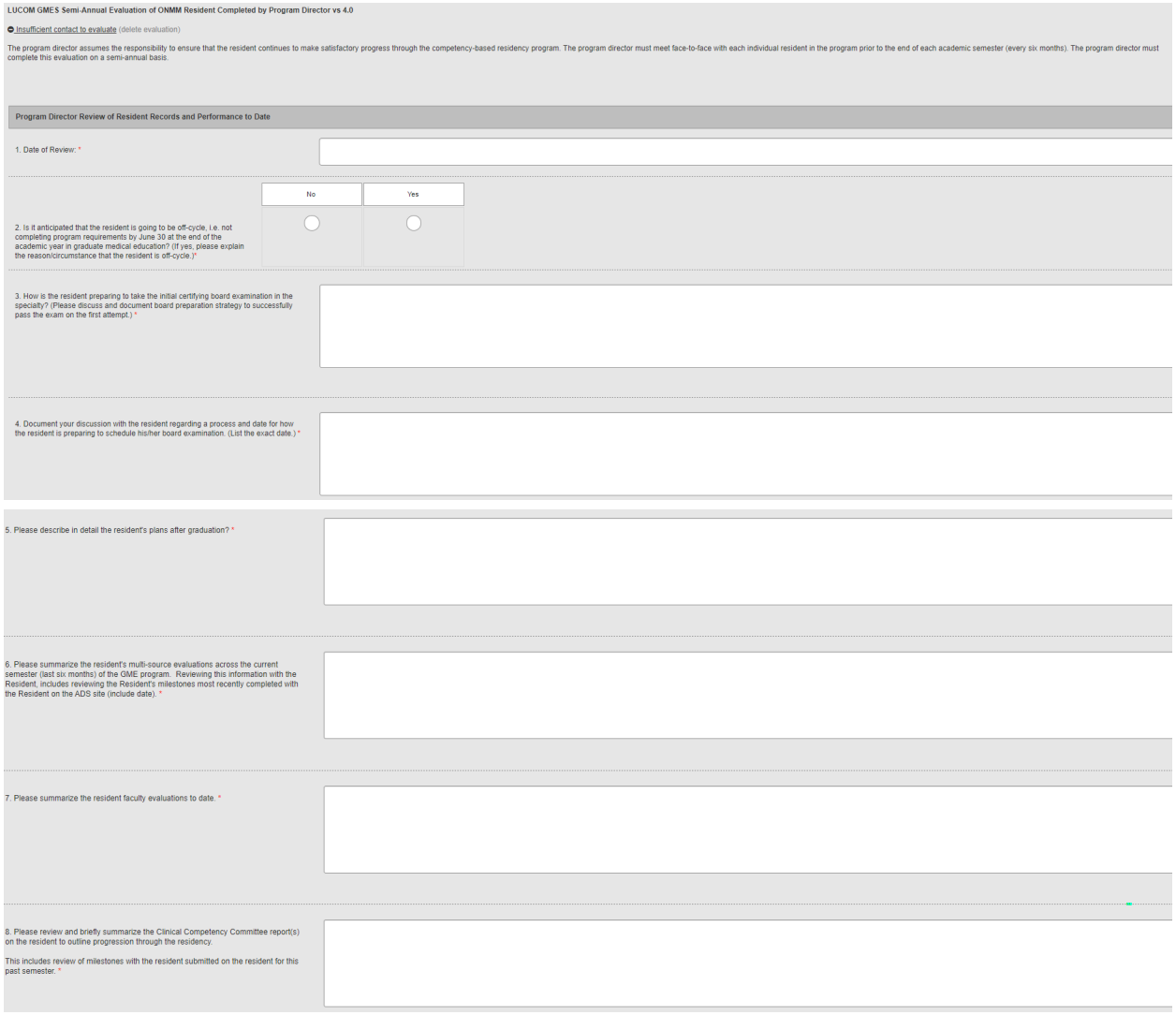
	Unable to Evaluate	Unsatisfactory	Below Average	Average	Above Average	Excellent
	0	1	2	3	4	5
45. Please provide an overall rating for this GME program.*	○	○	○	○	○	○

46. Please provide any additional thoughts for continuous improvement of the GME program. Identify the issue and propose potential solutions. *

Multi-Source Evaluation of Resident

Please see MedHub for Sample form

Semi-Annual Evaluations of Residents



LUCOM GMES Semi-Annual Evaluation of ONMM Resident Completed by Program Director vs 4.0

Insufficient contact to evaluate (delete evaluation)

The program director assumes the responsibility to ensure that the resident continues to make satisfactory progress through the competency-based residency program. The program director must meet face-to-face with each individual resident in the program prior to the end of each academic semester (every six months). The program director must complete this evaluation on a semi-annual basis.

Program Director Review of Resident Records and Performance to Date

1. Date of Review: *

	No	Yes
2. Is it anticipated that the resident is going to be off-cycle, i.e. not completing program requirements by June 30 at the end of the academic year in graduate medical education? (If yes, please explain the reason/circumstance that the resident is off-cycle.)*	○	○

3. How is the resident preparing to take the initial certifying board examination in the specialty? (Please discuss and document board preparation strategy to successfully pass the exam on the first attempt.) *

4. Document your discussion with the resident regarding a process and date for how the resident is preparing to schedule his/her board examination. (List the exact date.) *

5. Please describe in detail the resident's plans after graduation? *

6. Please summarize the resident's multi-source evaluations across the current semester (last six months) of the GME program. Reviewing this information with the Resident, includes reviewing the Resident's milestones most recently completed with the Resident on the ADS site (include date). *

7. Please summarize the resident faculty evaluations to date. *

8. Please review and briefly summarize the Clinical Competency Committee report(s) on the resident to outline progression through the residency.

This includes review of milestones with the resident submitted on the resident for this past semester. *

9. Please summarize the resident meetings with the faculty mentor. *

Procedures and Procedural Logs Review by the Program Director

10. Is the resident demonstrating expected progress in performing procedures in the specialty? (Review the resident procedure log in MedHub and the ACGME procedural case log. Outline a strategy and timeline for the resident as deemed necessary by the program director.)*	Yes	No
	○	○

Review of Conference Attendance

11. Please summarize the resident's conference participation:*	90%	70%	50%	30%	10%
	○	○	○	○	○

12. Please summarize the strategy and timeline for improving the resident's performance on the next In-Training Examination. (Include the resident's mentor and meeting schedule for performance improvement.) *

Review of In-Training Examination Performance

13. Please summarize the resident's In-Training Examination results:*	Level 1	Level 2	Level 3	Level 4	Level 5
	▪ ITE National Percentile Rank for PGY	▪ ITE National Percentile Rank for PGY Level	▪ ITE National Percentile Rank for PGY Level	▪ ITE National Percentile Rank for PGY Level	▪ ITE National Percentile Rank for PGY
	○	○	○	○	○

Review of Scholarly Activities

14. Please rate the resident's scholarly activity and outcomes in scholarship:*	Not Applicable/Insufficient Contact	Fails to meet expectations	Marginal	Meets expectations	Exceeds expectations	Significantly exceeds expectations
	0	1	2	3	4	5
	○	○	○	○	○	○

15. Please summarize the resident's scholarly activities and outcomes: projects, presentations, and publications *

Review of Core Competencies

Summarize the resident's/fellow's performance to date in the residency/fellowship program

	Not Applicable/Insufficient Contact	Fails to meet expectations	Marginal	Meets expectations	Exceeds expectations	Significantly exceeds expectations
	0	1	2	3	4	5
16. **Patient Care** (Demonstrates understanding of clinical problems; Demonstrates appropriate physical exam skills; Demonstrates appropriate test selection; Advocates for patients)*	○	○	○	○	○	○

	Not Applicable/Insufficient Contact	Fails to meet expectations	Marginal	Meets expectations	Exceeds expectations	Significantly exceeds expectations
	0	1	2	3	4	5
17. **Medical Knowledge** (Reads service specific literature; Develops appropriate differential diagnoses; Has appropriate knowledge base for level of training)*	○	○	○	○	○	○

	Not Applicable/Insufficient Contact	Fails to meet expectations	Marginal	Meets expectations	Exceeds expectations	Significantly exceeds expectations
	0	1	2	3	4	5
18. **Interpersonal & Communication Skills** (Note content is appropriate; Interpersonal skills with staff are appropriate; Presents cases in clear, concise manner)*	○	○	○	○	○	○

	Not Applicable/Insufficient Contact	Fails to meet expectations	Marginal	Meets expectations	Exceeds expectations	Significantly exceeds expectations
	0	1	2	3	4	5
19. **Professionalism** (Displays a professional attitude; Completes work in a timely fashion and attends rounds on time; Responsible for their workload; Display cultural humility)*	○	○	○	○	○	○

	Not Applicable/Insufficient Contact	Fails to meet expectations	Marginal	Meets expectations	Exceeds expectations	Significantly exceeds expectations
	0	1	2	3	4	5
20. **Practice-Based Learning & Improvement** (Identifies areas for improvement and applies it to practice; Shows interest in learning from complex care issues; Participates in educational activities)*	○	○	○	○	○	○

	Not Applicable/Insufficient Contact	Fails to meet expectations	Marginal	Meets expectations	Exceeds expectations	Significantly exceeds expectations
	0	1	2	3	4	5
21. **System-based Practice** (Effectively utilizes hospital resources; Communicates effectively with consultants; Advocates for quality patient care and assists patients in dealing with systems complexities; Understanding of health care delivery appropriate for level of training)*	○	○	○	○	○	○

22. **Summative comments on the competency based domains above:** *

Semi-Annual Questions For the Program Director:		
	Yes	No
23. Has the resident demonstrated the effective application of knowledge and clinical skill in patient care, utilizing effective clinical judgment?*	○	○
	Yes	No
24. Has the resident demonstrated basic scientific literacy and understanding of clinical study design and evaluation of research findings?*	○	○
	Yes	No
25. Does the resident demonstrate safe, effective, and evidence-based management of patients with acute and chronic conditions?*	○	○
	Yes	No
26. Is the resident demonstrating that s/he can effectively document patient care encounters in the electronic health records system?*	○	○
	Yes	No
27. Is the resident demonstrating growth and development as a medical educator of students, staff, and peers? (Outline a strategy and timeline as deemed necessary by the program director.)*	○	○

Final Summative Semi-Annual Attestations by the Program Director

	Yes	No
28. Is the resident completing the objectives for this graduate medical education program at the current level of training satisfactorily indicating their readiness to progress to the next level of training? (If no, please summarize a performance improvement plan to be implemented for this resident, including the faculty mentor who will be accountable with the program director.)*	○	○
29. During the residency program training period to date, has the resident physician been subject to any disciplinary action (remediation, probation, suspension, and/or termination)? If yes, the program director must provide a summary.*	○	○

	Not Applicable/Insufficient Contact	Fails to meet expectations	Marginal	Meets expectations	Exceeds expectations	Significantly exceeds expectations
	0	1	2	3	4	5
30. **Summative overall performance rating during residency/fellowship to date***	○	○	○	○	○	○
31. **Program Director Summary of Overall Competency At Current Level of Training** *	○	○	○	○	○	○

Overall Competency Comments:

Signature: Program Director

32. Program Director Electronic Signature:

Typed name will serve as an electronic signature *

Signature of Resident:

Typed name will serve as electronic signature:

33. Resident electronic signature:

Typed name will serve as electronic signature:

PROGRAM DIRECTOR SIGNATURE/DATE

_____Date:_____

Osteopathic Neuromusculoskeletal Medicine Milestones

The Accreditation Council for Graduate Medical Education

ACGME

Implementation: July 2022
Second Revision: January

Patient Care 1: Patient Management: Osteopathic Approach to Patient Care				
Level 1	Level 2	Level 3	Level 4	Level 5
Integrates history, examination, diagnostic testing, and medication management into osteopathic patient care plan, with direct supervision and guidance	Integrates history, examination, diagnostic testing, and medication management into osteopathic patient care plan, with indirect supervision	Independently integrates history, examination, diagnostic testing, and medication management into osteopathic patient care plan	Independently integrates history, examination, diagnostic testing, and medication management into osteopathic patient care plan in complex patients	Role models the effective use of osteopathic-focused history, examination, diagnostic testing, and medication management to minimize the need for further diagnostic testing or intervention
Performs osteopathic structural examination and diagnoses somatic dysfunction appropriate to patient condition, with direct supervision and guidance	Performs osteopathic structural examination and diagnoses somatic dysfunction appropriate to patient condition, with indirect supervision	Independently performs accurate and complete osteopathic structural examination and diagnoses somatic dysfunction appropriate to patient condition	Independently performs accurate and complete osteopathic structural examination and diagnoses somatic dysfunction appropriate to complex patients	Role models the complete osteopathic structural examination and diagnoses somatic dysfunction in patient care
Incorporates osteopathic principles to promote health and wellness in patients with acute and chronic conditions, with direct supervision	Incorporates osteopathic principles to promote health and wellness in patients with acute and chronic conditions, with indirect supervision	Incorporates osteopathic principles to promote health and wellness in patients with complex conditions, with indirect supervision	Independently incorporates osteopathic principles to promote health and wellness in patients with complex conditions	Role models the integration of osteopathic principles to optimize patient health
☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:				
			Not Yet Completed Level 1 ☐ Not Yet Assessable ☐	

Version 2 Osteopathic Neuromusculoskeletal Medicine, ACGME Report Worksheet

Patient Care 2: Osteopathic Manipulative Treatment (OMT) (Direct)				
Level 1	Level 2	Level 3	Level 4	Level 5
Performs direct OMT for identified somatic dysfunction, with direct supervision and guidance	Performs direct OMT for identified somatic dysfunction, with indirect supervision	Independently and effectively performs direct OMT for identified somatic dysfunction in routine patient presentations	Independently and effectively performs direct OMT for identified somatic dysfunction in complex patient presentations	Mentors others to become competent in performing direct OMT for identified somatic dysfunction in complex patient presentations
☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:				
			Not Yet Completed Level 1 ☐ Not Yet Assessable ☐	

Patient Care 3: Osteopathic Manipulative Treatments (OMT) (Indirect)				
Level 1	Level 2	Level 3	Level 4	Level 5
Performs indirect OMT for identified somatic dysfunction, with direct supervision and guidance	Performs indirect OMT for identified somatic dysfunction, with indirect supervision	Independently and effectively performs indirect OMT for identified somatic dysfunction in routine patient presentations	Independently and effectively performs indirect OMT for identified somatic dysfunction in complex patient presentations	Mentors others to become competent in performing indirect OMT for identified somatic dysfunction in complex patient presentations
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments:				
Not Yet Completed Level 1 ☐ Not Yet Assessable ☐				

Patient Care 4: Diagnostic Screening, Testing, and Interpretation				
Level 1	Level 2	Level 3	Level 4	Level 5
Explains the rationale, risks, and benefits for common diagnostic testing Interprets results of common diagnostic tests	Explains the rationale, risks, and benefits for complex diagnostic testing Interprets complex diagnostic data	Integrates value and test characteristics of various diagnostic strategies in patients with common diseases Integrates complex diagnostic data accurately to reach high-probability diagnoses	Integrates value and test characteristics of various diagnostic strategies in patients with comorbid conditions or multisystem disease Anticipates and accounts for limitations when interpreting diagnostic data	Demonstrates a nuanced understanding of emerging diagnostic tests and procedures
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments:				
Not Yet Completed Level 1 ☐ Not Yet Assessable ☐				

Patient Care 5: Management of Procedural Care (e.g., Trigger Point Injections, Joint Aspirations, Joint Injections)				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies the procedures that osteopathic neuromusculoskeletal medicine physicians perform Recognizes osteopathic neuromusculoskeletal medicine physicians' role in referring patients for appropriate procedural care	Identifies patients for whom a procedure is indicated and who is equipped to perform it Counsels patients about expectations for common procedures performed by osteopathic neuromusculoskeletal medicine physicians and consultants	Demonstrates confidence and motor skills while performing procedures, including addressing complications Performs independent risk and appropriateness assessment based on patient-centered priorities for procedures performed by consultants	Identifies and acquires the skills to independently perform procedures in the current practice environment Collaborates with procedural colleagues to match patients with appropriate procedures, including declining support for procedures that are not in the patient's best interest	Identifies procedures needed in future practice and pursues supplemental training to independently perform
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments:				
Not Yet Completed Level 1 ☐ Not Yet Assessable ☐				

Medical Knowledge 1: Applied Foundational Sciences				
Level 1	Level 2	Level 3	Level 4	Level 5
Explains the scientific knowledge (e.g., physiologic, pathologic, socioeconomic, and behavioral) for normal function and common conditions	Explains the scientific knowledge for complex conditions	Integrates scientific knowledge into an osteopathic treatment plan while respecting the patient's comorbid conditions	Integrates scientific knowledge into an osteopathic treatment plan while respecting the patient's complex comorbid conditions	Demonstrates a nuanced understanding of the scientific knowledge related to uncommon, atypical, or complex conditions
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐

Medical Knowledge 2: Manifestation of Systemic Disease through Neuromusculoskeletal System				
Level 1	Level 2	Level 3	Level 4	Level 5
Describes the basic interrelationship of structure and function through osteopathic structural findings	Consistently describes the interrelationship of structure and function through osteopathic structural findings	Consistently describes the complex interrelationship of structure and function through osteopathic structural findings as relates to the patient's systemic disease	Demonstrates knowledge of the effects of health and illness on the whole patient – body, mind, and spirit	Teaches the osteopathic tenets to the multidisciplinary team
Forms an osteopathic treatment plan based on the patient's history and physical exam findings, with guidance	Forms an appropriate osteopathic treatment plan based on the patient's history and physical exam findings	Consistently forms an appropriate osteopathic treatment plan based on the patient's complex history and physical exam findings	Develops a long-range treatment plan to support the health and well-being of the patient	Is a leader in the development and dissemination of osteopathic knowledge
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
				Not Yet Completed Level 1 ☐ Not Yet Assessable ☐

Systems-Based Practice 1: Patient Safety and Quality Improvement				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of common patient safety events	Identifies system factors that lead to patient safety events	Participates in analysis of patient safety events (simulated or actual)	Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual)	Actively engages teams and processes to modify systems to prevent patient safety events
Demonstrates knowledge of how to report patient safety events	Reports patient safety events through institutional reporting systems (simulated or actual)	Participates in disclosure of patient safety events to patients and families (simulated or actual)	Discloses patient safety events to patients and families (simulated or actual)	Role models or mentors others in the disclosure of patient safety events
Demonstrates knowledge of basic quality improvement methodologies and metrics	Describes local quality improvement initiatives (e.g., community vaccination rate, infection rate, smoking cessation)	Participates in local quality improvement initiatives	Demonstrates skills required to identify, develop, implement, and analyze a quality improvement project	Designs, implements, and assesses quality improvement initiatives at the institutional or community level
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				
				Not Yet Completed Level 1 ☐

Systems-Based Practice 2: System Navigation for Patient-Centered Care				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of care coordination	Coordinates care of patients in routine clinical situations effectively using the roles of the interprofessional team members	Coordinates care of patients in complex clinical situations effectively using the roles of interprofessional team members	Role models effective coordination of patient-centered care among different disciplines and specialties	Analyzes the process of care coordination and leads in the design and implementation of improvements
Identifies key elements for safe and effective transitions of care and hand-offs	Performs safe and effective transitions of care/hand-offs in routine clinical situations	Performs safe and effective transitions of care/hand-offs in complex clinical situations	Role models and advocates for safe and effective transitions of care/hand-offs within and across health care delivery systems	Improves quality of transitions of care within and across health care delivery systems to optimize patient outcomes
Demonstrates knowledge of population and community health needs and disparities	Identifies specific population and community health needs and inequities in the local population	Uses local resources effectively to meet the needs of a patient population and community	Participates in changing and adapting practice to provide for the needs of specific populations	Leads innovations and advocates for populations and communities with health care inequities
☐	☐	☐	☐	☐

Comments:

Not Yet Completed Level 1 ☐

Systems-Based Practice 3: Physician Role in Health Care Systems				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies key components of the complex health care system (e.g., hospital, skilled nursing facility, finance, personnel, technology)	Describes how components of a complex health care system are interrelated, and how this impacts patient care	Discusses how individual practice affects the broader system (e.g., length of stay, readmission rates, clinical efficiency)	Manages various components of the complex health care system to provide efficient and effective patient care and transition of care	Advocates for or leads systems change that enhances high-value, efficient, and effective patient care
States factors impacting the costs of osteopathic neuromusculoskeletal medicine care	Documents osteopathic neuromusculoskeletal medicine detail to facilitate accurate billing and reimbursement	Explains the impact of documentation on billing and reimbursement	Practices and advocates for cost-effective patient care	Engages in external activities related to advocacy for cost-effective care
Identifies basic knowledge domains for effective transition to practice (e.g., information technology, legal, billing and coding, financial, personnel)	Demonstrates use of information technology required for medical practice (e.g., electronic health record, documentation required for billing and coding)	Describes core administrative knowledge needed for transition to practice (e.g., contract negotiations, malpractice insurance, government regulation, compliance)	Analyzes individual practice patterns and prepares for professional requirements to enter practice	Role models effective practice and practice management
☐	☐	☐	☐	☐

Comments:

Not Yet Completed Level 1 ☐

Practice-Based Learning and Improvement 1: Evidence-Based and Informed Practice				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates how to access, categorize, and analyze clinical evidence Understands how to perform a focused literature review	Articulates clinical questions and elicits patient preferences and values to guide evidence-based care Locates and evaluates evidence-based resources to develop an OMT plan	Locates and applies the best available evidence, integrated with patient preference, to the care of complex patients Critically evaluates and develops the OMT plan, integrating evidence-based osteopathic care, to the care of complex patients	Critically appraises and applies evidence even in the face of uncertainty and conflicting evidence to guide osteopathic care, tailored to the individual patient and that patient's neuromusculoskeletal complaints	Coaches others to critically appraise and apply evidence for complex patients Collaboratively researches, develops, and disseminates evidence-based decision-making processes to promote best practices in osteopathic neuromusculoskeletal medicine
☐	☐	☐	☐	☐ ☐ ☐ ☐

Comments:

Not Yet Completed Level 1 ☐

Practice-Based Learning and Improvement 2: Reflective Practice and Commitment to Personal Growth				
Level 1	Level 2	Level 3	Level 4	Level 5
Accepts responsibility for personal and professional development by establishing goals Identifies the factors that contribute to gap(s) between expectations and actual performance Acknowledges there are always opportunities for self-improvement in both character and skill level	Demonstrates openness to performance data (feedback and other input) to improve on established goals Self-reflects and analyzes factors that contribute to gap(s) between expectations and actual performance Designs and implements a learning plan, with prompting	Intermittently seeks additional performance data with adaptability and humility Self-reflects, analyzes, and institutes behavioral change(s) to narrow the gap(s) between expectations and actual performance Independently creates and implements a learning plan	Consistently seeks performance data with adaptability and humility Challenges assumptions and considers alternatives in narrowing the gap(s) between expectations and actual performance Uses performance data to measure the effectiveness of the learning plan, and, when necessary, improves it	Leads performance review processes Coaches others on reflective practice for both treatment plans and OMT skill level Facilitates the design and implementing learning plans for others
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐

Comments:

Not Yet Completed Level 1 ☐

Professionalism 1: Professional Behavior and Ethical Principles				
Level 1	Level 2	Level 3	Level 4	Level 5
Describes professional behavior and potential triggers for personal lapses in professionalism	Demonstrates self-reflective behaviors and professionalism in routine situations	Demonstrates professional behavior in complex or stressful situations	Recognizes potential situations that may trigger professionalism lapses and intervenes to prevent lapses in oneself and others	Mentors others in professional behavior
Takes responsibility for personal lapses in professionalism	Describes when and how to report professionalism lapses in oneself and others	Recognizes need to seek help in managing and resolving complex professionalism lapses	Recognizes and uses appropriate resources for managing and resolving dilemmas as needed	Identifies and addresses system-level factors that induce or exacerbate ethical problems and professionalism lapses or impede their resolution
Demonstrates knowledge of ethical principles	Analyzes straightforward situations using ethical principles	Analyzes complex situations using ethical principles		
☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐ ☐

Comments:

Not Yet Completed Level 1 ☐

Professionalism 2: Accountability/Conscientiousness				
Level 1	Level 2	Level 3	Level 4	Level 5
Takes responsibility for failure to complete tasks and responsibilities, identifies potential contributing factors, and describes strategies for ensuring timely task completion in the future	Performs tasks and responsibilities in a timely manner with appropriate attention to detail in routine situations	Performs tasks and responsibilities in a timely manner with appropriate attention to detail in complex or stressful situations	Recognizes and addresses situations that may impact others' ability to complete tasks and responsibilities in a timely manner	Takes ownership of systemic processes and outcomes
Responds promptly to requests or reminders to complete tasks and responsibilities	Recognizes situations that may impact one's own ability to complete tasks and responsibilities in a timely manner	Proactively implements strategies to ensure that the needs of patients, teams, and systems are met		
☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐ ☐

Comments:

Not Yet Completed Level 1 ☐

Professionalism 3: Self-Awareness and Help-Seeking Behaviors				
Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes status of personal and professional well-being, with assistance Recognizes one's own limits in knowledge/skills, with assistance	Independently recognizes status of personal and professional well-being Independently recognizes limits in the knowledge/skills of oneself and the team and demonstrates appropriate help-seeking behaviors	Proposes a plan to optimize personal and professional well-being, with guidance Proposes a plan to remediate or improve limits in the knowledge/skills of oneself or the team, with guidance	Independently develops a plan to optimize personal and professional well-being Independently develops a plan to remediate or improve limits in the knowledge/skills of oneself or the team	Addresses system barriers to maintain personal and professional well-being Mentors others to enhance knowledge/skills of oneself or the team
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments: Not Yet Completed Level 1 ☐				

Interpersonal and Communication Skills 1: Patient- and Family-Centered Communication				
Level 1	Level 2	Level 3	Level 4	Level 5
Uses language and non-verbal behavior to demonstrate respect and establish rapport while communicating one's own role within the health care system Recognizes easily-identified barriers to effective communication (e.g., language, disability) Identifies the need to individualize communication strategies	Establishes a therapeutic relationship in straightforward encounters using active listening and clear language Identifies complex barriers to effective communication (e.g., health literacy, cultural differences) Organizes and initiates communication, sets an agenda, clarifies expectations, and verifies understanding	Establishes a therapeutic relationship in challenging patient encounters When prompted, reflects on personal biases while attempting to minimize communication barriers Sensitively and compassionately delivers medical information, managing patient/patient's family's values, goals, preferences, uncertainty, and conflict	Maintains therapeutic relationships, with attention to patient/patient's family's concerns and context, regardless of complexity Independently recognizes personal biases while attempting to proactively minimize communication barriers Independently uses shared decision making to align patient/patient's family's values, goals, and preferences with treatment options to make a personalized care plan	Mentors others in situational awareness and critical self-reflection to consistently develop positive therapeutic relationships Leads or develops initiatives to identify and address bias Role models shared decision making in communicating with the patient/patient's family, including in situations with a high degree of uncertainty/conflict
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments: Not Yet Completed Level 1 ☐				

Interpersonal and Communication Skills 2: Interprofessional and Team Communication				
Level 1	Level 2	Level 3	Level 4	Level 5
Respectfully requests a consultation, with supervision	Clarifies the goals of the consultation request	Ensures understanding of consultant recommendations	Integrates recommendations from consultant into the treatment plan	Leads the health care team in the provision of effective consultative services across the spectrum of disease complexity and acuity
Respectfully responds to a consultation request and conveys recommendations, with supervision	Clearly conveys recommendations following consultations	Seeks and integrates input from different members of the health care team and provides recommendations to the primary team in a clear and timely manner	Provides comprehensive and prioritized recommendations, including assessment and rationale, to all necessary health care team members	Facilitates regular health care team-based feedback in complex situations
Uses language that values all members of the health care team	Communicates information effectively with all health care team members	Communicates concerns and provides feedback to peers and learners	Communicates feedback and constructive criticism to supervising individuals	
☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐

Comments:

Not Yet Completed Level 1 ☐

Interpersonal and Communication Skills 3: Communication within Health Care Systems				
Level 1	Level 2	Level 3	Level 4	Level 5
Records information in the patient record in an accurate and timely manner	Demonstrates organized medical management reasoning through notes in the patient record	Uses the patient record to communicate updated and concise information in an organized format	Demonstrates efficiency in documenting patient encounters and updating record	Optimizes and improves functionality of the electronic health record within the institutional system
Learns institutional policy and safeguards patient personal health information	Appropriately uses documentation shortcuts; records required data in formats and timeframes specified by institutional policy	Appropriately selects direct (e.g., telephone, in-person) and indirect (e.g., progress notes, text messages) forms of communication based on context	Manages the volume and extent of written and verbal communication required for practice	Guides departmental or institutional communication around policies and procedures
Communicates through appropriate channels as required by institutional policy (e.g., patient safety reports, cell phone/pager use)	Respectfully communicates concerns about the system	Uses appropriate channels to offer clear and constructive suggestions for system improvement while acknowledging system limitations	Initiates difficult conversations with appropriate stakeholders to improve the system	Facilitates dialogue regarding systems issues among larger community stakeholders (residency institution, health care system, field)
☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐

Comments:

Not Yet Completed Level 1 ☐

GME Counseling and Remediation Template

	GME COUNSELING & REMEDIATION TEMPLATE	
Trainee Name:	Program Director:	
Date:	Program:	PGY:
Counseling		
☐ Documentation of Verbal Counseling (not reportable)	☐ Written Counseling (not reportable)	
Remediation Steps		
☐ Probation (disciplinary action - reportable and appealable)	☐ Extension of Training because of failure to meet competency milestones (disciplinary action - reportable and appealable)	
Area(s) of Deficiency/Affected Competencies (select one or more)		
☐ Interpersonal Skills and Communication	☐ Practice Based Learning	☐ Research
☐ Medical Knowledge	☐ Professionalism	☐ Systems Based Practice
☐ Patient Care	☐ Surgical/Procedural Skills	☐ Other (Please specify below)
If Other selected above, please explain:		
Description of Performance Issue (additional documentation may be attached)		

Resident/Fellow Performance Comments (Optional)			
Action for Improvement (Please add/delete rows as necessary) **Please provide SMART Goals** (Specific, Measurable, Achievable, Results Focused and Timely)			
Targeted Area for Improvement	**Expected Improvement**	**Measurement of Improvement**	**Time Frame**
1.			
2.			
3.			
Resource(s) Recommended/Provided to help the resident meet his or her goals:			
Monitoring Mechanism: *Name of responsible faculty member and responsibilities including frequency of meetings/audits, reporting, etc.*			
Consequences for failure to meet expected improvement in competency areas			
Signatures			
Program Director Signature:		Date:	
My signature does not signify that I agree with the information contained herein, it acknowledges that my program director (or his/her designee) has discussed this performance improvement plan with me and that I have read and understand the content and terms of the plan. If applicable, I have been advised that I will need to meet with the GME Designated Institutional Official (or designee) to discuss my rights to appeal this decision (remediation level only- appeals do not apply to counseling).			
Trainee Signature:		Date:	
Outcome of Action Plan			
☐ Successfully Remediated	☐ Written Counseling	☐ Probation	☐ Dismissal* ☐ Non reappointment*
Program Director Signature		Date	
Trainee Signature		Date	