HOUSESTAFF
POLICIES AND PROCEDURES

ORIENTATION MANUAL

UCLA-Olive View Program (UCLA-OVP)

Internal Medicine Residency Training

Olive View – UCLA Medical Center

2020-2021

Housestaff Orientation Manual Attestation

I certify that I have received the Housestaff Orientation Manual, in which the following policies and expectations are included or discussed:

- Professional Behavior
- Dress Code
- Promotion/Graduation Requirements
- Malpractice/Risk Management
- Miscellaneous Rules and Policies
- Documentation
- Resident Work Hours
- Moonlighting
- Absence/Leave Policy
- Stress in Medical Training/Resident's Assistance Program
- Procedure Requirement Document
- Needle Stick Policy
- Things to notify Program Director or Chief Resident about ASAP
- Things to avoid/Things that will get you into trouble
- Evaluation, Promotion, Problem Resolution and Due Process
- Stipend and Zoom etiquette
- Copy of a mini CEX
- Sample review forms used by the Program Director/Academic Advisor
- Social Media Policy
- Procedure Requirements

I have read and am responsible for the above information included in the Housestaff Orientation Manual:

_____ _____

Signature Date

_____

Printed Name

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Section I. Key People 2020-2021

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Section II. Program Policies and Expectations

A. Professional Behavior

Professionalism is one of the most important core competencies of the residency program (see page 12 for a discussion of all 6 core competencies). Professionalism is multi-faceted and includes but is not limited to the following:

1. Treat patients with respect, even when they are difficult or rude. Remember that medical illness may cause people to act out or lash out at you. Being professional means not engaging in emotional outbursts with a patient. Try to let the patient "cool down" and/or ask your Attending for help. Despite how tired you are, every patient should be treated with respect and compassion. The same applies to their families. Try to put yourself in their place: how would you feel and act, and what would you wish to be told? Respect also includes consideration for patients' religious, cultural and other practices and beliefs, even if you disagree with them.
2. Treat your colleagues with respect. This means many things. Do not fight with the E.D. over admissions. Do not write rude or inappropriate remarks in the medical record. Do not leave clinic early when your fellow housestaff need help. Also, show respect to other professionals and ancillary staff that you work with (i.e. nurses, clerks, administrators, and others).
3. Be honest with yourself, your patients, your colleagues and the faculty. Everyone makes mistakes. It's best to admit to them and learn from them. Ethical behavior is expected from you at all times.
4. Be on time for clinics, conferences, meetings, etc. Pay attention during lectures and conferences as a lot of work goes into these educational activities. It is unprofessional to frequently look at your cellphone or text your friends during conferences; this is discourteous to the lecturer/presenter.
5. Document your records appropriately and on time.
6. Maintain patient confidentiality and respect patient autonomy.
7. Complete program evaluation/feedback forms promptly.
8. Dress and act appropriately, consistent with standard professional behavior and expectations.

B. Dress Code

It is essential that you dress professionally. This is a sign of respect for your patients, and may help re-assure patients who tend to be concerned about the competency of their physicians. Dress appropriately at all times, even on weekends. Blue jeans, spaghetti straps, shorts, hats of any kind and T-shirts are NOT appropriate dress. You may wear scrubs when not in clinic. Please do not attach any stickers to your nametag which cover your name or credentials. Women should not wear open toed shoes or short skirts in clinic or on the inpatient services.

C. Social Media

Purpose: To help guide residents and faculty in professional practices in regards to social media and networking.

Introduction: One of our primary responsibilities as healthcare professionals is to protect patient privacy. In addition, we have a responsibility to maintain professionalism at all times and to protect and enhance the reputation of the Olive View-UCLA IM residency and Medical Center. Any communications online or offline have the potential to affect our reputation as well as compromise patient privacy, and therefore the utmost caution must be used when engaging in social media and networking.

Definitions:

Social Media: All online tools that are used to share content, opinions, insights, experiences, perspectives and media.

Guidelines:

1. Physicians should be cognizant of the standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online. (AMA)
2. Refrain from using de-identified discussion of patients and specific medical cases on social media.
3. Physicians should recognize that actions online and content posted may negatively affect their reputations among patients and colleagues and future employers. Even deleted information may at times be accessed through archived data. Information online should be considered permanent.
4. Always adhere to the same principles of professionalism online as you would offline.
5. To maintain appropriate professional boundaries, physicians should separate personal and professional content online. For example, use your personal email rather than work email to log on to social network sites, as content that is tagged with your DHS email will appear to represent our medical institution. (FMB)
6. Physician-patient interactions online should only take place in institutionally supported forums, e.g. patient communication portals.
7. When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the greatest extent possible, but should realize that privacy settings are not absolute and may be circumvented. (AMA)
8. Always respect the privacy of other people. Do not post photos, opinions or comments about residents, fellows, faculty, or hospital employees without their permission.
9. Be thoughtful about your posts. Social Media posts can be taken out of context and misinterpreted. Remember your comments can be used in public forums, i.e. courtrooms. Use sound judgment and think about all potential reactions to a post prior to posting information. Anything written and sent electronically can be forwarded easily to a large unintended audience (including program directors)! (ASG)
10. Be considerate: Respect yourself, colleagues and place of employment. Remember, once the words are out there you cannot get them back. Refrain from slurs, profanity and insults, as well as more subtle forms of disrespect. (ASG)
11. When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions and report the incident to the Chief Residents, APD or PD. (AMA/Federation of MB)
12. Cyberbullying by physicians toward any individual is unprofessional behavior and inappropriate.

Please remember to refrain from discussing any patient related information in social media forums!

D. Requirements for Promotion & Graduation

In addition to a satisfactory academic and professional behavior performance, the following are required for promotion to the next year/graduation. You will not receive your Certificate of Completion if you have not met the following requirements prior to the end of the academic year:

1. Three (3) mini-CEX's per year per level of training (see page 17).
2. Regular maintenance of Procedures on MedHub: must complete ABIM and programmatic requirements.

3. All evaluations of program, rotations, attendings, residents and students must be completed.
4. Noon Conference attendance: should be as close to 100% as possible when you are at Olive View, with absences only for urgent patient care or other required activities.
5. Morning Report attendance: should be as close to 100% as possible when you are on Olive View wards and consult rotations (with the understanding that patient care may take precedence in emergent situations).
6. **PGY-1's:** Apply for State of California Postgraduate Training License (PTL) within the first 6 months of your intern year. Pass the USMLE Step 3 exam for MDs or the COMLEX CBT exam for DOs. This must be scheduled during a non-call rotation block assigned by the Chief Resident. Interns must participate in an approved QI project.
7. **PGY-2's:** Follow through or complete your QI project. Apply for your DEA license before March of your PGY-2 year, and register for Electronic Prescribing of Controlled Substances (EPCS).
8. **PGY-3's:** Complete your QI project if not done already. Complete Academic Senior Projects and Senior Talks that are approved by the Program Directors. Complete all required procedure requirements.

E. Malpractice & Risk Management

All Housestaff are covered for malpractice while rotating through the UCLA-Olive View Program. Olive View-UCLA Medical Center is "self-insured." If a lawyer ever calls you, do not discuss a case with them. **Call the Risk Management Department at whichever institution you are rotating through.** Also, do not panic if you get a subpoena, but do not ignore it either. The standard practice is to subpoena every physician whose name appears in the chart. Simply contact Risk Management. At OVMC, contact Risk Management at (747) 210-3026, and notify your Chief Residents or Program Director.

F. Miscellaneous Policies

1. **Conferences:** Multiple conferences are provided for your education. It is expected that you will attend all sessions unless there is an emergency with one of your patients. You need to sign in at the beginning of each morning report and noon conference. Failure to attend lectures, signing in and leaving, or persistent tardiness may leave you open to disciplinary action. If your attending physician tries to continue rounds past 12:00 p.m., you have the Program Director's permission to excuse yourself and go to noon lecture. We will be happy to discuss this with your attending if need be.
2. **Autopsies:** It is an important part of your educational experience to review pathological material. If appropriate, ask the family of patients who have died if they will consent to an autopsy. Even when you think you know the cause of death, up to 50% of autopsies show that the patient had undiagnosed conditions that may have caused morbidity/mortality. We realize that it is difficult to get consent during this troubling period for the family. Some common concerns are that the patient will somehow "feel pain" or that an open casket is not possible. It can be helpful to discuss these concerns with the family. If the family still does not consent, you can ask for a "limited autopsy." Explain that this is just like taking a biopsy on a living patient. An autopsy report on your patients who have died can be sent to you per your request.
3. **Program Progress Meetings (CCC):** You will meet regularly (at least 2 times per year) with the Curriculum Competency Committee (CCC), consisting of Program leadership and core faculty, to review your procedure logs, evaluations, and progress. You will be given formal feedback at that time, but don't hesitate to speak with the Chief Residents or other faculty for feedback at any time.
4. **Program Evaluations:** In addition to being evaluated (see page 11 - Evaluation, Promotion, Problem Resolution and Due Process), you will be asked to complete evaluations on your attendings, residents, and students after every rotation. It is very important that you do these and that you are honest. Students cannot receive a grade in their course without your evaluation; comments are especially important. Attendings and residents rely on your

evaluation for feedback. Please be honest and constructive in your comments—these evaluations and feedback are meant to improve the quality of teaching in the program. The individual you evaluate will not see your name.

5. **Confidentiality/HIPAA rules:** Please remember that the elevators, hallways, and the cafeteria are public places. Do not talk about patients where anyone might overhear your HIPAA conversation. For documents with patient identification that need to be thrown away, place them in a HIPAA shredder and not in a trash receptacle.
6. **Ethics Committee:** Ethics consultations are available and should be utilized whenever you have a question about issues such as DNR status, allocation of resources, appropriateness of the level of care, etc. Contact the operator to find the Ethics Committee representative to contact.
7. **Be Punctual to Clinics:** The later you arrive, the later everyone gets out, and the less satisfied the patients are with your care. If there are no patients ready to be seen, have your attending review a topic with you. If your attending is not present, let the Program Director or Chief Resident know so the situation can be remedied.
8. **Narcotic Prescriptions:** Under the new California Medical Board law, residents may apply for DEA licensure after they have received their Post Graduate Training License. In the Department of Medicine, residents are not allowed to prescribe narcotics until they have completed a minimum of 18 months of training. In the event a narcotic medication is needed for your patient prior to obtaining your DEA license, the narcotic prescription will be written by the attending or other DEA licensed physician.

G. Documentation

Documentation is an essential piece of communication and part of being a good physician. Poor documentation is the primary reason that physicians lose lawsuits. Learning good habits now will save you a lot of grief later. The essentials of a note, regardless of the setting are:

1. **Legibility:** The Medical Board of California requires that documentation be legible. If it is not, you are subject to disciplinary action by the Board, which is costly, embarrassing (since it is published), and a major hassle. In addition, it is a major reason why people lose lawsuits. All notes are now done on the computer, but there may still be forms you fill out for the patient. These need to be legible.
2. **Copy-and-paste:** Ideally, you would not copy and paste any part of your notes. If you do copy and paste your progress note, be very careful to update the note thoroughly. This has become a particular problem with electronic record systems. Not updating your note properly can put the patient in jeopardy when consultants or others read incorrect information, can be very embarrassing for you, and can be a legal liability! Your note needs to reflect what's happening with your patient at the time you sign it.
3. Indicate that you discussed the case with the attending, (e.g. "Discussed with Attending Dr. Smith") for every note that you write (including discharge summaries). You must forward all notes to the attending for co-signature. Patient medication proposals must be forwarded to a licensed physician (typically your attending) if you are not licensed.
4. If part of an exam is not indicated (e.g. rectal or pelvic), state "not indicated" in the record. Do not write "deferred," as this means you plan to do it later.
5. Never alter a record. Add an addendum to the note if additional information must be added.
6. Make sure all medical student notes and orders are reviewed before they are co-signed.
7. Make sure you read pertinent notes from ancillary services and consults. Document that you have done so in your progress note.
8. Do not rely on second hand data. Like the old telephone game, "r/o cancer" easily becomes "cancer" in a chart if you don't verify the data.

9. **Do not criticize a patient, colleague, or service in the chart.** Just state the facts. Do not blame other services in the medical chart. Do not allude to internal processes like involvement by Risk Management or SI's in the medical record.
10. Do not leave patient information in the work rooms, resident lounge, conference rooms, etc. Any unneeded papers with patient identification should be placed in the secured shredding bins, available at all nursing stations.

H. Resident Work Hours

The UCLA-OV Residency Program is committed to provide an appropriate balance between patient care and resident education, in an environment that avoids undue stress and fatigue. The Department of Medicine fully supports the Resident Work Hours policy established by the ACGME with the following requirements:

1. A maximum of 80 hours per week averaged over four weeks is allowed, inclusive of all in-house activities. Moonlighting is counted in the 80 hours/week maximum.
2. For PGY-1 interns, a maximum of 24+4 hours is permitted on site. For PGY-2 and above residents a maximum of 24 hours of continuous on-site duty with up to four additional hours permitted for patient transfer and other activities ("24+4" policy). This is based on the new ACGME regulations.
3. No new patients after 24 hours of continuous duty.
4. At least an 8-hour, ideally 10-hour, period of rest and personal activities will be provided between all daily duty periods and after in-house call.
5. You will be provided with one day in seven free from all educational and clinical responsibilities, **averaged** over a four-week period, inclusive of call. One day is defined as a continuous 24-hour period free from all clinical, educational and administrative duties.

I. Moonlighting

Moonlighting is permitted for PGY-3's as long as it is approved by the Program Director. Moonlighting is NOT permitted while residents are on rotations that take call (e.g. Wards, ICU) or for residents on remediation or probation. The Residency Review Committee (RRC) requires that residents do not work more than 80 hours in one week, which includes moonlighting hours. If this is exceeded, corrective action will be taken. Outside activities must not interfere with the resident's performance in the educational process or duties at OVMC. Please do not take moonlighting shifts that require you to leave Clinic or Consult Services. Prior to starting moonlighting at any location, you must inform the Program Director and obtain permission.

J. Absences/Leave Policy

1. **General Policy:** UCLA-Olive View Residency Program allows each resident to take 4 weeks (28 days) off per year of training to be used for vacation time, parental leave, or illness. Any additional time that is missed is subject to review by the CCC, and additional training time may be required to ensure ABIM training requirements are met prior to sitting for the ABIM certification exam. Days off for fellowship and job interviews are not included in this 28 days up to a total of 35 days per ABIM academic year. In the interest of fairness, preliminary interns are held to the same standards as categorical trainees.
2. **Annual Leave / Vacation:** Each resident is given one 28-day or two 14-day paid vacation blocks each academic year. These are placed in the rotation schedule and cannot be changed without written acknowledgement and permission from the Chief Residents or Program Director.

3. **Unexpected Absences:** All unexpected absences must be immediately reported to the Chief Resident. For personal or family illness or tragedies, determination of time off and educational training requirements will be made on a case by case basis. The type and duration of payback is at the discretion of the Chief Residents and Program Director.
4. **Expected Absences:** All non-scheduled but expected absences (such as job interviews, doctor's appointments, jury duty, weddings, etc.) must be approved by the Chief Residents, at a minimum of 6 weeks in advance. Attempts should be made to schedule these absences on days when you are not working (weekends, days off, during vacation or research time). For time taken away from work, make-up days will be arranged with the assistance of the Chief Residents. Jury duty time does not need to be made up. Jeopardy is an assigned part of your clinical duties. Jeopardy will be assigned by the Chiefs Residents based on resident availability and program need. When on Jeopardy, you must carry your pager and be available for all clinical duties if called in. **You must be able to assume your duties within 90 minutes of being called in for Jeopardy.**
5. **Extended Illnesses:** If you become unable to perform your duties due to physical or mental disability, you must inform the Chief Resident and/or the Program Director as soon as possible. You may be asked for confirmation from your physician, and may require a statement that you are able to return to work. If you use up all vacation time, you can be placed on "disability." Any time missed that is not covered by vacation and the Deficit of Required Training waiver will be made up when you return to work. Quantity and type of work are at the discretion of the Program Director. Please note that if you make up time that you have already been paid for, you will not be paid again.
6. **Maternity:** Please refer to resident contract . All Maternity leave must be approved by the Program Director. Time above the allotted ABIM allowed time away from residency per year will need to be made up upon return from maternity leave.
7. **Paternity:** Please refer to resident contract. All Paternity leave must be approved by the Program Director. Time above the allotted ABIM allowed time away from residency per year will need to be made up upon return from paternity leave. .
8. **Other Work Absences:** If you are not on vacation or approved leave, it is expected that you will be at work. Any time missed that is not approved by the Chief Resident will be "made up." This includes religious holidays that are not approved program holidays. It is not acceptable to simply ask your attending for the day off. The Chief Resident must approve all unscheduled absences. Anyone found to take unscheduled time off without permission will face disciplinary action, including potential academic probation, and will have to explain their actions to the Program Director.
9. **Confidentiality:** The nature of all illnesses will be treated as confidential, unless you give permission to reveal it. If at any time the Program Director feels that you are physically or mentally impaired, you may be required to seek medical help. These results will be confidential; the Program Director will only require a statement that you are or are not able to work without endangering yourself or patient welfare. Also see below "Stress in Medical Training" regarding the confidential **Residents' Assistance Program (RAP)**.

K. Stress in Medical Training

We recognize that internship and residency can be very stressful. There are long hours of hard work dealing with very ill patients. Some patients die, through no fault of the physicians caring for the patient. When the workload is heavy, or the patients are particularly demanding, one may frequently feel irritable, frustrated and fatigued. It is totally normal for you, especially in the early days of training, to feel insecure and feel a lack of confidence in your clinical skills. We guarantee that if you experience such feelings, you are not alone. On the brighter side, there are also periods of great satisfaction, especially as you experience patients improving, as well as your own personal and professional growth.

However, if you have any persistent feelings of depression, sadness or questioning of your career goals (and this is not uncommon) please tell someone. Feel free to talk with the Program Directors, the Chief Residents, your attending, or Academic Mentor.

If there are any emotional or physical problems you consider serious, please contact someone immediately. There is a confidential **Residents' Assistance Program (Behavioral Wellness Center)** that you can contact if you do not wish the program to be aware of your personal situation. This program offers a psychological evaluation and referral for medical students and residents. It is confidential, free, and available for emergencies 24 hours a day. The telephone number at UCLA is (310) 825-9605. If you are not able to obtain an appointment through the Wellness Center, please contact your individual insurance plan for a mental health provider in your network. In addition, the Helping Healers Heal program and the "Medical Staff Aid Committee" at Olive View-UCLA Medical Center are also available for residents. Please see the residency website for details.

The following are a few helpful hints about stress and stress reduction as a House officer:

1. Your family, close friends, and fellow residents are an important source of strength and support during training. Keep close ties to them.
2. Adequate sleep and time off is important to your physical and mental well-being. The Program has tried to optimize this as much as possible, but there will be times of extra stress that may result in sleep deprivation. Be aware of this, and make sure that you get appropriate amounts of sleep when off duty.
3. Physical health and recreational activities are essential. Regular exercise decreases stress and fatigue, and enhances your overall mental acuity. It is not uncommon for residents to gain weight during internship. An early awareness of this problem and adherence to an exercise program and balanced diet will help.
4. Organize your time to be more efficient. This will save you a significant amount of time, decrease your stress level, and enhance your overall educational experience.
5. Periodically re-evaluate your goals and progress. Also, examine your expectations and discuss them with others (family/friends/faculty) to verify how realistic these expectations are.
6. Although alcohol and drug abuse is not found in physicians at a higher rate than the general population, this can still result in a significant number of physicians who may have a substance abuse problem. Do not turn to alcohol and drugs during times of increased stress. It doesn't help. If you feel you may be developing a problem, please speak to the Program Directors or Chief Residents for confidential counseling and referral. Or, contact the UCLA Behavioral Wellness Center (see contact information above in Stress in Medical Training).
7. Financial problems can be a great source of concern. Strategize expenses ahead of time. Let us know early if you are having problems. There are some programs we may have access to.
8. Remind yourself at all times that you did not give your patients their disease, and you are not the one responsible for it. Sometimes our patients die, through no fault of our own. It can be just as rewarding to help someone with the death process when it is inevitable, as it is to cure someone with a different disease.
9. Strengthening your religious or spiritual ties can be helpful, especially when dealing with critically ill patients. The hospital chaplains are available for counseling in most faiths. Please talk to others. You are not alone!
10. Remember that none of us are perfect. Mistakes will be made. By being appropriately compulsive you will avoid most big errors. If you do make an error in judgment, learn from it. Do not dwell on feelings of guilt. If you were perfect and knew everything, you wouldn't be in a training program.
11. When patients are sick, they also become easily frustrated and angry. Remember to try to remain objective and treat the difficult patient with compassion. Do not let personality or social judgments interfere with your medical care.

Although not always appreciated while you're in training, your residency will be one of the most rewarding and fulfilling times of your career. If there are any problems interfering with your well-being or your educational experience, please feel free to contact the Program Director, Associate Program Directors, or Chief Residents.

L. Procedures

Learning how to perform certain procedures appropriately and safely is a required part of training in Internal Medicine. All housestaff must have adequate and appropriate documentation of procedures that have been performed. Without such documentation, you will not be allowed to perform procedures independently. In addition, the Program Director will not be able to certify you for privileges in your future employment. Once a required number of procedures have been satisfactorily completed with supervision, you are rated as "competent" to do the procedure independently and to directly supervise or teach that procedure if you feel comfortable to do so. You are able to use one successfully completed simulation procedure toward your procedure requirement for central lines, arterial blood gas draws (ABG's), paracentesis, and thoracentesis.

ABIM and RRC expect residents to be competent with regard to knowledge and understanding of a larger set of procedures (arterial line placement, arthrocentesis, central line placement, incision and drainage of abscess, lumbar puncture, nasogastric tube placement, paracentesis, thoracentesis, and pulmonary arterial catheter placement). Residents do not need to demonstrate competency in performing these procedures on actual patients to sit for the ABIM. However, residents will need to demonstrate competency on patients before they can perform or teach any of these procedures independently, and it is the program's policy that residents demonstrate competency prior to graduation by performing certain procedures on actual patients. Please refer to the separate Medical Procedures Competency Requirements document for further details.

M. Needle Stick Protocol (Olive View-UCLA Medical Center)

For any needle stick, you must contact your supervisor (attending, Chief Resident or Program Director) and then immediately report to Employee Health Services (EHS) – (747) 210-3403. If the EHS is closed, report to the Urgent Care during business hours or the Emergency Department after hours You may be directed to go to UCLA to seek care as you are a UCLA employee.

N. Things to Notify the Program Director or Chief Residents about ASAP

1. Your attending does not let you out of clinic or rounds on time so that you can attend lecture.
2. You feel that you are not learning or the program is not meeting your expectations.
3. You have a medical condition that prevents you from working or perceivably will do so.
4. You are worried about impairment in yourself, a colleague, a faculty member, or a student.
5. You feel overwhelmed for any reason.
6. You are worried you can not perform expected duties for any reason.

O. Things to Avoid & Things That Will Get You in Trouble

1. Missing or coming late to lectures, conferences, clinics, and clinical assignments.
2. Signing in for lecture and then leaving.
3. Switching continuity clinic (having someone else do yours) without approval from the Chief Resident.

4. Unexcused absences.
5. Making a schedule change without written approval (all schedule changes should be in writing).
6. Deciding a clinic does not need your services and leaving without asking the attending first
7. Not answering your pager, particularly when you are on Jeopardy.
8. Being unconcerned about the welfare of your patients/peers.
9. Inappropriate documentation.
10. Incomplete evaluations
11. Unprofessional attitude/behavior towards colleagues, attendings, staff, or patients.
12. The Chief Residents not knowing where you are when you are scheduled to be at work
13. Not recording your duty hours in a timely fashion! This is an ACGME compliance issue.

This list is not all-inclusive. "Trouble" can be anything from an informal reprimand to academic probation.

P. Evaluation, Promotion, Problem Resolution and Due Process

The purpose of the following is to describe the evaluation and feedback system, the expectations of the program, and the procedures followed if a resident is unable to meet the program's expectations. It also describes the residents' rights of appeal.

1. Evaluation and Competencies

a. Residents are evaluated on an ongoing basis. For each rotation, you will be evaluated by your attending and other residents at different levels of training. For much of the following discussion, the word "resident" implies to all levels of residents (including interns).

b. You will be expected to complete evaluations of medical students, other residents, attendings, and the rotation itself. All comments you make should be constructive (i.e. should be considered "feedback," which means commenting on specific issues in order to help improve performance). If someone is really not good at something, this needs to be noted. It is the only way things can be improved. Positive comments are also an important part of constructive feedback. The evaluations will be completed using the MedHub online system at **https://oliveview.medhub.com**. Expect these evaluations after every rotation.

c. It is an expectation of the program that you will complete evaluations in a timely fashion. Most faculty and residents value feedback, and it is most effective when delivered immediately. Evaluations on you are held in strict confidence, and are only available to the Program Directors and faculty members of the Clinical Competency Committee (CCC).

d. **Clinical Evaluation Exercise (Mini-CEX forms):** You need to complete three (3) of these for each year of training. This needs to be arranged with an attending who will directly observe you perform part of a history and/or physical exam and give you feedback. The attending does not need to observe you complete an entire H&P (hence, the name "mini"-CEX). However, you cannot just go to an attending to whom you have presented a case in the past and ask him or her to complete the form. No one benefits from that. For example, let's say you were taught the cardiac exam wrong. How are you going to know if no one ever watches you? In addition, you will teach medical students an inappropriate examination. Cheating on the mini-CEX is an example of unprofessional conduct.

e. In addition to evaluations from attendings and residents, the program holds **Clinical Competency Committee (CCC) meetings**, composed of the Associate Program Directors and Core Clinical Faculty. All evaluations are discussed and reviewed in this committee, and also discussed with the trainee, in order to provide specific

feedback regarding progression and performance in residency. The CCC may also recommend to the Program Director whether residents should be continued on in the training program, held back, or require remedial education or probation. If an action is required on a resident's performance, the committee will vote on the plan, and the PD or APD will alert the resident or discuss it during CCC.

f. At various times, the Program Directors may receive informal evaluations or comments about a resident. These may be discussed with the involved resident, but will not be the sole basis of any action taken without written documentation or other corroborative data.

g. You will be evaluated on 6 core competencies, which are mandated by the Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committee (RRC) for Internal Medicine. The 6 core competencies above are further subdivided into 22 milestones, which are mapped to your evaluations in MedHub, and are further reported to the ACGME every 6 months. The core competencies are defined as follows:

   i. **Patient Care (PC):** "Residents are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life." (This competency includes histories, physical examinations, procedural skills, clinical organization and efficiency, and overall patient care as described.)
   ii. **Medical Knowledge (MK):** "Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and to apply this knowledge to patient care and the education of others."
   iii. **Interpersonal and Communication Skills (ICS):** "Residents are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams."
   iv. **Professionalism (PROF):** "Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practices, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession and society."
   v. **Practice-Based Learning and Improvement (PBLI):** "Residents are expected to use scientific evidence and methods to investigate, evaluate, and improve patient care practices." (This competency can be best explained by the analogy of holding yourself up to a mirror and "self-reflecting." That is, identifying your own weaknesses and that of your patient care. Developing strategies for improvement of your own patient care, learning from errors, and using evidence-based medicine and information technology for self-improvement are all part of this competency.)
   vi. **Systems-Based Practice (SBP):** "Residents are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care." (This competency is almost the opposite of Practice-Based Learning and Improvement. That is, instead of self-reflection, you need to look at the system of care around you. This involves utilization review, resource and cost issues, different practice types and delivery systems, collaboration with other healthcare team members, and approaches to improving systematic processes of care.)

2. Feedback

a. During or after each rotation, the attending physician will meet with you to discuss your performance. If you are having problems on the rotation, the attending should meet with you as soon as possible, identify any problems, and give suggestions for corrective action. We encourage you to take initiative and ask your attending or resident for feedback as early as possible. This will greatly facilitate timely feedback and is always considered appropriate. On occasion, your attending may request assistance in giving feedback from the Program Director or Chief Residents.

b. You will meet with the CCC two times per year. The written summary of the discussion becomes part of your permanent academic record. If you wish, you may obtain a copy of the written summary and access your file at any time

3. Promotion

a. The program expects you to pass each rotation. Any evaluations below expectations will be discussed with the Program Director or at the CCC meetings. A decision about corrective action will be made by the CCC and/or Program Director, based on your overall academic performance. The action taken will follow the due process, outlined below.

b. In order to be promoted from one year to the next, you are expected to complete all program requirements successfully. You may be asked to make up any rotations that were not completed satisfactorily, prior to receiving credit for that year of training. If you do not complete all of your rotations successfully, you may be asked to repeat the year. Additionally, if it is the overall assessment of the Clinical Competency Committee that you are not performing at the expected level, additional training may be recommended or required. Additionally, the program expects that you complete your call duties, dictations and continuity clinic responsibilities successfully. Failure to perform these duties may result in denial of credit for part or all of the year.

c. If you are unable to safely take care of patients for any reason, the Program Director and/or Clinical Competency Committee may take action. If physical or mental impairment is suspected, you may be required to seek professional evaluation prior to continuing your training. This decision may be appealed, as outlined below.

d. Every 6 months (December & June), the CCC and Program Director will assign you a final evaluation. This evaluation will be based on the data collected as described in the evaluation process. Throughout the year, you can view your evaluations online, and will have meetings with the CCC regarding your performance. If you receive an *unsatisfactory* overall rating you may not receive credit for that portion of the year. You will be notified of this rating in writing, and you will be required to meet with the Program Director or Associate Program Director. You have the right to appeal an unsatisfactory rating, as outlined below. Usually, you will have been placed on *probation* or *problem remediation*. However, there are times when a resident's overall performance was unsatisfactory, but there was not an opportunity or reason to place that resident on probation or problem remediation (e.g. a resident fails the last two rotations). The program has no responsibility to provide extra training or funding to individuals who have received an unsatisfactory rating. Lastly, the program may decide to assign a *marginal* rating to a resident. This describes a resident who has barely met the requirements of the training program, or is performing at a lower than expected level. This resident will continue on in the program, and will receive credit for training. You have the right to appeal an *unsatisfactory* or *marginal rating*.

4. Problem Resolution and Due Process

If you are not able to perform your duties at the level expected by the program, there is a set course of procedures that is followed. This guarantees that your rights are preserved, while maintaining the integrity of the program. This procedure is called ***due process***, and works as follows:

a. A problem with a resident is identified and brought to the attention of the Program Director and/or Clinical Competency Committee. The Program Director or designee discusses the problem with the resident and explores all involved issues, viewpoints, as well as possible etiologies for the perceived problem. If needed, a corrective plan is developed between the resident and the Program Director/designee.

b. If the problem does not improve or was of a very serious nature, the resident can be placed on *problem remediation*. This requires a majority vote of the Clinical Competency Committee, as well as agreement by the

Program Director. A plan will then be developed with specific recommendations for action. The resident will be given a copy of the plan, and it is his/her responsibility to comply with the recommendations.

c. The Program Director or faculty designee will then meet with the resident at a specified interval to review the resident's progress. If the problem has been resolved, it will be noted in the Clinical Competency Committee minutes. If it is ongoing, the resident will be continued on *problem remediation*. If the resident has not complied with *problem remediation*, he/she may be put on *probation*.

d. *Probation* is an opportunity period for a resident to bring his/her performance up to a satisfactory level with the aid of more intensive counseling and monitoring. A resident may be placed directly on *probation* (without *problem remediation*) if the perceived problem is of a serious nature. Probationary status will be reviewed and approved by the Clinical Competency Committee, and forwarded to the chair of the Graduate Medical Education Committee (GMEC; see below). When a resident is placed on *probation*, a written record of the discussion is made. The written record will include a precise delineation of the problem(s), the expectations that the program has of the resident, and the actions that will ensue if the expectations are not met in a specified period of time. The resident should sign this documentation. If the resident refuses to sign, a witness will be obtained and the refusal to sign will be so noted. If no witness is readily available, or the resident is unable to wait, the Program Director will document this on the probation summary. If the resident does not sign the probation summary, the Program Director must indicate whether or not the resident agreed with the *probation*. If not, then the issue should immediately be brought to the attention of the Clinical Competency Committee. In signing that he/she has received the terms of the *probation*, the resident may indicate that he/she does not agree with the listed problems (if so, the probation should be appealed to the CCC and GMEC). The Program Director or designee will report the results of probationary counseling to the CCC.

e. The term of *probation* is usually three or four months, but may vary, depending on the perceived problem. The outcome of probation is usually one of the following, although it is not limited to those listed:

   i. The *probation* is successfully completed, with the resident performing at an acceptable level in the problem area. The resident continues on in the program without additional training required.
   ii. The resident does not perform at an acceptable level and he/she is continued on *probation* for a specified time period.
   iii. The resident is continued on in the program for the remainder of the year, but their contract is not renewed for the following year of training. The resident may or may not be given credit for the year of training. This is to be specified in the terms of *probation*.
   iv. The resident is continued on in the program, but is not given credit for a specified amount of time. Generally, this is the entire year of training. This decision is sometimes made by the ABIM or the GMEC.
   v. A resident's *probation* is part of their official record, and outside agencies may request information about any probationary status. Probationary status may negatively affect medical licensure and/or hospital privileges. Since records of *problem remediation* may not be officially available to outside agencies, the program will always try to solve academic difficulties with *problem remediation* first.

5. Grievance Procedures and Due Process

You may appeal a negative evaluation or *probation* at any time. This process is not mandatory nor should it be considered adversarial, and you have the right to expect confidentiality in all such actions. The grievance process (as outlined in the "Resident Letter of Agreement" signed by the intern at orientation), is summarized as follows: the resident should first discuss his/her grievance with the Program Director. If the resident desires a further hearing, he/she may address the chair of the GMEC, the next level of appeal. (The GMEC is comprised of representatives of all of the various training programs based at the Olive View-UCLA Medical Center. It includes resident representation as well.) If the resident wishes to appear before the GMEC, the request must be made in writing. At the GMEC meeting, the resident will be given an opportunity to take issue with the Program Director's assessment of their competence,

call witnesses in support of his/her position, submit written and signed witness statements, and/or provide other additional evidence. The Program Director will also call witnesses or present written evidence. The resident is allowed to bring a representative of choice, such as an attorney or friend, who may aid and counsel the resident. However, there is no cross examination and an attorney may not directly participate in the process. The GMEC will listen to the evidence, and then vote to uphold or revise the Program Director's assessment of the resident.

6. Premature Dismissal and Temporary Suspension

If the Program Director believes that the retention of a resident would jeopardize patient care or welfare, or that the resident should not be permitted to continue with his or her responsibilities for some other serious reason, the resident can be temporarily suspended at once. If requested, the case should be taken up as soon as possible by the GMEC, pursuant to the above grievance procedures. Such a temporary suspension may also follow a probationary period in which the resident failed to meet the stated standards. After a temporary suspension, the resident can either be returned to duty, or dismissed from the program (pursuant to grievance to the GMEC).

7. Withholding Approval to Take the ABIM Certification Exam

You will be informed in writing if, based on your academic performance, conference attendance, humanistic qualities or other reason, you are not being certified to take the exam. All such actions can be appealed to the GMEC, as outlined above.

You need to be aware that the ABIM makes the final decision about whether or not individuals are allowed to take the examination. For example, the ABIM will not allow someone to sit for the boards if any of their third-year ratings are below satisfactory. Thus, it is conceivable that a resident will graduate from the program, but will be required by the board to do extra training prior to taking the examination. The program has no control over this decision. As stated above, the resident may appeal the program's assessment of his/her competency.

8. Institutional Standards

You are also required to follow all standards of the institutions at which you are working. If a behavior warrants corrective action, but is not of an academic nature, you may receive counseling from an institutional representative as opposed to the residency Program Director. These institutions also have due process policies, which will be followed in those situations.

Q. Salary

The annual salary for a PGY-1 through PGY-3 Resident physician is as follows (as of 7/1/2018): updates on July1, 2020 ← CHANGE DATES

Rank	Step	Annual Total	Monthly
Resident Physician	**I**	$61,903	$5158.58
Resident Physician	**II**	$63,955	$ 5329.58
Resident Physician	**III**	$66,468	$5539.00

R. Zoom Guidelines for Didactic Sessions

As we continue to navigate e-learning and try to maximize the use of technology in medical education, the UCLA- Olive View Internal Medicine residency and fellowships ask learners and instructors to follow these basic guidelines.

Learners:

- Plan for a quiet space. Treat your Zoom didactic as you would being in a classroom or small group learning session. Avoid doing other tasks during the session.
- Primary light source should be in front of you head, not at the back when possible
- Use a headset with microphone to provide improved audio quality
- Please mute your audio when entering the meeting and unmute when instructed by the facilitator. Mute yourself when not speaking and become familiar with how to mute and unmute quickly.
- Place your video on during the session to engage more fully with the instructor and participants.
- For a chat message, chose a target: either to a specific person or to everyone

Section III. Sample Evaluation Forms

1. Mini-CEX
2. Program Feedback Worksheet
3. Program Progress Form
4. Resident Self-Evaluation Worksheet

Mini-CEX Policy: All residents and interns (categorical and preliminary) need to complete 3 Mini-CEXs before each year of training is completed. Arrange for an Attending faculty to observe you do a history and/or physical exam (or part of a history or exam), and give you feedback. Submit a copy of the completed Mini-CEX to the Dept. of Medicine to put in your file, or give it to your Academic Advisor.

Mini-Clinical Evaluation Exercise (CEX)

Evaluator: _____ Date: _____

Resident: _____ O R-1 O R-2 O R-3

Patient Problem/Dx: _____

Setting: O Ambulatory O In-patient O ED O Other_____

Patient: Age: _____ Sex: _____ O New O Follow-Up

Complexity O Low O Moderate O High

Focus: O Data Gathering O Diagnosis O Therapy O Counseling

1. Medical Interviewing Skills (O Not observed)
   1 2 3 | 4 5 6 | 7 8 9
   UNSATISFACTORY | SATISFACTORY | SUPERIOR

2. Physical Examination Skills (O Not observed)
   1 2 3 | 4 5 6 | 7 8 9
   UNSATISFACTORY | SATISFACTORY | SUPERIOR

3. Humanistic Qualities/Professionalism
   1 2 3 | 4 5 6 | 7 8 9
   UNSATISFACTORY | SATISFACTORY | SUPERIOR

4. Clinical Judgment (O Not observed)
   1 2 3 | 4 5 6 | 7 8 9
   UNSATISFACTORY | SATISFACTORY | SUPERIOR

5. Counseling Skills (O Not observed)
   1 2 3 | 4 5 6 | 7 8 9
   UNSATISFACTORY | SATISFACTORY | SUPERIOR

6. Organization/Efficiency (O Not observed)
   1 2 3 | 4 5 6 | 7 8 9
   UNSATISFACTORY | SATISFACTORY | SUPERIOR

7. Overall Clinical Competence (O Not observed)
   1 2 3 | 4 5 6 | 7 8 9
   UNSATISFACTORY | SATISFACTORY | SUPERIOR

Mini-CEX Time: Observing _____ Mins Providing Feedback _____ Mins

Evaluator Satisfaction with Mini-CEX

LOW 1 2 3 4 5 6 7 8 9 HIGH

Resident Satisfaction with Mini-CEX

LOW 1 2 3 4 5 6 7 8 9 HIGH

Comments: _____

_____ _____

Resident Signature Evaluator Signature

Program Feedback Worksheet

(revised 1.25.17)

Resident: **, M.D.**	Track: Level: **PGY-**	Academic Year: **2017-2018** Evaluation Period: Meeting Date/Time:
Faculty: **Drs.**		

I. ACGME Milestone Evaluations

COMPETENCIES/MILESTONES	CCC Rank*	Resident Rank*	Comments (especially for discrepancies)
PATIENT CARE			
PC1: Synthesizes accurate information			
PC2: Comprehensive mngmt plans			
PC3: Progressive responsibil & indep			
PC4: Procedure skills			
PC5: Consultative Care			
Other: Efficiency; prioritization skills			
MEDICAL KNOWLEDGE			
MK1: Clinical knowledge			
MK2: Diagnostic tests & procedures			
SYSTEMS BASED PRACTICE			
SBP1: Works well in teams			
SBP2: Recognizes & acts on errors			
SBP3: Cost-effective care			
SBP4: Patient transitions			
Other: Message center upkeep			
PROBLEM BASED LEARNING & IMPROVEMENT			
PBLI1: Monitors practice to improve			
PBLI2: Improves w/ performance audit			
PBLI3: Improves with feedback			
PBLI4: Learns at point of care			
PROFESSIONALISM			
PR1: With patients & team members			
PR2: Responsible; follows through			
PR3: Responds to pt's unique needs			
PR4: Integrity; ethical behavior			
INTERPERSONAL COMMUNICATION SKILLS			
ICS1: With patients & caregivers			
ICS2: In interprofessional teams			
ICS3: Health Records/documentation			

*** Rank: 1** (critical deficiency), **2** (early learner), **3** (advancing as expected/demonstrating improvement), **4** (ready for unsupervised practice/graduation), **5** (aspirational/expert/role model) **(can use 0.5 ranking)**

Expect: 2.0-2.5 for early PGY1, **3.0** for late PGY1 - PGY2, **3.0-4.0** for early to late PGY3

Overall Comments:

II. Other commendations (e.g., leadership, teaching, academics):

III. Summary of other Program Requirements (modules, attendance, Mini-CEXs, procedures, etc.):

Hopkins Modules: /
Ambulatory Didactics: %
Noon Conference: %
CEX:
ITE: R1: % / %ile
R2:
R3:

IV. Milestones and Progress Summary:

[ ] Meeting all milestones and requirements to progress to next level of training

[ ] Other:

V. Specific Recommendations

Program Progress Form

(Revised 1.25.17)

Resident, Degree						
Meeting Dates:	PGY1: Mtg 1	PGY1: Mtg 2	PGY2: Mtg 1	PGY2: Mtg 2	PGY3: Mtg 1	PGY3: Mtg 2

I. Career Goals: **Mentor:**

1.

2.

II. Performance Improvement Project (PGY1): Pod:

Project:
Resident Role:

III. Academic/Scholarly Project (categorical residents):

Type (research, poster, publication, etc.)	**Title/Description**	**Mentor/PI**

IV. Sr. Talk (PGY3): **Mentor:**

V. Completion/Attendance:

	PGY1		**PGY2**		**PGY3**	
	1st Mtg	2nd Mtg	1st Mtg	2nd Mtg	1st Mtg	2nd Mtg
Hopkins Modules	/	/	/	/	/	/
Ambulatory Didactics	%	%	%	%	%	%
Noon Conferences	%	%	%	%	%	%
ITE Scores (score / percentile)	/ %ile		% / %ile		% / %ile	
Mini-CEXs (3/year)						
Procedures* (categoricals):						
Place peripheral IV (5)						
Draw venous blood (5)						
Draw arterial Blood (5)						
Arterial lines (3)						
Central lines (5)						
LPs (3)						
Paracentesis (3)						
Pap smears (5)						

* Running total of procedures completed *(only required procedures listed here*

Resident Self-Evaluation Worksheet

(revised 1.25.17)

Resident: **Resident, Degree**	Track: Level: **PGY-**	Academic Year: **2017-2018** Evaluation Period: Meeting Date/Time

I. Competency/Milestone Evaluations

Please rank yourself on the following 6 competencies. They are subdivided by individual ACGME Milestones for explanation. Choose one rank that best matches your evaluation of the competency using the ranking scale below. Comment on your perceived areas of strength or weakness.

1 = deficient
2 = early learner
3 = advancing as expected/demonstrating improvement
4 = ready for unsupervised practice/graduation

Can use 0.5 ranking (e.g. 2.5, 3.5) for "inbetween" ranks
Expectation: 2.0-2.5 for early PGY1; **3.0** for late PGY1 - PGY2; **3.0-4.0** for early to late PGY3

COMPETENCIES (with ACGME Milestones)	**Rank**	**Comments** (Areas of strength or needs improvement)
1. Patient Care Synthesizes accurate information Comprehensive management plans Progressive responsibility & independence Procedure skills Consultative Care Efficiency; prioritization skills		
2. Medical Knowledge Clinical knowledge Diagnostic tests & procedures		
3. Systems Based Practice Works well in teams Recognizes & acts on errors Cost-effective care Patient transitions ORCHID message center upkeep		
4. Problem Based Learning & Improvement Monitors practice to improve Improves with performance audit Improves with feedback Learns at point of care		
5. Professionalism With patients & team members Responsible; follows through Responds to patient's unique needs Integrity & ethical behavior		
6. Interpersonal Communication Skills With patients & caregivers In interprofessional teams Health Records/documentation		

II. Procedures (required) - *Include # of total completed procedures:*

Place Peripheral IV (5):	Arterial Lines (3):	Paracenteses (3):
Draw Venous Blood (5):	Central Lines (5):	Pap Smears (5):
Draw Arterial Blood (5):	Lumbar Punctures (3):	

III. Program Requirement Reminders:

	PGY1	PGY2	PGY3
Hopkin's Modules	≥80%	≥90%	≥90%
Amb AM Didactics	≥100%	≥100%	≥100%
Noon Conferences	≥70%	≥70%	≥70%
PI Project	1		
Mini-CEXs*	3	3	3
Scholarly project	Complete scholarly/academic project by graduation		
Senior talk	Scheduled during last half of PGY3 year		

* Bring your Mini-CEXs to these meetings or turn in to the Dept. of Medicine

IV. Self-Reflection

Please reflect on the above competencies/milestones, requirements, and your experiences over the last ~ 6 months, and write your impression for each of the following:

How am I doing? (circle) Feel uncomfortable Feel comfortable Feel very comfortable

Need improvement: (circle) A lot Some Little to none

a. My strengths:

b. Areas I need to improve:

c. Specific strategies to improve: