# FACULTY MANUAL

## Naval Medical Training Center - Portsmouth Emergency Medicine Residency Program

AY 2022-2023

CDR Daphne P. Ponce, MD | Program Director
CDR Levi K. Kitchen, MD | Department Head
LT Eric F. Sulava, MD | Research Director

# A Message from the Department Head

Welcome to Naval Medical Readiness and Training Command Portsmouth, The First and Finest! You were selected to join the staff here based on your experience and projected success fulfilling this challenging billet. As staff Emergency Physicians, we are the leaders of this department responsible for providing outstanding care to our beneficiaries. In addition, we cultivate the future of Navy medicine through training and mentorship across the entire spectrum of Navy medicine. This will be a challenging assignment with endless opportunities to excel in areas such as academics, research, leadership and operational support. With this amazing opportunity comes the responsibility to set the standard for professionalism throughout our department and the hospital. Work hard, support each other and prioritize your personal life away from work; do these things and you will be successful here.

As soon as possible, make an appointment to meet with myself, our Emergency Medicine Residency Program Director CDR Daphne Ponce and our Senior Medical Officer LCDR Max Noe to discuss your roles and responsibilities within the department and residency program.

Welcome aboard!

CDR Levi K. Kitchen, Department Head

# A Message from the Residency Program Director

Welcome to Naval Medical Readiness Training Center - Portsmouth! You have been selected over your peers to join our faculty due to your academic contributions and potential as an educator. Our residency program utilizes a team-based approach, with progressive levels of trainee responsibility, designed to slowly build residents into competent emergency physicians. Our faculty numbers are few, the work can be challenging but the vital part you play in the program is rewarding. The program prides itself for our family-like culture and you can count on your fellow faculty members to support your professional goals, provide guidance, and assistance in accomplishing our mission.

**Emergency Medicine is a team sport.**

NMRTC-P has tremendous opportunities for an academic physician. Our research infrastructure is the best in the Navy. NMRTC-P's Combat Trauma Research Group (CTRG) has won the Military Health System Research Symposium award for best Military Research Team in two of the last four years. We have a strong relationship with Uniformed Services University of the Health Sciences School of Medicine which offers academic appointments and faculty development opportunities. USUHS's convenient location, less than four hours north, allows our faculty and residents the ability to serve as training cadre for several rewarding training activities and field exercises. NMRTC-P also offers the Navy's only recognized faculty development program in Advanced Point-of-Care Ultrasonography. Additionally, the co-location of the Navy's only Global Health Engagement & Disaster Response Fellowship offers multiple overseas humanitarian assistance and global outreach opportunities each academic year. Please take advantage of all these opportunities while you are here to achieve your professional goals.

**Don't be a passive participant in your career.**

Training residents takes commitment and engagement. We definitely work hard and play hard. You will spend an exceptional amount of time with our residents and the faculty but the effort is worth it! Our training program activities foster camaraderie few other specialties in the institution and the Navy enjoy. You will develop friends, colleagues, and mentors that will support and advocate for you throughout your career. Enjoy these friendships and make the most of your tour.

**Welcome to the Family!**

CDR Daphne P. Ponce, Program Director

# Introduction & Getting Started

Welcome to the Naval Medical Training Center - Portsmouth Emergency Medicine Residency Program. You are now a member of a proud and prominent line of the nation's best and brightest Emergency Medicine physicians. The Naval Hospital Portsmouth saw its first patient in 1830 and is the oldest continuously running hospital in the Navy medical system. The Emergency Medicine Residency Program began in 1992. Since that time, our graduates have carried-on the "first to care" tradition throughout the globe.

This guide serves as an orientation to the residency program and outlines your role and responsibilities as a faculty member. Please review and keep for future reference. You are expected to abide by the expectations set forth.

Your initial POC when arriving to the ED is LCDR Noe, Senior Medical Officer, and your assigned department sponsor. Please be in contact with them regarding your arrival and check-in to the command. They can assist you in getting to the right place to stamp your orders and start the administrative check-in process.

In addition to the command check-in, you should meet the following people within your first month onboard:

1. Department Head – CDR Levi Kitchen (757-953-1406).

2. Senior Medical Officer – LCDR Max Noe (757-953-1373)

3. EM Residency Program Director – CDR Daphne P. Ponce (757-953-1407 or cell 618-201-5190).

4. Research Director (LT Sulava) and Research Coordinator (Amanda Osit) to apply for eIRB and complete required research certificates.

5. Ms. Marcia Gardner. Emergency Department Executive Assistant.

# Program Description and Aims

**Program Description**

The Emergency Medicine Residency Program at Naval Medical Center Portsmouth is an ACGME-accredited 48-month training program designed to prepare physicians to provide competent emergency care to Department of Defense beneficiaries anywhere in the world and under any circumstances. Compared to our civilian counterparts, Navy Emergency Physicians (EPs) must be more adaptable and self-reliant in order to perform under a variety of environmental conditions. Like our civilian colleagues, we must master emergency medicine core competencies in order to care for our active duty force, their children and spouses, as well as, veterans, retirees, and foreign military partners in military hospitals. Additionally, Navy physicians must provide tactical combat casualty care, extended forward resuscitative care, and damage control resuscitation in the austere operational environment. The program's educational curriculum develops physicians' cognitive expertise and procedural skill through multi-modal educational activities, including experiential clinical learning, lectures, small group discussions, high-fidelity simulated patient encounters, live tissue and cadaveric procedural laboratories, field exercises, and internet-based medical training. Recognizing that Navy physician success depends on more than medical knowledge and skill, our residency program builds medical leaders by developing trainees in operational medicine, program management, mentorship, education, negotiation and conflict resolution, and identifying team dysfunction through a dedicated military-unique curriculum.

**Program Aims**

1. We aim to develop Navy physicians into competent emergency physicians with sound skill sets, including acute resuscitation and stabilization, identification of life-threatening conditions, application of principles of symptom relief, determination of disposition and appropriate level of follow-on care, management of emergency department patient flow, and balancing customer service with resource allocation in order to be principled stewards of the public's welfare.

2. We aim to develop Navy physicians into expeditionary care providers capable of applying their cognitive expertise and procedural skill within any environment and healthcare system, including in-garrison care at military hospitals, the battlefield, and all austere environments in between, in order to fulfill our obligations as US Navy Emergency Physicians.

3. We aim to develop our trainee's leadership and managerial skills to facilitate our success as program champions and unit leaders within the US military and civilian business world.

# ACGME Faculty Requirements

**The Accreditation Counsel for Graduate Medical Education (ACGME)**

The ACGME accredits Sponsoring Institutions and residency programs, confers recognition on additional program formats or components, and dedicates resources to initiatives addressing areas of importance in graduate medical education. The ACGME employs best practices, research, and advancements across the continuum of medical education to demonstrate its dedication to enhancing health care and graduate medical education. The ACGME is committed to improving the patient care delivered by resident and fellow physicians today and in their future independent practice through clinical learning environments characterized by excellence in care, safety, and professionalism.

**ACGME Requirements for Core Faculty**

According to the ACGME, "faculty members are a foundational element of graduate medical education faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population. Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves."

The governing document for both resident and faculty requirements in emergency medicine residency training is the ACGME Common Program Requirements (available at https://www.acgme.org/). All faculty should be familiar with this document. According the Common Program Requirements (CPR), section II.B.2 "faculty members must:

a. be role models of professionalism;

b. demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care;

c. demonstrate a strong interest in the education of residents;

d. devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities;

e. administer and maintain an educational environment conducive to educating residents;

f. regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and,

g. pursue faculty development designed to enhance their skills at least annually: as educators; in quality improvement and patient safety; in fostering their own and their residents' well-being; and, in patient care based on their practice-based learning and improvement efforts."

According to the ACGME, section II.B.4, core faculty members are those faculty members who have "a significant role in the education and supervision of residents and devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents" and "core faculty members must be designated by the program director." The ACGME requires a minimum of one core faculty member for every three residents. For Academic Year 2022-2023 (AY22-23) we have 45 residents, our typical four classes of 10 residents plus five off-cycle PGY4+ residents. For this number of residents, we require 15 core faculty members. Because our program faculty is small compared to the number of residents we are responsible for and because of our frequent deployments and temporary additional duty draw our faculty away from the command so frequently, **all board-eligible/board-certified staff physicians assigned to NMRTC-P in the emergency department are designated as core faculty at the discretion of the program director**. Core faculty members must adhere to the ACGME and institutional requirements listed below; completion of the annual ACGME Faculty Survey is a requirement. Faculty billeted to 2$^{nd}$ Medical Battalion detachment at NMCP ("greenside") will be academic non-core faculty. Academic non-core faculty have the same conference/teaching requirements, but do not have an attendance or scholarly activity requirement.

Up until July 2019, core faculty members were capped by the ACGME at 28 clinical hours per week. "Core faculty members, must not work clinically more than 28 hours per week on average, or 1344 hours per year, whichever is less." For this clinical offset, faculty members were required to "at minimum produce at least one piece of scholarly activity per year (averaged over the past five years)" and "at minimum, this must include one scientific peer reviewed publication for every five core physician." Because the typical US Navy tour length is three years, in order to make the requirement enforceable, our program made the PubMed-listed publication requirement one scientific peer reviewed publication every three years for each core faculty member. Both the publication requirement and the 28 clinical hours per week cap have been removed from the Common Program Requirements by the ACGME in July 2019. **Although not required to do so, the departmental and program leadership are committed to upholding the pre-2019 core faculty clinical work hours cap for those faculty who still meet the publication and program function attendance requirements.** All new faculty are required to meet with the program director, program coordinator, and research coordinator (LT Eric Sulava) within 30 days of checking into the command to discuss their scholarly activity / publications and determine if they meet the criteria to be capped at 28 clinical hours per week. Therefore, you are expected to **<u>devote a minimum of 12 hours per week</u>**, outside your clinical shifts, to resident education (lectures, lecture prep, evaluations, mentorship etc.).

Program Faculty Requirements

| Metric | Conference Attendance | Journal Club Attendance | Scholarly Activity* | Publication* | New-Innov Evaluations |
|---|---|---|---|---|---|
| **NMRTC-P Requirement** | 20% | 20% | 1 work / academic Year | 1 article / 3 years | 100% (NLT 4 weeks post block) |
| **ACGME Requirement** | 20% | 20% | 1 work / academic Year | 1 article / 5 years | |

*"Scholarly activity" includes regional/national/international lectures, regional/national committee membership, teaching life support classes, text book chapters, non-peer reviewed publications, posters etc. "Publication" means peer reviewed and PMID indexed publication.

Departmental Faculty Requirements

| Metric | EMEC/CCC Attendance | Clinical Charts Locked | Peer Review Complete | Delinquencies (training/readiness) |
|---|---|---|---|---|
| **NMRTC-P Requirement** | 30% | 100% | 100% | 0% |

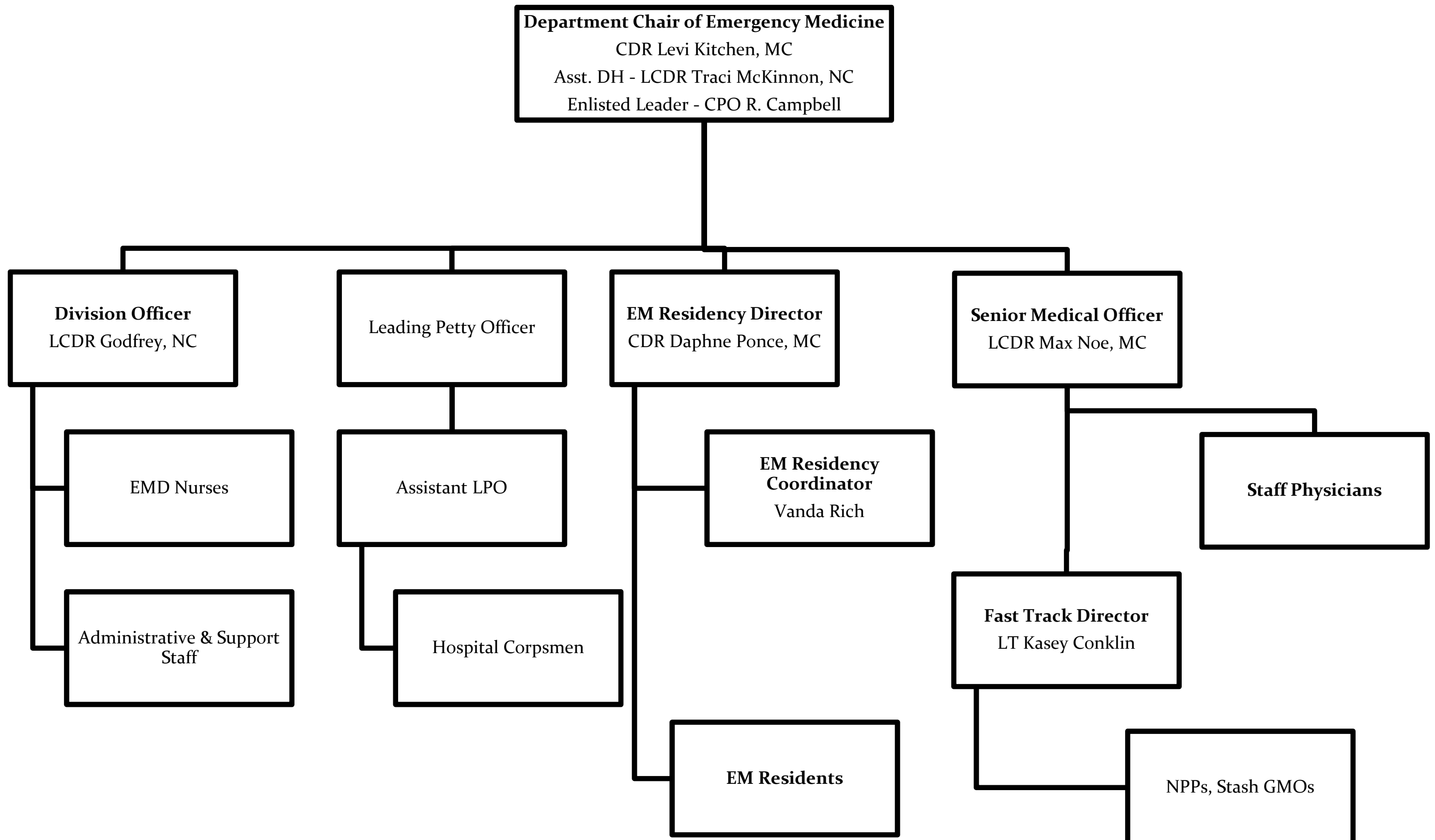
Faculty who have met the minimum requirements above are eligible for clinical shift reductions during faculty manpower surpluses. These metrics will be assessed every 3-6-months for a chance to earn this incentive. For new faculty, their first assessment of the above metrics will occur at 6-months on station. Similarly, for the first year on faculty, the publication (PMID indexed) requirement to attain this incentive is waived if all other metrics are met. Failure to meet minimum academic and departmental faculty requirements are grounds to revoke moonlighting privileges, revoke 28-hr/week cap and disapprove duty assignment extensions. Continued failure to meet basic requirements of academic faculty will result in increase of clinical shifts to 16/month, following written counseling.

**The ACGME Milestones**

To further define the 6 core competencies, the ACGME teamed with ABEM (the American Board of Emergency Medicine) to develop a set of 22 outcome-based developmental milestones within the core competencies. These milestones provide residents more transparent performance expectations, provide programs a developmental framework for resident evaluation, and provide the ACGME a framework for program monitoring. The EM-specific milestones can be found on the ACGME website available at: https://www.acgme.org/. Starting in July 2021

Program faculty are expected to participate in resident progression in their milestones. This includes assisting the APDs in assigning milestone values to the residents twice annually and linking clinical evaluations to milestones.

# Emergency Department Leadership




**Nurse Clinical Specialists** – LCDR Graeme Bannerman

**Quality Nurse Consultant** – Cathy Fox

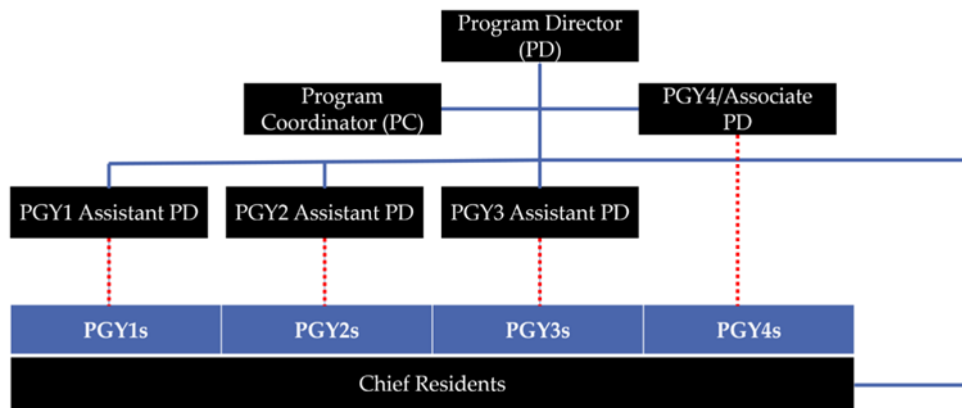
**Sexual Assault Nurse Examiner** – Michelle Ortiz

**EMD Executive Assistants** – Marcia Gardner, Vida Gibson

**Research Scientist** – Amanda Osit

# Residency Program Leadership

| | |
|---|---|
| 1. Program Director: | CDR Daphne Ponce, MD |
| 2. Associate Program Director: | LCDR Adam Bloom, DO |
| 3. Program Coordinator: | Ms. Vanda Rich |
| 4. PGY3 Assistant Program Director | LCDR Eric Koch, MD |
| 5. PGY2 Assistant Program Director | LCDR Jared Verga, DO |
| 6. PGY1 Assistant Program Director | LCDR Eric Schmieler, MD |
| 7. Chief Residents | LT Jessica Arrott, LT Robert Healy, & LT Kimberly Pistell |




In accordance with ACGME Common Program Requirements, the residency program director "must develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter, have the authority to approve program faculty members for participation in the residency program education at all sites, and have the authority to remove program faculty members from participation in the residency program education at all sites."

The program has four Assistant Program Directors (APD), one for each class. The APDs assist the Program Director (PD) and Program Coordinator (PC) in the education, evaluation, recruitment, and mentoring of emergency medicine residents and faculty, as well as, the administration and regulatory compliance of the Emergency Medicine Residency Program. His or her primary function is to oversee all matters pertaining to the trainees assigned to him or her. The APD will work directly with and

report directly to the PD. Each class APD who serves as an administrator, advisor, and mentor for his or her 10 residents. The PGY4 Class APD also serves as the Associate Program Director and Chair, Program Evaluation Committee (PEC). The PGY1 APD also serves as the Medical Student Clerkship Director, spearheading medical student education and recruitment activities. The program director and APDs have the following work requirements: "the program director must be provided with the salary support required to devote 50% FTE of non-clinical time to the administration of the program … each appointed assistant or associate program director must be provided with salary support to devote a minimum of 35% FTE non-clinical time to the administration of the program (ACGME CPR 2020 II.A.2 and II.A.2.a)). To mitigate the loss of APDs to TAD/deployments, we maintain four APDs to support the program and the shift reduction is split between them.

Additionally, an APD should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. Because military tour lengths vary but are generally three years in length, an APD should expect to function in their position for a minimum of two years.

The specific duties of the APD, within these specified domains, include:

1. Education

   a. assist faculty, adjunct faculty and residents with development of rotational goals and objectives

   b. recommend, advocate for, and implement educational changes to the program to address identified weaknesses

   c. develop and oversee the allocation of residents in their various rotations in order to satisfy ACGME and RRC requirements for successful completion of residency

   d. continuously re-evaluate the educational needs of the trainees as emergency medicine practice and the standard of care evolves

   e. aid residents in generating ideas, facilitate with mentor connection, and monitor progress in required scholarly and quality assurance/quality improvement projects

   f. review procedure logs in New Innovations to ensure adequate numbers of procedures are obtained for procedural skill acquisition

   g. organize, facilitate, and implement year-group specific educational modules

      1) PGY1 – Orientation

2) PGY2 – Orientation, Research & Evidenced-Based Introductory Learning (REBIL) Course

3) PGY3 – Operational Medicine and Resident Scholar Tracks

4) PGY4 – Academic Conference and CAPSTONE

h. identify subject matter experts for military unique curriculum lectures

2. Evaluation

a. evaluate the residency program (as a whole and designated year-group) annually to determine strengths, weaknesses, and adherence to educational objectives

b. evaluate specific rotations to determine strengths, weaknesses, and adherence to educational objectives

c. refine and maintain a system of competency-based evaluation of the residents by their attendings and supervisors

d. refine and maintain a system of competency-based evaluation of the attendings by the residents

e. refine and maintain a system of 360° competency-based evaluation of the residents by the nursing staff, corpstaff, and other services

f. monitor completion of evaluations by faculty

g. provide feedback to residents at least twice yearly during one-on-one meetings

h. complete the first draft of resident fitness reports and participate in resident tiering

i. participate in annual promotion boards

j. write student letters of evaluation (SLOEs) for students that request them (PGY1 APD)

k. serve on the Clinical Competency Committee

l. perform monthly chart review on residents

m. evaluate residents based on ACGME Milestones twice yearly

3. Recruitment

a. identify and recruit quality resident candidates

b. participate in the interview process

c. develop, refine, and maintain recruitment strategies

d. assist the residency coordinator with scheduling issues for medical students (PGY1 APD)

e. participate in offsite recruitment activities (these may involve travel)

4. Mentoring

a. ensure each resident has an assigned faculty mentor

b. ensure each intern has an assigned senior resident mentor

c. serve as a temporary mentor for residents assigned faculty on temporary additional duty or deployment

d. monitor the mentoring relationship and provide feedback for refinement

e. meet with each resident twice annually to ensure they are progressing academically (score milestones)

f. meet with residents on an as-needed basis to assist with problem solving and career counseling

g. advise the chief residents on faculty and career development (PGY4 APD)

h. advise the PD on faculty development needs and methods to meet those needs

5. Administration

a. interact and support the chief residents in their duties of administration of the rotation and call schedules, orientation, scheduling of lectures, problem-solving, and provision of resident support

b. attend weekly leadership syncs, when clinical schedule permits, to discuss residency-related issues

c. prepare for and participate in both internal and external reviews of the residency program by accrediting bodies and respond to any concerns or deficiencies that arise as a result of these reviews

d. assist in selection of residents for annual performance awards

e. meet with the PD and DH monthly at the EMEC/CCC to discuss programmatic issues

f. write letters of recommendation for residents applying for leadership, fellowship, and service school positions

g. ensure compliance with command requirements to include N95 fit testing, command training, command fitness requirements, PHAs, and others as necessary

6. Regulatory Compliance

a. ensure residents are logging procedures and duty hours

b. ensure residents are not violating duty hours rules and, if identified, address, and resolve this issue

c. ensure residents are meeting programmatic and RRC requirements to be eligible to sit for the board certification examination

# Clinical Work

This next section will help prepare you for what to expect when you start working clinically in the department.

**The Clinical Areas**: The emergency department has two areas, Fast Track and Mainside, patients are assigned by triage. The majority of your shifts will be on the Mainside. Fast Track is staffed by physician assistants and nurse practitioners (NPPs). Per hospital and DoD policy, NPPs independently evaluate and manage patients; they are able to consult the physician on the mainside when needed. Physicians do not co-sign the charts for patients seen in Fast Track, unless they are consulted. If you're consulted on a patient, you should open a separate supervisor note for that encounter.

**The Schedule:** The department has double attending coverage 18-hrs per day, with single coverage from 0000-0600. There are between 5 and 8 attending shifts per day depending on resident coverage. The times when there are no residents (Thursday conferences, Wednesday Journal Club, Wednesday Skills labs) there are extra ED physician or NPP shifts. Occasionally you may be assigned a D*, DS, JE, or N* shift during which you work independently floating to cover a lack of resident coverage. You may move from mainside to the Fast Track or the Flex rooms in triage to help move patients through the department. The times for the shifts are noted on the schedule.

Our physicians routinely have a total of 14 shifts per calendar month; however, that may be increased in times of under-manning secondary to deployments or if staff physicians fail to meet the ACGME and departmental requirements for core faculty. Staff Physicians receive 30 days of leave per year. When you take leave, you receive 1 shift credit towards that month for every 3 days of leave taken. Physicians also receive TAD for shift credit (1 shift credit per 3 days of TAD). As we transition to a DHA run faculty, expect changes to the FTE credit given, the specifics of these changes are not known at this time.

The department uses AMION for both staff ("NMCP em") and resident ("navy nmcped") physician coverage. All schedule requests need to be provided to the scheduler by the requested deadline, which is generally between 6 weeks prior to the start of the month. It is highly recommended that you sync the amion schedule to your personal calendar and/or download the app to your phone. For scheduling purposes, Amion represents the final version in case of disagreements.

**The Backup Shift:** The backup shift "B" runs from 0600-0600 on the day noted. This shift is used to provide emergency coverage due to illness, injury or short-fused taskers. During your backup shift, you're expected to be sober and able to be on-shift within 90 minutes. If you feel you need to utilize the backup physician, please call SMO and/or DH. We're lucky that this shift is rarely used.

**Resident Autonomy:** Residents in their 3rd and 4th year of training are considered "senior residents" in our department. They are able to independently provide EMS medical control, supervise procedures, proctor junior residents and students, and sign EKGs. As residents progress they are expected to take on a role of junior attending running the department with increasing awareness of department flow and systems-based practice. All outside hospital/ED transfer calls must go to the attending physician.

**Resident Teams:** The senior resident on the floor is expected to run the department. Your job is to assist the resident and provide oversight to ensure a supportive clinical learning environment and safe delivery of care. During busy shifts, you should try to see lower acuity patients (ESI level 4 and 5 patients) without residents in order to maintain patient flow through the department, with minimal interference to resident education. Shift turnover is a high-risk period during patient care. Formal turnover utilizing an EDPASS format with all staff and residents present, to include the Charge Nurse and Shift Supervisor, is conducted during every shift turnover. All patients within the department will be presented, to allow for teaching points and interesting cases. To comply with the "8+1" shift length expectation, all patients shall be dispositioned or turned over to the oncoming team 1 hour after turnover is complete. The goal is to streamline patient care and minimize interruptions to the oncoming team. Exceptions to this policy include critical patients with ongoing critical care and required emergency procedures. Incomplete notes for patients no longer in the department should be completed after leaving the department.

| ED-PASS Sign Out Tool | | |
|---|---|---|
| **E** | Emergency Severity | How sick is this patient? Stable, Watcher, Sickest, Do-over |
| **D** | Disposition | Overall plan, disposition if known or anticipated |
| **P** | Patient Summary | Summary statement "one liner" |
| **A** | Action List | Things to do or follow up |
| **S** | Situation Awareness | Important things to know or anticipate (e.g. parent is an Admiral, we gave a med they may be allergic to, if they code give TPA, the patient is upset about X) |
| **S** | Synthesis | Receiving resident summarizes case |

**Electronic Medical Record:** NMRTC-P will transition to the Genesis electron health record system in January 2023. Until the transition, the ED operates on an electronic T-system for charting and uses CHCS for lab results/orders and Synapse to review radiology images and obtain official radiology reads. AHTLA provides outpatient records and allows for results review. Your charts are expected to be completed (co-signed and locked) at the end of your shift, but must absolutely be completed within 72 hours. The Clinical Practical Resources (CPR) page has additional resources helpful for your ED shift including various forms, pathways, shift schedules and other important resources. To Access the CPR page:

1) Go to the NMCP Intranet page (this is the home page if you click 'internet' from a hospital computer).

2) Using the alphabetical listing (search under "E"), find and click on the Emergency Medicine link.

3) Click on the CPR page picture from the EM page and you will be routed to the CPR page with all ED resources.

From this page you will find clinical tools, pre-written discharge instructions as well as many practical resources and SOP's for the ED.

**Important ED Policies and Procedures:**

This is a very broad section. The hope is to offer the basic knowledge you will need to cover most daily occurrences in the ED. This is not meant to be a comprehensive review of all ED SOP's.

1) Culture/Radiology Call-backs - Culture/Radiology reviews are performed by a designated ED Callback Nurse, and occasionally handled by the charge nurse as well. Occasionally they will have questions pertaining to culture/radiology reports and ask you to complete the physician section with recommendations for additional actions. Review the cultures and radiology reads as necessary to determine which need to be called back and/or require additional intervention. You may need to enter appropriate prescriptions into CHCS as needed. The charge nurse will then arrange for the callbacks and other actions to be performed.

2) Fast Track

a. Occasionally physicians are assigned shifts in the Fast Track or 'Flex' shifts. The physician shifts in Fast Track are meant to facilitate the flow through the department due to NPP shortages.

b. Flex Team. When the waiting room begins to back up, staff physicians can partner with the charge nurse to activate the flex team wherein a nurse and corpsmen will accompany the physician to triage to assist with pre-emptive orders and evaluations of patients from triage. If no one is assigned to Fast Track, any physician can stretch themselves to see patients in Flex. Additionally, there are triage nurse protocols that allow for initiation of orders from triage during busy times.

c. Co-signing PA charts. Physicians are not required to co-sign PA charts unless the PA asks you to see the patient with them (open a separate note)

3) Sedations

a. Sedations are frequently performed in the NMCP ED. There is a Sedation Protocol with suggested medications available on the CPR website. Before agreeing to a sedation, check with the charge nurse to ensure you have sufficient staff for the sedation. Sedations (adult and pediatric) represent a core ACGME procedure, it is expected that the attending physician covers the department while allowing their resident to perform the sedation or procedure needed for graduation.

4) STEMI - NMCP is a designated Chest Pain center and there is a STEMI alert system in place. If you have a patient with an ST elevation MI call a STEMI alert utilizing the ED clerk and have the nurses retrieve the STEMI box that includes for current guidelines/protocols, necessary medication, etc. In addition to starting the appropriate medication and therapy in the ED, the STAFF cardiologist (not the resident cardiology service) should be contacted immediately. The cardiologist will take responsibility for activating the cath lab and getting the patient upstairs in a timely manner.

5) EMS/Ambulances - NMCP is NOT currently a designated Stroke center; but for patients who present or develop concern for stroke, please use “code stroke”. We are pursuing our accredidation as a trauma center. Please review the trauma activation criteria and use the appropriate activation for trauma patients. Given the evolving nature of the program, the current trauma criteria is not included here, but available at both attending computers and at the EMS radio.

6). Clinical Administrative Requirements - Like any job in the ED, you will be expected to complete certain administrative tasks for the ED. The following includes the very basics of what is expected. Incomplete Charts: Your incomplete charts can be found on the electronic t-systems under the incomplete charts tab. Your charts are expected to be completed (co-signed and locked) at the end of your shift, but must absolutely be completed within 72 hours. Chart Reviews: Every other month you will receive notice that you are to review the charts of an assigned colleague. The link to the review program will be provided with that email through NMCP Provider Dashboard. See the SMO or any other staff to walk you through your first review. In a timely manner please make an effort to review the charts assigned to you.

Moonlighting: ED physicians may moonlight after they complete full credentialling. You may not moonlight during required activities (Thursday academic conference, monthly EMEC/CCC meetings, W Journal Clubs etc.). Make sure to contact Ms. Marcia Gardner to receive your moonlighting packet (which you will have to complete prior to beginning an outside job). Be sure to keep track of your moonlighting hours as you will have to report these to the Command. All information about Moonlighting is located on the command SharePoint under “M”, for Moonlighting. **Staff members who fail to meet their academic requirements (both ACGME and institutional), will have their moonlighting privileges suspended and will no longer be scheduled with a 28 clinical hours per week limit. Evidence of**

**violation includes but is not limited to failure to meet requirements for scholarly activity/publication, conference attendance, and/or journal club attendance.** **See Page 7.**

# The Educational Program

The aims of our training program develop physicians' cognitive expertise and procedural skill through multi-modal educational activities, including structured experiential clinical learning, lectures, small group discussions, high-fidelity simulated patient encounters, live tissue and cadaveric procedural laboratories, field exercises, and internet-based medical training.

**1. Experiential clinical learning** – The experiential learning component of our residency program is a 48-month educational curriculum organized into fifty-two 4-week clinical rotation blocks.

| Emergency Medicine – 64% | 76 weeks | NMCP Emergency Department |
|---|---|---|
| | 40 weeks | Civilian Adult Emergency Departments |
| | 4 weeks | Military Community Emergency Department |
| | 4 weeks | Civilian Pediatric Emergency Department |
| | 4 weeks | Emergency Point-of-Care Ultrasound |
| | 2 weeks | Emergency Medical Services |
| Critical Care – 13% | 12 weeks | Civilian Burn/Trauma Unit |
| | 8 weeks | Civilian Academic Adult ICU |
| | 4 weeks | Civilian Community Adult ICU |
| | 4 weeks | Civilian Academic Pediatric ICU |
| Clinical Electives – 6% | 12 weeks | Various Locations |
| Inpatient Care – 2% | 4 weeks | NMCP Internal Medicine |
| Anesthesiology / Airway Management – 4% | 4 weeks | Military (Camp Lejuene) Anesthesiology Service |
| | 4 weeks | Civilian Anesthesiology Service |
| Operational Medicine – 4% | 2 weeks | Operational Elective |
| | 4 weeks | Operational Leadership |
| Cardiology – 2% | 4 weeks | NMCP Cardiology Consult Service |
| Medical Toxicology – 2% | 4 weeks | Civilian Poison Control Center |
| Quality Improvement / Patient Safety – 2% | 4 weeks | NMCP Emergency Department |
| Obstetrics – 1% | 2 weeks | NMCP Labor & Delivery Service |

PGY1 residents (interns) are responsible for the initial workup and development of a treatment plan under the direct supervision of senior residents and faculty physicians. Interns have no supervisory responsibilities, are directly supervised during procedures / resuscitations, and are expected to maintain ACLS and PALS course credentials throughout the year.

Specific guidance for individual rotations is provided by the class PGY1 APD. PGY1 Rotations:

| Rotation | Duration | Location |
|---|---|---|
| EM Orientation | 4 weeks | NMCP Emergency Department (ED) |
| NMCP EM | 8 weeks | NMCP ED |
| Leigh EM* | 4 weeks | Sentara Leigh Memorial Hospital ED |
| Maryview EM* | 4 weeks | Bon Secours Maryview Med Center ED |
| Anesthesiology / Airway Management | 4 weeks | Camp Lejeune Medical Center Anesthesiology, Camp Lejeune, NC |
| Adult Medical Critical Care* | 4 weeks | Sentara Norfolk General Hospital ICU |
| Cardiology | 4 weeks | NMCP Cardiology Consult Service |
| Trauma/Burn Care* | 4 weeks | Sentara Norfolk General Burn/Trauma Unit |
| Inpatient Care | 4 weeks | NMCP Internal Medicine Ward |
| Operational Elective | 4 weeks | Any clinical rotation with an operational unit |
| Clinical Elective | 4 weeks | Any clinical rotation that includes an outpatient experience |
| Emergency Medicine Ultrasound | 4 weeks | NMCP Emergency Department |

PGY2 residents are responsible for the initial workup and development of a treatment plan under the direct supervision of faculty physicians. They have no supervisory responsibilities until they have completed the Resident as Educator Symposium. PGY2 residents have procedural assignments in major resuscitations which are generally performed under the supervision of a senior resident or faculty physicians. PGY2 residents maintain certifications in ACLS and PALS. PGY2 Rotations:

| Rotation | Duration | Location |
|---|---|---|
| NMCP EM | 16 weeks | NMCP ED (incl. REBIL) |
| Leigh EM* | 4 weeks | Sentara Leigh Memorial Hospital ED |
| Maryview EM* | 4 weeks | Bon Secours Maryview Med Center ED |
| Community Military EM* | 4 weeks | Camp Lejeune Medical Center ED, Camp Lejeune, NC |
| Pediatric EM* | 4 weeks | Children's Hospital of the King's Daughters ED |
| Anesthesiology / Airway Management* | 4 weeks | Riverside Med Center Anesthesiology Service / Operating Rooms |
| Adult Medical Critical Care | 4 weeks | Chesapeake Regional ICU |
| Trauma/Burn Care* | 4 weeks | Sentara Norfolk General Burn/Trauma Unit |
| Riverside EM* | 4 weeks | Riverside Regional Med Center ED |
| EMS / En-Route Care | 2 weeks | NMCP |

| Obstetrics | 2 weeks | NMCP Labor & Delivery |
|---|---|---|

PGY3 residents are considered senior residents and have multiple patient management and supervisory responsibilities. PGY3 residents serve as team leaders during resuscitations, supervise both interns and medical students, respond to radio calls from EMS personnel, interpret triage EKGs, supervise procedural training in the vivarium and intern practicum laboratories, and maintain credentials in ACLS and PALS. PGY3 residents are physician-educators and contribute to the education of junior trainees during patient care in the emergency department. PGY3 Rotations:

| Rotation | Duration | Location |
|---|---|---|
| NMCP EM | 16 weeks | NMCP ED |
| NMCP EM Teaching & Research Service | 4 weeks | NMCP ED |
| Chesapeake EM* | 4 weeks | Chesapeake Regional Med Center ED |
| Leigh EM* | 4 weeks | Sentara Leigh Memorial Hospital ED |
| Riverside EM* | 4 weeks | Riverside Regional Med Center ED |
| Adult Medical Critical Care* | 4 weeks | Sentara Norfolk General ICU |
| Trauma/Burn Care* | 4 weeks | OSF St. Anthony's Med Center, Rockford, IL |
| Pediatric Critical Care* | 4 weeks | Children's Hospital of Richmond, Richmond, VA |
| Operational Leadership | 4 weeks | NMCP |
| Elective | 4 weeks | Variable |

PGY4 residents run the ED. While evaluating patients, PGY4 residents manage patient throughput by supervising junior resident patient care, ensuring clinical teaching, and coordinating care with EMS personnel and outside medical facilities. PGY4 residents are resuscitation leaders and direct resuscitations for critically ill and injured patients. PGY4 residents are responsible for many of the administrative functions of the residency program and help maintain the learning environment for all trainees. PGY4 Rotations:

| Rotation | Duration | Location |
|---|---|---|
| NMCP EM | 24 weeks | NMCP ED |
| NMCP EM Teaching & Research Service | 4 weeks | NMCP ED |
| Chesapeake EM* | 4 weeks | Chesapeake Regional Med Center ED |
| Maryview EM* | 4 weeks | Bon Secours Maryview Med Center ED |
| Virginia Beach EM* | 4 weeks | Sentara Virginia Beach Hospital ED |
| Medical Toxicology* | 4 weeks | Rocky Mountain Poison and Drug Center, Denver, CO |
| Quality Improvement / Patient Safety | 4 weeks | NMCP |

| Elective | 4 weeks | Variable |
|---|---|---|

**2. Structured Didactic Experience** – As required by the ACGME, our program provides protected time for a minimum of five hours per week of planned didactic experiences. Our weekly guaranteed didactic experiences come primarily from weekly academic conferences every Wednesday from 1200-1700 in the Emergency Medicine Residency Conference Room on Ward 5G, 5th Floor, Building 2. Additional faculty are scheduled in the ED during this event so that residents have protected time to attend. **Faculty are required to participate in 20% of academic conferences to maintain the programs ACGME certification. Moonlighting should not be scheduled during Wednesday morning conferences or other academic events. Faculty who schedule moonlighting experiences that preclude participation in resident academics can be disciplined and may result in the loss of the voluntary 28 clinical hours per week cap.**

## Weekly Academic Conference

| 1200 - 1300 | Core Content Hour | Resident Led |
|---|---|---|
| | Description: APD generated quiz based on core content reading, chapters reviewed by junior resident | |
| **1300 - 1400** | **Chiefs' Power Hour** | **Resident Led** |
| | Description: A 1-hour block of short lectures covering ECG review, follow-up cases, procedural skills, special populations, interpersonal communication and chief resident guidance/administration | |
| **1400 - 1500** | **Wellness Hour** | **Faculty or Resident Led** |
| | Description: A 1-hour wellness curriculum event that varies by week, including physical exercise/yoga, core wellness lectures, EM BROS (Building Relationships Outside of Service) lectures | |
| **1500 - 1630** | **Core Content Lectures** | **Faculty or Resident Led** |
| | Description: Multiple 15-30 minute lectures on various EM topics. Includes weekly faculty lectures 25 and 50 minutes and finesse of medicine. | |
| **1630 - 1700** | **Asynchronous Material** | **Not applicable** |
| | Description: Compensation time for asynchronous review of the assigned FOAM content | |

The residency program Associate Program Director LCDR Adam Bloom is responsible for the program's academic conference. Faculty should direct conference and lecturing questions to Dr. Bloom. The core content reading is assigned from Tintinalli's Emergency Medicine: A Comprehensive Study Guide textbook. An electronic copy of the text, as well as many others, is available through NMCP's Library Homepage available on the intranet. The weekly quiz helps identify those residents struggling to retain the core content, test reading comprehension, and allows residents to practice test-taking strategies. The quiz should be 8 question, multiple choice, board-style questions and will be written by the APDs. Any faculty interested in creating quizzes based on the reading should reach out to Dr. Bloom.

The faculty are required by the ACGME to deliver 50% of the academic content at our academic conference. This equates to 5-6 lectures per year or roughly one every other month.

Every fourth academic conference is dedicated to high-fidelity simulation resuscitation scenarios. These “Sim Conferences” are held in the Healthcare Simulation and Bioskills Training Center on the $12^{th}$ Floor, Building 3. Faculty are responsible for evaluating resident competency and providing educational instruction on the clinical material focus for the scenario. Faculty are paired with a PGY4 resident who facilitate running the scenarios. The PGY4 should run the cases and severe as the different roles (e.g. nurse, tech, family member etc.). The faculty is responsible for debriefing the scenario and providing teaching points. Over the course of the day, you should instruct and mentor your senior in leading team debriefs.

Three to four times a year, the weekly academic conference is replaced by a Mock Oral Boards session. During these sessions, residents rotate in pairs through multiple faculty-led stations where they are presented with ABEM Oral Examination-style clinical cases to manage. This experience offers residents to opportunity to practice and verbalize management of cases in preparation for the ABEM Certification Exam. The faculty provide written and verbal feedback to the residents regarding their performance in managing oral cases.

**All academic conferences are supervised by faculty members and faculty members are required to attend at least 20% of all academic conferences.** Residents are required to attend 70% of all academic conferences. As a courtesy to presenters, residents should be present on 5G no later than 1155 to ensure they are not interrupting conference lecturers.

As required by the ACGME, at least 50% of the material presented at our academic conference is delivered by the faculty. This material includes mock oral boards, ABEM In-Training Exam preparation, and our simulation resuscitation experiences which are generally 100% delivered by faculty. 10% of the academic conference is dedicated to individualized interactive instruction via web-based FOAM (free open-access medical education) resources. Residents interact with this material asynchronously and the material is reviewed by the chief residents and covered on the quiz. Residents are compensated with 30 minutes of protected time (generally 0730-0800 of academic conference) for this asynchronous requirement.

**3. Procedural Skills Laboratories** – Our program offers multi-modal procedural skill acquisition training. Procedural skill is primarily acquired during clinical experience with patients. However, to better novice learners and allowed more experienced residents to opportunity to refine their procedural skills in a low stakes environment, our program offers high-fidelity simulation-based, cadaveric model-based, and live tissue model-based procedural laboratories. These experiences are complementary as no single procedural training modality has been proven to meet all emergency medicine training needs. The staff simulation coordinator is LT Kasey Conklin. Please direct questions regarding cadaveric and Bioskills center simulation activities to him. LT Sulava is responsible for all live tissue training (vivarium lab) and is the Primary Investigator on the live tissue educational protocol for the institution. Please direct live tissue training question to him.

a. Healthcare Simulation and Bioskills Training Center

Frequency: monthly – every 4th Thursday of each block, during Academic Conference. Length: 4 hrs.

Format: An intense, realistic practice in resuscitation management in the NMCP state of the art simulation center. "Sim Lab" provides a comprehensive curriculum of resuscitation medicine. Each resident is evaluated by the Attending Physician proctoring each case and receives both written and verbal feedback after the session.

Attendance: Required for 5-6 faculty members per lab

b. Intern Practicum

Frequency: monthly – the first Monday of each block. Length: 5 hrs.

Format: This is an introductory procedural skills laboratory designed for the novice resuscitationist. Sessions include skills training to include central line placement, advance airway techniques, chest tube placement, point-of-care ultrasound, and other common resuscitative procedures required in emergency medicine practice.

Attendance: Supervised asynchronously by Off Service Intern Staff (Dr. Bob Frank) and the PGY1 APD

c. Cadaver Lab

Frequency: monthly – every 2nd Wednesday of the calendar month (not rotation block) Length: 4 hrs (0800-1200).

Format: Cadaver Lab provides an exceptional opportunity to practice essential but uncommon emergency procedures, review anatomical relationships, and explore airway manipulation. Several lab sessions are scheduled with each specimen. The lab is taught by a team of one faculty member and a lead PGY4 resident. The Faculty member has the primary responsibility for the educational content of the lab. The PGY4 resident has the primary responsibility of ensuring coordination with the laboratory staff, availability of equipment, and administrative tasks such as accountability and attendance. Emergency procedures are discussed and then practiced on a human cadaver in the NMCP Cadaver Lab (Bldg. 3 of the main hospital complex). Procedures include airway manipulation, advanced airway control, advanced airway procedures, ultrasonography, central line placement, thoracostomy, thoracotomy, pericardiocentesis, fracture reduction, lateral canthotomy, and complex laceration repair. Special instruction or anatomical dissection is carried out as interest or need directs. Direct verbal feedback is provided during the lab.

Attendance: Required for one faculty member per lab

d. Vivarium Lab

Frequency: monthly – every 2nd Wednesday of each calendar month (not rotation block). Length: 4 hrs (0800-1200).

Format: This procedural skill acquisition laboratory, sometimes referred to as the ERT (Emergency Room Trauma) Skills Lab by the veterinary staff, is conducted at the NMCP Clinical Investigation and Research Department (Bldg. 249) on the primary site campus. Emergency procedures are taught by faculty and senior residents who have successfully completed procedural instructor training as part of their PGY2 Promotion Board. Residents perform 29 resuscitative procedures in an IACUC-approved live tissue model. Procedural competency in the lab is formally evaluated as part of the PGY2 Promotion Board at the end of the PGY2 year.

Attendance: Required for one faculty member per lab. Note that this experience counts as a clinical shift. Only faculty members who have completed the required IACUC CITI training and have been added as AIs to the protocol may supervise this lab

Additional Instructions: There should be 4-6 participants at each table, including the table lead. The Life Support Resident has the authority to dismiss trainees from the lab if there are too many participants present. The goal is for each resident to attend at least 5-6 labs/academic year. PGY3-4 residents will have teaching and proctoring responsibilities. There will be at least one NMCP staff member with the appropriate animal use and care credentials proctoring the laboratory experience. If a staff member is not present, LT Sulava or CDR Ponce should be notified immediately. If there are not a minimum of 4 trainees at a given table then LT Sulava or CDR Ponce should be notified immediately.

**4. Journal Club** - Journal Club is conducted on the third Wednesday of each calendar month from 1830-2130. Residents have protected time and additional faculty are scheduled in the ED during this event. Journal Clubs are typically hosted by faculty with food and beverage provided. Faculty are expected to attend at least 20% of all journal clubs and host at least one journal club per academic year. Articles are selected by the Resident Research Coordinator, the Chief Residents and/or the APDs. An emphasis on Evidence-Based Medicine concepts is maintained throughout. Different formats for journal club will be used throughout the year (small group vs large group, etc.). Three times each year the Journal Club time is utilized for residency wellness/Navy customs and courtesy events. These include the Orientation Party in July, the Holiday Party in December, and the Graduation K-Court in June. Please direct all journal club questions to LCDR Adam Bloom and/or the Faculty Journal Club Coordinator.

**5. Field Exercises and Integrated Training Events**

a. MEDWAR – This is a demonstration incorporated into orientation. First year residents are expected to demonstrate wilderness emergency and resuscitative skills as part of a team in an adventure race that combine cognitive expertise and practical application of procedural skills. The race culminates in the cardboard board regatta.

b. Tactical Skills Training – Tactical Skills Training is provided during orientation and integrated into academic conferences throughout the year.

c. Operation Bushmaster – Operation Bushmaster is operational medicine field exercise conducted by the Uniformed Services University F. Edward Hébert School of Medicine (the military's medical school) for their MS4 students. It is a capstone activity that incorporates state of the specialty military applications for modern medicine. Serving as an instructor at Operation Bushmaster is a graduation requirement for our residency program. Prior to participating, PGY3 residents are taught the Joint Trauma System Clinical Practice Guidelines (CPGs) as part of their Operational Leadership rotation.

d. Joint Emergency Medicine Field Exercise (JEMX) – The JEMX is a tri-service 5-day experience used to provide operational application of the residents' four years of hospital-based clinical experience. The JEMX is part of the CAPSTONE PGY4 rotation and is held at Ft. Sam Houston in San Antonio, TX. In general, the first day is a didactic lecture series addressing various battlefield medical topics, including the Joint Trauma System Clinical Practice Guidelines (CPGs) relevant to military emergency medicine. The second day is a perfused cadaver lab utilized to teach resuscitative procedures, including REBOA. The last three days are a field exercise integrated into the 19th Special Forces Group's annual training. Residents plan medical support with their line colleagues and undergo full mission profile rehearsals prior to initiation. Residents cycle through three facets of operational medicine – care on target, en-route care, and Role II care.

d. CAPSTONE – Navy residents are expected to function as naval officers as well as physicians. The CAPSTONE curriculum has been placed at the end of the 48-month curriculum as an opportunity to fill in any gaps relevant to officership identified by the senior class. The program exposes residents to the special and unique aspects of Military Emergency Medicine thorough Military Unique Curriculum presentations, discussions of military policy literature, engagements with leaders in Navy Medicine, and field training exercises. Operational and deployment related topics are a primary focus as is the Navy Surgeon General's GME capability gaps as identified in Vice Admiral Nathan's Assessment Cell II.

# Resident Competency Progression & Evaluation

In accordance with the aim of our training program, to develop physicians' cognitive expertise and procedural skill in preparation to provide competent emergency care to Department of Defense beneficiaries anywhere in the world and under any circumstances, the program has a rigorous evaluation process. Compared to our civilian counterparts, Navy Emergency Physicians must be more adaptable and self-reliant in order to perform under a variety of environmental conditions. Additionally, Navy physicians must provide tactical combat casualty care, extended forward resuscitative care, and damage control resuscitation in the austere operational environment.

1. **Feedback and Evaluation**

The cornerstone of education is feedback. Formative evaluation is monitoring resident learning and providing ongoing guidance that can be used by residents to improve their learning in the context of patient care. This feedback helps residents identify their strengths, weaknesses, and behaviors to be focused on for improvement. The faculty provide residents with formative feedback in multiple ways.

Summative evaluation is evaluating a resident's learning by comparing the resident against a set of goals and objectives of the program. Summative feedback is used to make decisions about promotion and increasing levels of clinical autonomy/responsibility.

a. NMCP ED Shift Feedback – During and/or after each shift, the faculty should provide the residents whom with they've worked with feedback regarding positive behaviors to continue and negative behaviors that can be reflected upon so that residents can refine his/her clinical practice. Feedback provided informally in this fashion is as important as formal feedback provided in writing and is often more timely and actionable. To improve efficiency, this feedback may also be included in post-rotation evaluations.

b. NMCP ED Clinical Evaluations – After every 4-week clinical rotation in the NMCP ED, the entire NMCP faculty receives a request for clinical evaluations on each resident rotating in the department through the New Innovations online system. Faculty submit both formative and summative feedback in the form of written post-rotation evaluations that are archived in the New Innovations. **Faculty evaluations of residents are due 14 days after the end of the academic block.** We recommend the following 4-part format:

1. State the shifts you worked with the resident on which you are basing the evaluation. Ex. "This evaluation is based on two busy night shifts (N shift Jan. 13th and 14th)."

2. Identify a resident's positive behaviors (a strength) and encourage the resident to continue that behavior. Ex. "During the admission of the 57F with

chest pain, you did a great job advocating for your patient and communicating how the patient's individual circumstances make HEART scoring irrelevant as the patient would have been excluded from that study. Continue to individualize care for your patients and don't blinding apply scoring systems uniformly."

2. Identify an area for improvement and make a suggestion regarding how to improve. Try to be as specific as possible. Ex. "During the management of the 62M with atrial fibrillation it wasn't clear to me that you understand how chemical cardioversion works. Understanding of the various agents available and their contraindications is important to emergency physicians in order to individualize care for our patients. There is a good review of this topic in the March 2020 issue of Annals of Emergency Medicine. I recommend you read this article."

3. Provide a global assessment of competency in the context of level-of-training expectations. Ex. "Based on today's observations, you are function as expected for a mid-year PGY2."

c. Sim Lab Resuscitation Evaluations – During these monthly simulated resuscitation experiences, the faculty compare resident management of critically ill and injured patients against a pre-defined set of critical action items. Residents must perform all of the identified critical actions in order to successfully resuscitate the patient. Omitted critical actions and/or performed dangerous actions are recorded on the evaluation form. At the end of the scenario, the patient's diagnosis is revealed and the critical actions for the patient's proper resuscitation are discussed. The resident is provided with formative feedback regarding their performance and made aware of any critical actions omitted. Additionally, the resident is provided with summative evaluation in the form of how their performance compares to the expectations for a PGY1, 2, 3, or 4 resident. Note, it is possible for junior residents to omit a critical action and still be performing as expected within their year-group.

d. Mock Oral Board Evaluations – Faculty are expected to participate as proctors during Mock Oral Board Examinations that occur quarterly. Like sim lab evaluations, the faculty compare residents' oral articulation of the management of critically ill and injured patients against a pre-defined set of critical action items. The cases available for Mock Oral Boards have been developed and vetted by the Council of Emergency Medicine Residency Program Directors and represent cases that graduates can expect during the second half of their ABEM Certification Examination. Residents must perform all of the critical actions in order to pass the clinical scenario. Omitted critical actions and/or performed dangerous actions are recorded on the evaluation form. At the end of the scenario, the patient's diagnosis is revealed and the critical actions for the patient's proper resuscitation are discussed. The resident is provided with

formative feedback regarding his/her performance. The resident is made aware of any critical actions omitted and is given a pass, fail, or marginal pass score. Additionally, the resident is provided with summative evaluation in the form of how their performance compares to the expectations for a PGY1, 2, 3, or 4 resident. Note, it is possible for junior residents to fail a scenario and still be performing as expected within their year-group. We have added a structured interview to match the current virtual oral boards format and continue to practice triple cases.

e. Promotion Boards – All faculty are expected to participate in resident Promotion Boards. These are formal review boards conducted each academic year for each resident to ensure the minimum progressive development in EM specialty training. The resident's assistant program director will review the resident's procedure log, weekly quiz scores, Rosh Review performance, clinical metrics (for PGY3-4 residents), in-training exam scores, and his/her academic portfolio. Scholarly activity is summarized, and points are awarded. Afterwards, an oral examination affords the resident the opportunity to demonstrate proficiency regarding specific core EM topics. A board of two-three faculty members (or 2 faculty members and a chief resident in the case of PGY1s and new PGY2s returning from the fleet) administers the oral evaluation. The resident should demonstrate proficiency in the initial approach and emergency intervention regarding these topics, rather than exhaustive subject knowledge. The response should more closely simulate an algorithm than an oral board case. The topics have a heavy emphasis on items every Emergency Physician should have committed to memory for immediate recall. Drug doses are expected to be memorized.

f. Mentorship – All faculty are mentors to residents. The ACGME's first expectation of faculty is that they "must be role models of professionalism." All faculty not a part of program leadership are expected to participate as part of a "Mentorship Fire Team," consisting of one staff physician and one resident from each of the four classes. These are informal relationships that provide residents with low-stakes staff-trainee guidance outside of the residency program leadership hierarchy. **Faculty mentors are required to meet with each of their assigned residents twice a year.**

**2. Competency, Remediation, and Due Process**

The residency program uses a clinical competency structure to evaluate resident competency and milestone progression in a thorough, objective, and impartial due process. This structure assists the program director in the identification of achievements that residents are expected to demonstrate sequentially as they progress through residency (i.e. milestones) and facilitates determinations regarding the potential benefit of resident remediation. There are two portions of the NMCP EM residency program's clinical competency structure:

a. The Emergency Medicine Education Committee (EMEC) – All academic core faculty and the chief residents are members of the EMEC. The EMEC is chaired by the Program

Director. The EMEC meets once per month to assist the program director in achievement of the following goals:

- Provide updates on ongoing residency related projects and improvements

- Provide innovative ideas and critical evaluation of all aspects of the residency program as part of a continuous curriculum review.

- Provide input on individual resident competency, professionalism, milestone completion, and progression towards independence.

- Serves as the program's governing body for important residency related decisions. The EMEC votes on all individual resident remediation decisions. A majority (>50% of votes) approval is required for a resident to be placed on any form of institutional-level remediation. Note that the chief residents do not vote on remediation decisions for PGY4 residents (their classmates). The EMEC remediation recommendations are discussed by the Clinical Competency Committee (see below) before a final determination is made regarding resident remediation.

b. The Clinical Competency Committee (CCC) – The CCC is appointed by the program director. IAW ACGME requirements, the CCC must include at least three members of the program faculty, including at least one core faculty member. Unless unavailable due to military deployments, the NMCP emergency medicine residency program CCC consists of the PD, the four APDs and the program coordinator. The program director, having final responsibility for all resident evaluation and promotion decisions, chairs the CCC. At least three members of CCC must be present to form a quorum in order to make remediation decisions. In general, the CCC convenes immediately after the monthly EMEC meeting. Program-level remediation may be instituted based on the CCC determinations alone. The CCC's determinations regarding resident need for institution-level remediation are presented to the institution's Graduate Medical & Dental Education Committee (GMDEC), chaired by the DIO, for approval. However, the CCC may implement necessary educational requirements for the resident while awaiting final GMDEC decisions. The institution has an Adverse Action and Due Process Policy (last revised October 2014) which governs individual requests for voluntary withdrawal, probation and termination, prolonged absences from the program, and training hearing rights. This document is open access and available for resident review any time at https://esportal.med.navy.mil/nmcp/dir/dpe/gmde/GMEPolicyDocs).

Residents who disagree with an evaluation of any type, may notify the CCC. The CCC chair will address the issue with the evaluator or take other appropriate action, which may include modifying or removing that evaluation, or leaving the evaluation unchanged. If requested by the resident, a written rebuttal and response will be included in the residency file. If the program director is involved in the evaluation under review, the issue will be addressed by the Associate PD and the decision decided by majority vote among the remaining APDs. If the resident is not

satisfied with the CCC's decision, then the issue will be escalated to the Designated Institutional Official's Office (currently CAPT Rhett Barrett).

### 3. Program Quality Assurance

The program's primary mechanism to ensure program educational quality and refine existing curricula is the Program Evaluation Committee (PEC). The PEC is a subcommittee of the EMEC. The residency program utilizes the PEC to evaluate the program, the faculty, and their relationship with the overall hospital system. The members of the PEC are the Associate Program Director, the three remaining APDs, the program coordinator, and at least one chief resident. The Associate Program Director chairs the committee.

The Program Evaluation Committee considers the following elements in its assessment of the program: the educational curriculum, outcomes from prior Annual Program Evaluation(s), ACGME letters of notification (including citations, areas for improvement, and comments), key stakeholder assessments of graduate performance, quality and safety of patient care, workforce diversity, and assessments of aggregate resident and faculty well-being / recruitment and retention. Sources of information systematically reviewed by the PEC include ACGME Annual Program Evaluations, ACGME citations and letters of caution, ABEM Certification Examination performance reports, Graduate and Employer Surveys, ACGME Resident and Faculty Surveys, New Innovations Procedure Logs, internal Annual Program Reviews / Strategic Plan Briefs, internal Program Interview Sheets, IACUC Post-Application Monitoring Reports, and external Navy healthcare system analyses. Occasionally, this information may be compared to archived reports from prior program directors. After collecting and organizing the data, the Chair distributes analysis tasks to the other members of the PEC. The PEC members independently review this data and ask for clarifications or request more data. If available, the program director provides this information. The PEC then independently reviews the data and makes recommendations. The program director incorporates these recommendations into the strategic plan for the residency program and presents the plan, including any program changes, to the residents and faculty at the Annual Program Review in May of the academic year.

# Faculty Scholarly Activity

The ACGME recognizes that “medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. … Residents must participate in scholarship.”

As such, ACGME mandates staff physicians to participate in scholarly activity. As previously mentioned, the departmental and program leadership are committed to upholding the pre-2019 core faculty clinical work hours cap of 28 clinical hours per week. In exchange, core faculty are expected to uphold the pre-2019 scholarly activity requirements.

“Core faculty members, must be members of the program faculty, must be clinically active and teach, and devote the majority of their professional efforts to the program. Core faculty members, must not work clinically more than 28 hours per week on average, or 1344 hours per year, whichever is less. [This includes moonlighting.] Core faculty members, must be involved in scholarly activity. All core physician faculty members must be involved in scholarly activity. At minimum, each individual core physician faculty member must produce at least one piece of scholarly activity per year (averaged over the past five years). At minimum, this must include one scientific peer reviewed publication for every five core physician faculty members per year (averaged over the previous [three]-year period).” **Therefore, we expect all faculty members to publish one peer-reviewed, MEDLINE-listed article at least every three years.** Faculty members who fail to meet this requirement may not moonlight and may be required to work additional clinical shifts to permit compliant faculty members more protected time to dedicate to the academic mission of the department. The ACGME further states that “Core faculty members should have appropriate faculty appointments in the medical school.” Like all military residency programs, our program and the command are affiliated with the Uniformed Services University of the Health Sciences (USUHS). Instructions for obtaining a faculty appointment from USUHS can be found at: www.usuhs.edu.

An established record of scholarly activity is required of each faculty member. This scholarly activity may take many forms, including a formal research projects, obtaining grant funding, lecturing outside of the institution, authoring textbook chapters or review articles for publication, serving as a reviewer for a medical journal, and/or serving on committees at the national level. If you are interested in conducting research at NMCP, meet with the Research Director LT Eric Sulava to inquire about projects you can become involved with. The command has grant writers, statisticians, and librarians who facilitate research at NMCP.

# Faculty Development

No one is expected to be a perfect educator when they arrive at NMCP. The NMCP EM faculty development program is meant to help you progress as a faculty member, define and pursue your EM academic interests, and enhance your military career. Additionally, the Directorate of Professional Education has set the following faculty development goals for AY 2020-21:

1. Improve total faculty with scholarly activity within the academic year to 90% by next AIR
2. 50% of newly reported faculty attend or are scheduled for a faculty foundations course

The NMCP Faculty Development Program includes the following:

1. Academic Faculty Development Meetings – each year (in the Nov-Jan timeframe) faculty members meet individually with the Program Director and Chair to discuss academic and educational contributions, ambitions and career aspirations.

2. Military Faculty Development Meetings – each year faculty members meet individually with the Chair and/or Senior Medical Officer to discuss their military Fitness Report.

3. Continuing Medical Education – although continually challenged by funding and conference approval, our goal is for every faculty member to attend one funded CME conference per year.

4. Uniformed Services University of the Health Sciences (USUHS) Faculty Development Program – As previously mentioned, the program and the command have an affiliation with the University. USUHS's medical school has a robust faculty development program that can be accessed at https://www.usuhs.edu/medschool/faculty/facultydevelopment.

a. USUHS Faculty Development Foundations Course – (POCs CDR Melissa Buryk). The course, offered three times a year targets Medical and Dental Faculty who engage in graduate level education and desire to improve the skills as clinician educators. Specific goals include acquisition of educational skills that will translate into precepting, bedside teaching, small group, and large group educational settings, influencing the learning environment to drive effective educational interactions and maximize learning opportunities, and to apply adult learning educational concepts to increase learners engagement and retention.

b. USUHS Faculty Appointments – Appointments for Assistant Professor are expected for our core faculty. These applications will be initiated in bulk at the start of each academic year, however online submission and maintenance is a responsibility of the individual faculty member.

# Learning & Working Environment

**1. Patient Safety, Quality Improvement, Supervision, and Accountability**

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

• Excellence in the safety and quality of care rendered to patients by residents during training

• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice

• Excellence in professionalism and leadership through faculty and senior resident modeling of self-sacrifice in a humanistic environment that supports the professional development of physicians, as well as, the joy of curiosity, problem-solving, intellectual rigor, and discovery

• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team

a. Patient Safety – Staff physicians are encouraged to participate in scholarly activities that improve patient safety. The residency program has formal educational activities that promote patient safety-related goals, tools, and techniques are interwoven into the educational curriculum, such as disclosure of medical errors and adverse clinical events. Staff physicians can partner with PGY4 residents who have 4 weeks of protected time for their required Quality Improvement / Patient Safety project. The project is jointly developed by the residents and the department's Senior Medical Officer (SMO, LCDR Max Noe).

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are essential for the success of any patient safety. Residents are expected to report patient safety events that they observe during clinical care. The importance of and procedures for reporting these events is covered during both command and departmental orientation. Procedures for submitting Patient Safety Reports (PSRs) are also available of the command intranet website available at
https://esportal.med.navy.mil/nmcp/apps/MedicalErrors/SitePages/Home.aspx) .

Senior residents may be invited to participate in root cause analyses and clinical specialty reviews of adverse outcomes. All residents are expected to participate in Process Improvement & Patient Safety Conferences (previously Morbidity & Mortality Conferences). During these conferences, residents present clinical patient cases with suboptimal outcomes or near-misses and discuss cognitive errors, system failures, and implicit biases that result in areas for improvement in care delivery. The aim of these activities is to address individual knowledge

gaps, identify inefficient or inadequate process steps, and reduce healthcare disparities, while providing a collegial, low-risk framework for resolving of these problems.

b. Quality Improvement – All residents have access to data on quality metrics and benchmarks related to their patient populations. When data extraction software is functional, residents will receive performance metrics.  Halfway through their PGY2 year and beyond receive monthly practice performance metrics as a part of their monthly NMCP rotation evaluations. These metrics include the residents' mean patients/hour managed, mean patient length of stay, rotation admission rate, and rotation CT (computed tomography) utilization rate. PGY3-4 residents are also provided with class means so they are able to compare their individual performances to their peers. As previously mentioned, PGY4 residents have 4 weeks of protected time for their Quality Improvement / Patient Safety rotations where they are required to participate in a Quality Improvement projects. All residents also participate in the resident-initiated EM BROS (Building relationships Outside of Service). These monthly interdisciplinary conferences with subject matter experts from other specialties and institutions help to cultivate a shared vision of optimum healthcare quality and reduce inter-departmental / community barriers to delivering effective patient care.

c. Supervision and Accountability – Attending physicians who are board-eligible/board-certified by the American Board of Emergency Medicine (ABEM) are present in the emergency department for resident supervision 24 hours a day. EM is shift work and sleeping on shift is not permitted. All resident T-system charts must be reviewed and countersigned by faculty. For patients transferred to another facility, the chart needs to be completed and countersigned prior to patient transfer. For admitted patients and patients scheduled for follow-up within 72 hours of ED discharge, charts must be completed and countersigned before the end of the clinical shift. For other patients (i.e. discharged patients without < 72 hour follow-up), need to be countersigned within 72 hours. The program facilitates progressive mastery or clinical expertise and independence thorough a system of progressive resident responsibility and autonomy.

Supervision in the ED is postgraduate year-specific. Supervision status is conferred by the Program Director and based on the recommendations of the EMEC and CCC. All senior residents have the autonomy and responsibilities of classes below them.

i. PGY4 - The PGY4 resident on duty is responsible for supervising all aspects of the department relating to patient care, including orderly check-in, triage, bed utilization, timely evaluations and dispositions.  The PGY4 is responsible for the supervision of all trainees on their team, including all junior resident, intern, and medical student activities.  This includes discussing and dividing responsibilities with the faculty and the other members of the team at the beginning of each shift.

The PGY4 will keep the staff physician apprised of the state of the ED. The PGY4 is responsible for notifying the staff physician on all patients who are triaged Urgent or Emergent, arrive by ambulance, unstable or potentially unstable, associated with potential command high-visibility situations (VIP's, ship/aircraft accidents, etc.), and those requesting to leave against medical advice (AMA).

PGY4 residents are also responsible for assisting the attending physician proctoring simulation lab cases and cadaver labs.

ii. PGY3 - PGY3 residents function as seniors in our department and are responsible for supervision of their team of medical students and interns. Responsibilities include patient care, subordinate provider supervision, and clinical teaching as delegated by the senior EM resident at the beginning of the shift. The PGY3 resident will keep the staff physician apprised of all patients seen personally as well as those they are proctoring with other trainees as soon as physically possible after the initial evaluation. They are responsible for notifying the staff physician on all patients who are triaged Urgent or Emergent, arrive by ambulance, unstable or potentially unstable, associated with potential command high-visibility situations (VIP's, ship/aircraft accidents, etc.), and those requesting to leave against medical advice (AMA).

PGY3 residents are also responsible for serving as instructors/table leads for procedural skills labs at the vivarium on the second Thursday of each calendar month.

iii. PGY2 - PGY2s residents will have no proctoring responsibilities in the first half of the academic year to permit focus on continued development of clinical skills, acquisition of a broad knowledge base, and development of good bedside communication skills. After successful completion of the resident as educator course (generally offered in block 7 of the academic year), PGY2s may begin proctoring medical students and interns on a limited basis as per the PGY4 and faculty on shift.

iv. PGY1 - PGY1 residents have no supervisory responsibilities. This allows focus on activities to hone patient evaluation skills, acquisition of a broad knowledge base, and development of good bedside communication skills. PGY1s will discuss all patients with the senior resident (PGY3/4) on duty as soon as physically possible after initial evaluation. The initial plan of evaluation will be developed in collaboration with the EM resident and/or attending physician. Orders should not be carried out until staffed with the senior resident or attending physician on duty. Final disposition and plan for patients will also be developed in consort with EM resident or attending physician. If you pick up a patient triaged Urgent or Emergent (Category 1 or 2), take a senior resident and/or attending physician with you for direct supervision. Never see an Urgent or Emergent patient without notifying your attending. During their second NMCP ED rotation, PGY1 will be able to develop their own care plans without immediate oversight from senior residents or attending physicians.

Non-categorical PGY1 residents ("Off-service Interns") will have the same autonomy and responsibilities of categorical emergency medicine interns in their first NMCP ED rotation. Off-service interns potentially interested in specializing in emergency medicine after general medical officer tours will an effort to present at least one case directly to the attending physician on duty. In addition, interns who are interested in EM, should meet with the EM program director in June before graduation to discuss specifics. During slower times while on shift, faculty should provide non-categorical PGY1 residents with mini-lectures on the "5 Minute Topic Cards". These are multiple short lectures on a variety of EM topics. For issues of the intern not showing up for shifts or acting unprofessionally, contact the staff Off-Service Intern Coordinator (Dr. Robert Frank), the chief residents, and/or resident Off-Service Intern Coordinators (LCDR Calderon and LT Davison).

v. Medical Students - Medical students will notify the senior EM resident or attending physician on duty before evaluating any patient. The senior EM residents on duty are responsible for direct supervision the medical students. Medical student charting should be done using electronic T-system chart templates. Medical Students potentially interested in specializing in EM should make an effort to present at least one case to the attending physician on duty. The medical student faculty advisor is the PGY1 APD LCDR Alyssa Krepela, LT Eric Schmieler, and the resident Medical Student Coordinators: LCDR Joshua Lesko and LT Sally Mandichak. During slower times while on shift, faculty should conduct mini-lectures on "5 Minute Topic Cards." Medical students should have an evaluation card filled out by EM resident or staff after each shift.

**2. Professionalism and Leadership**

The Navy expects medical officers to be leaders. Further, the ACGME expects the program, in partnership with the command, to provide a culture of professionalism which supports patient safety and personal responsibility. Physicians must demonstrate an understanding of their personal role in the provision of patient- and family-centered care, safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events, as well as, the expectations of the line and the medical officer's role in maintaining readiness of operational units.

a. Processes for reporting unprofessional behavior – Residents should expect a work environment that facilitates their training. The military, the command, and the program have systems in place to ensure the work environment maintains a culture of trust and equality. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

1. The program, in partnership with the command, has established a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. Any staff member who feels they are being discriminated against for any reason should contact the department head immediately. If the staff member doesn't feel the issue can be resolved at the departmental level, then the staff member has several options. If the problem is a graduate medical trainee-specific issue, he or she should contact the program director, CDR Daphne Ponce (618-201-5190) directly.

If outside of the realm of GME, the staff member may seek guidance through the Department of the Navy Equal Opportunity and Sexual Harassment Adviceline (1-800-253-0931). The resident may also file a grievance. Institutional informal and formal grievance procedures are outlined on the Command Equal Opportunity webpage available at (https://nmcp.med.navvy.mil/EqualOp/SitePages/Home.aspx).

Sexual misconduct, including sexual harassment and micro-aggressions, degrade all aspects of the educational and work environment. It will not be tolerated. Staff Members who feel unsafe in an environment due to inappropriate sexual overtones or have been sexually assaulted should call the DOD Safe Helpline (877-995-5247), the NSA-Hampton Roads Sexual Assault Response Center (757-402-2568), or the NSA-Hampton Roads Human Resources Center (757-402-2571). If a staff member feels like they are in immediate danger, they should call 911. Additionally, if a resident has been or thinks they may have been sexually assaulted recently, they should:

* Go to a safe location away from the perpetrator.

* Preserve all evidence of the assault, if possible

* Do not bathe, wash hands, or brush teeth.

* Do not eat or drink (eating and drinking may compromise forensic evidence collection during a Sexual Assault Forensic Exam [SAFE]).

* If you are still in the location in which the crime occurred, do not clean, straighten up or remove anything from the crime scene.

* If you have already changed your clothes, place them in a paper bag.

* Write down or record by any other means all the details you can recall about the assault and the perpetrator.

2. The program, in partnership with the command, has a process for education of all staff members regarding unprofessional behavior and a confidential process for

reporting, investigating, and addressing such concerns. Unprofessional behavior should not be tolerated as it degrades the learning environment and distracts providers from patient-centered care. Any physician who observes unprofessional behavior should contact the department head immediately. If the staff member doesn't feel the issue can be resolved at the department head level, then he/she can contact the Professional Practice Evaluation Committee. The committee's coordinator is Ms. Laura Repass and the DMS (Directorate of Medical Services) representative is LCDR John Roman. Their emails can be found in the Navy global Outlook Webmail system.

**3. Physician Well-being**

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training. Emergency medicine residents and attending physicians are at particular risk for burnout and depression. We have a responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other.

a. The Wellness Curriculum – The residency program has education in physician wellness interwoven into its educational curriculum. This begins during orientation and continues with weekly wellness sessions integrated into our academic conference. Although weekly topics will vary, the curriculum is based on the American College of Emergency Physicians' An Evidence-Based Longitudinal Curriculum for Resident Physician Wellness: The 2017 Resident Wellness Consensus Summit published in 2018. Each week our academic conference includes a wellness-related core content lecture, physical wellness activity (cardiovascular fitness, resistance training, or yoga), a consultant services combined activity (see EM BROS), or a simulated difficult patient scenario that may impact wellness. Additionally, the ACGME has approved the use of four of our academic conferences exclusively used for activities designed "to enhance the meaning that each resident finds in the experience of being a physician."

b. Travel, Vacation, and Military Leave Policies – This is addressed elsewhere in the Faculty Manual but will be summarized here. In order to prevent burnout and foster relationships outside of the workplace, faculty are encouraged to maximize their leave and vacation time. Staff physicians accrue 30 days of leave each calendar year. In accordance with Navy regulations, active duty leave is submitted through the NSIPS online system available at

https://nsipsprod.nmci.navy.mil. Staff physicians should list the Senior Medical Officer LCDR Max Noe as their 'watch coordinator' and their 'approver' as the Department Head CDR Levi Kitchen. Leave requests must be approved in NSIPS and then leave dates entered as schedule requests in AMION.

Though we encourage taking leave, all officers understand that leave may be denied or cancelled, when necessary, by either the command or the department leadership. Tickets purchased before approval will not be considered when granting or denying leave. Failure to comply with mandatory online General Military Training (GMT), medical readiness, healthcare training (Relias) training, scholarly activity, and educational program attendance minimums are grounds for denying leave.

Emergency Leave is granted when appropriate circumstances arise (NAVMED Instruction 1050.3A - Leave and Liberty), and is approved by the Department Head. As per US Navy policy, emergency leave is deducted from service members regular leave balance.

Maternity & Paternity Leave – Naval officers who are or become pregnant will be granted pregnancy accommodation and parental leave IAW current NAVADMIN guidance. Similarly, paternity leave is available for naval officers who have a child born, or have adopted a child and will be granted parental leave as instructed.

OCONUS Leave – Outside the Continental United States – Leave outside the continental United States is a special case and requires special force protection and security considerations. First you MUST be approved by the department head. Then visit the Physical Security Office (Building 3, 1st Deck) and initiating the request process. The staff in the Physical Security Office will let you know what requirements must be fulfilled before going on leave. If you do not do this, your leave will be cancelled. Additionally, OCONUS travel without proper authorization is considered an Unauthorized Absence which has significant effects on medical coverage while traveling, as well as, disciplinary consequences that may affect future promotion. Submit leave requests through NSIPS in the usual fashion. Just because you are approved through NSIPS, does NOT mean that you are approved by the command.

Liberty – Physicians who are not scheduled for clinical duty, have no academic obligations (such as academic conference and journal club attendance), have completed all command-required online training, and have up-to-date readiness metrics may leave the immediate area for recreation and relaxation so long as they remain within the liberty boundary. Liberty outside of the Hampton Roads area (the cities of Chesapeake, Franklin, Gloucester, Hampton, Isle of Wight, Newport News, Norfolk, Portsmouth, Smithfield, Suffolk, Virginia Beach and York) require notification of the Senior Medical Officer regarding your travel plans. Travel beyond the liberty boundary requires an approved leave request documented in NSIPS. The liberty policy is put forth by the command. The current liberty boundary is 250 miles from NMRTC-P.

Temporary Additional Duty and Conference Attendance – Physicians are responsible for maintaining CME via institutional and online resources. The command can support one TAD CME activity every three years. All TAD orders and travel should be entered and approved in DTS. Any TAD requests required approval by the SMO/scheduler prior to committing. Please see Ms. Marcia Gardner for assistance and questions.

Travel to present research – every effort is made to obtain funding to support physicians presenting research, with a goal of funding the day of the research presentation, one additional day at the conference and travel time.

All official travel falls under one of the following titles:

Costed Travel - Travel with associated cost, for registration, transportation, housing, or meals and incidentals, requires approval of the Director for Professional Education (DPE) or the Director of Medical Services (DMS). In general, presenting research conducted under an IRB or IACUC-approved protocol is funded by the DPE. All other travel is funded by DMS. Requests for costed travel must be submitted to the Program Coordinator at least 30 days in advance of travel.

Costing information, airline tickets, housing, meals & incidental totals will be generated in the Defense Travel System (DTS). Ms. Marcia Gardner can help you generate travel orders in DTS using these forms.

Permissive Travel ('no-cost TAD') - Travel in which the traveler agrees to accept all financial burden will be approved at the Department Head Level. Ms. Marcia Gardner can assist.

House Hunting Leave - House hunting travel is grouped into Permissive Travel, and is not to exceed 10 days in total. Please discuss with DH/SMO.

Submitting Travel Vouchers - Upon completion of travel, a voucher must be submitted in the DTS system within 5 days. You are responsible for timely payment of your government credit card. Failure to complete the travel voucher within 60 days of return from TAD will result in a delinquent government credit card bill, which as an institutional policy, is reportable to the NMCP Commanding Officer for disciplinary action.

The MILPERS Manual provides higher authority guidance for all types of Navy leave.