Educational Program:

1. **What is the status of the program's accreditation?**

   Our program received Initial Accreditation in May of 2023. This means that the ACGME has performed a site visit, and that the OBGYN Review Committee has approved our residency program to recruit and teach residents.

2. **When is the next Residency Review Committee (RRC) review?**

   Our program is anticipated to have its next review 2 years after initial accreditation, which would put it in 2025.

3. **Are there any plans for changing the program size or structure?**

   We are accredited for 4 residents per year and have no plans to change the program size or structure.

4. **How solid is the financial status of the sponsoring institution?**

   AdventHealth maintains a strong financial position. Our audited financial statements and other accreditation and survey documents are publicly accessible.

5. **How committed is your institution to resident education and graduate medical education in general? How is this evidenced?**

   In 1973, AdventHealth opened its first Florida residency, a family medicine program in Orlando, focused on training graduates for the mission field. Then in 2006, AH started opening additional programs at its flagship Orlando hospital, quickly growing to a half-dozen programs.

   In 2013, then Governor Rick Scott formally recognized the state's developing doctor shortage and, along with the Florida Legislature, created the Statewide Medicaid Residency Program (MRP) with $80 million in recurring annual funding. The MRP was designed to help hospitals serving Medicaid patients offset the expense of operating physician residency programs. In 2015, the Governor and the Legislature increased their support by creating the Graduate Medical Education Startup Bonus & Retention Programs (GME Startup Bonus and GME Retention). These programs were appropriated $100 million in local and federal funds in order to provide hospitals a one-time $100,000 bonus for every new residency slot created in a shortage specialty. Additionally, the MRP program was expanded in 2017 to an annual budget of $97.3 million. Together, since 2017, the Medicaid Residency Program and GME Startup Bonus & Retention Programs contribute $197.3 million annually to Florida's efforts to address physician workforce deficits.

   Due to these statewide initiatives, AdventHealth began expanding its GME presence by starting residency programs in several of its Florida hospitals, including AdventHealth Tampa. Since 2022, AdventHealth Tampa has invested $4.3 million to establish clinical and learning facilities, hire dedicated, full-time staff and create learner-centered programs to advance teaching and scholarship.

   The first residency program at AdventHealth Tampa, in Internal Medicine, was accredited in 2023 and matriculated its inaugural class in July 2024.

6. **What percent of your residents complete your program?**

   We will graduate our first class of residents in 2028.

7. **What percent of your graduates pass the specialty boards on their first attempt?**

Our first class of graduates will take the specialty certification written board exam in 2030.

8. **Where do your graduates go (e.g. fellowship, academics, private practice)?**

   Although our residents may choose to pursue any number of post-residency options and our curriculum provides the requisite training and experience to choose any path. It is our desire to recruit residents that plan to practice in Florida long-term.

Resident Performance:

1. **How are residents assessed?**

   Residents are assessed in a variety of ways. Milestone-based competency evaluations are completed by faculty at the end of each monthly clinical rotation block, multi-source evaluations are completed by peers, clinical staff and patients on a quarterly basis, and learning session evaluations are completed by faculty following each M&M, Journal Club, and Simulation-Based Training (SBT) sessions. The CREOG in-training exam is taken yearly by all residents in January. These data are aggregated into a resident portfolio.

2. **What are the ways residents receive formative feedback?**

   Residents are provided formative feedback using a variety of approaches. The goal of formative feedback is to immediately reinforce well-performed duties and tasks, as well as correct deficiencies. Formative feedback following educational activities is provided using four main approaches:

   I. Feedback at the Bedside: Faculty provide frequent verbal feedback to residents during the course of routine clinical care. Feedback may occur during rounds, patient hand-offs and during and after procedural activities.

   II. Feedback using MyTipReport: When applicable, either a resident or faculty may initiate a structured real-time completion of a report following an applicable patient encounter or procedure.

   III. Feedback following Simulation-based Training (SBT): All SBT sessions include a structured debrief. The debrief session includes review and discussion of the written SBT evaluation.

   IV. Feedback following Didactic Presentations: Following didactic presentations, residents meet with their faculty mentor to review the written didactic evaluation.

   V. Feedback from rotation evaluations: Residents receive notification following completion of any written rotational or multisource evaluations. They may immediately access this evaluation and review its contents.

3. **What is the structure and frequency of summative feedback meetings with the Program Director?**

   The goal of summative feedback is to evaluate a resident's learning as compared to the goals and objectives of a rotational experience and the program as a whole. Towards that end, each resident has a face-to-face meeting with the program director on a semi-annual basis. Prior to this meeting, residents complete a self-evaluation of their competency across all 6 ACGME competency domains. At the semi-annual meeting, each resident's portfolio and self-evaluation are reviewed and together, the resident and program director synthesize a composite semi-annual assessment. This feedback serves a formative purpose in guiding efforts and activities in subsequent rotations and to ultimately complete the residency program.

4. **What support structures are in place for residents in academic need?**

The Clinical Competency Committee, which meets on a semi-annual basis, makes recommendations to the program director when a resident may benefit from academic support. Residents who need modifications to their educational program may be paired with a mentor who guides him/her in this endeavor. The mentor then devises a program in conjunction with the resident.

Scholarly Requirements and Opportunities:

1. **How do you define scholarly activities?**

   Prior to 1990, the dominant view of scholarly activity was research in the basic science or clinical domains, and publication was the only measure of scholarly productivity. *Scholarship Reconsidered: Priorities of the Professoriate*, a groundbreaking report commissioned by the Carnegie Foundation and authored by Earnest Boyer, ignited a national dialogue that changed our understanding of what defines scholarship and how it can be measured. Boyer proposed a broader view of scholarship by dividing it into 4 categories:

   I. **Discovery** (the pursuit of new knowledge)
   II. **Integration** (synthesizing new knowledge into the broader context)
   III. **Application** (applying new knowledge to solve problems)
   IV. **Teaching** (transferring new knowledge to educate and entice future scholars)

   Our residency embraces Boyer's broad view of scholarly activity both for its faculty and residents.

2. **Are scholarly opportunities provided to residents? Is this a required experience?**

   Scholarly activity is a valued and important part of our curriculum and completion of a scholarly project is required for graduation from the program. Scholarly projects are typically initiated within the context of the Resident Team-based Research curriculum. Together, team members identify a theme and specific research questions. Each resident designs and submits a research proposal to the IRB by the end of the PGY-1 year and conducts the study during the PGY-2 and 3 years. All research is presented at the end of the PGY-3 year at a formal research symposium. Finally, in the PGY-4 year, residents publish their work.

3. **Is "protected" time provided for research?**

   Our residency has a unique Resident Team-based Research curriculum. The longitudinal curriculum spans all 4 years and includes 1-hour monthly team-work sessions which are "protected". Altogether, this design offers 120 hours of structured research time, 1/3 of which is team-based and 2/3 of which is individual self-directed learning.

4. **How are fellowships handled?**

   Residents who desire to pursue a fellowship after residency receive mentorship from faculty in that subspecialty. Residents are encouraged to use their PGY-2 elective rotation month to do an away rotation at institutions where they are interested in applying. Most fellowship applications occur at the end of the PGY-3 year with interviews occurring at the beginning of the PGY-4 year. There is time built into the PGY-4 year for interviewing.

Teaching Responsibilities:

1. **What teaching responsibilities for medical students are expected of residents?**

   AdventHealth Tampa offers fourth year electives in the OBGYN specialty. In the future, student activities will expand to third year clerkship experiences.

2. **If residents have teaching responsibilities, how much time per week is spent with students? Is it "protected" time?**

It's hard to quantify how much time per week is spent with the students. They accompany the residents throughout the daily team activities with the exception of their lecture series. Teaching usually is on a one-to-one basis during rounds or at the patient bedside. Each resident on an individual basis can develop more formal "lectures". There is no "protected" time for student teaching built into the schedule.

3. **Is there any formal training for residents on how to teach students and other learners effectively, and how to provide feedback?**

   Training in effective teaching is the primary focus of the Wellness Series in the PGY-2 year. Excellence in resident teaching is recognized with an annual teaching award presented by the medical school.

Employment Issues:

1. **What are the resident salaries and benefits?**

   Details of salary and benefits offered to residents can be found here **(insert link to Benefits page)**

2. **Is parking a concern for residents at your program?**

   There is a large, well-lighted, parking garage at the rear of the hospital where staff parks. Most of the time, there is ample space in this lot. The lot is safe and patrolled by security. There is no cost for parking.

3. **Are meals paid for when on call?**

   Residents get substantial access to food, snacks and meals for on-call and daily workdays. Residents receive a weekly meal stipend, that they can use at the cafeteria.

4. **What is your policy for leaves of absence?**

   Our approach to leaves of absence, vacation and sick time is built around the requirements of the American Board of Obstetrics and Gynecology. We want to make sure that all of our graduates are eligible for ABOG certification. The ABOG principles are as follows. Click on this link for the details:

   Leaves of absence and vacation are granted at the discretion of the Program Director in accordance with local policy:

   - But the total of such vacation and leaves for any reason—including, but not limited to, vacation, sick leave, parental leave, or personal leave - may not exceed 12 weeks in any of the four (4) years of residency training.
   - If any of these maximum weeks of leave per year are exceeded, the residency must be extended for the duration of time that you were absent in excess of 12 weeks in years one, two, three, and four.
   - Time missed for educational conferences does not count toward the eight weeks.

   In addition to the yearly leave limits above, you can't take more than a total 24 weeks of leave over the four (4) years of residency training. If this limit is exceeded, the residency must be extended for the duration of time that you were absent in excess of 24 weeks.

5. **Is there reimbursement for educational supplies and books?**

   Each resident has an educational stipend, which he/she may use for books and supplies. This stipend increases each year. Please see this link for the details.

6. **What are the rules for moonlighting?**

Moonlight is not permitted.

7. **How are residents represented at the institution level? How is the resident member of GMEC selected?**

   The House Staff Organization is open to all residents and meets quarterly. Led by elected co-presidents, this forum offers residents an opportunity to meet as a group to discuss issues of concern without the presence of program leadership, unless desired.

   One peer-selected resident representative from each program is required to attend GMEC meetings. Through this representation, residents can voice suggestions, concerns or complaints directly to GME leadership. The representative for our residency is selected on a volunteer basis.

8. **Is there a union? Is membership mandatory? Are there dues?**

   There is no resident union. Additionally, because Florida is a right-to-work state, it is illegal for an employer and a union to have a contract that requires each employee to join a union. The contract cannot require an employee to pay dues to the union, either.

9. **Is there a House Officers Association?**

   See Above.

Clinical Learning Environment:

1. **What is the general call schedule?**

   Our residency has a night float system, which runs from Sunday – Thursday. Residents assigned to the Night Float rotations work a 14 hour shift from 5:30 pm – 7:30 am. Weekend call is covered by the residents who are not on night float. The weekend shifts are as follows:

   - Friday 5:30 pm – Saturday 7:30 am and Sunday 7:00 am – 6:00 pm = Total of 25 hours
   - Saturday 7:00 am – Sunday 7:00 am = Total of 24 hours

   All residents work 1-2 weekend shifts per month.

2. **What provisions are made for back-up call or sick-call coverage?**

   AdventHealth Tampa is fully staffed with board-certified OB/GYN physicians. As such, residents are not required to fulfill service demands, allowing for an appropriate balance of education and service in the residency program. Board-certified OB/GYN physician faculty and advanced practice providers such as Certified Nurse Midwives serve as backup for any resident who determines his/her clinical care responsibilities exceed their ability.

3. **What type of structure for supervision is in place?**

   All residents are always supervised by an attending physician. A dedicated faculty attending is present on-site in the AdventHealth Tampa Hospital 24/7. Each patients' care is the ultimate responsibility of the attending physician, but certain aspects are completed by or in conjunction with a resident. The attending physician is responsible for delegating specific aspects of patient care to a resident based on their competency level and year in training.

   During the PGY1 and PGY2 years, residents are initially responsible for the care of uncomplicated obstetric and gynecologic patients. As they demonstrate advancement in the milestones, they are given increased

responsibility in patient management, especially in the sub-specialty rotations of MFM and GYN ONC. PGY2 residents advance into the care of moderately complex patients in these same sub-specialty rotations, with additional experiences in REI.

During the PGY3 and PGY4 years residents' autonomy and responsibility increases. They are responsible for supervising junior residents, as well as participating in the care of more challenging patient conditions. Residents are required to demonstrate an increase in competence in both complex medical management of patients and surgical/procedural skills. Residents continue to treat patients and gain advanced experience in the obstetrics and gynecology subspecialties.

4. **How does the resident's autonomy change as he/she progresses through the program?**

Trainees are directly supervised by their assigned attending until such time they are able to demonstrate level-specific competence recommended by the ACGME and as outlined in the goals and objectives for each rotation. Supervising physicians delegate portions of care to residents based on the needs of the patient and the demonstrated skills of the resident. PGY-1 residents function under direct supervision until competence in patient management and procedural skills are demonstrated and verified by the supervising attending. There is a progressive increase in responsibility and authority at each PGY-level if appropriate benchmarks are obtained. As the resident progresses to PGY-3 and PGY-4 levels, there will be more opportunity for autonomy and supervisory roles as recommended by the CCC and approved by the Program Director.

The CCC considers multiple evaluation tools to ensure consistency and thoughtful consideration of the residents' performance. The CCC is charged with the responsibility of providing an objective assessment of clinical competence for each resident based on the OB/GYN milestones. The CCC then advises the program director regarding resident progression, including promotion, remediation, or dismissal.

5. **Does the general volume of clinical responsibility support a balance between service and education?**

Our residency program is dedicated to ensuring that residents have an appropriate balance between service and educational activities. All residents receive protected time for program educational activities such as daily rounds, didactic conferences, workshops, in-training exam, and any other educational events. All educational events and clinical services adhere to the ACGME Clinical Experience and Education hour requirements. To ensure that this time remains protected, all clinical schedules are created well in advance and everyone is made aware of the schedule to ensure that there are no last-minute changes that would require a resident to miss a clinical or educational activity. In the event ample time is not provided for a change, faculty are responsible to cover the clinical care of the patient or additional faculty back up will be called in. Appropriate and thorough scheduling is critical to providing the residents with the ability to attend educational events while maintaining responsible patient care.