TO: (RESIDENT UNDERGOING FORMAL REMEDIATION)

FROM: PROGRAM DIRECTOR NAME
Program Director, RESIDENCY PROGRAM NAME
Marshfield Clinic
1000 North Oak Avenue
Marshfield, WI 54449

TODAY'S DATE:

DATE OF DISCUSSION WITH RESIDENT:

DATE OF PERFORMANCE IMPROVEMENT PLAN INITIATION:

RE: Structured Plan of Performance Improvement (Remediation)

As we have discussed, *Graduate Medical Education Policies of Marshfield Clinic/St. Joseph Hospital* includes a Performance Improvement policy. The purpose of this policy is to allow timely and effective correction or improvement in areas of identified deficiency.

The purpose of this communication is to outline a specific plan of performance improvement, ensuring everyone involved has a clear understanding of area(s) of concern, specific plan for intervention, oversight of the intervention, and the expected duration. A copy of this plan will be kept in your file, given to you, and forwarded to the Chair of the [PROGRAM] Residency Evaluation Committee.

(INSERT SUMMARY OF JUSTIFICATION FOR THE PERFORMANCE IMPROVEMENT PLAN, INCLUDING ANY INITIAL DISCUSSION WITH RESIDENT, AT WHICH TIME THE PROGRAM DIRECTOR & RESIDENT WOULD HAVE DISCUSSED THE AREAS OF CONCERN, AND POSSIBLE AVENUES FOR ACTION)

IDENTIFIED AREAS OF CONCERN:

1.
2.
3.

PERFORMANCE IMPROVEMENT PLAN:

1.
2.
3.

OVERSIGHT/SUPERVISION/MENTORING:

1. Primary contact:
2. Other involved individual(s)

TIMELINE:

1. Frequency of follow up:
2. Date of next progress assessment:

IMPLICATIONS:

Failing to significantly improve performance to reach the expectations outlined above could place this resident's employment status at risk: □ YES □ NO □ UNSURE

If YES, in what way: □ Non-Renewal of Contract
□ Summary Suspension/Termination
□ Retained without Promotion (Remain at current PGY level)

Note: Performance on In-training exam will not be used as a factor to decide retention, but can be used as a trigger for performance improvement. Mentors will not be asked to provide assessment data to the Program Evaluation and Promotion Committee. Mentors are to serve as a trusted resident advocate in the Performance Improvement Process. Mentors should not be selected if scheduled to be an evaluating physician on the rotation(s) assigned during the above Performance Improvement plan

AGREEMENTS:

The signatures affixed below indicate a receipt and understanding of the above plan, and agreement to participate in the performance improvement. Failure to follow the terms of this plan may result in additional performance improvement and/or disciplinary action.

_____

INSERT RESIDENCY PROGRAM DIRECTOR NAME
Program Director, XXXX [PROGRAM] Residency

_____

Date

_____

(RESIDENT SIGNATURE)

_____

(PRIMARY MD RESPONSIBLE FOR OVERSIGHT OF REMEDIATION)

Resident Performance Improvement Plan: Progress Meeting #[x]

RESIDENT: [NAME OF RESIDENT]
PROGRAM: [NAME OF PROGRAM]
Year in Training: [PGY X]

Date of Plan initiation: [DATE PERFORMANCE IMPROVEMENT BEGAN]

Date of this Progress Meeting: [DATE]

Performance Improvement Plan Directives: [LISTED INDIVIDUALLY]

Progress Report: [AFTER EACH LISTED DIRECTIVE, COMMENT ON PROGRESS]

COMMENTS ABOUT OVERALL PERFORMANCE IMPROVEMENT PLAN PROGRESS, INCLUDING NEXT STEPS

BASED ON PERFORMANCE, IS THIS PERFORMANCE IMPROVEMENT PLAN CONCLUDED AT THIS POINT? ☐ YES ☐ NO

HAS A DECISION ON RESIDENT CONTRACT STATUS BEEN MADE PRIOR TO THIS MEETING?

☐ YES ☐ NO

IF YES, WHAT IS THE CURRENT STATUS OF THE RESIDENT'S CONTRACT?

- ☐ Full Promotion
- ☐ Conditional Promotion
- ☐ Retained without Promotion (Remain at current PGY level)
- ☐ Summary Suspension/Termination

IF NO, HAS THE RESIDENT'S PERFORMANCE DURING THIS PERFORMANCE IMPROVEMENT PLAN INTERVAL ALLOWED THE EVALUATION AND PROMOTION COMMITTEE OF THE RESIDENCY TO MAKE A DECISION ON RESIDENT'S CONTRACT STATUS?

- ☐ Yes, Full Promotion
- ☐ Yes, Conditional Promotion to next PGY level
- ☐ Yes, Retained without Promotion (Remain at current PGY level)
- ☐ Yes, Summary Suspension/Termination
- ☐ No, Performance Improvement must be continued further before a decision on promotion can be determined

_____
INSERT RESIDENCY PROGRAM DIRECTOR NAME
Program Director, XXXX [PROGRAM] Residency

_____
Date

_____
(RESIDENT SIGNATURE)

_____
(PRIMARY MD RESPONSIBLE FOR OVERSIGHT OF REMEDIATION)