

Resident Handbook

*Shasta Community Health Center
Family Medicine Residency Program*

2023-2024

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Resident Handbook

SCHC Family Medicine Residency Program

I. WELCOME:

Our Educational Philosophy:

We recognize our family practice residents as adult learners who will achieve clinical competence through an evidence-based competency directed experience. We are committed to providing appropriate clinical experiences and effective supervision and teaching to achieve the highest level of competency with a focus and particular sensitivity to the clinical, social and other needs of the medically underserved of our community.

Our Aim and Mission Statement:

The SCHC Residency Aim aligns with the SCHC Mission and Values that include: Honesty and Integrity; Teamwork; Caring and Compassion; Community; Excellence and Quality; Education, Teaching, and Training.

The overall Residency Aim is to train full spectrum Family Medicine physicians who are prepared to practice in a rural or underserved environment with a wide range of skills. Our residency rotations, potential jobs at our site post-graduation, and mission driven values to serve the underserved are what drive our residency. Our rotation strengths include Obstetrics, Integrated Psychiatry, Hospice, Pain Management and Palliative care, Pediatrics, Telemedicine and Homeless medicine.

Our Mission:

Is threefold: To select family medicine residents with a strong background/interest in service to the medically underserved; to prepare them to graduate as family physicians who are highly qualified and competent to practice in rural and suburban areas with a strong interest and competency to provide care to the medically underserved in our community; and to further the science and practice of family medicine through the application of Information Technology and Management.

At its inception in 1975, the first Family Medicine Residency Program in Shasta County was based at the Shasta General Hospital in Redding, California. The program began with the mission to produce well-trained family physicians to enter practice in the surrounding region. These graduates have met many of those needs, especially as the population has grown, but there remain substantial, under-served populations in the north state in need of basic primary care services.

This need is particularly acute among those served by Shasta Community Health Center and its own satellite health centers and associated health centers in the region. A fundamental goal of this residency is to meet the specific needs of the traditionally medically underserved of the region while helping to advance the public health mission of Shasta Community Health Center in the areas of health promotion and disease prevention in the community.

Our Background and History:

In February of 1988, Shasta General Hospital closed. Through the efforts of many, but perhaps most notably the resident staff, sponsorship of the original residency program was transferred to Mercy Medical Center, Redding. With this new hospital partner, the underlying residency mission to address the unmet health needs of the north state, through training qualified family physicians was reaffirmed. The Sisters of Mercy, and parent organization Dignity Health, now CommonSpirit, sponsor this residency program as a tangible effort to meet the needs of the poor and underserved in our community. In 1996, there was a track of this program based at Shasta Community Health Center. This track was very successful in identifying, training and graduating family practice residents who eventually became family physicians in community health centers, rural health clinics, Indian health facilities and other teaching programs. Unfortunately, due to budget issues at the hospital based program, this track was eliminated in 2004. In 2012, SCHC became a fully accredited ACGME Family Medicine program with a rural focus dedication. We are a 3-3-3 program that started our first Residents in July, 2013. We received approval for a 4-4-4 expansion in October 2021. In contrast, our program is not a “track” of the Mercy program, but rather an ACGME fully accredited residency program with SCHC as the sponsoring institution. Our program works in close coordination with the Mercy Family Health Center Family Medicine Residency Program and its sponsoring institution, Mercy Medical Center-Redding. We are proud to have a freestanding Residency program, and recently received continued ACGME accreditation for the next 10 years after our site visit in April, 2016.

In your role as a family physician in training, you will be called upon to provide competent and compassionate care to others in a variety of challenging circumstances. With the support of your fellow residents, the residency faculty, the clinical and support/management staff of SCHC, as well as area hospitals and the community in general, you will further your confidence and skills as a physician. We challenge you to take a broad perspective of your developing role as a family physician. You have entered training as a generalist and the community in which you practice will need you as a community physician working with the medically underserved. Use your time with us to enhance your understanding of, and effectiveness in, working with the community you serve. In doing so, you will truly reach your potential to positively impact the lives of your patients who will be cared for in a comprehensive medical home while you are training at SCHC.

While becoming a family physician, we do not expect you to sacrifice your life outside of residency. Family Medicine training can be a demanding task, yet truly effective family doctors have learned to balance their personal needs for

fulfillment with the demands of their job. While short-term compromises must be made, our goal is to support a healthy personal, family and emotional lifestyle during residency that you will carry into practice. You will only be effective and satisfied as a family physician to the degree that you can find balance and fulfillment in the many roles you play.

Your first year in residency training will be divided between SCHC and Mercy Medical Center. The following two years will focus more at SCHC, along with other community opportunities. The majority of first year clinical rotations are spent at Mercy Medical Center where you'll learn to function effectively in the hospital environment. As you progress through your residency training, an increasing proportion of your time will be spent at the Family Medicine Residency Clinic at SCHC and at other ambulatory rotations. Each week in the Residency Clinic, you will build relationships with a growing panel of your own patients. Your patients will look to you for ongoing care and advice. Through these relationships you will learn to be a personal physician. Try to stop by the clinic, or log in to your laptop, every day, if possible, to keep up with patient messages, prescription refill requests, etc. You'll know your patients better, be more help to the health center staff, and everyone will get more satisfaction out of the relationship. We expect you to check your inbox and PAQ in our EMR, which is why you are given a laptop computer. Following your patients when they are hospitalized, or when they deliver an infant, is part of your education as well. While this can be a challenge at times, continuity of care is a foundation of family medicine.

The Family Medicine Residency Clinic at SCHC is within the infrastructure of the main health center facility in downtown Redding. While being somewhat self-contained, there will be plenty of opportunity for you to integrate yourself with the wide range of clinicians, support staff, programs and services of SCHC. To the extent that your training time and commitments allow, you are highly encouraged to seek out and engage with the many other facets of the health center. This will give you great insight and experience as to what it is like to be a family physician within a Community Health Center environment.

The family medicine clinic is actively involved in the training of primary care associates such as Family Nurse Practitioners and Physician's Assistants. SCHC has started a PA/FNP two year post graduate Fellowship Program that Residents will participate in helping to train the Fellows. The center will have medical students and residents from the UC Davis Rural PRIME program, UC Davis COMPADRE program, Chicago Medical School, Touro University, Western University, CHC affiliated programs like AT Still School of Medicine (DO) and other partners. This association of resident physicians and advanced practitioners gives you the opportunity to learn to function as a team member in an interdisciplinary approach to health care. Take advantage of it as the skills to function effectively as a team member and a team leader will be essential to your success as a modern physician. You will have exposure to the use of a medical scribe during your training to experience the Interdisciplinary team model.

Shasta Community Health Center is a member of a large family of Community Health Centers from throughout California (over 400) and across the United States (over 2,000 such organizations). SCHC is designated by the federal government

(HRSA) as a Federally Qualified Health Center or FQHC. This FQHC designation recognizes and qualifies SCHC as a “safety net” health care provider in the region, entitling the program to enhanced Medi-Cal, Medicare and other reimbursement along with some significant federal grants.

This financial support is designed to ensure that those who are income qualified, whether they be on a public payer program like Medi-Cal or are medically uninsured, can access a wide range of primary and preventive care services-based services at SCHC. Along with this funding comes a wide range of federal program expectations involving access, quality and efficiency. The medical staff at SCHC is very much engaged in the leadership and direction of the health center and through the SCHC Residency Program Director, you will have a strong voice in the priorities and performance of the health center. While the focus of your time will be learning and refining your knowledge base of medicine and its application with patients, the public health mission of SCHC will also give you ways to engage on community wide, population-based health improvement opportunities. It is well documented that while clinical medicine is a very important part of maintaining the health of a community, a much larger component of good community health is in the social determinants of health in which influencing good public policy becomes critical. One area of great interest to SCHC is in the promotion of reading among the youngest patients and their parents/caregivers. You will have an opportunity to learn and help influence your patients as to the importance of reading at a young age, as a type of “inoculation” that can overcome many other disadvantages that many of these children will face in their lives. Residents will develop a quality improvement project that centers on improvement of medical care to our patients.

Other advantages of SCHC include a focus on the “patient centered medical home” (PCMH) model. The PCMH concept has the ability, under one roof, to integrate mental/behavioral health, oral health, patient education and outreach (such as our HOPE program geared to providing clinical care, case management and outreach services to the area’s homeless populations) as well as a range of specialty care in one place. SCHC has been operating with an Electronic Medical Record (EMR) NextGen for over 10 years and the use of EMR will be your primary tool for charting, tasking and communicating relevant clinical information to your nursing/support teams, your colleagues and faculty members and to the patients themselves while at SCHC. We have an active patient portal email for patients to access their care. In the Community Health Center world, SCHC is noted for its information technology innovations. You will be exposed to our IT innovations, and in turn this will give you a glimpse of the future of information technology as it relates to the practice of family medicine.

The faculty is here to support you in your clinical care and professional growth. Family Physicians from the community (many of whom are program graduates) share the time as family medicine preceptors as well. Many other physicians are actively involved in the Family Medicine Residency Program as preceptors, guest lecturers and consultants. As noted, SCHC has a wide range of dedicated, skilled, mission-oriented, and motivated clinical teachers outside of the main SCHC Residency Clinic who will share time with you. We welcome you to our community, look forward to working with you, and hope your experience offers both challenge and achievement.

Program Contact, Administration, Faculty, & Clinical Staff Information

Location: 1035 Placer St, Redding CA 96001

Residency Coordinator Phone Number: 530-246-5951

Residency Email Address: schcresidency@shastahealth.org

Program Director: Debbie Lupeika, MD

The program director provides overall leadership and oversight to the residency program and ensures program compliance with Accreditation Council for Graduate Medical Education (ACGME) requirements for a family medicine residency training program, which is built consistent with the needs of the community. The program director is responsible for resident progression and matriculation from the program. They track and review all resident evaluation, feedback, procedure logs, patient logs, and duty hours to ensure resident and program compliance. In addition, the program director has the responsibility, authority, and accountability for:

- Administration and operations
- Teaching and scholarly activity
- Resident and Faculty recruitment and selection
- Evaluation and promotion of residents, and disciplinary action
- Supervision of residents
- Resident education in context of patient care
- Report to various committees and organizations, including DIO, GMEC, ACGME, ABFM, and grants.

Associate Program Director: Amanda Mooneyham, MD

The associate program director assists the program director in developing and implementing program, including updating family medicine residency curriculum, assist with didactic teaching, and help with resident selection process. They may represent the program at official meetings within and outside of the institution. They help coordinate Diversity, Equity, and Inclusion training and help coordinate visiting medical student schedules.

Medical Director: Maria Nicora, MD

The medical director oversees the residency clinic daily operations, along with reporting clinical quality data to the department. The medical director is also involved in clinical didactics and implementation of clinical programs within residency, particularly with resident quality improvement projects and scholarly activities.

Program Coordinator: Amy Fahnestock

The program coordinator is responsible for day-to-day operations of the program and serve as an important liaison with learners, faculty, and other staff members, and the ACGME. They are critical to program success

and are responsible for understanding ACGME and Program requirements, policies, and procedures. They assist the program director in accreditation efforts, educational programming, and support of residents.

Center Manager: Randi Holscher

The center manager oversees the daily clinical operations of the family medicine residency clinic, manages physician patient panels, helps schedule resident rotations, and oversees medical staff who also support the residents in clinic.

Resident Advisors:

Each resident is assigned to a faculty advisor for the duration of their training. The advisor's role is to monitor the resident's progression in training and provide guidance to their scholarly pursuits throughout residency. The program encourages the development of Individual Learning Plans for each resident based on their long-term career goals. They should be familiar with program graduation requirements and inform residents of their ongoing progress and evaluations. They will also review the results of the In-Training-Exam with their resident regardless of testing results and review their ABFM study plans.

Shasta Community Health Center (SCHC)

CORE FACULTY AND ADMINISTRATION

Center Manager:	Randi Holscher, RN
Medical Director:	Maria Nicora, MD
Program Director	Debbie Lupeika, MD
Associate Program Director:	Amanda Mooneyham, MD
Program Coordinator:	Amy Fahnstock
Assistant Program Coordinator:	Susie Mueller

Faculty:

Doug McMullin, M.D., Family Physician
Paul Davainis, M.D., Family Physician, Rural Coordinator, POCUS, OB Faculty
Imran Khan, M.D., Psychiatrist Physician/Internal Medicine
Carey Venglarcik, M.D., Pediatric Medical Director
Collin Lynn, M.D., Family Physician, PA/FNP Fellowship Medical Director
Elaine Porter, M.D., Family Physician
Sahaile Kristoffersen, D.O., Family Physician
Calvin Ruiz, MD, Advisor and Transgender Director
Darrick Nelson, MD, CMO/DIO
Myles Ketchum, MD, MAT Director
Clint Evans, DO, Advisor and Urgent Care
Dan Rubanowitz, PHD, Behavioral Science

Mercy Family Health Center Clinic

THE FAMILY PRACTICE CENTER

Mercy Family Health Center is the other Residency clinic that is intended to function like a physician group practice within the parameters of educational and supervisory mandates. Residents develop panels of patients for which they are responsible as the Primary physician, and develop strong relationships as well as provide continuous, comprehensive and compassionate care. SCHC Residents will occasionally rotate at Mercy Family Health Center during their C1 or C2 rotations. Resident will rotate in the Derm, Plastic Surgery, Allergy, Ortho, and Colpo clinics at Mercy Family Health Center.

CORE FACULTY AND ADMINISTRATION

Clinic Manager:
Medical Director:
Program Director
Program Coordinator:
Assistant Program Coordinator:

Sharon Babcock, RN
Steve Namihas, MD
Duane Bland, MD
Kathy Waurig
Lynda Phanh

Faculty:
John Coe, M.D., Family Physician
Jennifer Moranda, MD, Family
Physician
Steven Namihas, M.D., Family
Physician
Nena Perry, M.D.,
Internists/Geriatrician
Dan Rubanowitz, Ph.D., Behavioral Science
Coordinator Christine Woroniecki, M.A., Behavioral
Science

II. RESIDENCY GOALS & COMPETENCIES

The residency has implemented a competency- based curriculum that defines the knowledge, skills, and attitudes necessary to be a high-quality family physician. The content has been determined by first understanding the tasks and responsibilities of family physicians in suburban, rural and remote locations, and then working backward to define our training experiences. Each rotation has a competency-based set of expectations provided to residents before the start of the rotation that will help guide the educational process. These are divided into cognitive knowledge and skills. Some

of these skills are procedurally based. Specific procedural competencies and expectations have been developed for this residency program; these will be refined with ongoing feedback from residents, faculty, staff, and graduate surveys.

Residents are adult learners, ultimately responsible for their own educations utilizing the competency curriculum. The program is responsible for providing the proper type of learning experiences and for maintaining its full accreditation from the Accreditation Council for Graduate Medical Education and complying with the American Board of Family Medicine's requirements.

Graduate medical education is different from most of the educational experiences of the residents prior to residency where the learning curve was steep, linked to specific courses, and then followed by new material. The residency represents a transition from knowledgeable senior medical students to independent practitioners able to problem solve effectively and manage people and processes. The only way to develop this professional maturity is through responsible patient care with supervision and feedback on skills, management decisions, and outcomes. In the residency, you will encounter undifferentiated problems, complex patients, practice management issues, and the medical system. Repetition will be frequent and not every case will be new material even though each patient has a unique set of personal, family, cultural, and genetic issues. There really is no such thing as a —routine (i.e., uninteresting) case. Your patients are the best teachers.

This learning experience is also a service experience. We learn through providing care and we contribute to our hospital, our clinics, and the people in the community we serve through responsible and compassionate care. Our residents provide extraordinary hospital care to the underserved on medicine, pediatrics, and obstetrics, as well as in our family health center. The relationship that exists between patient care services and graduate medical education is a mutually dependent partnership.

Our goal is to graduate truly accomplished physicians that will enter practice comfortably, be able to handle the difficult cases as well as the straightforward, recognize limitations, obtain consultations as appropriate, and function successfully as a community-based family physician.

A. ACGME MILESTONES

As of July 21, 2021. These are used by faculty advisors to guide progress through residency and presented at Clinical Competency Committee (CCC) meeting twice yearly in December and June. Residents do not attend this meeting per ACGME requirements.

Version 2

Family Medicine, ACGME Report Worksheet

Patient Care 1: Care of the Acutely Ill Patient				
Level 1	Level 2	Level 3	Level 4	Level 5
Generates differential diagnosis for acute presentations	Prioritizes the differential diagnosis for acute presentations	Promptly recognizes urgent and emergent situations and coordinates appropriate diagnostic strategies	Mobilizes the multidisciplinary team to manage care for simultaneous patient visits	Efficiently manages and coordinates the care of multiple patients with a range of severity, including life-threatening conditions
Recognizes role of clinical protocols and guidelines in acute situations	Develops management plans for patients with common acute conditions	Implements management plans for patients with complex acute conditions, including stabilizing acutely ill patients	Independently coordinates care for acutely ill patients with complex comorbidities	Directs the use of resources to manage a complex patient care environment or situation
Recognizes that acute conditions have an impact beyond the immediate disease process	Identifies the interplay between psychosocial factors and acute illness	Incorporates psychosocial factors into management plans of acute illness for patients and caregivers	Modifies management plans for acute illness based on complex psychosocial factors and patient preferences	Implements strategies to address the psychosocial impacts of acute illness on populations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: <div style="text-align: right;"> Not Yet Completed Level 1 <input type="checkbox"/> Not Yet Assessable <input type="checkbox"/> </div>				

Patient Care 2: Care of Patients with Chronic Illness				
Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes that common conditions may be chronic (e.g., anxiety, high blood pressure)	Identifies variability in presentation and progression of chronic conditions	Determines the potential impact of comorbidities on disease progression	Balances the competing needs of patients' comorbidities	
Formulates a basic management plan that addresses a chronic illness	Identifies and accesses appropriate clinical guidelines to develop and implement plans for management of chronic conditions	Synthesizes a patient-centered management plan that acknowledges the relationship between comorbidities and disease progression	Applies experience with patients while incorporating evidence-based medicine in the management of patients with chronic conditions	Leads multidisciplinary initiatives to manage patient populations with chronic conditions and comorbidities
Recognizes that chronic conditions have an impact beyond the disease process	Identifies the impact of chronic conditions on individual patients and the others involved in their care	Develops collaborative goals of care and engages the patient in self-management of chronic conditions	Facilitates efforts at self-management of chronic conditions, including engagement of family and community resources	Initiates supplemental strategies (e.g., leads patient and family advisory councils, community health, practice innovation) to improve the care of patients with chronic conditions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: <div style="text-align: right;"> Not Yet Completed Level 1 <input type="checkbox"/> Not Yet Assessable <input type="checkbox"/> </div>				

Patient Care 3: Health Promotion and Wellness				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies screening and prevention guidelines by various organizations	Reconciles competing prevention guidelines to develop a plan for an individual patient, and considers how these guidelines apply to the patient population	Identifies barriers and alternatives to preventive health tests, with the goal of shared decision making	Incorporates screening and prevention guidelines in patient care outside of designated wellness visits	Participates in guideline development or implementation across a system of care or community
Identifies opportunities to maintain and promote wellness in patients	Recommends management plans to maintain and promote health	Implements plans to maintain and promote health, including addressing barriers	Implements comprehensive plans to maintain and promote health, incorporating pertinent psychosocial factors and other determinants of health	Partners with the community to promote health
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: <div style="text-align: right;"> Not Yet Completed Level 1 <input type="checkbox"/> Not Yet Assessable <input type="checkbox"/> </div>				

Patient Care 4: Ongoing Care of Patients with Undifferentiated Signs, Symptoms, or Health Concerns				
Level 1	Level 2	Level 3	Level 4	Level 5
Acknowledges the value of continuity in caring for patients with undifferentiated illness	Accepts uncertainty and maintains continuity while managing patients with undifferentiated illness	Facilitates patients' understanding of their expected course and events that require physician notification	Coordinates collaborative treatment plans for patients with undifferentiated illness	Coordinates expanded initiatives to facilitate care of patients with undifferentiated illness
	Develops a differential diagnosis for patients with undifferentiated illness	Prioritizes cost-effective diagnostic testing and consultations that will change the management of undifferentiated illness	Uses multidisciplinary resources to assist patients with undifferentiated illness to deliver health care more efficiently	Contributes to the development of medical knowledge around undifferentiated illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: <div style="text-align: right;"> Not Yet Completed Level 1 <input type="checkbox"/> Not Yet Assessable <input type="checkbox"/> </div>				

Patient Care 5: Management of Procedural Care				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies the breadth of procedures that family physicians perform	Identifies patients for whom a procedure is indicated and who is equipped to perform it	Demonstrates confidence and motor skills while performing procedures, including addressing complications	Identifies and acquires the skills to independently perform procedures in the current practice environment	Identifies procedures needed in future practice and pursues supplemental training to independently perform
Recognizes family physicians' role in referring patients for appropriate procedural care	Counsels patients about expectations for common procedures performed by family physicians and consultants	Performs independent risk and appropriateness assessment based on patient-centered priorities for procedures performed by consultants	Collaborates with procedural colleagues to match patients with appropriate procedures, including declining support for procedures that are not in the patient's best interest	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: <div style="text-align: right;"> Not Yet Completed Level 1 <input type="checkbox"/> Not Yet Assessable <input type="checkbox"/> </div>				

Medical Knowledge 1: Demonstrates Medical Knowledge of Sufficient Breadth and Depth to Practice Family Medicine				
Level 1	Level 2	Level 3	Level 4	Level 5
Describes the pathophysiology and treatments of patients with common conditions	Applies knowledge of pathophysiology with intellectual curiosity for treatment of patients with common conditions	Demonstrates knowledge of complex pathophysiology and the comprehensive management of patients across the lifespan	Integrates clinical experience and comprehensive knowledge in the management of patients across the lifespan	Expands the knowledge base of family medicine through dissemination of original research
Describes how behaviors impact patient health	Identifies behavioral strategies to improve health	Engages in learning behavioral strategies to address patient care needs	Demonstrates comprehensive knowledge of behavioral strategies and resources to address patient's needs	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: <div style="text-align: right;"> Not Yet Completed Level 1 <input type="checkbox"/> Not Yet Assessable <input type="checkbox"/> </div>				

Medical Knowledge 2: Critical Thinking and Decision Making				
Level 1	Level 2	Level 3	Level 4	Level 5
Incorporates key elements of a patient story into an accurate depiction of their presentation	Develops an analytic, prioritized differential diagnosis for common presentations	Develops a prioritized differential diagnosis for complex presentations	Synthesizes information to reach high probability diagnoses with continuous re-appraisal to minimize clinical reasoning errors	Engages in deliberate practice and coaches others to minimize clinical reasoning errors
Describes common causes of clinical reasoning error	Identifies types of clinical reasoning errors within patient care, with guidance	Demonstrates a structured approach to personally identify clinical reasoning errors		
Interprets results of common diagnostic testing	Interprets complex diagnostic information	Synthesizes complex diagnostic information accurately to reach high probability diagnoses	Anticipates and accounts for errors and biases when interpreting diagnostic tests	Pursues knowledge of new and emerging diagnostic tests
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: <div style="text-align: right;"> Not Yet Completed Level 1 <input type="checkbox"/> Not Yet Assessable <input type="checkbox"/> </div>				

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

Systems-Based Practice 2: System Navigation for Patient-Centered Care				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of care coordination	Coordinates care of patients in routine clinical situations effectively using the roles of the interprofessional team members	Coordinates care of patients in complex clinical situations effectively using the roles of the interprofessional team member	Role models effective coordination of patient-centered care among different disciplines and specialties	Analyses the process of care coordination and leads in the design and implementation of improvements
Identifies key elements for safe and effective transitions of care and hand-offs	Performs safe and effective transitions of care/hand-offs in routine clinical situations	Performs safe and effective transitions of care/hand-offs in complex clinical situations	Role models and advocates for safe and effective transitions of care/hand-offs within and across health care delivery systems including outpatient settings	Improves quality of transitions of care within and across health care delivery systems to optimize patient outcomes
Demonstrates knowledge of population and community health needs and disparities	Identifies specific population and community health needs and inequities in their local population	Uses local resources effectively to meet the needs of a patient population and community	Participates in changing and adapting practice to provide for the needs of specific populations	Leads innovations and advocates for populations and communities with health care inequities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Systems-Based Practice 3: Physician Role in Health Care Systems				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies key components of the complex health care system (e.g., hospital, skilled nursing facility, finance, personnel, technology)	Describes how components of a complex health care system are interrelated, and how this impacts patient care	Discusses how individual practice affects the broader system (e.g., length of stay, readmission rates, clinical efficiency)	Manages various components of the complex health care system to provide efficient and effective patient care and transition of care	Advocates for or leads systems change that enhances high-value, efficient, and effective patient care and transition of care
Describes basic health payment systems, (including government, private, public, uninsured care) and practice models	Delivers care with consideration of each patient's payment model (e.g., insurance type)	Engages with patients in shared decision making, informed by each patient's payment models	Advocates for patient care needs (e.g., community resources, patient assistance resources)	Participates in health policy advocacy activities
Identifies basic knowledge domains for effective transition to practice (e.g., information technology, legal, billing and coding, financial, personnel)	Demonstrates use of information technology required for medical practice (e.g., electronic health record, documentation required for billing and coding)	Describes core administrative knowledge needed for transition to practice (e.g., contract negotiations, malpractice insurance, government regulation, compliance)	Analyzes individual practice patterns and prepares for professional requirements to enter practice	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Systems-Based Practice 4: Advocacy				
Level 1	Level 2	Level 3	Level 4	Level 5
Identifies that advocating for patient populations is a professional responsibility	Identifies that advocating for family medicine is a professional responsibility	Describes how stakeholders influence and are affected by health policy at the local, state, and federal level	Accesses advocacy tools and other resources needed to achieve (or prevent a deleterious) policy change	Develops a relationship with stakeholders that advances or prevents a policy change that improves individual or community health
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Practice-Based Learning and Improvement 1: Evidence-Based and Informed Practice				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates how to access, categorize, and analyze clinical evidence	Articulates clinical questions and elicits patient preferences and values in order to guide evidence-based care	Locates and applies the best available evidence, integrated with patient preference, to the care of complex patients	Critically appraises and applies evidence even in the face of uncertainty and conflicting evidence to guide care, tailored to the individual patient	Coaches others to critically appraise and apply evidence for complex patients; and/or collaboratively develops evidence-based decision-making tools
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Practice-Based Learning and Improvement 2: Reflective Practice and Commitment to Personal Growth				
Level 1	Level 2	Level 3	Level 4	Level 5
Accepts responsibility for personal and professional development by establishing goals	Demonstrates openness to performance data (feedback and other input) in order to inform goals	Intermittently seeks additional performance data with adaptability and humility	Consistently seeks performance data with adaptability and humility	Leads performance review processes
Identifies the factors which contribute to gap(s) between expectations and actual performance	Self-reflects and analyzes factors which contribute to gap(s) between expectations and actual performance	Self-reflects, analyzes, and institutes behavioral change(s) to narrow the gap(s) between expectations and actual performance	Challenges assumptions and considers alternatives in narrowing the gap(s) between expectations and actual performance	Coaches others on reflective practice
Acknowledges there are always opportunities for self-improvement	Designs and implements a learning plan, with prompting	Independently creates and implements a learning plan	Uses performance data to measure the effectiveness of the learning plan and when necessary, improves it	Facilitates the design and implementing learning plans for others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Professionalism 1: Professional Behavior and Ethical Principles				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>Describes professional behavior and potential triggers for personal lapses in professionalism</p> <p>Takes responsibility for personal lapses in professionalism</p> <p>Demonstrates knowledge of ethical principles</p>	<p>Demonstrates professional behavior in routine situations</p> <p>Describes when and how to report professionalism lapses in self and others</p> <p>Analyzes straightforward situations using ethical principles</p>	<p>Demonstrates professional behavior in complex or stressful situations</p> <p>Recognizes need to seek help in managing and resolving complex professionalism lapses</p> <p>Analyzes complex situations using ethical principles</p>	<p>Recognizes situations that may trigger professionalism lapses and intervenes to prevent lapses in self and others</p> <p>Recognizes and uses appropriate resources for managing and resolving dilemmas as needed</p>	<p>Mentors others in professional behavior</p> <p>Identifies and seeks to address system-level factors that induce or exacerbate ethical problems and professionalism lapses or impede their resolution</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Professionalism 2: Accountability/Conscientiousness				
Level 1	Level 2	Level 3	Level 4	Level 5
<p>Takes responsibility for failure to complete tasks and responsibilities, identifies potential contributing factors, and describes strategies for ensuring timely task completion in the future</p> <p>Responds promptly to requests or reminders to complete tasks and responsibilities</p>	<p>Performs tasks and responsibilities in a timely manner with appropriate attention to detail in routine situations</p> <p>Recognizes situations that may impact own ability to complete tasks and responsibilities in a timely manner</p>	<p>Performs tasks and responsibilities in a timely manner with appropriate attention to detail in complex or stressful situations</p> <p>Proactively implements strategies to ensure that the needs of patients, teams, and systems are met</p>	<p>Recognizes and addresses situations that may impact others' ability to complete tasks and responsibilities in a timely manner</p>	<p>Takes ownership of system outcomes</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

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

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

Interpersonal and Communication Skills 2: Interprofessional and Team Communication				
Level 1	Level 2	Level 3	Level 4	Level 5
Respectfully requests/receives a consultation	Clearly and concisely requests/responds to a consultation	Checks understanding of consult recommendations (received or provided)	Coordinates recommendations from different members of the health care team to optimize patient care, resolving conflict when needed	Role models flexible communication strategies that value input from all health care team members, resolving conflict when needed
Uses language that values all members of the health care team	Communicates information effectively with all health care team members	Communicates concerns and provides feedback to peers and learners	Communicates feedback and constructive criticism to supervising individuals	Facilitates regular health care team-based feedback in complex situations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Interpersonal and Communication Skills 3: Communication within Health Care Systems				
Level 1	Level 2	Level 3	Level 4	Level 5
Accurately and timely records information in the patient record	Demonstrates organized diagnostic and therapeutic reasoning through notes in the patient record	Uses patient record to communicate updated and concise information in an organized format	Demonstrates efficiency in documenting patient encounters and updating record	Optimizes and improves functionality of the electronic medical record within their system
Learns institutional policy and safeguards patient personal health information	Appropriately uses documentation shortcuts; records required data in formats and timeframes specified by institutional policy	Appropriately selects direct (e.g., telephone, in-person) and indirect (e.g., progress notes, text messages) forms of communication based on context and policy	Manages the volume and extent of written and verbal communication that are required for practice	Guides departmental or institutional communication around policies and procedures
Communicates through appropriate channels as required by institutional policy (e.g., patient safety reports, cell phone/pager usage)	Respectfully communicates concerns about the system	Uses appropriate channels to offer clear and constructive suggestions for system improvement while acknowledging system limitations	Initiates difficult conversations with appropriate stakeholders to improve the system	Facilitates dialogue regarding systems issues among larger community stakeholders (residency institution, health care system, field)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

B. CLINICAL LEARNING ENVIRONMENT REVIEW PROGRAM

The Clinical Learning Environment Review (CLER) Program was created by ACGME as result of the 2009-2010 ACGME “Duty Hours Task Force” and implemented in 2012 with site visits to our Sponsoring Institution every 24 months. The recommendations resulting from this task force were to create a program that:

- Links adherence to duty hours, policies, and integrity in reporting to professional responsibilities for patient safety and healthcare quality.
- Educates residents/fellows on institutional patient safety and quality improvement programs.

The CLER Program defines the following six specific focus areas targeted in GME programs:

- Integration of residents/fellows (along with demonstration of impact) into:
 - Patient safety: We strive to educate our residents on patient safety issues and aim to facilitate a culture of safety. We encourage reporting of adverse events, near misses and unsafe conditions if present. Residents have opportunities to observe root cause analysis in group setting and our Safe Prescribing Committee.
 - Health Care Quality: Every resident is required to engage in a quality improvement project and be an active voting member on our various Quality Committees, including Clinical Quality Improvement, Operational Quality, and Medical Information Systems Quality. We utilize ResPIP through ABFM to approve, track and report on resident quality improvement projects. There is longitudinal learning on healthcare disparities.
 - Teaming: We encourage interprofessional learning when possible, including partnering with pharmacy residents, dental residents, and NP/PA fellows. We regularly assess our transitions of care in the hospital and high-quality communication with staff.
 - Supervision: All residents are supervised by an attending for all aspects of training with progressive autonomy throughout training. All procedures are supervised appropriately.
 - Well-being: We have written policies for duty hours restrictions, fatigue management, and mitigation. Events are regularly planned throughout the year by resident and faculty wellness champions to engage in resident and faculty well-being. Peer Support is available. Interns engage in a mindfulness curriculum biweekly with faculty and behavior health clinician.
 - Professionalism: Faculty, staff and learners are expected to cultivate a culture of professionalism, including timeliness with administrative duties, honesty, integrity, and respect. This is built into our core values as an institution and any corrective feedback for professionalism issues are communicated in a timely manner.

c. EPAs (ENTRUSTABLE PROFESSIONAL ACTIVITIES)

EPAs for Family Medicine

In 2015, Family Medicine for America's Health developed 20 Entrustable Professional Activities (EPAs) for family medicine. EPAs are the critical activities that constitute a specialty and the elements that experts and society consider to belong to that specialty. EPAs also define the knowledge, skills, and attitudes that resident physicians must have before they graduate.

Following the approval of the family medicine EPAs, the Association of Family Medicine Residency Directors (AFMRD) formed an EPA Task Force, comprised of program directors and associate directors from rural, community and university-based programs from around the United States. The goal was to develop resources and tools that would help family medicine residencies use EPAs to improve education and help achieve the goal of clarifying for society and practices what they can expect from graduating family medicine residents.

1. Provide a usual source of comprehensive, longitudinal medical care for people of all ages.
2. Care for patients and families in multiple settings.
3. Provide first-contact access to care for health issues and medical problems.
4. Provide preventive care that improves wellness, modifies risk factors for illness and injury, and detects illness in early, treatable stages.
5. Provide care that speeds recovery from illness and improves function.
6. Evaluate and manage undifferentiated symptoms and complex conditions.
7. Diagnose and manage chronic medical conditions and multiple comorbidities.
8. Diagnose and manage mental health conditions.
9. Diagnose and manage acute illness and injury.
10. Perform common procedures in the outpatient or inpatient setting
11. Manage prenatal, labor, delivery and post-partum care.
12. Manage end-of-life and palliative care.
13. Manage inpatient care, discharge planning, transitions of care.
14. Manage care for patients with medical emergencies.
15. Develop trusting relationships and sustained partnerships with patients, families and communities.
16. Use data to optimize the care of individuals, families and populations.
17. In the context of culture and health beliefs of patients and families, use the best science to set mutual health goals and provide services most likely to benefit health.
18. Advocate for patients, families and communities to optimize health care equity and minimize health outcome disparities
19. Provide leadership within inter-professional health care teams.
20. Coordinate care and evaluate specialty consultation as the condition of the patient requires.

EPAs for COMPADRE

To transform the workforce to be better prepared, more equitably distributed, and more deeply connected to rural, underserved, and tribal communities, the **COMPADRE Curriculum team** aimed to answer the question:

“How do we best train providers to thrive in rural, indigenous, and underserved settings?”

The COMPADRE EPAs were created as a response to the above question using a modified Delphi method and building on existing rural competency domains. The EPAs describe tasks that a provider must master to thrive in a rural, underserved, indigenous health setting. While many of these tasks are not unique to these settings, they are **particularly challenged** in rural, underserved, and indigenous health settings, and **particularly necessary for success**. These are tasks for which a master clinician could make decisions about how entrustable a learner was to accomplish these tasks.

EPAs are tasks or responsibilities that can be entrusted to a trainee to perform unsupervised once they have obtained sufficient skills. They are intended to be representative of the real-world work that doctors do. Rather than breaking down a task to multiple sub-components or competencies a learner is assessed by how well an experienced teacher or mentor would trust them to complete the entire task. EPAs are affected by several factors: attributes of trainee, attributes of supervisor, context, the nature of the EPA (complex or simple).

Each EPA below has an explanatory paragraph to expand on the intentions and challenges addressed, key functions that are required to achieve entrustability, and the progression of skills around which programs should build curricular activities. The learning strategies include a single exemplary tool for each instructional method but are intended to be accompanied by the longer Learning Strategies Toolkit, a repository of many different tools that can be used and modified for the programmatic context. Details, key functions, and skills progression can be viewed at learncompadre.com under Canvas→Curriculum

1. Expands or adapts skills and methods to meet community health and health care needs.
2. Partners with the community to address challenges and barriers to health.
3. Collaborates across the health care system to improve health for all.
4. Mentor and invest in the future rural/underserved health care professionals.
5. Balances personal and community needs in a defined community context that demands accountability and transparency
6. Negotiates dual relationships with integrity and role fidelity.
7. Demonstrates the ability to face adversity and use difficult situations to grow personally and professionally and sustain wellness in concert with the community.
8. Recognizes knowledge, power, and wisdom from people in the community.
9. Incorporates ways of inhabiting a place into identity and health of self, patients, and communities.
10. Engages with community in anti-racist ways.

D. OUR PARTNERSHIP IN LEARNING

Learning and teaching represents a partnership that is dynamic and challenging. Every person has their own background experiences, their "best" way to learn, and their "style" of teaching. At one moment the resident may be the learner, and at the next the teacher. Different teachers may have very different (and equally successful) methods for managing a particular clinical problem. As a result, clear communication on needs and expectations will help the process along substantially. The full time, part-time and volunteer clinical faculty teaches because they want to, and the residents are Here to develop in three short years the skills necessary to launch a successful career.

E. ROTATION CORE COMPETENCIES AND EXPECTATIONS

ABFM/RADIOLOGY/LAB ROTATION

Year: PGY2
Rotation Name: ABFR
Location: MMCR
Preceptor: varies
Duration: 2 weeks

The Radiology, Lab, ABFM rotation usually occurs during the second year. This rotation is a two-week block that includes continuity clinic three half-days per week. One half-day will be spent in the Clinical Laboratory, and a minimum of four half-days will be spent doing ABFM modules. The remaining time will be spent in Radiology at Mercy Medical Center. The exact number of radiology days may vary depending upon the availability of radiologists. The following is a description of each component of this rotation.

ABFM Rotation

A. Service Goals and Competencies

Through this rotation, the resident will gain experience in the ABFM Maintenance of Certification process (MC-FP) which is required for achieving and maintaining family medicine board certification. (Medical knowledge). They will also start or continue their Performance Improvement portion of ABFM Certification (Systems-Based Practice)

B. Service Description

The ABFM Board of Directors has determined that all PGY1 family medicine residents who enter training must accumulate a combination of 50 MC-FP points to be eligible to sit for their respective ABFM examination. Points are accumulated by completing modules. Completion of fifty (50) MC-FP points prior to the MC-FP Examination must include:

- Minimum of one (1) Self-Assessment Module (Part II)
- Minimum of one (1) Performance in Practice Module (Part IV) with data from a patient population (or an ABFM approved alternative Part IV activity with patient population data *(Completed SAMs receive 15 points and PPMs receive 20 points)*
 - *Your PI credit for quality improvement project can be awarded through ResPIP.*

The ABFM has made all Part II and Part IV MC-FP tools available to residents without cost, which is normally \$200 per module.

This rotation will include four - half days to work on the modules. Residents will be scheduled additional time to complete a module during their C2 Rotation, if needed; the Performance in Practice Module (Part IV) typically takes Note: Completion of the ABFM modules may also involve work at home either during or outside of this rotation block.

C. Duties

The resident will access the resident portfolio to utilize the tools/modules after they have been entered into The Resident Training Management System (RTMS) by the Program Coordinator. Residents will complete the modules during the scheduled rotation using a computer set up in the preceptor room at SCHC. You are not expected to complete all of the modules, but rather the modules necessary to be eligible to sit for ABFM in their graduating year. The resident must submit certification of completion of the fifty (50) MC-FP points in order to receive credit for this rotation. This is not considered a research activity.

ABFM – Further information: <https://www.theabfm.org/moc/part2.aspx>

Radiology

A. Goals and Competencies

The primary objective of the radiology portion of this rotation is to help the Family Medicine resident develop the skills needed to utilize radiological services for maximum patient care, safety and cost effectiveness.

At the end of residency training, a family medicine resident should:

- Be able to interpret basic radiological tests. (Patient Care)
- Understand the basic principles of radiological tests, including selection of different imaging methods and risks and benefits of various imaging modalities. (Medical Knowledge, Practice-based Learning and Improvement)
- Be knowledgeable about cost considerations of radiological testing. (Medical Knowledge, Systems-based Practice)

B. Service Description

Residents will have scheduled time during the two-week rotation at Mercy Medical Center's Radiology Department.

C. Service Duties

The resident will spend pre-assigned time with radiologists who are interpreting radiological tests. In addition, residents may log in to the American College of Radiology website to go over cases online with the attending radiologist. And interventional radiologist may also ask the resident to observe direct inpatient procedures.

Laboratory Medicine

A. Service Goals and Competencies

The primary objective of the Lab portion of this rotation is to help the family practice resident more fully develop the knowledge base needed to effectively and efficiently manage the laboratory portion of patient care. Laboratory testing, both inpatient and outpatient, constitutes a significant portion of patients' medical care. Residents will gain an appreciation of the ordering, costs, utility and limitations of laboratory tests. Every

year all residents are required to participate in CLIA lab training as well as “Provider Performed Microscopy Procedure” (PPMP) direct observation. At the completion of residency training, a family medicine resident should:

- Be able to perform and interpret common tests done in the laboratory setting. (Patient care, Practice Based-Learning and Improvement).
- Know the significance of quality control in the lab, including the importance of documentation. (Patient Care, Systems-based Practice).
- Understand the basic principles of laboratory tests, including method selection, method verification, sensitivity, specificity, precision, accuracy and bias. (Medical Knowledge, Practice-based Learning and Improvement)
- Be knowledgeable in the cost considerations of laboratory testing. (Medical Knowledge, Systems-based Practice)

B. Service Description

One 4-hour block during the Radiology, Lab, ABFM rotation occurs during the second year. This will take place in the Clinical Laboratory at Mercy Medical Center Redding

C. Service Duties

During the rotation, the resident will meet with the medical technologists in the laboratory. This will include spending time in each of the following areas: Microbiology, Hematology, Urinalysis, Blood Bank, Chemistry, Coags, Immunology. The resident will be able to participate actively in some areas, eg. urinalysis. The medical technologist will evaluate each resident’s participation and understanding. This will be reported to the lab supervisor who will then forward the assessment to the residency office.

ADVANCED LIFE SUPPORT TRAINING

Year: PGY1, PGY2, PGY3
Rotation: During orientation and PRN
Location: off-site
Preceptor: outside vendor

A. Service Goals and Competencies

At the completion of residency training, a family medicine resident should:

- Demonstrate an ability to rapidly assess and gather information pertinent to the care of patients in an urgent and emergent situation and develop treatment plans appropriate to the stabilization and disposition of these patients. (Patient Care, Medical Knowledge)

- Be able to identify the indication and perform procedures appropriately for the stabilization of the patient in an urgent and emergent care setting. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement)
- Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care). (Systems-based Practice)
- Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns. (Practice-based Learning and Improvement)

B. Service Description

Residents are required to maintain certification in NRP and PALS, Cardiopulmonary Resuscitation (Basic Life Support) and Advanced Cardiac Life Support (ACLS) all of which are completed during orientation.

C. Service Duties

Re- certifications are required at the end of the PGY-2 year and can be taken at Mercy. Advanced Trauma Life Support (ATLS) is an excellent intensive course, which is required for any resident who is licensed and who wishes to moonlight at a rural/remote ED in California. ATLS courses are available but often hard to schedule, so planning ahead is very important. Shasta Community Health Center's residency program will pay for the course registration, but all other costs are the resident's. Finally, Advanced Life Support in Obstetrics (ALSO) courses are provided through Shasta Community Health Center in collaboration with Mercy Family Health Center residents. All PGY1 residents will be required to attend an ALSO course.

CARDIOLOGY

Year: PGY2, PGY3

Rotation Name: EUOC, C1, Elective

Location: Private offices

Preceptor: Dr. Khan, Dr. Mufti, Dr. Mendelsohn, Dr. Gill, Dr. Chandramouli

Duration: 2 weeks

A. Service Goals and Competencies

The goal of this experience is to prepare a resident to enter practice with the knowledge, attitudes, and skills to effectively evaluate, manage, and treat patients with cardiac conditions. Residents will also learn when to seek consultation appropriately.

- Understand basic and clinical knowledge of cardiac anatomy and pathophysiology of common cardiovascular diseases. Be confident in EKG interpretation. (Medical Knowledge)

- Perform an appropriate cardiac history and physical examination, document findings, develop an appropriate differential diagnosis, and plan for further evaluation and management. (Patient Care, Medical Knowledge, Interpersonal and Communication Skills)
- Use evidence-based knowledge regarding primary and secondary prevention of cardiovascular disease. (Medical Knowledge, Patient Care)
- Review current practices regarding the care of patients with cardiovascular disease and develop plans to improve the care. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Professionalism)
- Work with physicians, nurses, pharmacists, dietitians, and other health care professionals who care for patients with common cardiovascular diseases. (Patient Care, Medical Knowledge, Professionalism, Systems-based Practice)

B. Service Description

The cardiology rotation is usually in the third year of residency. Cardiology is incorporated into a 6-week EUOC (which is ENT, urology, ophthalmology, and cardiology) rotation. This experience is designed to expose residents to the evaluation and management of common cardiac conditions that present in the ambulatory and inpatient settings. The experience is based in a cardiologist's office practice with case-based, one-on-one teaching. Where appropriate to accomplish educational goals, residents may accompany cardiology preceptors into the hospital setting to consult on hospitalized patients. This rotation represents one component of a resident's training in cardiology. Substantial training in the primary care of patients with cardiac conditions is received in the Residency Clinic and during time spent on the inpatient medicine service. Responsibility for the medical management of inpatients with cardiac conditions occurs throughout residency training.

C. Duties

Attendance at the cardiologist's office is scheduled. During this time Residents will work one-on-one with the cardiologist. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/weeks. A syllabus of relevant readings on the primary and hospital care of common cardiac conditions is available for each resident as a component of the rotation.

EKG INTERPRETATION

Year: PGY1, PGY2, PGY3
Rotation Name: EUOC, C1, C2
Location: SCHC
Preceptor: Dr. McMullin
Duration: ½ day

A. Service Goals and Competencies

Recognizing the large load of learning material that confronts a Family Medicine resident, and recognizing the importance of fundamental cardiology skills, an electrocardiogram interpretation experience is now available for residents matriculated in the Shasta Community Health Center Residency as well as Mercy Family Health Center Residency programs.

B. Service Description

Dr. McMullin has a designated clinic time for EKG review for any resident of these programs, or rotating medical students to review the basics and learn the important aspects of EKG interpretation. Stress treadmill tests may also be performed and taught during this dedicated time.

Each week, 40-50 EKGs are performed at Shasta Community Health Center. These EKGs are each reviewed for interpretation accuracy and constitute the clinical material for review and learning with the residents/students.

The following topics are reviewed:

- Vector and electrical axis
- Measurement of rate, EKG segments and voltage
- Assessment of rhythm, blocks and pacing
- Chamber enlargement
- Injury patterns

The students are referred to:

- Rapid interpretation of EKGs/ Dubin
- www.ecg.utah.edu – an online EKG tutorial with testing

C. Duties

It is recommended that residents and students review the basic learning modules of the University of Utah online EKG tutorial prior to coming to the rotation.

Ideally, two sessions are accomplished with each resident/student. The first session covers the physics and

physiology/anatomy of the EKG. The second session focuses on the pathology of the abnormal EKG.

It has been our experience to date with several residents and students that a focused review of EKG interpretation, and the reading of numerous EKG tests, results in marked improvement in skills and in confidence in this subject. Final assessment is via online EKG testing modules similar to those administered to physicians requesting privileges.

CLINIC I AND CLINIC II ROTATIONS

Year: PGY2, PGY3

Rotation Name: C1, C2

Location: SCHC primarily, also various specialty clinics

Preceptor: varies

Duration: 2 weeks

A. Service Goals and Competencies

The Clinic I and Clinic II Rotations are unique and valuable sets of ambulatory family practice and specialty experiences primarily scheduled at SCHC. The general goal is to provide the resident with a hands-on, longitudinal experience in various specialty areas (Allergy, Colposcopy, Dermatology, ENT, Family & Community Medicine, GYN, HIV, and Orthopedics) as defined below under the supervision of the relevant attending. The resident also develops a higher level of involvement and responsibility for the daily operations of the SCHC Family Medicine Residency Center, seeing acute add-on patients, participating in office management, ancillary services, review of patient care studies, and process improvement. Residents will spend some time of this rotation at the Mercy Family Health Center in their specialty clinics.

B. Service Description

The Clinic I (C1—8 weeks) and the Clinic II (C2—6 weeks) rotations occur in the PGY II and PGY III years. See the Specialty Clinic descriptions under section D, which indicate the rotation (C1 and/or C2.) Each month, the C1 & C2 clinic schedule may vary slightly, so the resident must consult the published schedule.

C. Duties

During this rotation the resident will be in clinic from 8:00 a.m. to 5:00 p.m. daily, Monday - Friday. The resident will be responsible for all specialty clinics as scheduled. Residents will be blocked out for one hour each day they are in the SCHC continuity clinic for covering duties.

When not scheduled for a specialty clinic, the resident will see his/her continuity patients and/or work-ins. Following call, the resident will have the day off.

Covering:

The C1/2 residents are expected to check the physical and EMR inbox, PAQ, and patient portal of those residents on night float, rural, away electives and vacation. While at the SCHC, much of the indirect patient care functions are done through the EMR, working alongside nursing triage and other nursing and support personnel.

D. Specialty Clinics

During Clinic I and II rotations, time is scheduled in the specialty clinics held either at Mercy Family Health Center or Shasta Community Health Center. Continuity clinic time is maintained throughout the rotation at the minimum of three half-days / week, sometimes more.

Clinic 1 Specialty Clinic

Allergy; Dental; Dermatology; Early Intervention Services; Minor Surgery/Plastics; Vasectomy; Practice Management

Clinic 2 Specialty Clinic

Colposcopy; Gyn; Nephrology; Obstetrics

Quality Improvement

Residents will engage in quality improvement training by attending one of the quality improvement committees at SCHC. The Residency Department will perform a PDSA study and quality improvement project to present to the SCHC medical staff and to ABFM.

Allergy Clinic

Year: PGY2, PGY3
Rotation Name: C1
Location: MFHC
Preceptor: Dr. Renard
Duration: ½ day

Core Competencies

At the completion of residency training, a family medicine resident should:

- Be able to demonstrate knowledge of the diagnosis, treatment, and prevention of allergic and immunologic conditions, including but not limited to rhinitis, asthma, urticaria, anaphylaxis, immunodeficiency, and hypersensitivity reactions. (Medical Knowledge)
- Be familiar with the performance and interpretation of spirometry and skin testing. (Patient Care)

- Be able to discuss diagnostic, therapeutic, and preventive strategies of allergic and immunologic conditions with the patient and his or her family in a compassionate, effective manner. (Interpersonal and Communication Skills)
- Demonstrate respect and sensitivity to patients and their families. (Professionalism)
- Be familiar with the appropriate application of evidence-based guidelines regarding allergic and immunologic conditions. (Practice-based Learning and Improvement)
- Appropriately utilize allergy and immunology consultation and be familiar with established reporting processes for allergies and allergic reactions. (System-based Practice)

You will be working with Dr. Renard, an internist specializing in allergy/clinical immunology. During this outpatient rotation, the resident will gain experience in the recognition and proper management of common allergic problems and procedures. The resident must be always present in the allergy clinic during this rotation. The resident does an initial history and examination, and then presents them to the allergist to discuss management and strategy. Attendance at any allergy lectures during this rotation is mandatory. Upon completion of the allergy rotation, a short, written or verbal test is optional pending the discretion of the allergist.

Colposcopy Clinic

Year: PGY2, PGY3
 Rotation Name: C2
 Location: SCHC, MFHC
 Preceptor: Dr. Lupeika, Mooneyham, Porter
 Duration: ½ day

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Be able to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to sensitive issues, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform a comprehensive pelvic examination with appropriate screening tests and wellness counseling, based on the patient's age and risk factors. Be able to perform a colposcopy of patients with abnormal PAP smears. Exposure to the treatment of abnormal biopsy results including LEEP procedures. (Patient Care, Medical Knowledge)
- Be able to perform routine gynecological procedures (Patient Care, Medical Knowledge)

- Develop treatment plans for common conditions affecting female patients, including reproductive issues, utilizing community resources when indicated. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women. (Patient Care, Interpersonal and Communication Skills)
- Consult with obstetrician-gynecologists, other physician specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice)

Training is provided in the management of abnormal cervical pathology under the supervision of Dr. Lupeika, Dr. Mooneyham and Dr. Porter. Procedures include Colposcopy, cryotherapy and LEEP. Colposcopy clinic is held several times per month at SCHC and once every other month at MFHC.

Dental Clinic

Year: PGY2, PGY3
 Rotation Name: C1
 Location: SCHC Main Dental Clinic
 Preceptor: Dr. Pierce
 Duration: ½ day

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Perform oral health evaluations linking patient history, risk assessment, and clinical presentation (Medical Knowledge).
- Implement appropriate patient-centered preventive oral health interventions and strategies (Patient Care).
- Provide targeted patient education about importance of oral health and how to maintain good oral health, which considers oral health literacy, nutrition, and patient's perceived oral health barriers (Patient Care).
- Facilitate patient navigation in the oral health care delivery system through collaboration and communication with oral health care providers and provide appropriate referrals (Systems Based).

This clinic is intended to introduce residents to basic dental and oral health care, especially as these issues will come up in both outpatient and inpatient practice. Residents will spend 1-2 half days at SCHC Main Dental Clinic with dental residents and faculty. Time can also be spent learning how to do fluoride varnish for well child visits through

online training at: <https://www.smilesforlifeoralhealth.org/all-courses/>. This course is endorsed by AAFP and AAP for learning outpatient fluoride varnish application. This is especially important given the high rates of dental caries in children in Shasta County, where water sources are not fluorinated.

Dermatology Clinic

Year: PGY1, PGY2, PGY3
Rotation Name: C1, C2
Location: SCHC, MFHC
Preceptor: Dr. Stratte and Dr. Reece
Duration: ½ day

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Provide compassionate and culturally appropriate patient care that recognizes the effect of skin problems on the patient and emphasizes the importance of comprehensive preventative care. (Patient Care)
- Be proficient in the diagnosis and treatment of common dermatologic diseases and be adept at performing common dermatologic procedures. (Medical Knowledge) Residents will learn about acne, dermatitis, neoplasm, warts, hair loss and hirsutism among many other topics.
- Utilize diagnostic and evidence-based treatment guidelines as well as maintain up-to-date knowledge of appropriate usage of evolving dermatologic treatment technology. (Practice-based Learning, Improvement)
- Demonstrate the ability to communicate effectively with the patient so that dermatologic diagnosis and treatment is provided in a non-judgmental, caring manner. (Interpersonal Communications, Professionalism)
- Incorporate knowledge of the dermatology specialty in order to determine which problems can be managed by a family physician and to understand how to coordinate needed referrals to specialty providers. (Systems-based Practice) Residents will learn basic skin biopsy procedures including shave/desiccation/punch/excision. Ingrown toenail management and wart removal will be taught.

During this outpatient rotation the resident will gain experience in recognition and proper management of common dermatological problems and minor dermatological surgical procedures. This rotation is a hands-on experience that depends on the residents to provide direct care, so residents must be always present in the dermatology clinic during this rotation. The residents see patients, present them to the dermatologist and discuss management / strategy. All extensive surgical procedures are referred to the Lumps and Bumps Clinic. The resident on Dermatology

does biopsies while excisions are referred to the Minor Surgery Clinic and Procedure Clinic.

Early Intervention Services Clinic

Year: PGY2, PGY3

Rotation Name: C1

Location: SCHC

Preceptor: Dr. Kynaston, Dr. Miles, Dr. Shiu

Duration: ½ day

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Recognize HIV risk factors to actively counsel patients regarding primary and secondary prevention, risk reduction, testing, diagnosis, treatment, and management. (Medical Knowledge)
- Recognize the symptoms of acute retroviral syndrome and appropriately diagnose and treat HIV infection in this setting. (Medical Knowledge)
- Synthesize an appropriate diagnosis and management plan for conditions associated with HIV infection. (Patient Care & Medical Knowledge)
- Optimize treatment plans based on knowledge of local HIV care resources that include governmental and non-governmental agencies. (Medical Knowledge)
- Communicate effectively with patients to ensure a clear understanding of diagnosis and plan of care. (Interpersonal Communications)
- Recognize own practice limitations; seek consultation from other health care providers and resources to provide optimal patient care. (Professionalism, Systems-based Care)
- Understand the legal, ethical, and social context of HIV, and its impact on the care of special populations. It is especially important for the resident to understand forms of HIV stigma that exist in the community where they are working. (Professionalism)
- Recognize preventive care screening required for HIV positive patients and how this differs from recommendations for the general population. (Medical Knowledge)

This clinic is designed to promote resident and community understanding of the diagnosis and treatment of HIV disease and its complications. This clinic is conducted at SCHC under the direction of Dr. Joe Villalobos working with Dr. Coe and Dr. Miles. The Resident participates in the work-up and management of HIV patients on a consultative basis developing their knowledge and skills in the management of HIV patients in their own practice.

GYN Clinic

Year: PGY2, PGY3

Rotation Name: C2

Location: SCHC

Preceptor: Dr. Ketchum, Dr. Lupeika, Dr. Mooneyham, Dr. Nicora, Dr. Shaw, etc.

Duration: ½ day

As a second- and third-year rotation, the gynecology experience is intended to strengthen resident's knowledge base and skills in the wide range of primary care gynecology complaints seen by a family doctor.

At the completion of residency training, a family medicine resident should:

- Be able to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to sensitive issues, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform a comprehensive pelvic examination with appropriate screening tests and wellness counseling, based on the patient's age and risk factors. (Patient Care, Medical Knowledge)
- Be able to perform routine gynecological procedures (Patient Care, Medical Knowledge)
- Develop treatment plans for common conditions affecting female patients, including reproductive issues, utilizing community resources when indicated. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
- Understand management of common gynecological problems, such as abnormal uterine bleeding, infections, trauma, sexual assault, benign and malignant neoplasms, and management of abnormal cervical pathology (Medical Knowledge, Patient Care).
- Residents will learn Nexplanon, IUD, OCP treatment, Depo-Provera, the birth control patch and diaphragm use. (Medical Knowledge, Patient Care)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women. (Patient Care, Interpersonal and Communication Skills)
- Consult with obstetrician-gynecologists, other physician specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice)

You will be working with community gynecologists at SCHC, and private gynecologist's offices approximately 15 half-days/month developing appropriate experience in, recognition of, and proper management of common GYN problems and procedures. The resident will see patients and present them to the gynecologist

as appropriate to discuss diagnosis and management.

Other educational activities related to this field are provided by:

1. Opportunities for learning generated by patient care in the Residency Clinic.
2. Opportunities for learning generated by patient care on the Family Practice Inpatient Service and other hospital services including the Emergency Room
3. Discussion of case presentations in Family Medicine and other conferences
4. Lecture topics pertinent to gynecological problems

Practice Management and Management of Healthcare Systems

Year: PGY2, PGY3

Rotation Name: C1

Location: SCHC

Preceptor: CMO and Admin

Duration: ½ day

A. Service Goals:

This instruction is integrated throughout the three years of training to develop management and leadership skills in the resident including both the didactic and the practical settings. The curriculum prepares residents to assume leadership roles in their practices, their communities, and the profession of medicine. SCHC's residents will be based at the Shasta Community Health Center Family Medicine Residency Program located within Shasta Community Health Center in Redding. This SCHC site is considered the primary site for teaching management and leadership skills with a Community Health Center focus. This site also serves as an example on which residents may model their future practices as a physician and potential future clinical leader in Community Health Center world. Residents may also work with community and rural physicians to further develop their practice management skills in alternative settings. At the completion of residency training, a family medicine resident should:

- Demonstrate physician leadership as an uncompromising advocate for patient-centered care of the highest value within the constraints of a viable and sustainable business model for the Patient-Centered Medical Home (PCMH), Patient-Centered Medical Neighborhood (PCMN), and the Health Home (Healthy Community) for the patient's welfare while balancing the business realities of practice management and financial success. (Patient Care and Professionalism)
- Actively conduct a practice search, interviews, contract negotiations, and successfully enter practice. (Interpersonal and Communication Skills)
- Demonstrate knowledge of the legalities and ethics of hiring, promoting, and firing of employees in a practice setting. (Professionalism)
- Identify the structure and operations of health organizations and systems, and the role of the family physician in this structure. (Systems-based Practice)
- Exposure to Electronic Medical records and quality measures of clinical outcomes (Systems-based Practice)

- Identify the measures of health, including determinants of health, health indicators, and health disparities. Advocate for the development of value metrics which will optimize Meaningful Use reporting and payment for value in the healthcare system. (Practice Based Learning and Improvement)
- Identify and foster partnerships that maximize achievement of public health goals. (Systems-based Practice)

B. Service Description:

This rotation will be incorporated into the C1 rotation with two half days during the R2 year and two half days during the R3 year. It will take place at Shasta Community Health Center under the direction and coordination of Dr. Doug McMullin CMO, Brandon Thornock COO, and Dr. Maria Nicora, MD, medical director. The experience will primarily focus on Practice Management within a Community Health Center, with opportunities to meet with the various office staff and physicians to learn how to provide patient care efficiently and effectively in a CHC setting. Residents will learn the following skills:

1. Accurate and appropriate coding and billing
2. Understanding CHC budgets and managing personnel and overhead costs
3. Understanding the billing process including the use of sliding fee scale
4. Understanding patient flow, workflow and practice staffing requirements
5. Understanding the role and responsibilities of the CHC department leadership team including the medical director, nursing director and lead visit coordinator.
6. Understanding basic personnel management and labor issues including employment law and procedures.
7. Understanding the role and importance of new technologies and opportunities to adopt/adapt to those technologies in support of high quality patient care
8. Determining the value of patient care in one's community
9. Measuring clinical quality, current metrics, reporting and understanding basic QI theory and processes
10. Tort liability and risk management
11. Office scheduling systems
12. Use of computers/EMR in practice
13. Alternate practice models

C. Duties

The curriculum for Management of Health Systems involves a variety of formats to achieve over 100 hours of instruction in both the didactic and the practical settings. Residents will attend the rotations and meetings, perform the required reading, and analysis, and will maintain appropriate documentation of their training, which will be reviewed bi-annually with their academic advisor.

1. Intern Orientation Activities

All interns receive at least 15 hours of health systems management training during a two week orientation period.

a. Department Director Meetings: Interns meet with inpatient and outpatient department directors, learning the policies and procedures of each department. They learn how to work with and lead the ancillary staff of the hospital and clinic.

b. Compliance

Billing, Ethics, including review of fraud and abuse laws

c. HIPAA and Relias Healthcare training

2. Medical Staff and Committee Meetings

Residents participate in several monthly medical staff meetings, including SCHC Medical Staff Meeting, their assigned Quality Committee meetings, and faculty-resident meetings. There is also the monthly Perinatal Morbidity and Mortality Conference, Friday Grand Rounds, Journal Club, and weekly Morning Report. During these presentations, residents discuss and receive feedback from the residency faculty and medical staff on case presentations and quality care improvement. Residents participate by developing and providing presentations which are evaluated by faculty physicians and medical staff physicians. Residents also evaluate presentations provided by community and faculty physicians.

3. Inpatient Resident Physician Assessment and Evaluation Training

Senior residents evaluate junior residents for all inpatient rotations, including OB, Peds, and Internal Medicine. Residents also evaluate their attending physicians regarding the quality of instruction provided. There is a yearly retreat that also helps develop these skills necessary for teaching and evaluating learners.

4. Health Systems Management Training at SCHC

This training has several components through all three years of residency training as outlined below.

A. Clinic Staff Team Training and Billing Education

Interns spend two hours observing and learning the role of each member of the front office and nursing staff.

B. Clinic Care Coordination Training (C1 rotation)

Significant training continues during second and third years of residency when residents spend time on the C1 Clinic Doc Rotation. Residents must review and triage daily inbox, PAQ, and prescription requests for all of the other residents, determining the appropriate follow-up, and making sure prescriptions are appropriately refilled for patients seen by residents on away electives or vacation. Residents will be given a review of Clinic Doc responsibilities and ways to coordination of care with the clinic staff. The CMO or medical director will orient residents to SCHC clinic practice duties. Please see copy of clinical competency process for chart audit review.

C. Clinic Quality Improvement Project (C2 rotation)

Residents will join one of the SCHC Quality Committees and participate in a quality project through a PDSA department study. These include:

Medical Information Systems Quality Committee (MISQ)

1. Assure clinical leadership and direction in EHR development and use
2. Provide a forum for collaborative decision making in EHR development and use.
3. Develop SCHC best practices regarding documentation of clinical activity and communication
4. Set priorities for EHR development

Meets the second Tuesday from 8-9am in Sundial Bridge Boardroom

Operational Quality (Ops Q)

1. The mission of the Ops Q committee is to seek out, analyze, implement, and improve operational efficiency throughout SCHC as it relates to the overall strategic plan of the organization. The primary focus of the committee is centered on the strategic plan elements of: 1) Patient Access to Care, 2) Care Teams, Models and Services to Care for Complex Patients 3) Strong and Stable Workforce
 - a. Oversight and development of ongoing operational activities
 - b. "Task-orientation"
 - c. Provides a venue for discussion and collaboration across areas of specialty
2. Implement operational improvements primarily in these three areas-Patient Access to Care, Care Teams, Models and Services to Care for Complex patients, and strong and stable workforce.
3. Implement operational improvements on ongoing projects as they present with specific improvement goals

Meets the second Thursday of each month from 8-930am in Sundial Bridge Boardroom

Clinical Quality Improvement (CQI)

Purpose

1. Define clinical quality and clinical patient safety priorities for SCHC.
2. Develop and implement action plans for clinical quality and clinical patient safety related issues.
3. Provide oversight for QIP and UDS clinical quality data (metrics). Focus on the goals outlined by the SCHC strategic plan 2018-2020 and PCMH related to Quality and Population Health.

Scope and Oversight

1. Responsible for monitoring care for patients that is safe, appropriate, and effective at SCHC
2. Responsible for improving clinical measure performance in UDS and QIP metrics

Meets the first and third Thursdays 8-930am in Sundial Bridge Boardroom

***Residents will rotate through the following committees:**

Quality Improvement and Risk Management Committee

The purpose of the Quality and Risk Management Committee is two-fold. With respect to quality, the committee is responsible for defining, prioritizing, overseeing, and monitoring quality activities, including patient and environmental safety, at Shasta Community Health Center (SCHC). With respect to risk management, the Committee ensures that appropriate procedures are in place to identify, assess and manage risk from a strategic and operational perspective, to monitor implementation of risk management procedures and to report to the SCHC's Board of Directors as necessary.

1. Review and approve the committee structure that supports quality improvement and patient safety.
2. Maintain quality committee reporting process that defines frequency and format.
3. Conduct record-keeping of risk management activities.
4. Align resources to meet the goals of the strategic plan in the areas of patient access and care, care team models, quality and population health and strong and stable workforce.
5. Mitigate barriers related to achievement of quality and safety goals.

Meets the second Thursday of each month from 8-10am in Sundial Bridge Boardroom

Safety and Emergency Preparedness Committee

The mission of the Safety and Emergency Preparedness Committee is to improve the safety culture of our organization through cross departmental collaboration, data analysis and implementation and enforcement of safety standards.

- a. Monitoring and adjustment of safe practices
- b. Emergency preparation
- c. Provides a venue for discussion and collaboration across multiple department
- d. Decrease the number of safety related incident reports by 10%
- e. Decrease the number of Worker's Compensation incidences to below 9 per 100 employees in the dental practice and to below 3.5 per 100 employees in the medical practice
- f. Better prepare the staff at SCHC for our role in the event of a local or regional emergency

Meets the Fourth Wednesday of each month

Safe Prescribing

1. Assist in the formulation of professional practices and policies regarding the primary care management of patients on chronic opioid medications.
2. Develop indicators for clinical care assessment for pain management.
3. Act in an advisory capacity for questions or issues related to pain management with chronic opioid medications.
4. Assure compliance with federal and state regulations or laws.
5. Develop clinic-wide policies regarding chronic pain management.
6. Recommend, review, and revise clinical tools, documentation forms and standard letters for the management of chronic pain.
7. Act as a clinical resource group for clinicians in the management of chronic pain.
8. Perform periodic audits to measure compliance, uniformity, and adherence to policy

Meets the first Tuesday from 945-11am in Sundial Bridge Boardroom

Peer Review-Chart Review and Morbidity and Mortality

1. Ensure high quality of patient care consistent with the six core competencies of medical practice
2. On-going Professional Practice Evaluation (OPPE): Monitor clinical practice patterns through process and outcome measures.
3. Focused Professional Practice Evaluation (EPPE): follow-up on issues identified through OPPE that require more focused/detailed review.

Meets the fourth Thursday from 8-930am in Diestelhorst Bridge Room 3

5. Community Health Systems Management Training and Practice Site Evaluation

- a. Each resident will perform a thorough investigation and evaluation of at least one practice site typically during their practice management rotation (C1) using the Practice Site Evaluation instrument. While doing this, residents will learn to identify the key components of a practice and community health system. They are also encouraged to use this tool when evaluating a practice that they are considering for a future job or during their rural rotation.

6. Practice Management Rotation (C1 Rotation)

- a) This rotation will include two half day training sessions for a total time of 8 hours.
- b) SCHC residents will go to Shasta Community Health Center where the current CMO will be responsible for their introduction to Community Health operations assisted by Brandon Thornock, Chief Operations Officer at SCHC.
- c) If requested 12 weeks in advance, residents may schedule this rotation at other sites such as one of SCHC's rural satellite sites in Anderson or in the City of Shasta Lake as coordinated by Dr. Paul Davainis.
- d) Residents meet with the various office staff and physicians in the practice, learning how to provide patient care efficiently and effectively in a private community practice or rural health setting.

This will occur through a variety of means in the family health center, hospital, and community.

a. SCHC Management Team Meetings

Resident on their C1 clinic doc rotations will serve as resident representative at least once a month with the clinic management team. Meetings include discussions of practice-related policies and procedures, business and service goals, practice efficiency, billing and staffing issues, communication with patients and co-workers, discussions of patient and provider surveys, and quality improvement.

b. Leadership Training

Residents will also get additional leadership training while serving in one of the leadership positions or hospital committees listed below. Residents are expected to participate in at least four meetings during their residency training.

- i. Resident Leadership (i.e., Chief Resident, UCD Conference Planning Committee)
- ii. Residents are expected to be on one quality (operation, clinical, technical) committee at SCHC and if available, another committee (CME, Ethics, 403b, Credentials)

c. Community Leadership Training

During their community medicine rotation, residents work with the county Public Health Officer learning various aspects of health in the community. They also have the opportunity to participate in a variety of public health community projects such as tobacco cessation or STD education. Residents will be involved in SCHC sponsored community wellness and health promotion events and activities both within the Health Center and in the community in general. Residents are encouraged to speak to community groups or patient education classes on health education topics. There is time designated on the community medicine rotation.

8. Academic Advisor Meeting and Analysis of Clinic Productivity Reports

Residents will demonstrate progress in completion of duties and mastery of skills in the management of health systems during their bi-annual faculty advisor meetings. An academic advisor assigned for each resident will summarize the meeting using the academic counseling form. This will include the following:

- Review of rotation specific evaluations to assess clinical competencies
- Assessment of diligence in maintaining medical records
- Review of opportunities for future practice
- Completion of required documents for medical licensure
- Review of procedure training
- Analysis of SCHC-FPRP reports regarding individual and practice productivity and financial performance
- Review of patient continuity for individual resident, including number of OB patients delivered
- Review of Leadership Training experience

9. Management of Health Systems Didactic Training

Residents receive at least 4 hours of lectures each year on a variety of practice management topics, including professionalism, malpractice, evaluation of contracts, preparing for a job interview, billing, and coding, and providing feedback to co-workers. They will also be exposed to information regarding federal loan repayment programs and commitments to such programs.

10. Directed Reading and Study in Practice Management

Residents will spend at least four hours in directed reading of practice management materials during the C1 and 2 rotations.

11. Summary of Hours for Management of Health Systems

1.	Intern Orientation Activities	15 hours
2.	Medical Staff Q/I Meetings and Presentations	36 hours
3.	Inpatient Resident Physician Assessment and Eval Training	6 hours
4.	Health Systems Management Training at SCHC	24 hour
5.	Community Health Systems Mgmt and Practice Site Eval.	3 hours
6.	Practice Management Rotation (C1 Rotation)	8 hours
7.	Leadership Training	12 hours
8.	Academic Advisor Meeting and Analysis of Clinic Reports	6 hours
<hr/>		
9.	Management of Health Systems Didactic Training	17 hours
10.	Directed Reading and Study in Practice Management	4 hours
		<i>Total= 131 hours</i>

12. Additional Meetings

In addition to this, residents spend another 90 hours participating in a variety of additional meetings which occur regularly during residency training.

Bi-weekly Meetings:

- Intern Conference
- Senior Conference

Monthly Meetings:

- Director/Resident Meetings, aka “Duane and Debbie” (1st Monday 12:30-1:30 PM)
- Residency Department Meeting (3rd Tuesday 8-9 AM)
- Resident/Faculty Meeting (1st Wednesday Even Months, 1st Thursday Odd Months)

Bi-weekly Meetings:

- SCHC OB Meeting (1st Wednesday Odd Months)

Meeting Topics include the follow:

- A. Health systems training
- B. Practice-related policies and procedures
- C. Business and service goals

- D. Budget issues
- E. Practice efficiency
- F. Patient satisfaction surveys
- G. Billing practices
- H. Staffing issues
- I. Ways to improve communication with patients and co-workers
- J. Quality improvement

General Goals:

1. Family medicine residents will be prepared to be active participants and leaders in their practices, their communities, and the profession of medicine.
2. Residents will interface with systems, providers and other professionals involved in Health Systems in a longitudinal fashion via structured experience in order to learn to lead, improve, and sustainably work within systems of health care.
3. Residents will attain competencies, attitudes, knowledge, and skills defined by the Accreditation Council for Graduate Medical Education regarding Health Systems Management by caring for ambulatory patients visiting the family medicine center, didactic lectures, conferences, participation with management and interactive interface with providers and professionals.
4. Residents will learn the issues involved with ethical care delivery, regulatory agency compliance, institutional privileging, provider communication, employee management, care marketing, peer review, record management, liability, financial sustainability and more importantly - establishment of a patient centered medical home for patients.
5. Training in Management of Health Systems will foster Milestone development areas of: Patient Care, Medical Knowledge, Practice Based Learning, and Improvement, Interpersonal and Communication Skills, Professionalism and Systems Based Practice.

Attitudes

The resident should develop attitudes that encompass:

- Effective leadership and collaborative participation in multidisciplinary teams with other health professionals.
- Adaptive reserve manifested as modeling and leading highly adaptive care teams.
- An understanding and endorsement of The Improvement Model as developed by the Institute for

Healthcare Improvement (www.ihl.org/ihl) and its application to Quality Improvement within the medical home, the medical neighborhood, and the community.

- An understanding of structured peer review within the medical home and medical neighborhood
- Competencies for effective participation and leadership in outcomes research in the community and academic setting.
- A professional approach to job interviewing and contract negotiation.
- Flexibility in responding to interviewing and contract negotiation.
- Respectful participation in multidisciplinary teams with other health professionals.

Knowledge

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of:

1. Practice opportunities
 - a. Location
 - i. Part of the country or world
 - ii. Size and type of community
 - iii. Region of the community
 - b. Mode of Practice
 - i. Traditional solo or group practice
 - ii. Urgent care or emergency department
 - iii. Staff and group model health maintenance organization (HMO)
 - iv. Managed care contracting
 - v. Administrative
 - 1) Private industry
 - 2) Government-based systems of care (safety net, VA, military)
 - 3) Academic
 - vi. National Health Service Corps and Indian Health Service
 - vii. Federally Qualified Health Center (FQHC)
 - c. Configuration
 - i. Solo
 - ii. Partnership
 - iii. Group
 - iv. Salaried employee
 - v. Corporate management
 - vi. Educator

- d. Employment agreement / contracts
 - i. Compensation and benefits
 - ii. Workload and performance expectations
 - iii. Professional liability coverage
 - iv. Legal provisions
 - v. Ethical issues

- 2. Practice facilities
 - a. Location and market analysis
 - b. Design and regulations
 - c. Financing
 - d. Equipment and services
 - e. Inventories and supplies
 - f. Rent, lease or own
 - g. Laboratories and government regulations
 - h. Radiology and ultrasonography
 - i. Special office-based procedures

- 3. Office organization
 - a. Lean Method of organizational leadership and management
 - b. Chain of command
 - c. Schedules
 - d. Number and type of support staff
 - e. Health Information Technology and Exchange infrastructure including
 - i. Practice Website Design
 - ii. Practice Management Systems
 - iii. E-Prescribing
 - iv. Electronic Medical Record
 - v. Risk stratified patient registries and risk-based intervention bundles
 - vi. Virtual patient care (email, phone)
 - vii. Practice Website-based care

 - f. Supply and inventory management

- 4. Practice operations
 - a. Patient flow and scheduling
 - b. Vendors
 - c. EMR and chart documentation

- d. Written office policies and procedures
- e. Front desk duties
- f. Insurance and other third-party billing
- g. Management of pharmaceutical representatives and samples
- h. Management of phone calls, emails, website-based communications
- i. Telephone and paging systems
- j. Advanced planning and timetable for entering practice
- k. EMR options, records retention
- l. Consultation referrals, prior authorization
- m. Management of patient education
- n. Clinical tracking systems and preventative services
- o. 360-degree evaluations of self and staff
- p. Patient satisfaction surveys, secret shoppers
- q. QA / Improvement and patient safety
- r. Risk management – patient / employee

5. Office and business management

- a. Systems-based practice and analysis
- b. Taxes and insurance
 - i. Estate planning and investment
 - ii. Pension plan and / or profit sharing
 - iii. Tax considerations and social security payments
 - iv. Payroll systems
 - v. Insurance needs
 - 1) Personal (life, disability, health, malpractice, general liability, home)
- c. Monitoring the business
 - i. Reading financial reports
 - ii. Cash flow and lines of credit
 - iii. Accounting systems
 - iv. Billing and collection principles and policies
 - v. Accounts receivable management
 - vi. Financing and capital
 - vii. Overhead management
- d. Personal financial planning
 - i. Budgeting, debt consolidation

- ii. Retirement funding
 - e. Billing
 - i. Billing compliance issues: coding and documentation
 - 1) How to
 - 2) Importance of inpatient and ambulatory coding
 - ii. Fee for service
 - iii. Third party payers
 - f. Contracting
 - i. Medicare
 - ii. Medical, Partnership Health
 - iii. Capitation
 - iv. Fee for Service
 - v. Care Network Contracts (PPO, HMO, ACO)
- 6. Medical Records
 - a. Storage and filing systems; server based / cloud based
 - b. Release of information
 - c. HIPAA / Privacy and Security
 - d. Audits and tracking
 - e. EMR systems, desktop, mobile products
- 7. Staff and personnel policies
 - a. Employee relations / human resources
 - i. Mutual respect
 - ii. Salaries and benefits
 - iii. Motivation
 - iv. Training/ personal development
 - v. Recruitment and retention
 - vi. Terminations
 - vii. Evaluations / COLA
 - viii. Accountability
 - ix. Job descriptions
 - b. Labor laws (sexual harassment, ADA, etc.)
 - c. Workers Compensation
 - d. Benefits programs (health insurance, retirement options, cafeteria plans, wellness programs)
 - e. Personnel records / confidentiality

8. Legal issues
 - a. Risk management and medical / personal liability
9. Office hardware / software / IT options
10. Hospital issues
 - a. Hospital selection
 - b. Staff appointments and privileges
 - c. Medical staff and departmental responsibilities
 - d. Systems management
 - e. Care transitions and service linkage
11. Marketing
 - a. Marketing strategy, ethical marketing goals
 - b. Patient-retention techniques (availability, accessibility, assessment, care coordination)
 - c. Patient support groups / classes
12. Resources
 - a. Practicing physicians (private, hospital based, FQHC, government)
 - b. Practice management consultants
 - c. Accountants
 - d. Lawyers
 - e. Financial planning consultants
 - f. Bankers
 - g. Marketing consultants
 - h. Administrative support
 - i. Compliance officers
 - j. Billing consultants
13. Professional relations
 - a. Medical and specialty society involvement
 - b. Community and government
 - c. Interdisciplinary, multidisciplinary, and transdisciplinary
14. Health care risk contracting
 - a. Metrics
 - b. Patient registries
 - c. Risk stratification

- d. Risk-based intervention bundles

Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer:

1. Balance personal and professional goals
 - a. Effective leadership skills
 - b. Professionalism
 - c. Determining personal and professional goals

2. Selection of practice type (lifestyle, location, professional geography)
 - a. Position application
 - i. Career goal setting
 - ii. Curriculum vitae development
 - iii. Letter of interest
 - iv. Identification of available position, recruiters
 - v. Interviewing skills
 - vi. Culture and politics of the practice
 - b. Practice configuration
 - i. Single vs multispecialty
 - ii. Solo vs group
 - iii. Private vs clinic

3. Contract negotiation
 - a. Employment agreements
 - i. Harassment
 - ii. Confidentiality
 - iii. Requirements of employee
 - iv. Obligation of employer
 - v. Productivity / bonuses
 - vi. Vacation time and scheduling
 - vii. PTO time
 - viii. Salary / benefits
 - ix. Termination timeframes / bilateral / non-competition clause
 - x. Teaching opportunities

4. Prudent selection and utilization of advisors and vendors
5. Personnel management and delegation of responsibilities
6. EMR and electronic competency
7. Time management
8. Personal and public communication, advocacy
9. Resource management
10. Leadership of health care teams
11. Adapting to changes in the health care environment (contracting, compliance, team building)
12. Networking and collaboration / linkage: staying connected to the patient while obtaining services they need.

Resources:

[Physician Leadership in PCMH](#)

Accreditation Council for Graduate Medical Education (ACGME) - www.acgme.org

AAFP Curriculum Guidelines - www.aafp.org/cg

[Risk Management and Medical Liability](#)

[Office Laboratory Medicine](#)

[Medical Informatics](#)

[Training Residents in Community Health Centers](#)

CAFP - www.familydocs.org

Additional Requirement for Site Visits (outside SCHC)

Senior residents are allowed to take 3 days from their usual resident duties providing that any time off is arranged around their clinic schedule, as per the clinic scheduling policy. Time spent for evaluating a site beyond three days will be counted as PTO time. The resident must fill out an elective rotation application form prior to this activity and have it signed by the program director. This is considered an educational opportunity in the area of practice management; the resident must complete a practice site evaluation form (available in residency office). The supervisor at the practice site who provides the information about the site must sign and date the form.

Renal Clinic

Year: PGY2, PGY3

Rotation Name: C1

Location: private office, SRMC, MFHC

Preceptor: Dr. Krahlring, Dr. Bartlow

Duration: ½ day

This clinic will improve the care of patients with renal disease by consulting renal specialists.

Vasectomy Clinic

Year: PGY2, PGY3
Rotation Name: C1, C2
Location: SCHC
Preceptor: Dr. Namihas, Dr. Curran
Duration: ½ day

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Be proficient in communicating in a sensitive and cogent manner with the patient and others involved in his care (when appropriate) all aspects of diagnosis and treatment. (Interpersonal and Communication Skills, Patient Care, Medical Knowledge)
- Be knowledgeable about local resources that are available to assist in assuring appropriate services to male patients. (System-based Practice, Patient Care)

Residents will participate in Vasectomy Clinic, which is incorporated into a procedure training clinic located at SCHC and precepted by family physicians. The goal is to have residents become proficient at performing vasectomies, and all aspects relating to the procedure, including counseling, pre-op exam, and post-op care. Dr. Dr. Namihas primarily oversees this clinic.

COMMUNITY MEDICINE

Year: PGY1, PGY2, PGY3
Rotation Name: CM, Elective
Location: HOPE van, One Safe Place, Good News Rescue Mission
Preceptor: Dr. Patton
Duration: 2 weeks

A. Service Goals and Competencies

Family physicians work predominantly in the ambulatory care environment and must have a strong understanding of the community and its resources for assisting in a patient and family's care. The family physician's role in providing health care to a community includes the application of medical knowledge to the care of various populations, school medicine, outreach to the homeless, occupational medicine, epidemiology, health education, Home Care and Hospice, and public health. This rotation will also emphasize health care delivery issues unique to rural and remote locations in Far Northern California. Residents are expected to achieve the full set of defined Community Medicine Competencies during this rotation. Finally, additional and important longitudinal experiences are structured in the Family & Community Medicine rotation in the PGY II and PGY III years.

At the completion of residency training, a family medicine resident should be able to:

- Demonstrate an ability to work effectively with multicultural and impoverished patients/populations. Special emphasis will be placed on care of the homeless population on the HOPE Van. Residents will have exposure to the mental health and substance use challenges of the homeless population. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Systems-based Practice)
- Define the needs of special populations in the urban setting. (Medical Knowledge, Systems-based Practice)
- Be knowledgeable in adapting the health delivery organization to the culture and the needs of the patients and community being served. (Practice-based Learning and Improvement, Systems-based Practice)
- Describe the epidemiological / demographic characteristics of the population being served. (Medical Knowledge)
- Be knowledgeable in improving and transforming patient services based on patient outcome data and self-assessment. (Practice-based Learning and Improvement)
- Explain how the social determinants of health contribute to health outcomes. (Medical Knowledge)
- Be knowledgeable in effecting health behavior change. (Medical Knowledge, Interpersonal and Communication Skills)
- Be knowledgeable in self-care practices that prevent burn out. (Professionalism)

B. Service Description

Residents will primarily work at HOPE Van clinic sites and outreach camps. Residents will also work at various rural sites, along with our satellite clinic sites in Shasta Lake City, Enterprise, and Anderson. Experience in these rural clinics, servicing multiple small, isolated communities gives the resident the chance to learn clinical skills without the assistance of labs, radiological imaging, and nearby consultants. Telemedicine, however, is a link to long distance specialty care.

C. Duties

Residents will show up to their assigned times to work on HOPE Van, One Safe Place, or Good News Rescue Mission for clinic, bringing their Surface Pro or laptop with them. These clinics usually start at 8 AM and is first-

come, first-serve until all patients are seen. If on Homeless Outreach, they shall wear scrubs or casual clothes. They shall be prepared to engage in wound care and wear comfortable shoes to walking to camps with their team. They must never venture on their own for safety reasons. The team will carry a backpack with medical supplies.

Additional Learning Resources from COMPADRE:

[Population Health Training Module](#)

[Social Determinants of Health](#)

[AAFP's The EveryONE Project Toolkit](#)

Other relevant Links:

[Healthy People 2030](#)

[STFM Advocacy Course](#)

[STFM Leading Change Course](#)

AFP Articles:

[Primary Care for Refugees: Challenges and Opportunities](#)

[Caring for Latino Patients](#)

[Caring for Transgender and Gender-Diverse Persons: What Clinicians Should Know](#)

[Preventive Health Care for Women Who Have Sex with Women](#)

[Preventive Health Care for Men Who Have Sex with Men](#)

[Care of the Homeless: An Overview](#)

[Care of Incarcerated Patients](#)

[Adults with Developmental Disabilities: A Comprehensive Approach to Medical Care](#)

[Care of the Military Veteran: Selected Health Issues](#)

[Incorporating Medical Interpretation into your Practice](#)

Optional Activities:

1. Review the [Community Health Assessment](#) for Shasta County and come up with a quality improvement or community engagement project based on health needs.
2. Create a food budget for a family of 4 living on CalFresh (SNAP) benefits. The current benefits are \$835/month (\$208.75/week). Your goal is to create a nutritious menu for the family of four that fits within that budget. Bonus experience is to use these limits to feed your own household for the week (2 member household is \$114/week).
3. Learn about Redding's public transportation system or ride RABA at least once to get to your rotation.
4. Attend local health fairs/booths. We generally staff: Airports for Autism, local high school STEM events. Please inquire more from Patient Education department.

Residents spend a day at the Shasta County Public Health Department. The following is a sample schedule:

8:30 – 9:00 am	Welcome & Overview of Public Health <i>Robin Schurig, Branch Director, Public Health</i>	Rosalee Davis Conference Room
9:00 – 9:30 am	Outcomes, Planning & Evaluation <i>Daniel Walker, Epidemiology & Evaluation Supervisor</i>	Rosalee Davis Conference Room
9:30 – 9:55 am	Communicable Disease Experience	Rosalee Davis Conference Room
9:55 – 10:40 am	Lab Tour <i>Heather Hood, Public Health Microbiologist</i>	Public Health Lab
10:40 – 10:55 am	Break	
10:55 – 11:40 am	Preventative Medicine & Health Officer Overview <i>Karen Ramstrom, DO, MSPH</i>	Rosalee Davis Conference Room
11:40 – 2:00 pm	Lunch	
2:00 – 2:30 pm	Immunization Clinic Tour <i>Scott Bray, Public Health Clinic Services Coordinator</i>	Public Health Clinic
2:30 – 3:00 pm	Syringe Exchange Program <i>Rochelle Tomlinson, Senior Public Health Assistant</i>	Public Health Lobby

COMPLEMENTARY MEDICINE

Residents will be exposed to different practice styles of medicine. Dr. Featherstone is a D.O. faculty who practices acupuncture, Chinese Herbal medicine, and OMT. Leah Harper is a Native American cultural medicine woman who works with the local Native American tribes. During community medicine, residents will rotate at the Redding Rancheria, a local Indian Health Service Clinic. Other opportunities will be made available per resident requests and through elective times. Residents will be introduced to other therapies including Reiki, ART, therapeutic touch, yoga and Tai Chi. SCHC runs an osteopathic manipulation medicine clinic (OMT) twice a month where both D.O. and M.D. Residents will be exposed to this treatment modality.

CONTINUITY HOME AND SNF CARE VISITS

Year: PGY2, PGY3
Rotation Name: n/a (usually outpatient rotation)
Location: Various long term care homes
Preceptor: Dr. Lupeika, Nelson, Nicora, Mooneyham
Duration: Once monthly

A. Service Goals and Competencies

The goals of performing continuity home care visits are to allow residents to see patients in their home environments and to identify social and/or environmental concerns which impact patient's ability to maximize their health/health care system. These visits will assist the resident in better understanding the obstacles to, as well as resources for, improving their patient's overall health and well-being. At the completion of residency training, a family medicine resident should:

- Be able to perform standardized comprehensive assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high-quality care. (Interpersonal and Communication Skills, Professionalism)
- Recognize self- limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)
- Be able to communicate effectively with patients of all ages, demonstrating active listening skills, a respectful approach to issues that may be sensitive for patients, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform comprehensive physical examinations of female anatomy with appropriate screening tests for women (detailed below). (Patient Care, Medical Knowledge)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive issues in women as well as comprehensive wellness counseling based on the patient's age and risk factors. (Patient Care and Interpersonal and Communication Skills)

- Demonstrate the ability to take an age-appropriate history and perform a physical exam. (Patient Care, Medical Knowledge)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient’s family and caregivers, to ensure that the diagnosis and the treatment plan are clearly understood. (Interpersonal and Communications Skills)
- Recognize his or her own practice limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care. (Professionalism, Systems-based Practice)

B. Service Description:

Each resident must perform at least two home visits during his/her residency training. An additional way that residents can fulfill the adult Home Visit requirement is on their hospice rotation.

C. Duties:

Each resident will identify patients from their continuity clinic panel, who would be appropriate for, and accepting of, a home visit.

Dr. McMullin, Dr. Nicora, Dr. Nelson, and Dr. Lupeika are Home Visit Faculty Supervisors. A faculty member must supervise all home care either on site or by prompt chart review, as is appropriate based on a resident’s level of expertise and competence. If a faculty member is unable to accompany the resident to the patient’s home, it is recommended that he/she use a staff nurse. For charting and clinical order’s purposes the resident will have a laptop and wireless connection to the SCHC EMR system. If EMR connectivity is a problem, the resident will be given a “Home Visit Packet” with the appropriate forms documenting pertinent social/clinical information and education. This documentation can be picked up at the SCHC preceptor room from the Center Manager, Randi Holscher.

If EMR connectivity is not reliable it is preferable that these visits be recorded on the forms provided, opposed to dictating, as this will ensure prompt chart reviews and verification/tracking of these educational experiences. Any written and completed home visit forms will be filed into the patients SCHC clinic record as a scanned copy into the EMR but the resident should ensure that critical information/data and orders be completed on the EMR upon their return to the health center or after hours via a secure internet link to the health center’s EMR. Each home visit should also be entered by the resident into the New Innovations on-line tracking program.

Home Visit Instructions

- 1) Identify an appropriate patient for home visit and contact the patient to discuss the home visit, schedule a time, and get directions. Coordinate with a faculty member's schedule if he/she is to attend the home visit with you.
- 2) Obtain an SCHC Laptop computer and wireless engaged card to enable connectivity to the secured SCHC EMR system and chart on the appropriate templates for that visit. If in doubt or if connectivity is unreliable, obtain the Home Visit Packet from Randi Holscher.
- 3) Enter the home visit in New Innovations and task your faculty preceptor to sign off your EMR visit note.

ELECTIVES

Year: PGY2, PGY3
Rotation Name: Elect
Location: varies
Preceptor: varies
Duration: 1-2 weeks

A. Service Goals

Electives are primarily intended to enrich the resident's training with experiences relevant to their future practice, their special interests, or for rounding out the training experience with competencies not attained through the required rotations. As adult learners responsible for their continuing medical education beyond residency, each resident must be able to identify educational opportunities and then craft experiences that will address those individual needs. The program supports and encourages this self-directed learning opportunity. Up to one month of elective time may be used for remediation, determined by the SCHC Residency Program Director. Residents may be called into the hospital or clinic duties during elective time if an emergency or disaster situation arises.

B. Service Description

There are 16 weeks of elective time (6 weeks away) in the R-2 and R-3 years. R-1s do not have elective time unless it is needed for remediation or other special circumstances. While on Elective, residents participate fully in their continuity health center duties, call, and conference attendance. If an Away Elective is approved by the Program Director, even if that time is taken locally, the resident has no health center, call or conference responsibilities, which nearly doubles the actual amount of time for the elective experience(s) during this Away Elective block. While we will make every attempt to accommodate resident requests for time away, that is not a

guarantee, because of Medicare funding, and provision of continuity services to the resident's patients at the clinic. International electives must meet the criteria below before they will be considered. Out of state electives will also require exceptional justification. Finally, Research Electives can be structured as a research or academic project, focused on a research or evidence-based literature clinical project resulting in a formal presentation for residency. Elective rotations must be local in order for the Resident to be available for clinic, call duties, hospital coverage if needed during a disaster situation, daily conference and continuity OB patients.

C. Duties

The residency must comply with the regulations of both the Accreditation Council for Graduate Medical Education (ACGME) and Medicare for the appropriate approval and documentation of elective time if the resident's time and expense is being used by SCHC. Without this documentation, credit cannot be given to the resident for the elective rotation. Such rotations may only be considered if they do not undermine the financial or operational integrity of the Health Center and/or Hospital under Medicare. For these reasons, the Elective Form, that contains the required steps to obtain approval for the elective and document approval from the supervising physician, must be completed in its entirety. If the resident has not submitted the proper and completed Form to the Program Director (who approves each Elective) one month in advance at the latest (earlier for international electives – see below), the resident will be assigned to an in-patient rotation with the usual clinic duties. There is an Elective Binder available in the Residency Office to help guide Elective rotations. The Resident is responsible for setting up their Electives and turning in the appropriate paperwork on time. Please also complete the elective feedback form through New-Innovations so we can continue to build on our Electives Binders to help guide future learning.

General Elective Procedure: (see Request for Elective form)

Section 1: The resident must identify the experience and develop educational objectives that describe what the resident seeks to learn in the experience.

Section 2: The resident must obtain the signature and other demographic information requested from the supervisor

Section 3: The resident must submit the Request for Elective form to the Residency Program Director for approval

- a. No later than one block in advance of the Away Elective (30 days)
- b. No later than 3 1/2 blocks in advance of international electives and electives if any special scheduling requests involving the health center or call are desired. If not, one block advance is sufficient (120 days)

- c. A copy of this form will be sent to the Chief Resident (for master schedule approval), the Health Center (for clinic scheduling) and the Resident (for records).
- d. The final evaluation must be completed by the supervisor for the resident to receive credit for the rotation. It is the resident's responsibility to have the supervisor complete Section 4 Final Evaluation and return this to the residency office.

Section 4: The Resident bears all costs of housing, food and travel for Electives and Away Electives.

Away Electives

Away electives require a CV from the preceptor and a description of the location (clinic) they will be working at (brochure or copy of web site preferable).

International Electives

Resident is performing well in competency areas of patient care, medical knowledge, and practice-based learning and improvement, interpersonal communication, professionalism, system-based practices, procedural skills, and is functioning at a level appropriate to training. (Based on resident's rotation evaluations, ITE scores, and academic counseling reports). For clinic-sponsored Global Health Electives, please refer to that separate section.

- i. Faculty quality preceptor available on-site
- ii. Medical repatriation insurance is obtained, and resident understands/accepts the limitations of SCHC's Federal Tort Claims Act (FTCA) and/or other malpractice and other insurance coverage that will likely not follow them to their external site. Resident will be personally responsible for the cost of this insurance. (Note: The AAFP has information on their website under International Travel and Health which includes links on travel information, insurance, etc.).
- iii. Specific Rotation goals and objectives established ahead of time
- iv. Fluency in native language or access to bona fide translator
- v. Grand rounds caliber presentation on relevant clinical topic after return
- vi. Resident bears all costs of travel, housing, food, pre-health screenings and immunizations
- vii. Resident will be responsible for acquiring and paying their own separate malpractice insurance during the international rotation

Parental Newborn Elective

A. Service Goals:

To augment the practical education inherent in experiencing pregnancy, postpartum and care of a newborn in the resident's family. At the end of this rotation, residents are expected to:

- Improve counseling of new parents on normal postpartum experience and difficulties
- Improve counseling of new parents on care of the infant in the neonatal period (Patient Care)
- Understand the experience of the role of patient and of families of patients
- Understand the management of pregnancy and delivery through experience and relevant literature review
- Understand the psychosocial literature on childbirth, parenting and parental roles (Medical Knowledge)
- Conduct a critical review of the evidence underlying the management of a condition of importance to patients, regarding pregnancy, postpartum, or newborn care (Practice-Based Learning and Improvement)
- Present a synthesis of experience (Interpersonal Communication Skills)
- Using reflective discussion and/or writing to deepen understanding of the role of physician and patient in expressing and responding to change and to physical and emotional stressors. (Professionalism)
- Describe the differences between the patient's view and the medical professional's view of childbirth and family development in early childhood. (System-Based Practice)

B. Service Description:

This rotation is 2-week Away Elective structured academic experience to augment the practical education inherent in experiencing pregnancy, postpartum and care of a newborn in the resident's family. It is intended to be taken by residents experiencing the birth or adoption of a child. Most parental/newborn electives will be taken near the time of birth or adoption. The program director may grant, on an exceptional basis, electives planned more than one month after the birth or adoption (or the end of a medical or parental leave).

At the completion of the rotation, the resident must meet and discuss the rotation competencies with their academic advisor. A written proposal must specify obstetric, postpartum, or neonatal topics the resident will investigate, with a list of references and resources. Additionally, a noon conference presentation must be completed following the rotation.

Service Resources:

- Maternal Mental Health flyer provides access to up to 8 no-cost telehealth visits for parents in the perinatal period (Residents could opt in for themselves if desired)
- Perinatal psychiatry consults available system wide (all of Common Spirit Health) – for providers
- Downloadable toolkit that addresses a wide range of perinatal mental health issues (in OB binder at MFHC).
- Google Drive/Independent Study: Learning Resources/Obstetrics

Service Evaluation:

The resident’s Faculty Advisor evaluates the resident based on discussion and presentation of the learning objectives.

Addendum:

The Parental Newborn Elective is considered a part of the residency training curriculum. If a resident wishes to take a leave of absence, this will be subject to SCHC policies and the Family Medical Leave Act. A leave of absence may result in an extension of residency training and an equivalent delay of the resident’s graduation date.

Research Electives

Define the scope of the project and how it directly relates to the care of your patient(s) at SCHC.

Limit to 2 weeks per the span of residency training unless there are exceptional circumstances.

Schedule as Elective (addressing when resident will be in clinic). Research Electives will generally not be scheduled as “Away electives” unless the nature of the project requires the resident to be away from Redding or with Program Director approval. Requests for exceptions to this policy will be made on a case-by-case basis and reviewed by the residency office. Define how the resident plans to organize and present the material covered during the elective. Choices include:

- 1) Giving a noon conference or grand rounds at the Hospital (If a resident elects to give noon conference he must talk to the SCHC Residency Program Director and coordinate this with the MFHC faculty member assigned to this). The presentation of the material covered in the research elective must be ready at the completion of the designated elective time.
- 2) Summarizing the material in a written report and presenting it to the faculty advisor. The summary of the material must be ready for presentation at the completion of the designated elective time.

ENT (Ears, Nose, Throat)

Year: PGY2, PGY3

Rotation Name: EUOC

Location: Private offices

Preceptor: Dr. Domb, Dr. Bergstrom

Duration: 2 weeks

A. Service Goals and Competencies

The goal of this rotation is to prepare a resident to enter practice with the knowledge, attitudes and skills to effectively evaluate, initiate management and, when appropriate, seek consultation on patients with more complex ENT conditions.

At the completion of residency training, a family medicine resident should:

- Be able to perform a surgical assessment and develop an appropriate treatment plan (Medical Knowledge, Patient Care)
- Coordinate ambulatory, inpatient, and institutional care across health care providers, institutions, and agencies (Systems-based Practice, Patient Care)
- Demonstrate the ability to communicate effectively with the patient, as well as with the patient's family and caregivers, to ensure that the diagnosis and treatment plan are clearly understood (Interpersonal and Communication Skills)
- Demonstrate the ability to communicate effectively with the surgeon supervisor/consultant about the patient's symptoms, physical findings, test results, and proposed plan of care (Interpersonal and Communication Skills, Professionalism)
- Recognize his or her practice limitations and seek consultation with other health care providers when necessary to provide optimal care (Professionalism, Practice-based Learning and Improvement)

B. Service Description

The ENT rotation is integrated into 6 weeks in the third year of residency along with Urology, Cardiology and Ophthalmology (EUOC) and is designed to expose residents to the evaluation and management of common ENT conditions that present in the ambulatory setting. The experience is based in an ENT office practice. Where appropriate to accomplish educational goals, residents may accompany ENT preceptors into the hospital setting to assist or observe surgical procedures. This rotation represents one component of a residents training in ENT. Substantial training is provided in the primary care of patients with ENT conditions. Responsibility for the medical management of inpatients with ENT complaints occurs throughout residency training.

C. Duties

Attendance at the ENTs office is required. If approved by the ENT attending, you may also join them at other practice locations. During this time, you will work one-on-one with an ENT. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/week. A syllabus of relevant readings on the primary and hospital care of common ENT conditions is available on our residency website under learning resources and is considered a required component of the rotation.

EMERGENCY MEDICINE

Year: PGY1, PGY3
Rotation Name: ER
Location: MMCR, St. Elizabeth's
Preceptor: varies
Duration: 2 weeks

A. Service Goals

The goal of this rotation is to develop the skill in the assessment and management of acute medical and surgical disease entities in the emergency department setting. This rotation will allow the resident to better see things from the perspective of an ED physician, which is different from continuity of care outpatient medicine. In the ED, all patients are seen as having the worst possible diagnosis until that diagnosis is “ruled-out”. In many cases, patients who do not have a clear diagnosis must be admitted for further evaluation. By the end of the rotation, residents will be able to triage many patients within a few minutes regarding the need for admission.

Residents will be encouraged to evaluate and manage an increasing number of acute medical and surgical patients simultaneously. The goal for a first-year resident is 1 to 2 patients at a time, then 2 to 3 as a second year, and 3 to 4 as a third year. At the completion of residency training, a family medicine resident should:

- Demonstrate an ability to rapidly assess and gather information pertinent to the care of patients in an urgent and emergent situation and develop treatment plans appropriate to the stabilization and disposition of these patients. (Patient Care, Medical Knowledge)
- Be able to identify the indication and perform procedures appropriately for the stabilization of the patient in an urgent and emergent care setting. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement)
- Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care). (Systems-based Practice)

- Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns. (Practice-based Learning and Improvement)
- Appropriately inform, educate, and elicit patient and family participation in medical decision making in a professional and caring manner with sensitivity to cultural and ethnic diversity. (Professionalism, Interpersonal and Communication Skills)
- To achieve competence in diagnosing and managing emergency conditions as appropriate for the primary care physician (Knowledge, Patient Care)
- To achieve competence in recognizing, stabilizing, and referring complex emergencies (Knowledge, Patient Care)

Knowledge Objectives:

The Family Practice Resident should have knowledge of:

1. Principles of history taking appropriate to the emergency situation
2. Principles of problem solving in Internal Medicine
3. Technique of basic and advanced cardiopulmonary resuscitation, including Assessment, resuscitation & stabilization of critically ill patients (including codes)
4. Indications for and method of procedures including venipuncture, arterial puncture, lumbar puncture, thoracentesis, paracentesis, airway insertion and chest tube placement
5. Indications for referral and consultation
6. Pathophysiology, diagnosis, and management of emergencies including:
7. Cardiovascular emergencies (e.g. hypertensive crisis, acute myocardial infarction, cardiopulmonary arrest, acute coronary syndrome, cardiac arrhythmias, ruptured aortic aneurysm)
8. Pulmonary emergencies (asthma, COPD, foreign body, pneumonia, CHF, PE)
9. Endocrinological emergencies (e.g. diabetic 70tatus70dosis, hypoglycemia, hyperosmolar coma)
10. Pulmonary emergencies (e.g. 70tatus asmaticus, acute pulmonary edema, pneumothorax, smoke inhalation, airway obstruction, pulmonary embolus, near drowning)
11. Hematological emergencies (e.g. shock, acute blood loss, bleeding disorders, sickle cell crisis, thromboembolus)
12. ALOC (toxic, metabolic, infectious, trauma)
13. Gastroenterological emergencies (e.g. GI bleeding, thrombosed hemorrhoid, abdominal pain, peritonitis, AAA, renal calculi, gallbladder disease, appendicitis, mesenteric ischemia, Hernia)
14. Infectious disease emergencies (e.g. meningitis, septic shock)

15. Genitourinary emergencies (e.g. hematuria, renal colic, electrolyte disorders, obstructive uropathy, testicular torsion)
16. Allergic emergencies (e.g. anaphylaxis)
17. Neurological emergencies (e.g. stupor and coma, head injuries, status epilepticus, heat injury, CNS bleeding, meningitis, CVA, TIA, peripheral deficits, e.g. Bell's palsy or w/LBP)
18. Surgical emergencies (e.g. trauma, burns, foreign bodies, abrasions including corneal abrasions, sprains, bites)
19. Gynecological emergencies (e.g. PID, rape, pelvic pain, ectopic pregnancy, first trimester bleed, DUB, ovarian cyst/torsion)
20. Pediatric Fever (how kids are different, ED w/u, 1st 1-3 months)
21. Psychiatric emergencies (e.g. acute psychosis, suicide attempt)
22. Chemical emergencies (e.g. poisoning, drug intoxication)
23. Orthopedic trauma (e.g. splinting, casting, interpreting x-rays, general assessment, orthopedic and soft tissue injuries)
24. Ophthalmologic emergencies (e.g. corneal abrasions, eye pain, foreign bodies)
25. Minor surgery (e.g. suturing, I&D)

Skill Objectives:

The Family Practice Resident should be able to:

1. Take a history and conduct a physical examination appropriate to the emergency
2. Perform and interpret results of arterial blood gases, lumbar puncture, and paracentesis
3. Perform endotracheal intubation
4. Perform basic and advanced cardiopulmonary resuscitation
5. Evaluate laboratory and radiographic test results
6. Establish stabilization of the trauma victim
7. Efficient patient evaluation & disposition (directed H&P, testing, communication with physicians, f/u, and multiple patients).
8. Airway/ Breathing (intubations, non-invasive adjuvant, ventilator, meds)
9. Circulation (access lines, cardioversion, vasopressors, monitoring)
10. Conscious Sedation/ Pain Management (indications, meds, monitoring)
11. Orthopedic interventions (immobilization, reductions)
12. Wound care (infiltration, blocks, irrigation, laceration repairs, bites, I&D)
13. Eye procedures (slit lamp exam, FB removal, and tonometry)
14. ENT procedures (nasal cautery/packing, peritonsillar abscess, dental blocks, FB removal)
15. Miscellaneous (use & interpretation of x-ray, LPs, urinary caths, NG/Ewald, lavage, anoscopy)

Implementation: The major component of the emergency medicine portion of the curriculum is a required one-month rotation during the first year of residency. The primary teaching method is the evaluation and management of emergencies in the Emergency Room under the supervision of Emergency Department faculty, as well as didactic teaching per week.

Other educational activities related to this field are provided by:

1. Evaluation and management of emergencies in the Emergency Room during the outpatient pediatric rotations
2. Opportunities for learning generated by patient care on the Family Practice Inpatient Service and other hospital services
3. Evaluation for learning generated by patient care practice patients while on family medicine call
4. Opportunities for learning generated by patient care in the Family Medical Center (e.g. office emergencies)
5. Discussion of case presentations in family medicine and other conferences
6. Lecture topics pertinent to emergency medicine

B. Service Description

As required by the ACGME, residents receive over 200 hours of emergency medicine training. It is scheduled in each of the first, second years, and third year. The ED physicians are all partners with Vituity Physician Group and work at both Mercy Medical Center Redding and St. Elizabeth's in Red Bluff. The hospitals are considerably different and provide varied opportunities for learning. St. Elizabeth is a small community hospital that has a significant migrant worker population and limited subspecialty resources, while Mercy is a Level II trauma center for the whole north state.

The amount of time residents will be scheduled in the ED will vary by resident year, due to differences in call and continuity clinic time. R1s will be scheduled for a minimum of 36 hrs. /wk. (72 hrs. over the two week rotation). R2s will work a minimum of 34 hrs. /wk. (68 hrs. over the two week rotation) and R3s will be scheduled a minimum of 30 hrs./wk. (60 hrs. over the two week rotation). Residents will work a minimum 12 hours for a 2-week rotation. Residents will work peak patient volume times including 1 swing/night shift/wk and 1 weekend shift/wk. with a priority to schedule on Friday or Saturday nights since they offer the best training opportunities.

Residents will have off all post-call days. Residents will be scheduled, as much as possible in morning clinic at SCHC and then in the afternoon shifts in the ED at Mercy since afternoon and evening times provide the best training opportunities and this will avoid having EM training interrupted by noon conference or clinic. Usual shifts at Mercy for doctors are 6a-2p, 10a-6p, 2p-10p, 6p-1a, and 10p-6a (the schedule has been in flux and there may be changes). At St. Elizabeth shift times are 7a-3p, 3p-11p, and 11p-7a. There will be flexibility for scheduling shifts but for the most part, they should

coincide with an oncoming doctor's shift with a minimum of 8 consecutive hours (except 6p-1a which is 7) to maximize patient care continuity and work flow. We will also try to schedule longer shifts of 10-12 hours when possible. When two residents are scheduled for ED rotation during the same block, they cannot be scheduled in the same ED during the same shift but may overlap. While on shift a resident may see a patient with any of the attending physicians there if they are part of the volunteer faculty pool, but understand near shift change, it makes sense to staff the case with the doctor that will be staying or newly arrived. Look and ask to get involved with higher acuity cases, traumas, procedures, and other interesting cases. Please introduce yourself to the physicians as you meet them and let them know you're working the day's schedule. R2s may spend up to eight hours in the pre-hospital arena to develop an understanding of the challenges in the field. (Air Ambulance exposure is excluded due to liability problems). Attending ED physicians can provide supervision, but not mid-level providers.

Nicholas Schulack, DO will coordinate the ED rotation and manage the schedule. He is available at Mercy ED, his cell is 515-661-0867 (preferred), email: nick.schulack@gmail.com.

Scheduling issues should be worked out at least 2 weeks before the beginning of the ED rotation. Please contact him directly to initiate this. There will be a brief orientation before the rotation starts.

Although residents may be excused to attend noon conference, that hour does not count toward the total time expected for the ED. Residents must inform the ED attending when leaving and returning to the ED. Before leaving, residents must also inform the ED attending of their action plan for each patient, including test results pending, written instructions, and prescriptions if needed.

Twice monthly Dr. Schulack will schedule a 1-2 hour session that will cover a range of didactic topics, emergency medicine skills, and case presentations. Residents, medical students, and others rotating in the department will be encouraged to bring interesting cases they have encountered to briefly present and discuss. Dr. Schulack will arrange the time and place so as to make it most accessible for all.

Tuesday Trauma Rounds in the ICU (8-9 am) does count towards the total expected ED clinical time. Although they do not count towards the ED hour requirements above, they will be factored into the self-directed learning part of the evaluation.

If the rotation coincides, residents are also encouraged to attend the Emergency Medicine Journal Club and are invited to bring their spouse/significant other. The EM journal club is scheduled on a quarterly basis.

C. Duties

To maximize learning opportunities, residents should "box-shop", taking new cases out of order, asking the ED attending for advice as needed. Residents should be alert for codes or patients arriving by ambulance, helicopter, or being brought straight back from triage since most critical patients offer good learning opportunities. These cases must be discussed

with the ED attending prior to ordering therapeutic and diagnostic interventions. Although, residents will be granted greater autonomy with additional experience, part of the educational benefit comes from learning how an experienced ED physician approaches clinical problems. Unstable patients may require resuscitation prior to obtaining the entire H&P and diagnostic studies. Residents may observe codes, but are encouraged to participate, as they feel comfortable, particularly intubations or other procedures. If residents are aware of specific experience for which they need additional training, they are encouraged to inform the attending at the beginning of the shift so the attending can direct the resident to those patients or discuss with Dr. Schulack.

Residents are expected to be available to see patients during their entire shift and encouraged to ask as many questions as needed. They must notify the ED staff when leaving the department for any reason.

Residents will be evaluated on the following:

1. Patient care- which includes gathering essential and accurate history and physical exam data, ordering appropriate tests, integrating medical facts with clinical data, formulating logical plans, and documenting appropriately. Residents must present cases in a concise, logical, structured, appropriate manner. Residents must see a minimum number of patients per shift according to year of training: 0.5 patients per hour for R1s, 0.8 patients per hour for R2s, 1 patient per hour for R3s. (e.g., In a 10 hour shift, R1s will see a minimum of 5 patients, R2s 8 patients, and R3s 10 patients). These are minimum numbers with the expectation that residents will see more.
 - i. To keep track of total numbers of patients seen, residents should keep a paper with the stickers of the patients they see and the diagnoses they encountered. If more than one diagnosis was addressed, please document and include any procedures performed. Place a copy of this list at the end of each shift in Dr. Schulack's hanging file (located in the bottom drawer of the file cabinet under the far-left ED physician's desk). Dr. Schulack has created a form for this purpose which is included in the rotation folder. Residents will also give the SCHC Residency Coordinator a copy and the resident will hold on to the original for their own record. Residents will also track their encounters in either Google Docs or New Innovations.
2. Medical knowledge- which includes formulating extensive differential diagnoses for all patient problems, integrating biopsychosocial factors, and applying evidence-based medicine. Residents will be encouraged to see patients throughout their rotation to get exposure to the broad curriculum of emergency medicine. A curriculum list will be included in your rotation folder for your reference. Reading topics have been included in the rotation folder also. While they all are not required, they are strongly suggested and Dr. Schulack will meet periodically to assign readings and discuss. Please feel free to use the books and resources in the ED and online to further you're learning about cases you have encountered or other topics or skills. The textbook where most of the readings are derived is Harwood-Nuss's —Clinical Practice of Emergency Medicine" Fifth Edition, 2010. Others are from, Roberts and Hedges —Clinical Procedures in Emergency Medicine" Fifth Edition 2010 and Tintinalli's —Emergency Medicine: A comprehensive Study Guide" Seventh Edition 2010. A variety of other sources are included.

3. Procedural skills- with attention to proficiency, patient comfort and safety. Noon conferences for EM occur once a month (on the third Monday from 12:45 to 1:30 in conference room AB. Periodic (goal will be twice monthly) sessions with Dr. ER Director as mentioned earlier. Topics will include procedure training. Residents will be expected to visit PHI Aeromedical Transport headquarters for training in Airway management. This will be arranged by Dr. ER Director
4. Self-directed learning- including self-initiative, asking for assistance and consults appropriately, accepting criticism, and applying new information.
5. Interpersonal and communication skills- including effective and appropriate communication with nurses, ED attendings, peers, consultants, patients, and families.
6. Professionalism- relating with staff and patients in a responsible, ethical, empathic, compassionate, and trustworthy manner.
7. Systems based practice- uses all care resources and ancillary care providers appropriately.

ED Organization:

Patient flow: a triage nurse and Mid-level provider will first see all patients arriving to the ED through the lobby entrance. A brief history will be taken, limited physical exam, and vitals will be done. The patient disposition may sometimes be made directly from there, and other times the mid-level provider will start the work-up and treatment while the patient awaits bedding in the main emergency department or the ED Annex.

When a bed is available, the patient's chart will then be put in the main ED rack. Seriously ill patients will be taken back immediately to a bed. The bottom left side of the rack has the patients who have been waiting the longest. A yellow chart will indicate that the patient has not been seen by a physician or mid-level provider yet (they may have arrived by ambulance or brought straight back). These are priority and should be seen first. Before going to see the patient, please make the attending aware you are taking the chart from the rack and will see the patient in a timely manner. This helps to avoid confusion as to where you may be and the location of the medical chart. Residents will want to see those patients who appear challenging and unusual. Many orthopedic injuries and lacerations, which may be of interest to residents, are triaged to the ED Annex. These patients, however, must be staffed with the ED attending and not the mid-level providers. Please note that Mercy has changed to an EMR system called "Cerner." New protocols will be updated when established.

At SECH, color codes on the Chart: Each chart has 4 tabs: Red – nurse orders. Yellow – specimen collection; Blue – physician re-evaluation. Green – discharge patient. Residents must review each case with the attending who will also personally evaluate the patient.

Referral/Transfer Calls: Residents may not accept these phone calls even if asked to do so by the nurses (if the ED attendings are busy). Most of the nurses know this. But if asked, residents must decline taking the call.

Documentation: Residents must document their findings on the paper chart and consider (discuss with attending) dictating a note, including the name of the supervising attending physician. Residents, who participate in resuscitations or assist with procedures but are not primarily involved with the care of that patient, will not be expected to dictate. If a resident performs a procedure entirely, he should check with the supervising attending to clarify who will dictate the procedure note.

FAMILY PRACTICE SERVICE

Year: PGY3

Rotation Name: FPS

Location: MMCR

Preceptor: varies

Duration: 2 weeks

A. Service Goals:

The family practitioner must be competent to manage the care of his/her patients in the hospital, either in its entirety or as the coordinator and manager of the more complex patients involving multiple specialists. In addition, the practitioner cares for the patient pre- and post-hospitalization and interacts with family members as appropriate. The skills and experience therefore go well beyond a disease/illness orientation. The RRC in Family Practice considers this experience so important that it requires the family practice resident to follow any of their continuity patients when admitted to the hospital unless their current rotation makes this impossible (e.g., Away Elective). At the completion of residency training, a family medicine resident should:

- Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning, and Improvement)
- Coordinate admissions, inpatient care, and throughput within the hospital system. (Systems-based Practice)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high-quality care. (Interpersonal and Communication Skills, Professionalism)
- Recognize self- limitations with regards to practice and seek consultation with other health care

providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning, and improvement)

- Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)
- Demonstrate the ability to take an age-appropriate history and perform a physical exam. (Patient Care, Medical Knowledge)
- Synthesize an appropriate diagnosis and treatment plan for common pediatric conditions in both the outpatient and inpatient settings. (Patient Care, Medical Knowledge)

B. Service Description:

All resident adult and pediatric continuity patients from MFHC and only resident patients from SCHC are admitted to the Family Practice Service (FPS) at Mercy Hospital.

C. Duties

All Residents are required to follow their continuity patients in-house along with the FPS team, writing a “primary care doctor” note daily. While this can be a challenge at times, continuity of care is a foundation of family practice and one of the Essential Requirements of the ACGME. One PGY III resident is assigned to the service each rotation and provides primary in-house coverage for patients and meets daily with Family Practice preceptors who rotate onto the service each week. This senior resident runs the service and has oversight of continuity residents as well. On weekends, holidays, and after 5:30 p.m., the residents on call will be responsible for covering the FPS patients in addition to other service patients on medicine, pediatrics, and obstetrics. Occasionally, an additional resident may be assigned to the service for remedial training and will work with the senior resident and attending.

Residents are expected to round on all patients between 7:00 am and 9:00 am. Rounds with the attending have been occurring from 8:00 am to 9:00 am, but several attendings are scheduling rounds in the afternoon to give more time for teaching. This is arranged on an attending-by attending basis. Outpatient clinic is an important part of this rotation. Residents will be in the clinic from 10 to 12, seeing work-ins, hospital follow-ups, acute patients, and their own continuity patients. Call for the FPS resident will include two Fridays/month, thus eliminating any post-call afternoon coverage problems in house and allowing for Saturday am rounds.

When a resident (or faculty member) sees and admits his/her continuity patient from SCHC, it is the responsibility of that PCP in the clinic to write admit orders and the admission H&P. If another provider is

seeing the patient and the FPS resident is available, the FPS resident should do admit orders and the H&P. If the FPS resident is not available, then admit orders and the H&P are to be done by the provider seeing the patient at clinic. It is the duty of the physician writing the admission orders to contact the FPS preceptor at the time of admission.

The PCP of admitted patients, whether resident or faculty, should be alerted that their patient is in house no later than the morning following admission on weekdays, and on Monday morning for weekend admissions. PCPs are expected to round daily on weekdays, and to be actively involved in their patient's care and disposition on discharge. As a reminder, a list of residents who have patients in the hospital will be available at noon conference; residents are expected to sign-off that they have seen their continuity patients.

SCHC continuity OB patients are to be taken care of by their PCP or their OB resident partners under the supervisions of Dr. Davainis/Dr. Mooneyham or the laborist, whomever is on-call for SCHC. Newborns go to the FP Service.

Once six to eight (depending on complexity) patients are on the FP service, a redistribution policy will go into effect unless the FP service team (resident & attending) agrees not to enact the policy. Once the policy is enacted, the FP service will communicate with the other residency inpatient services; FP service admissions will be admitted to the residency internal medicine or pediatric services. If the internal medicine and pediatric services are full, the faculty and/or 3rd year resident patients that have been on the service the longest will be taken over by their PCP until six to eight or fewer patients are on the service (the family practice attending physician will continue to provide preceptor services to the R3 in such circumstances). If the service still has an excess number of patients, R2s will assume care of their continuity patients with attending backup. All patients being taken care of by their PCPs will remain on the FPS computer list. Once a patient's care is taken over by his PCP, that person will provide care throughout the remainder of the hospital stay. Well newborns will not count towards the total number of patients on the service and should be followed by the resident providing care for the newly delivered mom. The faculty members or senior residents following their own patients are responsible to sign out those patients before 5:30pm Mon. – Fri to the FPS resident so the resident can provide night sign-out for the call team. During evening and weekend hours the on-call residents will provide care for both FPS patients and those patients whose hospital care has been assumed by their PCP. The FP service will never close to FP ER admissions.

Faculty Notification Guidelines: The FPS preceptor MUST be notified at the time of admission for all emergency room and direct admits after the patient has been evaluated by the admitting resident (or faculty member).

Admissions or transfers to any of the critical care units MUST involve the immediate notification of the preceptor who is required to personally see the patient within four hours. The preceptor should be notified of

any significant deterioration in the status of any service patient. The preceptor should also be notified of all sick or unstable newborns at the time of birth or deterioration. For normal, stable, uncomplicated healthy newborns, the preceptor can be notified in the morning following birth. Note: It is the responsibility of the resident or faculty member arranging the direct admission of a patient from the clinic to directly contact the on-call FPS preceptor to relay the appropriate information regarding the admission. Timely contact allows the attending to make appropriate arrangements to see the patient and assist with care without delay. The FPS resident will be admitting ER admissions by phone when scheduled in the clinic and must inform the preceptor at the time of admission.

Expectations and Duties: The FPS intends to have the senior resident function as a “real world” family physician, combining inpatient duties with ongoing office responsibilities. We encourage, and expect, the senior resident will function with greater autonomy than when on categorical services. The preceptor, who remains ultimately the attending physician of record, should serve more as a consultant and role model to the senior resident while at the same time exercising his/her supervisory responsibilities.

The preceptor should be available from 8:00am to 10:00 am on weekdays for rounds; earlier rounding times, or afternoon rounding times maybe negotiated under unusual circumstances only. This timing is critical, as the resident is expected in clinic for scheduled patients at 10:00 am. Sit-down-rounds, followed by bedside rounds of new and critical patients, will have to be accomplished efficiently. The attending will then have another hour to complete notes and contact the resident by phone with any important communications. The attending will still be responsible to supervise care of patients handed over to their PCP by the Cap. The preceptor is responsible for ensuring the PCP residents round on their patients.

Change of service for attendings occurs Friday at noon. Weekend and holiday rounding times should start no later than 9:00 am. As the covering resident team on weekends frequently does not include the FPS resident, close communication between the attending and the on-call team is essential.

Sign out: Weekday sign out is scheduled for 7:00 am and 5:30 pm. Weekend 24-hour call is scheduled for 7:00 am, in resident lounge.

GERIATRICS

Year: PGY2, PGY3
Rotation Name: Geriatrics
Location: VA
Preceptor: Dr. Vogus
Duration: 4 weeks

A. Service Goals

The goals of this rotation are to achieve a greater understanding and knowledge of the clinical care of older adults in both inpatient and outpatient setting. At the end of this rotation, residents are expected to:

- Perform comprehensive, standardized geriatric assessments, and develop patient-specific treatment plans that incorporate the patient's goals of care, optimize function, and alleviate symptoms. (Patient Care, Medical Knowledge)
- Optimize treatment plans based on knowledge of local geriatric care resources, including local, state, and federal agencies. (Systems-based Practice, Practice-based Learning, and Improvement)
- Lead coordination of care for older adults across ambulatory, inpatient, and institutional care settings and across health care providers, institutions, and governmental agencies. (Systems-based Practice)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure the treatment plan is developed collaboratively and is clearly understood. (Interpersonal and Communication Skills)
- Recognize practice limitations and seek consultation with other health care professionals when necessary to provide optimal care for older adults. (Patient Care)

The Entrustable Professional Activities expected to achieve are:

- Provide a Usual Source of Comprehensive, Longitudinal Medical Care for People of All Ages
- Diagnose and Manage Chronic Medical Conditions and Multiple Co-morbidities

B. Service Description:

Residents will have at least one month dedication to the care of the older adult, to include functional assessment, disease prevention and health promotion, and management of patients with multiple chronic disease across a continuum of sites. These sites include inpatient SNF/rehab facilities and outpatient clinic.

C. Duties

All residents are expected to show up on time and prepared for their clinical days and to be an active participant in the care of the older adult. Knowledge can also be gained through self-study, case reviews, clinical case discussions, and participation in didactic opportunities. At the clinical sites, residents will examine their own attitudes toward aging, disability, and death; they are encouraged to provide empathy towards older adults and their caregivers to appreciate the need for functional status assessments of individual patients rather than focusing on diseases alone.

Trainees should complete tasks related to the Institute for Healthcare Improvement's Age-Friendly Health Systems 4Ms Framework. *(Reference: What Does It Mean to be Age-Friendly? Institute for Healthcare Improvement. 2019.)

1. What Matters

- The resident will have confidence in counseling patients/families on advance directives and goals of care for end-of-life. The resident will demonstrate professionalism and a caring attitude in working with older adults and frail elderly.
- Identify when end-of-life care is appropriate. The resident will be able to describe when to utilize feeding tubes, make referrals, and propose pain management and hospice.

Task:

- o Participate in an advance care planning discussion.
- o Assist or observe the completion of one of the following documents: medical power of attorney, directive to physicians, out of hospital DNR, or Texas MOST Form.

2. Medication

- The resident will be able to conduct a medication review and evaluate appropriateness considering creatinine clearance, medication interactions and side effects.

Task:

- o Interact with a clinical pharmacist.
- o Review the Beer's List.
- o Conduct a medication reconciliation during ambulatory visits.

3. Mentation

- The resident will be able to administer a brief cognitive assessment for screening purposes and identify when it is appropriate to refer for neuropsychological testing.
- The resident will be able to identify and recommend community resources available for older adults and their families to assist with care giving.

Task:

- o Perform an MMSE, MOCA, or SLUMS.
- o When possible, participate in a Dementia Care Conference and Care Plan Session (Stayton).
- o Interact with a clinical social worker regarding community resources.

4. Mobility

- The resident will be able to assess a patient's basic activities of daily living and perform a falls risk assessment.

Task:

- o Complete a Timed up and Go for a patient.
- o Interact with a physical therapist regarding mobility assistive devices for a patient case.
- o Assess Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) for a patient.

Online modules for downtime:

www.unthsc.edu/GeriCE

Other resources:

www.choosingwisely.org

GLOBAL HEALTH ROTATION

Year: PGY2, PGY3

Rotation Name: AwE

Location: varies internationally

Preceptor: Dr. McMullin, Dr. Lupeika

Duration: 1-2 weeks

B. Service Goals

The goals of this rotation is to achieve a greater understanding and knowledge of the disparate status of health, health systems, resources and social determinants of health globally. It is also to understand the elements of an effective, safe, ethical, and sustainable global health outreach experience. We also hope to give family practice residents a “hands on” real life experience in a developing country interfacing with the healthcare systems, providers and local health education systems At the end of this rotation, residents are expected to:

- Demonstrate cultural awareness in providing care or teaching in a setting of limited resources
- Understand the importance of sustainability and ethics in working with developing healthcare systems
- Identify strategies of public health intervention that highly impact health of communities
- Effective leadership and collaborative participation as a part of a traveling healthcare and teaching team
- Adaptive reserve as unforeseen events and obstacles present while working in a developing community
- A desire to show compassion, encourage self-reliance and endorse empowerment of developing health care systems
- Culturally competent interactions with team members as well as community members

- Master a working knowledge of the flowcharts and workflows of Helping Babies Survive and the Golden Minute
- Understand the impact and scope of healthcare disparities in developing communities and the social determinants of health
- Understand the impact on health of persecution, refugee status and displacement status
- Have a working understanding of the morbidity and mortality statistics, economic and social status and common diseases of the area visited
- Have a working knowledge of the political status of the community and country and its effects on outreach as well as community health status
- Be prepared to interface with community members that live with a disparate lack of resources, finances, and educational opportunities in a productive and positive manner
- Develop teaching skills while instructing HBS curriculum
- Understand how to safely negotiate travel and lodging / connections in a developing community
- Skillfully demonstrate newborn resuscitation techniques
- Understand how to instruct using an interpreter
- Understand the workings of local government health departments and associated politics and how to align with positive partners in a developing community.

C. Service Description:

This rotation is intended to be established as a yearly rotation with two senior residents attending the trip on their Away Elective time. Family members are welcome to attend as well, though must pay their own way. Dr. McMullin is the lead trainer and participants are expected to be fully engaged in teaching Helping Babies Survive course. The resident must have met all travel requirements well ahead of time, including any required visas, vaccinations, or other travel necessities. In general, trips are planned in countries with low resources, and everyone is responsible for their personal safety and travel supplies. Please notify the program director well in advance of Master Schedule planning to make sure the rotation aligns with this trip.

D. Duties

The following are expectations if attending a SCHC-sponsored HBS global health elective:

- Carry a current Neonatal Resuscitation certification
- Successfully complete the pre-trip Helping Babies Survive (HBS) curriculum for trainers
- Complete all required pre-trip requirements (current passport, visa, immunizations, health screening, malaria prophylaxis, etc)
- Two-week teaching trip to an underdeveloped country identified by the AAP and WHO as a

target country for Helping Babies Survive implementation

- Effectively train a group of midwives or providers in the principles of HBS as a part of the group teaching model
- Represent the sponsoring institution well with courtesy and culturally competent demeanor while traveling and in-country
- Present the Global Health experience to their institution, fellow residents or students in form of a poster presentation, oral or group learning presentation upon return home

INTENSIVE CARE UNIT

Year: PGY1, PGY2
Rotation Name: ICU
Location: MMCR
Preceptor: varies
Duration: 2 weeks

A. Service Goals and Competencies

The intensive care unit rotation is an introduction to critical care management, with emphasis on the aspects most relevant to those in primary care positions. As guests of the unit in a busy working environment, it is vital to contribute and as much as possible without disrupting the workflow of the ICU staff. At the completion of residency training, a family medicine resident should:

- Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)
- Coordinate admissions, inpatient care, and throughput within the hospital system. (Systems-based Practice)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high-quality care. (Interpersonal and Communication Skills, Professionalism) Geriatric care will be included in the medicine service.

- Recognize self- limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)

B. Service Description

This rotation is set up as two-week rotations scheduled in both 1st and 2nd years of residency. There is a total of 4 weeks of ICU experience during residency. You will be working directly with the intensivist with some one-on-one teaching if time allows.

The following topics are targeted:

- Sick / not sick
 - A basic understanding of what constitutes critical illness
- Admissions to the unit
 - Criteria for ICU admission and when to consult the intensivist
 - Provider communication skills and handoffs
- Transfers from the unit
 - Criteria for discharge out of the ICU
 - Disposition and placement for patients leaving
- Palliative care
 - Goals of care knowledge and communication skills
- Systems-based patient presentation
 - Thorough and concise organized presentation of complex patients
 - Different versions of patient presentations in varied medical settings
- Procedures
 - Procedural experience depends on availability and includes:
 - Central lines, intubation/extubation, paracentesis/thoracentesis, chest tubes, bronchoscopy, bedside ultrasound, nerve blocks, lumbar puncture, bedside ultrasound, incision and drainage
- Medicine topics to cover:
 - Shock, with particular focus on sepsis
 - Stroke and seizure
 - ACS and heart failure
 - Common causes of respiratory failure
 - Complications of diabetes including DKA/HHNC
 - Drug and alcohol toxic ingestion and withdrawal
 - Extubation criteria

C. Duties

- Shifts begin at 0800 on weekdays and last until the residents' duties are finished
- The residents will follow a minimum of 2 ICU patients and write notes daily
- One or more systems-based patient presentation directly to the intensivist daily
- Attend morning multidisciplinary rounds at 10:00 daily
- Be present for at least 1 admission to and 1 discharge from the unit weekly
- Participate in any procedures on your patients during your shift
- Participate in any family conversations regarding your patients during your shift
- **Residents should log all ICU encounters as a "procedure" in New Innovations**
- Optional attendance at Trauma Rounds in Aud A/B Tuesday Mornings 8-9 AM
- Optional, though encouraged, to follow Rapid Response team

Tips and Tricks:

- The more you put into the ICU experience, the more you get out
- Focus on the aspects that most appeal to you personally
- The nurses are very knowledgeable, ask them about their patients
- Push for procedures to get more experience
- Make working relationships that will help you later
- Don't be afraid to try things out and make mistakes, you have a lot of back-ups

Resources:

- The intensivist on duty is available for discussing topics of interest as time allows
- Senior residents and FP faculty are always available for questions
- ICU nurses are happy to answer questions as time allows
- Multidisciplinary staff in the unit are happy to discuss their topics of expertise
- Many resources are posted on the program google drive
- The residency handbook provides a quick reference and helpful pointers
- Up-to-date subscription has convenient daily working knowledge
- Pubmed and NIH databases will inform scholarly research
- ABFM modules are available for further study
- Textbooks are available using education funds

* Clinic time will be scheduled only on Thursday PM and Friday to minimize ICU experience disruption.

INTERNAL MEDICINE SERVICE

Year: PGY1, PGY2, PGY3
 Rotation Name: Med
 Location: MMCR
 Preceptor: Dr. Perry, various hospitalists
 Duration: 2 weeks

A. Service Goals

The service provides resident physicians with experiences in general medicine, primarily managing common medical problems. Additionally, residents will learn to recognize uncommon problems, obtain consultations as needed or make referrals to facilities for treatment not locally available. Residents are expected to develop the

full set of defined Medicine Competencies over the course of their three years of experiences. At the completion of residency training, a family medicine resident should:

- Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)
- Coordinate admissions, inpatient care, and throughput within the hospital system. (Systems-based Practice)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high-quality care. (Interpersonal and Communication Skills, Professionalism) Geriatric care will be included in the medicine service.
- Recognize self- limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)

B. Service Description

This service is staffed by 3 residents. The internal medicine preceptors cover for 7 days at a time. At times medical students and FNP/PA students also participate on the service. The medicine senior resident is charged with coordinating admissions and assigning patients as well as providing research on topics relevant to patient care. The service will be assigned every-other unassigned admission from the ED, although the preceptor may determine that the service is “closed” (i.e., accepting no more patients) depending on the circumstances of number of residents and patients. When admitting a patient to the service, the ED should page the primary medicine resident, (via the medicine pager).

Residents are responsible for ward work, including daily notes and close monitoring of patients.

Residents will pre-round on their patients each morning. During teaching rounds (usually starting at 8:30am in

the Lower-Level Conference Room) the preceptor will carefully review new patients or those with acute problems and review existing patients as well. The senior will then be responsible for overseeing and assisting daytime work, consulting with the preceptor as needed. Preceptors will provide the ultimate supervision of patient care.

At all times, including nights and weekends, the preceptor will be consulted promptly about any admission, with discussion of the assessment and plan. Medicine service consultation requests by other specialists will be directly handled by the senior resident on service with approval of the attending physician. The senior resident will promptly see the patient, and provide a consultation note and dictation including the elements of a pertinent history and physical. The medicine service will then follow the patient as usual until discharge or the attending decides that signing off is appropriate.

Please be sure to document preceptor involvement in patient charts. Include the preceptor's name on admission H&Ps, discharge summaries, and procedure notes. Discharge orders must include the current attending and the physician or clinic assuming responsibility for the patient's care after discharge. Please also send a copy of the discharge summary to the outpatient physician. Any significant communication with the attending regarding the patient's status or management must be noted in the chart; especially if/when the patient's condition changes significantly. Any transfer to the ICU must be communicated immediately to the attending.

Sign out: Weekday sign out is scheduled for 7:00 am and 5:30 pm. Weekend 24-hour call is scheduled for 7:00 am, in resident lounge.

Medicine Admissions and the cap:

Unassigned medicine admissions from the ED are **shared with the hospitalist services**. This should even out the flow of admissions and allow for an appropriate service census. **The attending of the week has the authority to determine the service full and invoke the cap after a discussion with the senior resident.** The medicine cap works as follows:

a. First medicine rotation goals (initially in first two months):

-During an R1's first medicine rotation, the first week should emphasize learning how to use Cerner, putting in orders, and writing notes/call consults.

-Initial cap **per R1** should be **3 patients in the first week** and expand to **5 patients during the second week of the first medicine rotation.**

-**R2s are not encouraged to take on their own patients at this time** as they learn how to manage a team and communicate with the attending. *R3s may elect to take 1-2 overflow patients.*

b. Second medicine rotation to beginning of night float training (months 3-6)

- For R1s, the minimum average census should be **5 patients** each
- R2/R3s at this point may elect to take up to 2 patients to help with any overflow.

c. February -June

- For R1s, the minimum average census should be **6 patients** each and **may expand to 7 max** should the senior and attending feel the team can handle the patient load.
- R2s/R3s at this point may elect to take up to 2 patients to help with any overflow

- B. The medicine senior resident will let the ED know if the service is “open” or “closed” after discussion with the attending. If the service is open, the medicine senior will communicate to ED how many admissions the team can accommodate that day. This will be determined by the attending preferences.**
- C. During the evening, the night float resident will be responsible for contacting the ED. When the service is closed, all further admits will go to the hospitalist service. The day team will be responsible for communicating to the night float resident how many overnight admissions the team can take **is determined by the attending.**
- D. If an attending is called for an admission before a resident, the attending must inform the resident from whom he needs to get sign out, and the ED doctor must also contact the resident.
- E. On blocked admissions, direct admissions, and transfers:**
- All blocked ER hits must be discussed with the ER doc and, if there is any conflict, the attending must be notified. If the primary resident wants to block a hit and the ER doc is not in agreement, the primary resident must first discuss the case with the senior resident. If both are in agreement but the ER doc feels otherwise, the attending must come in to see the patient and make the final decision.
 - All incoming hospital transfers must be first accepted directly by the attending
 - Attendings also have the right to do a direct admission to the team, in which case the attending will call the house supervisor for a bed assignment and contact the resident taking the admission.
- F. Each attending has the prerogative to go above or below the cap given the overall volume and acuity of the service based on the team’s overall abilities.**

Weekend Policy

- A. When an R1 and a senior resident are on for the weekend, the cap for FPS and Medicine lists combined should be **16 patients total****. Admissions on medicine should be closed if this cap is met or exceeded in case of additional FPS admissions.
- B. When only an R1 is present, **cap for both FPS and Medicine should be 12-14 patients**, depending on acuity of the lists. Admissions on medicine should be closed if this cap is met or exceeded in case of additional FPS admissions. ***All of this is negotiable—the IM service patient volume cannot be so low as to make it foolish and cause an onslaught of Monday admissions.
- C. The attending can change the number of admissions on medicine.

Bounce Backs

- A. A patient who has been admitted to the residency service within 30 days will be readmitted to the resident medicine service for continuity of care regardless of the cap..

- B. Senior residents may oversee this patient regardless of the cap until patients have been discharged, at which time the patient can be assigned to an R1.
 - C. The attending may change this policy if the returning patient is considered inappropriate.
- **AS always, be careful what you ask for...

Pager policy

- A. The pager will be the **ED’s primary method** of calling the medicine team for admissions.
- B. Pager should be answered in a timely manner, but ED should be made aware that during the following times, pages may not be answered as quickly:
 - 7-7:30AM for sign out
 - 12:30-1:30PM for lunch conference
 - 5:30PM-6PM for sign out

Medical Students

- A. 3rd year medical students should be expected to follow patients with our R1s, R1s are still expected to round on their patients and submit a daily note.
- B. 4th year medical students should be expected to carry their “own” patients **with the senior resident** as a part of their rotations.
- C. The senior resident must round on each patient and submit a daily note.

C. Duties

Senior resident duties:

- See new admits each morning before rounds
- Perform all consults at the attending’s direction.
- Assure that ICU patients are seen twice a day
- Pre-round each day with the R1s if appropriate
- Review progress notes each day
- Write backup admit notes on all admits and review all orders when on duty in the hospital
- Assign admissions
- Spend what time is available and appropriate to support the teaching functions of the service
- Encourage team efforts and support
- Give feedback and evaluations to junior residents
- Provide appropriate sign out of the Medicine Service to covering resident when going to afternoon continuity clinic. To facilitate this, the senior resident will have his/her afternoon continuity clinic blocked off for the first time slot and the resident will not be expected at clinic until 2:00 pm. Note: Only the senior resident on IM will have clinic schedule blocked for this purpose.

Junior resident duties:

- Admit patients from the ED and other sources as assigned by the senior resident
- Follow those patients each day with assistance as needed from the senior resident and attending.
- Update google drive sign out sheet daily
- Call for any needed specialty consults
- Follow-up on all lab and imaging tests ordered, and on information provided by consultants

Resident Duties on Weekends and Holidays – coverage of patients on the service

First call:

The first call residents on each service who are coming on and going off will divide up the patients on the service, see them with the assistance of the second call resident and attending, and write daily progress notes. First call residents are responsible for dictating an H&P at the time of every new admission.

Second call (if applicable):

The second call resident will see all new admits and review orders and notes. They will also be responsible for assigning admissions to the service.

Third call (if applicable):

The third call resident will be available for assistance/supervision as needed. (Also see Call Policy) Weekday sign out to the resident on call will be between 5:30-6:00 p.m. Clinical duties for residents working at the Family Health Center must be completed prior to attending sign out. Any changes to the call schedule should be made at least two weeks in advance. The senior resident will contact the oncoming preceptor about rounding and communicate this information to the rest of the team at least one day in advance.

If both services require backup, the jeopardy resident is called in and gets 1st choice of service.

It is the responsibility of the jeopardy call person to be able to hear and answer a phone call early in the morning (e.g. around the time of morning sign out or just before). The overnight resident, while preparing the sign-out sheet, may call in backup at a reasonable time to allow short call time to make the morning sign-out.

Attending duties:

- Be the attending physician of record and supervise care according to the Graduate Medical Education Committee policy.
- Round daily with residents, review service notes, see the patients on service and make personal chart documentation as appropriate.
- Be available to residents for specific questions related to the management of patients on the service.
- Supervise residents as appropriate for any procedures.

- Complete an evaluation on each resident’s performance and review the evaluation in person with the resident. (Please see EVALUATION, SECTION)

A full-time faculty member at Mercy, Dr. Nena Perry, is the coordinating attending. She is responsible for overseeing the residents’ overall responsibilities and experience and providing assistance with issues as they arise.

Physician Guidelines for Admit Status

The following are key points to consider in assigning patient status on admit, or, in changing patient status after initial assignment. If you have questions, a Case Manager can assist you in making a determination.

- Patients are assigned Inpatient, Observation or Outpatient upon admission.

Inpatient: Orders must include

- The order and location
- Admitting diagnosis
- The need for care is greater than 24 hours (2+ midnight for Medicare)
- Evidence of services planned or provided
- The discharge plan for the patient

Observation: This is a hospital service given to help the doctor decide if the patient needs to be admitted as an inpatient or discharged within 24-48 hours.

Outpatient: Defined by CMS using surgical or procedural CPT codes. This patient is being brought into the hospital for ambulatory services like surgery, lab, radiology, endoscopy, or OB checks that typically do not require an overnight stay

Outpatient in a Bed: A new term for patients who have had an outpatient surgery/procedure but require an overnight stay for supervision. The patient does not have an adverse condition but would benefit from staying overnight rather than going home. The expectation is that this patient will go home immediately in the am.

** Basic guidelines. You may contact ER case manager at ext. 6413

- Your order must read “Admit to Inpatient to (location)”, “Admit to Observation for (what is being observed)”, or “Admit as Outpatient for (procedure)”. No other verbiage is acceptable.
- The admitting order must be based upon severity of illness and intensity of service (InterQual criteria).
- Observation status is appropriate for the patient who can be evaluated and treated within 24 hours, if rapid improvement is expected within 24 hours, or if additional time is needed to determine appropriate diagnosis or treatment.
- Observation status may progress to inpatient status if severity of illness and intensity of service warrant a longer stay in the hospital.

- Patient status should never be changed to inpatient based upon the length of time the patient has been under observation.
- Patients should never be kept overnight for observation for the convenience of the physician, patient, or family.
- Status can be changed from inpatient to observation if an error occurred in the patient registration process and the physician's intent for observation is clearly documented in the record.
- Inpatient status can be changed if the patient has not been discharged and upon review it is found that the patient meets observation criteria.
- The three-day qualifying stay required for Medicare coverage in a skilled nursing facility (SNF) begins on the day of admit to inpatient and will only qualify if inpatient criteria is met.

Consultation Etiquette

When consulting an intensivist or other specialist, please follow these three steps:

1. **State the problem or the presumed diagnosis and then offer key details that support the reason for the call.**
2. **Formulate as best as you can a differential diagnosis AND what you think the next steps should be to address the problem, AFTER having evaluated the patient and researching solutions.**
3. **Be available to meet the specialist at the patient's bedside. If the patient is critically ill, this should be a top priority.**

NIGHT FLOAT MEDICINE

Year: PGY1, PGY2, PGY3
 Rotation Name: NFM
 Location: MMCR
 Preceptor: same as Inpatient Medicine
 Duration: 2 weeks

A. Service Goals

The purpose of this rotation is to maintain the internal medicine educational goals while decreasing the amount of call and fatigue associated with traditional call. The night shift rotation helps us maintain our educational and service objectives while adhering to the ACGME work hour restrictions. The educational goals of the night shift rotations are similar to those described on the internal medicine service. The service provides resident physicians with experiences in general medicine, primarily managing common medical problems. In addition, residents will learn to recognize uncommon problems and obtain consultations when needed. Residents are expected to develop the full set of defined Medicine Competencies over the course of their three years experiences. These goals and competencies are the same as for Internal Medicine rotation.

B. Service Description

The service is staffed by a single resident working closely with the internal medicine service and family practice service attending. All PGY1, PGY2, and PGY3 residents will participate in Night Float. PGY1s will have two 2-week blocks later in the academic year. PGY1s will always have an upper-level resident available on the Night float Ob/Pediatrics service to provide supervision. The night shift resident will work from 5:30 p.m. to the 7 a.m. check out. The night shift resident will work five shifts Monday-Friday. In addition, the night shift resident has family practice clinic on Monday afternoons. Admission policies are described in the internal medicine rotation section above. The night shift should review all admissions with the attending physician during the night or prior to end of shift – this assures both quality of care for the patient and education for the resident. This rotation promotes oversight of resident supervision by attendings, while providing for graded authority and responsibility through direct supervision, indirect supervision, and oversight supervision.

C. Service Duties

The rotation hours are Monday through Friday 5:30 PM until 7:00 AM. The Night Float Medicine resident is expected to attend their continuity clinic on Monday afternoons for a total of about 75 hrs/week including time for sign-out.

- Medicine/FPS Sign-Out is located in resident lounge at 5:30 PM and 7:00 AM.

Clinic: Residents scheduled in the clinic must arrive on time on Monday. Patients are scheduled starting at 1:50 PM. The last patient will be scheduled to ensure enough time to arrive to sign-out by 5:30 PM.

Clinic Inbox: Night float resident inboxes will be covered by the Clinic I or II resident. If there is no Clinic doc, then please reach out to your cohort to help cover.

The night shift resident duties are as follows:

- Admit new patients from the ED
- Perform Consults
- Follow-up on patient care issues as requested during check-out
- Update computer sign-out sheet

Weekend Note Writing: The night team on Friday and covering call team on Saturday will not be mandated to pend/prep notes for the oncoming team when the teams are well-staffed with 2 residents per call shift from July through March. Solo call begins in April (one resident per call shift) and the night float and Saturday resident are expected to start or pend at least 1/3 of the notes for the oncoming resident. Short call should come in to help

round on patients if there are 16 or more patients combined on Med/FPS and leave after rounds. We always encourage residents to help each other out.

With the approval and supervision of emergency room attendings, night shift residents are encouraged to seek experiences in the emergency room as time allows.

There is clinical oversight of all residents at all times. There is a stepwise supervision process where junior residents are supervised by senior residents with attending oversight of all residents at all times. Each resident should have access to and take advantage of the call room for rest periods to mitigate fatigue.

NIGHT FLOAT OB/PEDS

Year: PGY1, PGY2, PGY3

Rotation Name: OBPNF

Location: MMCR

Preceptor: Same as weekly peds preceptor for inpatient peds and daily laborist

Duration: 2 weeks

A. Service Goals:

This rotation is to ensure continuity of care for both inpatient pediatrics and obstetrical/gynecological patients who are admitted to Mercy on their respective daytime services. The learning goals are the same as written for pediatric and OB rotations.

B. Service Description:

The service is generally staffed by a single resident working closely with the obstetrical service and pediatric service attendings. This resident is responsible for all patients on both the OB and pediatric services, which includes newborns, pediatrics, OB, and gynecological admissions. Every OB triage should be seen promptly. Admission policies are described in the OB and Peds rotation sections. PGY1s, PGY2s, and PGY3s all participate in the OB/Peds Night Float rotation. PGY1s will always have a senior resident available in-house as either Night Float Senior or on the opposing Night Float Medicine service to provide direct supervision. The night float OB/Peds resident will work from 5:00 p.m. to the 6:30 a.m. in five consecutive overnight shifts Monday-Friday. In addition, the night float resident has continuity clinic on Monday afternoons. The night float resident should review all admissions with the Night Float Senior and their attending physician during the night or prior to end of shift – this assures both quality of care for the patient and education for the resident. This rotation promotes oversight of resident supervision by attendings, while providing for graded authority and responsibility through direct supervision, indirect supervision, and oversight supervision.

C. Service Duties:

The rotation hours are Monday through Friday 5:00 PM until 6:30 AM. The Night Float OB/Peds resident

is expected to attend their continuity clinic on Monday afternoons for a total of about 75 hrs/week including time for sign-out.

- OB/Peds Sign-Out is located in LLCR at 5 PM and 6:30 AM.

Clinic: Residents scheduled in the clinic must arrive on time on Monday. Patients are scheduled starting at 1:50 PM. The last patient will be scheduled to ensure enough time to arrive to sign-out by 5 PM.

Clinic Inbox: Night float resident inboxes will be covered by the Clinic I or II resident. If there is no Clinic doc, then please reach out to your cohort to help cover.

Weekend Note Writing: The night team on Friday and covering call team on Saturday will not be mandated to pend/prepare notes for the oncoming team when the teams are well-staffed with 2 residents per call shift from July through March. Solo call begins in April (one resident per call shift) and the night float and Saturday resident are expected to start or pend at least 1/3 of the notes for the oncoming resident if the combined total of patient is greater than 16. Short call should come in to help round on patients if there are 20 or more patients combined on OB/Peds and leave after rounds. We always encourage residents to help each other out.

Admissions: There is no cap to number of newborn, pediatric, gynecological, or obstetrical patients on service. Interns are expected to work with in-house senior resident for all admissions, triaging patient care on the floor, transfers, and to ask questions if needed. Senior residents in-house are expected provide direct supervision to interns for those activities. The OB/Gyn attending should be available in-house for direct supervision and the pediatric attending will provide either direct supervision, indirect supervision, or oversight of patient care. The night float resident will promptly inform the attending of any relevant patient care concerns. There is clinical oversight of all residents at all times. There is a stepwise supervision process where junior residents are supervised by senior residents with attending oversight of all residents at all times. Each resident should have access to and take advantage of the call room for rest periods to mitigate fatigue.

NIGHT FLOAT SENIOR

Year: PGY1, PGY2, PGY3
Rotation Name: NFS
Location: MMCR
Preceptor: Attendings for FPS, Ped, OB, and Med
Duration: 2 weeks

A. Service Goals

Family Physicians actual practices vary considerably in the extent to which they provide inpatient care for _____ patients. This portion of the curriculum is designed to provide residents with the skills and expertise expected _____

of family physicians with active practices involving this area. Additionally, this rotation emphasizes the care of adult, pediatric and obstetrical patients with a variety of medical disorders. The learning goals and competencies are the same as for OB/Peds/Medicine/FPS.

B. Service Description:

This rotation was created with the intention of providing interns appropriate oversight during their first night float rotation, beginning in November of each academic year. This rotation promotes oversight of resident supervision by attendings, while providing for graded authority and responsibility through direct supervision, indirect supervision, and oversight supervision. The interns are directly responsible for the patients of all four inpatient services (OB/Peds or Medicine/FPS), the night float senior, also known as “Super Senior,” should be familiar with all patients and be available to help with admissions, answering questions, and triaging patient responsibilities at all times. The purpose of this rotation is to create a safe environment for the learning and care of patients, while providing a supervised independence for junior residents. Every third-year resident will be assigned in this role for 2 weeks.

C. Service Duties:

The rotation hours are Monday through Friday 5:30 PM until 7 AM. The Night Float Senior is expected to attend their continuity clinic on Monday afternoons for a total of about 75 hrs/week including time for sign-out.

- OB/Peds Sign-Out is located in LLCR at 5 PM and 6:30 AM.
- Medicine/FPS Sign-Out is located in resident lounge at 5:30 PM and 7 AM.

SCHC Clinic: Residents scheduled in the clinic must arrive on time on Monday. Patients are scheduled starting at 1:50 PM. The last patient will be scheduled to ensure enough time to arrive to sign-out by 5:00 PM.

Clinic Inbox: Night float resident inboxes will be covered by the Clinic I or II resident. If there is no Clinic doc, then please reach out to your cohort to help cover.

The night float senior is expected to be available for all admissions and patient care activities on the floors and maintain clear and open communication with their teams. They will be supervising the night float interns who are covering the OB/Peds and Medicine/FPS services and should be familiar with all of the patients. By being in a supervising role, they should demonstrate a commitment to excellence and role model behaviors they would expect of their interns. Supervision and oversight of all of the night float residents is with the attendings on-call for those respective services. There is clinical oversight of all residents at all times. There is a stepwise supervision process where junior residents are supervised by senior residents with attending oversight of all residents at all times. Each resident should have access to

and take advantage of the call room for rest periods to mitigate fatigue.

OBSTETRICS

Year: PGY1, PGY2, PGY3
Rotation Name: OB
Location: MMCR
Preceptor: Daily laborist
Duration: 2 weeks

A. Service Goals

The success of this service will require the senior resident to carefully manage the demands of the various services against his/her resources, assign duties, adjust for volume and acuity, have the full support of the attendings and the understanding of the nurses. Open communication will be critical. On-time Rounds must be maintained to get through the teaching and supervision tasks of the morning. Finally, there will be times when the residents will not be able to cover all patients and attendings on OB may be required to deliver patients; this option should be uncommon.

The OB component provides intensive obstetrical training, giving residents a broad knowledge and experiential base in normal and abnormal obstetrics. Residents will learn to diagnose and manage common OB problems, obtain consultations as needed and make referrals when appropriate to facilities that can provide services not available locally. Residents are expected to achieve the full set of defined Obstetrics Competencies over the course of their three years' experiences.

- Be able to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to issues that may be sensitive for women, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform comprehensive physical examinations of female anatomy with appropriate screening tests for pregnant and non-pregnant women and be able to perform routine gynecological and obstetrical procedures (detailed below). (Patient Care, Medical Knowledge)
- Develop treatment plans for common gynecologic conditions and pregnancy complications, utilizing community resources when indicated, and demonstrate appropriate post-operative care following caesarean section or gynecologic surgery, both inpatient and for office follow-up. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive issues in women as well as comprehensive wellness counseling based on the

patient's age and risk factors. (Patient Care and Interpersonal and Communication Skills)

- Consult and communicate appropriately with obstetrician-gynecologists, maternal fetal medicine specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice, Professionalism)

B. Service Description:

The residents will, actively participate in all deliveries involving patients from Shasta Maternity Clinic. The patient population consists of a spectrum of patients from the uncomplicated to the very complex. The experience continues throughout all three years on rotations and during the on-call periods. Preceptors are ultimately responsible for the care delivered by the resident's hospital and are assigned for 24-hour shifts to supervise in compliance with the Mercy Medical Center Policy on Resident Supervision. They are expected to be physically present at all deliveries, and to supervise all standard procedures. Teaching rounds at the hospital should address all current L&D, postpartum and GYN patients as well as provide time to plan the coming day's events. **NOTE: Obstetric patients involved in Trauma, seen in our ED, and admitted, must be discussed between the ED attending and the OB attending prior to admission per MMCR Policy.**

C. Duties

Sign out: Weekday sign out is scheduled for 6:30 am and 5:00 pm. Weekend 24-hour call is scheduled for 6:30 am, in LLCR.

Residents should meet in the OB nurses' station as arranged with the OB attending and be prepared to present all OB/GYN patients to the OB attending. Coordination with the attending is especially important prior to the weekend so that rounds occur smoothly and the resident familiar with the service patients can be available to round with the attending. As time and hospital duties allow, residents may spend a limited amount of time providing prenatal and postpartum care for the **Shasta Maternity Clinic** patients at the outpatient clinic.

The residents will be actively participating in all unassigned deliveries. The patient population consists of a spectrum of patients from the uncomplicated to the very complex. The experience continues throughout all three years on rotations and during the on-call periods. Preceptors are ultimately responsible for the care delivered by the residents in the clinic and hospital and are assigned for in-house 24-hour shifts to supervise these areas in compliance with the Mercy Medical Center Policy on Resident Supervision. They are expected to be physically present at all deliveries. Teaching rounds at the hospital should address all current L&D, postpartum and GYN

patients as well as provide time to plan the coming day's events. NOTE: Obstetric patients involved in Trauma, seen in our ED, and admitted, must be discussed between the ED attending and the OB attending prior to admission per MMCR Policy.

The resident team (excluding the night float resident) will generally consist of one PGY1 and one senior residents. Each senior resident/PGY1 team generally spends two 2-week blocks on the obstetrical service. The senior resident is the team leader and assigns duties as appropriate. The resident team on pediatric service will cover when obstetrical service residents are in clinic. Each attending for OB, Pediatric, and NICU will arrange with the senior resident the time for rounding.

Residents are responsible for:

- a. Managing prenatal care at the Shasta Maternity based on the schedule defined above.
- b. Managing labor and delivery and postpartum care of patients from the Shasta Maternity Clinic or unassigned patients.
- c. Notifying the attending preceptor of patients being admitted in labor and all discharges.
Residents shall also contact the attending preceptor about management plans including when to call the attending with updates on labor and for the delivery.
- d. Residents must present cases in a standard format and interns should discuss with upper-level residents before calling the attending after hours and on weekends:
 1. Age
 2. Gravida____Para____AB _____
 3. EDC, or weeks gestation
 4. Presenting condition
 5. Onset of labor
 6. Contraction pattern and intensity
 7. Membranes
 8. Sterile Vaginal Exam (dilation, effacement, station)
 9. Vitals
 10. Strips or other tests
 11. Complications if any
 12. Prenatal course
 13. Plan

All deliveries will be done with preceptor in attendance. It is the resident's responsibility to communicate appropriately with attendings on the progress of labor and the expected time (as much as possible) of delivery. The delivery note on the mother's chart should comply with Mercy Medical Center operative note guidelines.

The OB residents are expected to pre-round and be prepared for daily inpatient obstetrics rounds with the attending of the day by having seen each patient and formulated a management plan prior to rounds with attending at 8 am.

In the Maternity Clinic, residents will provide patient care along with the nurse practitioners under the supervision of the OB attending. When the need to perform an emergency C-Section arises, the following procedure should be pursued:

1. Call the OB attending regarding the case.
2. If the OB attending agrees C-section is needed, notify the OB nursing staff, and make sure they contact the anesthesiologist.
3. Complete an H&P for the patient before the C-section unless it is a “crash” C-section.
4. Contact the on-call neonatologist as discussed with the obstetrician.
5. Residents are expected to attend Noon Conferences unless an urgent patient responsibility takes precedence (e.g., a delivery. Seeing routine prenatal patients at Shasta Maternity Center is not a reason to miss noon conference). Compliance with these guidelines is essential to a determination of “successful completion” of this rotation.

Monthly Perinatal Morbidity and Mortality Conference:

Presentations are usually the 4th Wednesday of each month

Perinatal M&M should be a learning experience for all in attendance. You will do up to 2 presentations for this during your 3 years of residency – the latter half of the first year or later. Selection of your date for presentation is usually during or soon after an OB rotation. This does not always work out ideally due to factors like night float, vacation and other scenarios that make it difficult to have good timing to proximity of the case you present. It is therefore a good idea to keep interesting cases in mind as you go through any OB rotation or OB call in general.

When you are the presenter, it is best to have researched the topic for the discussion, but the ultimate goal is that you are the facilitator of the discussion with the goal of improving patient care. You should be prepared to offer your own points for areas of improvement in the case, but a true M&M often should involve overall peer discussion and not just defense against errors or bad outcomes that occurred in a case in which you were involved. The difference in this setting is the academic nature of learning and therefore it will of course be expected that you have researched your topic for the presentation. More questions may be asked of you as the

presenter than to the group in this academic setting. Part of your challenge is to have command of the discussion but to also direct questions you don't know the answer to back to your audience.

In most cases, you will find a case topic that is unique from other topics presented in previous recent months. Recycling of topics over time is helpful however for the frequency in which certain problems are seen and the differences in how the cases present. Some topics to consider but not limited to:

Sepsis Workup	Polyhydramnios	Gestational HTN
Gestational DM	Hemolytic Disease of Newborn	Cervical Insufficiency
Cholestasis in pregnancy	Nephrolithiasis in pregnancy	Preterm Labor
Fetal Demise	SLE in pregnancy	Postpartum Hemorrhage
Substance abuse in pregnancy	Cord prolapse	Fetal Demise
Ambiguous genitalia	Chorioamnionitis	

Basic Outline:

Choose a case that interests you to discuss its management. It is best that it be a case you were involved in but that is not required if you otherwise have a more interesting case in which your peers were involved, and they would allow you to share.

Cases that involve areas for improvement on management and/or outcome tend to be best. However, a case in which all aspects of care appear to be within accepted guidelines or opinions is fine to present too and often can generate as much discussion as a case that suggests need for improvement.

OVERVIEW:

Make the introduction brief and to the point. Make sure to check and know the facts of the case so as not to waste time searching through a chart record. The audience can ask questions when gaps in the history are needed to be filled as the discussion ensues.

OUTLINE OF TOPIC – be brief

Eclampsia and Preeclampsia

Definition

Current recommended screening

Current recommended management

Retrospective analysis of the presented case for areas where management could have been improved. Avoid singling out any particular physician, nurse, or other involved care staff. M&M in this setting is about improving management and patient outcomes and is not intended to be punitive.

OSTEOPATHIC MANIPULATION THERAPY

Year: PGY1, PGY2, PGY3

Rotation Name: C1, Ortho, Elective

Location: SCHC

Preceptor: Dr. Pitcher

Duration: ½ day

Osteopathic manipulative medicine is done at the family health center under the following policies:

- Direct supervision of OMT by osteopathic faculty is required until competency is demonstrated and documented using the OMT Competency Form.
- Periodic direct supervision, or more frequently as deemed appropriate, will occur by osteopathic faculty.

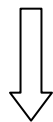
SCHC – OMM CLINIC – GOALS

General:

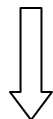
1. Improve Palpatory Ability and expand Clinician's diagnostic/treatment skills so they may apply OMM in every day practice
2. No HVLA will be performed at SCHC by a Resident unless they are under direct supervision by their attending.
3. Each Resident interested in performing OMM treatment in their continuity clinic here at SCHC will be required to have an evaluation of their skills formally signed off by an osteopathic Faculty member.

BASICS

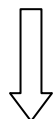
Structure & Function



Scanning



Area of Greatest Restriction



Sequencing

SCHC “Top 10” Basic Skills in Osteopathic Manipulative Medicine

Principles of Selection of OMT Procedures:

The OMT techniques described in this program were selected for their effectiveness and safety as well as for simplicity of supervision by SOMA preceptors who may be unfamiliar with such procedures.

Student Preparation:

The curriculum in Osteopathic Principles and Practice (OPP) program at SOMA is a four year curriculum. Prior to the completion of the first year, all students will have achieved and demonstrated competency in the OMT basic skills presented in this program. Competency evaluation occurs by live practical examination and evaluation of participation in small group discussion of clinical applications.

The "Top 10" OMT Basic Skills:

1. Osteopathic Structural Examination: standing, seated
2. Soft Tissue and Myofascial Release Techniques: cervical, thoracic, lumbar regions
3. Indirect Techniques(Balanced Ligamentous Tension) : cervical, thoracic, lumbar regions
4. Diaphragm Release Techniques: thoracic inlet, respiratory diaphragm
5. Thoraco-Lumbar Junction Inhibition
6. Occipito-atlantal Release and Decompression
7. Venous Sinus Release Technique
8. Sacroiliac Release Techniques: sacral rocking, indirect to sacrum
9. Strain-Counterstrain Techniques: cervical, thoracic, lumbar, lower extremity
10. Lymphatic Pump Techniques: thoracic and pedal pumps; rib raising

**** See next page for Grading Rubric for OMT Skills'**

GRADING RUBRIC

Resident Name: _____

Date: _____

**Note- each resident will only be examining two areas.

**Note- examiners should verify and re-examine the findings.

Osteopathic Structural Examination and Treatment of the Cervical Area

1. Identify two landmarks of the examined area
2. Perform gross motion testing of the involved area
3. Perform an intersegmental structural examination of the involved area
4. Diagnose somatic dysfunction of the involved area
5. Demonstrate two different treatment techniques for the somatic dysfunction that was previously diagnosed
6. Discuss the mechanism behind the use of these techniques and how they would aid in the treatment of this somatic dysfunction

Osteopathic Structural Examination and Treatment of the Thoracic Area

1. Identify two landmarks of the examined area
2. Perform gross motion testing of the involved
3. Perform an intersegmental structural examination of the involved area
4. Diagnose somatic dysfunction of the involved area
5. Demonstrate two different treatment techniques for the somatic dysfunction that was previously diagnosed
6. Discuss the mechanism behind the use of these techniques and how they would aid in the treatment of this somatic dysfunction

Osteopathic Structural Examination and Treatment of the Lumbar Area

1. Identify two landmarks of the examined area
2. Perform gross motion testing of the involved area
3. Perform an intersegmental structural examination of the involved area
4. Diagnose somatic dysfunction of the involved area
5. Demonstrate two different treatment techniques for the somatic dysfunction that was previously diagnosed
6. Discuss the mechanism behind the use of these techniques and how they would aid in the treatment of this somatic dysfunction

Osteopathic Structural Examination and Treatment of the Sacrum and Pelvic Areas

1. Identify two landmarks of the examined area
2. Perform gross motion testing of the involved area
3. Perform an intersegmental structural examination of the involved area
4. Diagnose somatic dysfunction of the involved area
5. Demonstrate two different treatment techniques for the somatic dysfunction that was previously diagnosed
6. Discuss the mechanism behind the use of these techniques and how they would aid in the treatment of this somatic dysfunction

Osteopathic Structural Examination and Treatment of the Shoulder Area

1. Identify two landmarks of the examined area
2. Perform gross motion testing of the involved area
3. Demonstrate how you would test for rotator cuff tendonitis and biceps tendonitis
4. Diagnose somatic dysfunction of the involved area
5. Demonstrate two different treatment techniques for the somatic dysfunction that was previously diagnosed
6. Discuss the mechanism behind the use of these techniques and how they would aid in the treatment of this somatic dysfunction

Osteopathic Structural Examination and Treatment of the Hip Area

1. Identify two landmarks of the examined area
2. Perform gross motion testing of the involved area
3. Perform a FABER test and a straight leg raising test
4. Diagnose somatic dysfunction of the involved
5. Demonstrate two different treatment techniques for the somatic dysfunction that was previously diagnosed
6. Discuss the mechanism behind the use of these techniques and how they would aid in the treatment of this somatic dysfunction

Examiner Name: _____ Examiner Signature: _____

OPHTHALMOLOGY

Year: PGY2, PGY3
Rotation Name: EUOC
Location: SCHC, Private offices
Preceptor: Dr. Bowen
Duration: ½ day

A. Service Goals

The goal of this rotation is to prepare a resident to enter practice with the knowledge, attitudes, and skills to effectively perform an ophthalmologic evaluation, initiate management and seek consultation on patients with more complex ophthalmologic conditions.

At the completion of residency training, a family medicine resident should:

- Demonstrate an understanding of the impact of ocular illness and dysfunction on patients and their families. (Patient Care, Professionalism)
- Demonstrate an understanding of the ophthalmic consultant's role, including the different responsibilities of ophthalmologists, optometrists, and opticians. (Professionalism, Systems-based Practice)
- Recognize his or her own practice limitations and seek consultation with other health care providers when necessary to provide optimal patient care. (Professionalism, Systems-based Practice)
- Use of a slit lamp and fluorescein test to evaluate eye emergencies (Medical Knowledge, Patient Care)

B. Service Description

The ophthalmology rotation is integrated into a four-week block in the third year of residency along with Urology, Cardiology and ENT and is designed to expose residents to the evaluation and management of common ophthalmologic conditions that present in the ambulatory setting. The experience is based in an ophthalmologist's office practice with case based, one on one teaching. Where appropriate to accomplish educational goals, residents may accompany ophthalmology preceptors into the hospital setting to consult on hospitalized patients with ophthalmologic conditions. This rotation represents one component of a resident's training in ophthalmology.

Substantial training in the primary care of patients with ophthalmologic conditions are received in the Family

Practice Center. Responsibility for the medical management of inpatients with ophthalmologic complaints occurs throughout residency training.

C. Duties

Attendance at the ophthalmologist's office is scheduled. During this time, you will work one on one with an ophthalmologist. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days / week. A syllabus of relevant readings on the primary and hospital care of common ophthalmologic conditions are provided to each resident and are considered a required component of the rotation. Exposure to the use of a slit lamp and fluorescein dye will be expected on the rotation.

ORTHOPEDICS / SPORTS MEDICINE

Year: PGY1, PGY2, PGY3

Rotation Name: Ortho

Location: SCHC, Shasta Orthopedics

Preceptor: Dr. Chang, Dr. Sabet, Dr. Schillen, various others

Duration: 2 weeks

B. Service Goals:

Musculoskeletal injuries comprise a common part of family medicine, and family physicians provide a huge amount of school and team medicine in the communities we serve. Degenerative arthritis is becoming a constantly growing problem as our population ages and as our youth's obesity epidemic grows. This rotation is intended to prepare the resident to appropriately manage such problems. At the completion of residency training, a family medicine resident should:

- Perform an appropriate musculoskeletal history and physical examination, and formulate an appropriate differential diagnosis and recommend treatment, including requisite subspecialty referrals (Patient Care, Medical Knowledge, Systems-based Practice)
- Perform an evidence-based, age-appropriate, and activity-specific pre-participation physical examination (Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism)
- Communicate effectively with a wide range of individuals regarding musculoskeletal health care, including patients, their families, coaches, school administrators, and employers (Interpersonal and Communication Skills)
- Understand how exercise impacts disease states such as diabetes and hypertension and be able to

formulate an appropriate exercise prescription (Patient Care, Medical Knowledge, Interpersonal and Communication Skills)

- Understand that sports medicine involves caring for the medical conditions of athletes in addition to the musculoskeletal conditions (Patient Care)

C. Service Description:

Residents are assigned to various orthopedic physicians, sports medicine fellowship trained physicians (both family medicine and orthopedic), physical therapists, physiatrists, and trainers in this rotation. Residents will attend at least two sports medicine events, which may include major athletic events and/or assist in pre-participation evaluations which, given the nature of the sports seasons may not happen during this actual rotation. In addition, orthopedics specialty clinics occur while on the Clinic 1 rotation up to two times per month. The sports medicine component of this rotation involves the following: 1) Working the with sports medicine fellowship trained family physician, Dr. Tony Chang, in his office, at athletic events and post-game clinics and 2) Participating in pre-participation physical exams at local schools. Residents will also rotate with various physical therapist offices in Redding.

Didactic training will include the following lecture topics covered during the course of residency training:

- 1) Shoulder anatomy and exam
- 2) Spine anatomy and exam
- 3) Knee anatomy and exam
- 4) Hip anatomy and exam
- 5) Ankle/foot anatomy and exam
- 6) Elbow/wrist anatomy and exam
- 7) Hand anatomy and exam
- 8) Fracture care/splinting/casting
- 9) Sports nutrition/supplements
- 10) Concussion
- 11) Athlete's heart
- 12) Pre-participatory Sports Physical Exam

D. Duties:

During the orthopedic/sports medicine rotation, residents are assigned to work with a variety health care

providers covering a broad spectrum of musculoskeletal medicine – orthopedic surgery, casting, sports medicine, psychiatry, athletic training, and physical therapy. Residents must participate in two sports medicine events, which could be pre-participation physicals or supervising local athletic events with a supervising physician. Please log these as “procedures” in New-Innovation.

PAIN, HOSPICE, AND PALLIATIVE CARE

Year: PGY2

Rotation Name: Pain

Location: SCHC, MMCR, VA, private homes

Preceptor: Dr. Sand, Dr. Gasman

Duration: 1 month

A. Service Goals and Competencies

General Goals: (adapted from ACGME *Program Requirements for Residency Training in Pain management and end-of-life care*). Family medicine residents will have a supervised clinical experience in the assessment, diagnosis, and treatment of patients with serious, chronic illness that necessitates an inter-disciplinary approach to care. This experience will include a wide variety of disorders, patients and treatment modalities commonly encountered in management of malignant and non-malignant chronic pain, palliative, and end-of-life care. Residents will demonstrate the ability to gather and organize multi-dimensional data, integrate these data into a comprehensive, goal-oriented treatment plan, implement and monitor treatment in outpatient and home settings. They will demonstrate competence in assessment and treatment of pain and other common symptoms encountered in chronic serious illness. Residents are expected to demonstrate professional and ethical behavior in the care of their patients and in their interactions with other health care providers. They are expected to gradually develop higher levels of understanding and skills as they complete a 4-week rotation.

By the completion of residency training, a family medicine resident should:

Patient Care: Residents must be able to provide care of outpatients that is compassionate, appropriate, and effective for the treatment of chronic, serious illness and end-of-life. Specifically, residents will:

- Demonstrate the ability to conduct assessments of a wide variety of patients presenting with chronic pain and serious illness commonly seen in primary settings while attending to psychological, biological, emotional, spiritual, social and cultural contributions to their illness.
- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.

- Counsel and educate patients and their families and demonstrate the ability to convey difficult information.
- Formulate and carry out treatment plans based on the above patient-focused formulation and define a rationale for specific treatment goals, considering also patient personal and psychosocial resources and ability to participate in the plan. Treatment paradigms will include:
 - Clear patient-centered goals of care,
 - Symptom focused treatment and management
 - Supportive psychotherapy for patient and family/caregiver
 - Inter-disciplinary teamwork
- Implement biological and psychosocial treatment strategies to optimize quality of life.
- Appropriately and proficiently employ commonly used rating scales during assessment and follow-up to reach an accurate diagnose, optimize patient function, and advance symptom management.
- Identify outpatients who should be referred for specific community treatments or higher levels of care.
- Be able to evaluate patients with a view to the risks and benefits of, and indications for hospitalization for symptom management using relevant palliative care principles and practices.
- Identify and manage co-morbid substance use disorders, including the prescription of evidence-based pharmacotherapy and psychotherapy.

Medical Knowledge: Residents must demonstrate knowledge of the biological, psychological and sociocultural underpinnings of chronic pain, serious illness and end-of-life and apply this knowledge to the care of outpatients. Specifically, residents will:

- Understand the pathophysiology and treatment of various types of chronic pain.
- Conceptualize chronic, serious illness in terms of biological, psychological, and sociocultural factors that affect coping, resilience, and adaptation to change.
- Understand the pharmacological treatment of common symptoms experienced in chronic serious illness, including treatment algorithms, the management of treatment-resistant symptoms, augmentation strategies and combination therapies.
- Appreciate that pharmacological treatment must take into account the wide variety of interactions with other pharmacologic agents, impact on other medical conditions, and the wide range of medication side effects that may impact patient quality of life.
- Understand the central principles of medical ethics and their role in managing chronic serious illness and

end-of-life care.

Practice Based Learning: Residents will be able to investigate and evaluate their patient care practices, appraise, and assimilate scientific evidence, and improve their patient care practices. Specifically, residents will:

- Seek feedback from their supervising faculty, including clinic supervisors, and the faculty about their own practice and will use this feedback to improve their performance.
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
- Use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records, and other computer-based resources.
- Conduct a chronic pain chart review to identify strategies for improved care.

Interpersonal Communication: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and other health care providers. Specifically, residents will:

- Create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
- Use effective listening skills in interactions with patients, their family members and other health care providers.
- Demonstrate empathy and compassion towards patients with chronic pain.

Professionalism: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.

Specifically, residents will:

- Obtain informed consent for treatment plans, including for the use of narcotic and psychotropic medications, and will demonstrate understanding of the ethical principles underlying informed consent.
- Provide care to a patient that takes into account (a) collaboration with other professionals, agencies and family members, (b) ethical decision making, (c) confidentiality, (d) medical record keeping (e) financial and health system issues, (f) legal issues and (g) risk management and quality assurance issues.
- Demonstrate sensitivity and responsiveness to each patient's age, gender, culture, ethnicity, religion, and disabilities.

Systems-Based: Residents must demonstrate an awareness of and responsiveness to the larger context of the health care system and the ability to effectively call on system resources to provide optimal care to outpatients. Specifically, residents will:

- Appreciate the model of community-based, integrated health employed at SCHC and Hospice and understands the difference between these model and others, such as private office and hospital-based practice.
- Understand how their patient care affects and is affected by other health care providers.
- Collaborate with other health professionals.
- Advocate for quality patient care and assist patients in dealing with the complex health system.
- Appropriately utilize available community resources to optimally manage pain. (System-based Practice)
- SBIRT training and exposure to the substance abuse clinic at SCHC.

B. Service Description

Chronic pain has become an increasingly difficult area to manage in practice. The C1 or Pain resident will work with Dr. Michael Gasman at SCHC, to learn how to adequately address chronic pain issues. The goal of the rotation is to increase patient's understanding of the disease process and develop a variety of modalities on how to deal with chronic pain.

C. Duties

SCHC Residents will rotate through the MAT Clinic and Pain Management Clinic, according to curriculum. SCHC Residents will complete and online training on substance abuse and buprenorphine as treatment for opioid use disorder.

Lines of Clinical Responsibility/Authority in Supervision for Patients:

The direct line of authority for patient care rests with the faculty staff member seeing a given patient on a given day. (And this may vary from appointment to appointment and from day to day). Concerns about the final decision of patient care remain with the attending faculty for that patient for each visit.

Unique Aspects of This Rotation Training:

SCHC and Mercy Hospice provide integrated primary care to patients with serious, chronic disease including at end-of-life. Care includes patients with both non-cancer and cancer diagnoses and many with co-occurring mental illness and substance use. Care occurs in the office, the hospital, the home, and in other community settings.

Residents will be supervised and trained to conduct independent assessment, function as a member of an

interdisciplinary team, and facilitate patient-family advanced care planning. Residents are expected to see at least four new pain evaluations, four primary care pain consultations and serve as primary physician on four hospice patient care teams during their training. This will include joint home visits with faculty and hospice team members where they will assess, monitor for side effects and adjust medication for established patients. Residents will be involved in 2 hours/week of treatment planning meetings and 3 hours per week with faculty for education and supervision.

Palliative Care Curriculum for Resident Rotation

One on one teaching/videoconference with reading ahead of time.

Week 1 - Goals of Care

- Decisional Capacity
- Surrogate decision maker
- Prognostic awareness
- POLST

Week 2 - Pain management in serious illness with limited life expectancy

- Narcan training
- Buprenorphine training
- Opiate pharmacology
- Regulatory process

Week 3 - Other symptom management

- Nausea physiology/pathophysiology
- Anti-emetic classes/mechanisms
- Common scenarios
- Treatment strategies
- Constipation physiology/pathophysiology
- Laxative classes/mechanisms
- Prevention and treatment strategies

Week 4 - Medical Ethics “Death cannot be our enemy”

- Balancing ethical conflicts
- Medically assisted dying
- Working to include family in care and decision making
- Choosing and using an interpreter

Topics and Readings			
Week	Topic	URL	
1 - Goals of Care	Decisional Capacity	Informed Consent Article	Medical Decision Making Capacity
	Surrogate decision making/POA	Shared Decision Making	Shared Decision Video
	Prognostic Awareness	Prognosis Video	Prognostication Article #1
	Physician Orders for Life Sustaining Treatment (POLST)	Prognostication Article #2	
2 - Pain Management in Primary Care	Narcan	Narcan Training Video	Narcan Outpatient Article
	Buprenorphine	Bup for Chronic Pain Article DEA Letter re: Bup	Convert to Bup Article MME Conversation Table for Bup
	Essential Opiate Pharmacology	Stanford Opioid Training	Methadone Training
	Regulatory Process	CURES Training	Converting on/off Bup
3 - Sx Management in Primary Care	Nausea and Vomiting in advanced disease	Nausea/Vomiting Article	N/V Presentation
	Constipation/Obstruction	Constipation in Palliative Care	
	Anxiety	Anxiety Case Study	Grief-Induced Anxiety Causes/Dx of Anxiety in Palliative Care
	Depression	Managing Depression at End of Life	Suicide Risk in Palliative Care
4 - Medical Ethics	Balancing ethical conflicts	End of Life Care Borderline Personality	Psychotherapy Video
	Medical assisted dying in California	Intro to CA End of Life Option Act	Case Discussion Video
	Including family in shared decision making	Family Meeting Podcast	Family Meeting Training
	Choosing and using an interpreter	Interpreter Article	EthnoMed

PEDIATRICS INPATIENT

Year: PGY1, PGY2, PGY3

Rotation Name: Ped

Location: MMCR

Preceptor: Dr. Joo, various private pediatricians and locums physicians

Duration: 2 weeks

A. Service Goals:

The pediatric in-patient component provides intensive pediatric training throughout the 3 years of residency training. Residents will diagnose and manage common pediatric problems and will learn to recognize uncommon problems, to obtain pediatric and neonatology consultations and to make referrals to facilities, which can provide services not available at Mercy Medical Center. Residents are expected to develop the full set of defined Pediatric Competencies over the course of their three years of experiences.

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Demonstrate the ability to take an age-appropriate history and perform a physical exam. (Patient Care, Medical Knowledge)
- Synthesize an appropriate diagnosis and treatment plan for common pediatric conditions in both the outpatient and inpatient settings. (Patient Care, Medical Knowledge)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure that the diagnosis and the treatment plan are clearly understood. (Interpersonal and Communications Skills)
- Recognize his or her own practice limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care. (Professionalism, Systems-based Practice)

B. Service Description:

Residents are expected to be able to:

- a. Complete history and physical examination, appropriate orders, and procedures
- b. Learn appropriate diagnosis, treatment, and management of common pediatric hospital problems.
- c. Write appropriate progress notes; communicate with parents, referring doctors and involved agencies
- d. Dictate discharge summaries
- e. Arrange appropriate follow up plan for outpatient visit(s)
- f. Maintain appropriate partnership relationships with fellow resident

- g. Newborn Nursery
- h. Follow sick or high-risk neonates > 36 weeks with attending neonatologist
- i. Attend high risk deliveries with neonatal nurse/ neonatologist
- j. Attend C-sections on request
- k. Make appropriate follow-up referral to pediatric clinic
- l. Collaborate on Family Practice newborns with resident if needed.
- m. Gain experience at neonatal circumcision if done as in-patient.

Inpatient Pediatrics: The SCHC Family Medicine Residents will participate alongside their MFHC counterparts during inpatient Pediatric service rotations. Care of Pediatric inpatients, as well as well newborns, will be modeled while the Resident provides hands-on care to children within the hospital setting.

Sign out: Weekday sign out is scheduled for 6:30 am and 5:00 pm. Weekend 24-hour call is scheduled for 6:30 am.
Located in LLCR

Newborn Care: When a SCHC Residency patient delivers a baby, newborn care is provided by the Family Practice Service (FPS), whether the prenatal care was provided by SCHC, a private OB, or the Maternity Clinic. It is expected that the resident/physician involved in the prenatal care/delivery will perform the Newborn H&P and in-hospital care, with their OB partner covering as needed. The FP attending will provide back-up.

A patient who does not receive primary care or prenatal care at SCHC may arrange ahead of time for a SCHC Residency physician to provide newborn care for their baby, who then remains on the resident panel. In this situation, the patient will notify the nursery staff who will then notify the identified SCHC resident/physician directly when the baby is born. In the event the resident/physician is not available (evenings, weekends, & vacation) the nursery staff will notify the Pediatric resident, who will either admit the baby and perform the H&P (after hours) or contact the FPS resident to do so (daytime/weekdays). The newborn will be on the FPS, with the FP attending providing back-up.

In the Nursery, the residents are responsible for doing admission History & Physicals on all of the babies admitted to their service, regardless of the time of day in which they were delivered. On the weekends, it will be the responsibility of the covering resident to perform this duty. Residents are responsible for stable patients > 36 weeks in the normal newborn nursery. Involvement in intensive care patients is encouraged, especially to become proficient in resuscitation and procedures for stabilization. After the patient is stabilized, the resident may withdraw from the case with the agreement of the preceptor. With all newborns, including "normal cases" it is expected that the resident will write appropriate daily notes. A brief delivery note must accompany the newborn to the nursery. This should include: Type of delivery, with or without complications, condition of amniotic fluid, Apgars, resuscitation needs, evidence of fetal distress, Visualization of cords, Complications, Feeding issues.

On the Pediatric Ward, the resident will follow all pediatric and newborn patients. Residents should meet as arranged with the pediatric and newborn nursery attendings and be prepared to present patients to the pediatric attendings according to their preferred schedules. Coordination with the attendings is especially important prior to the weekend so that rounds occur smoothly and the resident familiar with the service patients can be available to round with the attending.

SCHC Clinic: Residents scheduled in clinic must arrive on time, with first appointment usually ready to be seen at 1:50 PM. These patients count on you being there. The supervising PGY2 or PGY3 resident in-house will manage the corresponding Peds/OB service and assign opposing PGY1s to admissions, L&D, and other duties as needed.

Admits: Newborns are typically managed on the newborn service with the senior assigning those newborns to first year residents as appropriate. There are some patients who arrange for private pediatricians, but most newborns are seen by resident service. Expect that the transition nurse will be able to help discern these for you. Pediatric ward admissions will be followed by pediatric team.

MERCY INPATIENT PEDS RESIDENT GENERAL EXPECTATIONS

1. At the beginning of the block the team should sit down together to talk about the team's expectations

- a. Seniors should give expectations to the interns and each other
- b. Interns should also have expectations for their seniors
 - i. Ex. "I want to become more efficient in writing my progress notes". "I want the interns to practice talking to the consultants on their own"

2. Be professional at all times

- a. Be respectful to your fellow residents, attendings, staff, nurses, and parents
 - i. If your nurse voices a concern, please address their questions/concerns promptly
 - ii. If your attending goes to check on a sick patient, please follow as well. This can serve as a learning opportunity to be able to distinguish between sick children vs. stable children

3. Always be on time

- a. Each attending will specify what time they like to round. Please make sure to follow up with the attendings accordingly
- b. Ensure to see **all** your patients before the attendings come for rounds

4. Read up on your patients

- a. You will learn a lot if you take the time to read up on each patient you have
 - i. It will also make for better patient care

5. Work as a team

- a. Communicate often—if interns have a question, **ask your senior before speaking/asking the attending**
- b. Run the list frequently, including with your attending before afternoon sign outs, as there may have been changes in the plan.

- i. It is the **senior's responsibility** to talk with the attending before **going to the evening sign out**

6. Intern responsibilities

- a. The intern's role is to see patients, do H and Ps, admission orders, discharge orders, progress notes and other sundry duties
- b. Residents should strive to have their notes done by the time rounds have started
 - i. If not finished before rounds, then the interns should have seen all of their patients and be ready to discuss them including PE, assessment, and plan
 - ii. **If the progress notes are not finished by rounds, then they need to be completed before 15:00** (unless specified differently by the attending)
 - If you are finding it difficult to finish before 15:00, consider coming in early prior to sign-out (without breaking ACGME work duty hours) or ask senior/attending on tips for efficiency
- c. The intern is responsible for presenting any new patients admitted overnight
 - i. This means pertinent positives and negative of HPI, other history, ER management, labs, pertinent PE, admitting assessment and plan
 - ii. This will then be rolled over into the following days progress note
 - iii. If there is any incomplete information or questions about the patient try to figure those out before rounds start

7. Daytime Senior responsibilities

- a. See all of the Peds patients before rounds start
- b. Go through all of the charts to get pertinent labs, info, check orders, etc
- c. Be ready to help the interns with their management decisions during rounds
- d. In the afternoons, help guide the intern
 - i. Help prioritize what the interns should be doing
 - ii. Delegate responsibilities that need to be done with the intern

8. Night float Senior responsibilities

- a. Remember that you are not there to just "babysit" and admit patients, but you are an integral part of the team caring for the patient
- b. Round and see all of the sick/worrisome patients each night
- c. Look through all of the charts to see what has been going on, AND to make sure that nothing was missed by the previous team
- d. Go over thoroughly the H and P of the intern, their admission orders, or other decisions they make during the night
- e. Discuss with the attending any questions or admissions that are difficult or concerning

9. Night float Intern (Weekends)

- a. It is the intern's responsibility to answer pages/calls from the nurses, ER, attending, etc i. These should then be discussed with the senior resident in a timely fashion
- b. Do admissions during the night, including orders, in an efficient manner
- c. Read up on the patients you admit
- d. Follow up with the team the next day on what happened to those admissions
 - i. This is the best way to understand how your decisions affected the patient

10. Nursery Matters

a. Hyperbilirubinemia

- i. We will get a **Tcb (cutaneous)** level at 22hrs of life, if this is elevated (HIR/HR range) then will order a **Tsb (serum)** –nurses will notify physician, physician is responsible for telling them/putting in the order
 - If baby is DAT +, then must get a TcB at 6hrs of life and a TSB at 24hrs of life
- ii. Please use the Bhutani curve (*what is in Cerner*) **AND** the phototherapy graphs appropriately—these are two DIFFERENT curves (*please don't mix them up*)

- Please speak to your attendings about your management plan AFTER reviewing the graphs yourself and coming up with an appropriate plan

iii. No baby will be discharged home if they are in the HR range on the Bhutani curve – *discuss plan with attending*

b. Bili list

- i. Residents are expected to follow up on patients on the bili list on a daily basis

c. All children should go home with prescription for Vitamin D suspension

- i. Infants do NOT get (enough) vitamin D from breast milk
- ii. Need 1 L/day of formula to get the recommended dosage of vitamin D needed—which is not possible. Hence, please send all nursery babies with a rx for Vitamin D (*regardless if they are on formula*)
- iii. **Rx: Vitamin D (400 IU/ml): take 1ml po Q day #1 bottle, refills: 12**

11. Attending communication

- a. Attendings should be contacted for a number of different reasons. They are here to help and supervise the residents for a reason. You should feel free to call them at **ANYTIME** as there will be no excuse later if you do not contact the attending when you should have
 - i. Any major change in status of a patient
 - ii. Any unexpected lab result
 - iii. Any confusing or strange admission²
 - iv. Any discharge change, such as a child who was planned to stay the night but is now ready for discharge, or vice versa
 - v. Any patient/parent that wants to go AMA
 - vi. Any transfer of a patient to another facility, when the attending has not seen the patient or was unaware that they were going to be transferred
 - vii. Or just plain any other question you might have. It is more likely there will be a problem if you don't ask, then if you do ask

*** Please refer to the 75-page Mercy and Shasta Peds Guide on the Mercy Google Drive***

SCAN PROTOCOL

Suspected Child Abuse or Neglect (SCAN) Protocol

Mercy Medical Center, Redding CA

Shasta Community Health Center, Redding CA

Author: Sean Dugan, MD, FAAP

Revised 03/2017

This protocol provides recommendations for clinicians who encounter children suspected of child abuse or neglect. It covers physical abuse (suspicious fractures, bruising, pattern injuries, sentinel events, non-accidental injuries, or injuries not consistent with the child's level of development), medical neglect, malnourishment/caloric deprivation, and sexual abuse. This DOES NOT cover rape or SART exams, which are covered under a separate protocol. [1]

All children suspected of child abuse or neglect shall be admitted to the inpatient pediatric department regardless of the extent of their injuries.[1] This is done to protect the child while medical work up and CFS/Law Enforcement investigations are completed, which may take several days. The ER physician is to report via telephone to CFS and/or Law Enforcement and the Pediatric Attending immediately. To avoid interfering with the investigation, it is recommended that the ER physician avoid telling the parent(s) their child is being admitted for suspected child abuse or neglect. Instead tell the parents that "further work up is needed" or "we want to observe the child." If a parent refuses hospitalization, notify CFS/Law Enforcement immediately and take appropriate action.[1] Please do not place any personal opinions or comments in the note, but rather state the facts (for example, 1 month old admitted for bruising, 7-month-old admitted for fracture, etc). The family will be notified at the appropriate time by members of the investigating team and/or the inpatient team if child abuse is suspected. Keep in mind not every case will have child abuse substantiated and there are many forms of accidental trauma.

In very rare cases when the suspect is an individual outside of the home such as a babysitter or person who is currently incarcerated, the child may be discharged from the ER without admission to the floor as long as the following criteria are met:[1]

- 1) CFS and Law Enforcement have adequate time to conduct their initial investigation and clear the patient to be discharged home with the non-offending care giver.
- 2) The case is presented to the inpatient attending who agrees that the medical work up was complete, and discharge is appropriate.

Medical Evaluation

The ER physician is to determine if the child is appropriate for admission to the inpatient pediatric department or if they require a higher level of care at an outside hospital (usually UC Davis or Sutter). Examples include significant

head trauma, significant burns, etc. Excluding those situations, a majority of the patients will be admitted to the inpatient pediatric department where the medical work up and CFS/Law Enforcement investigation will take place.

Bruising in non-ambulatory infants is incredibly rare. Studies show that bruising occurs in less than 1% of infants under the age of 6 months [2,3,4,5,6,14] and in 2.2% of infants between the ages of 6-9 months (so called pre-cruisers) [2,3,4,5,7,14]. Compare this to 40-90% of infants and toddlers age 9 months or older [2,6,8,9,14]. Harper's 2014 landmark study showed that children < 6 months of age with isolated bruising had a 25% chance of having a fracture on skeletal survey and another 25% had a positive finding on head CT.[10] Among those with new injury discovered on neuroimaging 90% had a bruise to the face or head.[10] Remember "those who don't bruise rarely bruise." [8]

Any part of the body can bruise from abuse, however, bruising to the **Torso, Ears, or Neck** in a child < 4 years of age is predictive of abuse. Remember the mnemonic "**TEN 4**" to easily identify concerns for abuse in that age group. [11];

When child abuse is suspected, the child's siblings, other young children in the household, as well as other child contacts of the suspected abuser should be assessed for injuries. This is especially important for twins, who are at substantial risk of injury, including occult fractures.[2]

Imaging

Skeletal Survey:

All infants < 6 months of life should receive a skeletal survey and non-contrast CT scan of the head if 1 or more bruise or fracture is found on exam.[2,3,4,12,13]

Children younger than 2 years of age with fractures suspicious for child abuse should have a radiographic skeletal survey to look for other bone injuries or osseous abnormalities. [2,3,4,12,13]

Children 2-5 years – Skeletal survey may be indicated depending on clinical suspicion of abuse and developmental stage (or delay) of the child. [2,3,4,12,13]

The American College of Radiology (ACR) Recommendations for Skeletal Survey Includes 21 views [2, 3, 12,13]

Appendicular Skeleton (12 views total)

AP View of both left and right: Humeri, Forearms, Hands, Femurs, Lower legs, Feet Axial Skeleton (9 views total)

Thorax (AP, Lateral, right and left obliques) which include the sternum, ribs, thoracic and lumbar spine.

Abdomen & Pelvis (AP view)

Lumbosacral spine (Lateral view) Skull (Front and Lateral view)

Cervical Spine (Lateral View) if not completely visualized on the lateral skull

Additional Views to consider: Lateral views of the long bones, Towne view of the skull, AP and lateral views of selected joints, additional oblique views of the ribs, or other areas of concern.

NOTE: The ACR recommends AGAINST a single radiograph (babygram) of the entire infant or entire extremity. The reason for doing individual views is to look for CML's (classic metaphyseal lesions) which are highly specific for child abuse and difficult to visualize on babygrams or whole extremity films. [2, 3, 12,13]

Non-contrast CT Scan of The Head

As noted above, all infants < 6 months of age should receive a non-contrast CT scan of the head if 1 or more bruise or fracture is found on exam. [2,3,4,12,13]

Should also be considered for any child < 1 year of age with a fracture suspicious for abuse because head injuries are often occult. [2,3,4,12,13]

Non-contrast CT Scan of the Abdomen

Should be considered if abdominal trauma is suspected or AST/ALT is > 80 or lipase is elevated. Remember that abdominal bruising RARELY occurs despite significant trauma to the abdomen

Lab

CBC, Complete metabolic panel (includes AST, ALT, Alk Phos), Lipase, should be performed on each patient admitted if child abuse or neglect is suspected.

Fractures

If there is concern for an organic cause, the following labs may be ordered. [2,3,4]

Serum Calcium, phosphorous, alkaline phosphatase (may be elevated in healing fractures), PTH, 25- hydroxyvitamin D, random urine calcium/creatinine ratio. CMP, Amylase, lipase. UA to screen for occult blood. Serum Ca, Vitamin C, ceruloplasmin if at risk for scurvy or copper deficiency and has radiographic findings to support these. [2,3,4]

Bruising

If there is concern or a bleeding disorder, the following labs may be ordered. [2,3,4,14]

CBC with platelet count, PT/PTT, bleeding time, Von Willebrand Panel, PFA-100, Factor VIII & IX. Add D-dimer and Fibrinogen if abusive head trauma present. [2,3,4,14]

Please note in the Harper Study, none of the children that received a work up for coagulopathy had a positive result.

Retinal Hemorrhages

Consult pediatric ophthalmology for urgent evaluation if there is evidence of head trauma on CT or MRI. Note that retinal hemorrhages can resolve within 24-48 hours.

Consultation

SCAN TEAM: Please consult Dr. Sean Dugan (Child Abuse Pediatrician) or the on call SCAN team clinician for evaluation of possible non-accidental trauma and notify him of the admission during normal business hours. If Dr. Dugan is unavailable, please consult the child abuse pediatrician on call at UC Davis or Sutter Memorial in Sacramento.

Follow Up

A repeat skeletal survey should be performed 2-3 weeks after the initial skeletal survey if child abuse is strongly suspected. The number of views on the f/u examination may be limited to 16 by omitting the skull (2 views), pelvis (1 view) and lateral spine (2 views). [2,3,4]

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PEDIATRICS EMERGENCY MEDICINE

Year: PGY1, PGY3
Rotation Name: PedER
Location: UC Davis Medical Center
Preceptor: various
Duration: 2 weeks

A. Service Goals

Beginning in 2019, SCHC interns rotate in the Pediatric Emergency room at UC Davis. Per ACGME requirements, each resident is required to document 75 Pediatric Emergency visits. In response to this requirement, and feedback from Faculty and Residents, a Pediatric Emergency room rotation was set up in order to fulfill this requirement. At the completion of this rotation, a family medicine resident should:

- Demonstrate the ability to take an age-appropriate history and perform a physical exam, along with determining the level of acuity of patient complaint. (Patient Care, Medical Knowledge)
- Synthesize an appropriate diagnosis and treatment plan for common pediatric conditions in the Emergency Room setting and determine if patients can be safely discharged home or admitted to the hospital. (Patient Care, Medical Knowledge)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient’s family and caregivers, to ensure that the diagnosis and treatment plan are clearly understood. (Interpersonal and Communications Skills)
- Recognize his or her own practice limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care. Understand how the Tertiary medical center handles transfers and manages higher level of care patient acuity issues. (Professionalism, Systems- based

Practice)

B. Service Description:

This is a two-week rotation at UCDCM. Housing will be provided for the resident. Please refer to Emergency Medicine EMR Workflow and Welcome Shasta letter from the Education Program Coordinator at UC Davis for further information on the rotation. The contact information and further details will be given to each PGY1 resident prior to the rotation. SCHC will reimburse for housing, food, and transportation for this rotation.

C. Duties:

This rotation is a two-week block for each PGY1. Tentative schedule:

Week 1

Monday-Redding clinic in AM-travel to Sacramento Monday afternoon

Tuesday am: on-boarding at UC Davis and ER conference after with first shift 2pm-midnite UC Davis Peds ER: ON—TU,

WE, TH, SA

OFF-- FR, SU

Week 2

UC Davis Peds ER: ON—MO, TU, WE, TH

Thursday shift will be 6am-4pm with travel back to Redding that night or on Friday morning Friday-Redding clinic in PM

PEDIATRICS OUTPATIENT

Year: PGY2, PGY3

Rotation Name: OtPed

Location: SCHC

Preceptor: varies, Dr. Venglarcik is Medical Director

Duration: 2 weeks

A. Service Goals

The goal of this rotation is to expose first year residents to common ambulatory pediatric problems seen in a community health center practice and to develop the cognitive knowledge and skills as outlined in the pediatric outpatient competencies.

At the completion of residency training, a family medicine resident should be able to:

- **Patient Care:** Residents will receive training in using age-appropriate manner of caring for children of different ages and cultural backgrounds. The use of interpreters will be modeled and taught as needed to optimize the interaction between the Resident and the family during the visit. Medical care of children of all ages and backgrounds will be expected.

- **Medical Knowledge:** Residents will be competent in the diagnosis of acute medical illness, screening techniques for all developmental disabilities for all ages of children, use of standard screening techniques for special diagnoses such as Vanderbilt Scales for the diagnosis of ADHD, the appropriate timing and administration of all of the vaccines recommended during childhood, and how to deal with chronically ill subspecialty children as a general primary care physician. Inpatient treatment of Well Newborns as well as common newborn issues will be experienced, as well as treatment of children requiring admission to a Pediatric Unit in a Community Hospital setting. Residents will be expected to review the up-to-date literature and articles as assigned by the preceptor.
- **Practice-Based Learning and Improvement:** Residents will be expected to be competent in the use of electronic resources to access the most recent evidence-based care and algorithms for various conditions found in childhood. They will be evaluated in their continued progress in the use of their knowledge, both previously learned as well as discovered during their rotation.
- **Interpersonal and Communication Skills:** As interpersonal communication skills are essential in effectively dealing with children and their families, Residents will be taught various techniques regarding the most effective ways of caring for children so superior outcomes can be achieved.
- **Professionalism:** Remaining professional yet approachable and friendly is paramount in the field of Pediatrics. Respect for patients and their families' ways of caring for their children will be practiced and emphasized, while at the same time teaching residents the identifying potential signs and symptoms of child mistreatment. How to discuss and report possible mistreatment from a professional as well as legal standpoint will be included in the curriculum.
- **System-Based Practice:** How Pediatric care fits into the Family Medicine Clinic, how to use Pediatric Generalists and Sub-specialists when necessary, and ways of ensuring consistent practice-based competencies while caring for children will be stressed.

B. Service Description:

Approximately 30% of Shasta Community Health Care patients are ages 18 and under. Children are cared for both in the Family Practice Residency Center, as well as in the Pediatric Department, which is staffed by Board Certified Pediatricians, Family Medicine Physicians, and a Pediatric Nurse Practitioner. Residents will receive intensive Pediatric training in the care of Well Children, Immunization use/schedules, children with chronic illness/conditions, acute illness, developmental disabilities, those with behavioral/mental health issues, and perform routine procedures such as circumcisions. The Residents will rotate to the Pediatric Department for a set block of time. Upper-level residents will spend 4 weeks on this service working with an attending pediatrician in SCHC pediatric clinic. Dr. Carey Venglarcik will coordinate this rotation. Continuity clinic time is maintained throughout the rotations at the minimum of three half days per week.

- Supervision: Residents will be supervised by Board Certified Pediatricians (5 currently on staff), Qualified Family Physicians and Board Certified Pediatric FNPs while doing their outpatient Pediatrics.
- Facilities/Support Staff/Equipment: Nursing support will be provided as per usual SCHC staffing mechanisms.
- Record Systems: All Resident notes will be monitored by the Pediatric Preceptor using set EHR Protocols.
- Residents will see patients and write notes to send to supervising physician just like in Residency Center.

D. Duties

Residents will work in the SCHC pediatric department with the pediatricians Monday through Friday.

Residents will continue to have their continuity clinic at SCHC during this rotation.

Resident Pediatric Clinic will take place on Monday and Friday with one preceptor supervising two residents in the same model as Resident Department continuity clinic. The preceptor will oversee and sign-off on all resident notes/patients.

1. Resident templates will be 6 patients in the morning and 5 in the afternoon for PGY2. More patients added if PGY3 (Center Managers for both Pediatrics and Residency to coordinate schedules).
 - i. Resident clinic will be 8am-12:15pm in the morning and 1:50pm-5pm in the afternoon to accommodate lectures from 12:30pm-1:30pm daily
 - ii. All resident patients will be billed under the preceptor
 - iii. Goal is to have on PGY2 and one PGY3 resident at the same time.
2. There must always be 2 residents on the preceptor days (SCHC and Mercy may have to pull residents from other rotations to participate in this clinic)
 - i. If a resident is post-call, then another resident will take their place in clinic
 - ii. Ideally both residents have scribes, however PGY3 SCHC residents do have Dragon to assist with notes
 - iii. This will take place in Pediatrics department, though we may consider placing Pediatric preceptor/resident team in Residency on Fridays due to possible space issues.
3. Tuesday, Wednesday, and Thursday the two residents will shadow and work one-on-one with the preceptors. The resident schedule will be staggered so there is only one resident at a time in Pediatric department-coordinate clinic schedules and online modules.
4. All residents will be given the online Mount Sinai Pediatric curriculum each week during their Pediatric two-week rotation
 - i. ½ day weekly devoted to the online modules

- ii. Module days are alternated with clinic days to assist with quality clinical experiences where capacity is limited.
5. Curriculum for SCHC and Mercy is 4 weeks in PGY2 and 4 weeks in PGY3
- i. Ideally have a PGY2 and PGY3 resident paired together
 - ii. Ok for two PGY2's, but not ideal for teaching.

Residents can rotate on Saturdays during UC Well Child clinics and adjust their schedule to have a day off during the week either Tues, Wed, Thurs. These residents are precepted by either a pediatric or family medicine attending. They cannot be supervised by a PA or NP. Dr. Austin regularly works biweekly Saturday Well Child Clinic, and each resident will have the opportunity to work with her.

Supplemental Learning:

[Mount Sinai Curriculum](#)

POINT OF CARE ULTRASOUND (POCUS)

SCHC received a grant in 2017 to purchase an ultrasound for the clinic. A curriculum will be established to teach Residents how to use ultrasound in the clinic at the bedside. There is dedicated teaching time every Wednesday from 8-9 am at SCHC to practice POCUS.

PSYCHIATRY

Year: PGY1, PGY2, PGY3
Rotation Name: BSC, Elective
Location: SCHC at PCN Dept
Preceptor: Dr. Imran Khan, various others
Duration: 2 weeks

Lines of Clinical Responsibility/Authority in Supervision for Patients: The direct line of authority for patient care rests with the faculty staff member seeing a given patient on a given day. (This may vary from appointment to appointment and from day to day). Concerns about the final decision of patient care remain with the attending faculty for that patient for each visit.

General Goals: (adapted from ACGME Program Requirements for Residency Training in Psychiatry)

1. Family medicine residents will have a continuous supervised clinical experience in the assessment, diagnosis and treatment of outpatients that emphasizes a developmental, biopsychosocial, and culturally sensitive approach to integrated primary care behavioral health model.
2. Residents will have an outpatient experience that includes a wide variety of disorders, patients, and

treatment modalities, including biological treatments, and psychotherapy.

3. Residents will demonstrate the ability to gather and organize data, integrate these data with a comprehensive formulation of the problem to support well-reasoned differential diagnosis, formulate a treatment plan, and implement treatment care follow-up in an outpatient setting.
4. Residents will demonstrate competence in assessment and treatment of psychiatric conditions in primary care and assessment of psychiatric emergencies.
5. Residents will demonstrate professional and ethical behavior in the care of their patients and in their interactions with other health care providers.
6. Residents are expected to gradually develop higher levels of understanding and skills as they complete 4-week rotation.

Competency-Specific Objectives:

Patient Care: Residents must be able to provide care of outpatients that is compassionate, appropriate and effective for the treatment of mental illness. Specifically, residents will:

1. Demonstrate the ability to conduct assessments of a wide variety of patients presenting with psychiatric disorders commonly seen in primary care integrated behavioral health settings and attending to development, psychological, biological, social, and cultural contributions to their illnesses.
2. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
3. Counsel and educate patients and their families and demonstrate the ability to convey difficult information.
4. Develop patient formulations that include the following elements:
 - a. DSM-IV diagnoses on all five axis, including all necessary specifiers
 - b. Biopsychosocial formulation
5. Formulate and carry out treatment plans based on the above diagnostic formulation and define a rationale for specific treatment goals, considering also patient personal and psychosocial resources and ability to participate in the plan. Treatment paradigms will include:
 - a. Psychopharmacological treatment and management
 - b. Individual psychotherapy
 - c. Integrated, multidisciplinary treatment
6. Implement biological treatment strategies, including psychopharmacological treatment with antidepressants, antipsychotics, sedative-hypnotics, and mood stabilizing medications.

7. Appropriately and proficiently employ commonly used rating scales during the assessment and follow-up of outpatients, including anxiety and depression scales, cognitive measures (e.g., Folstein Mini-Mental State Examination) and neurological scales (e.g., Abnormal Involuntary Movement Scale.)
8. Identify outpatients who should be referred for specific community treatments or higher levels of care.
9. Understand the risks and benefits of and indications for psychiatric hospitalization and will be able to evaluate patients with a view to determining their psychiatric risk (risk of suicide or otherwise) and need for hospitalization.
10. Identify and manage co-morbid substance use disorders, including the prescription of evidence-based pharmacotherapy and psychotherapy.

Medical Knowledge: Residents must demonstrate knowledge of the neurobiological, psychological, and sociocultural underpinnings of mental illness and will apply this knowledge to the care of outpatients.

Specifically, residents will:

1. Conceptualize mental illness in terms of biological, psychological, and sociocultural factors that determine normal and disordered behavior.
2. Demonstrate knowledge of the epidemiology, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions in primary care settings.
3. Understand the psychopharmacological treatment of mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.
4. Appreciate that psychopharmacological treatment must take into account the wide variety of interactions with other pharmacologic agents, impact on other medical conditions, and full appreciation of all side effect problems including compliance, sleep, weight, sexual problems, and other organ system difficulties.

Practice-Based Learning and Improvement: Residents will be able to investigate and evaluate their patient care practices, appraise, and assimilate scientific evidence, and improve their patient care practices. Specifically, residents will:

1. Seek feedback from their supervising faculty, including clinic supervisors, and the faculty about their own practice and will use this feedback to improve their performance.
2. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
3. Use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records, and other computer-based resources.

Interpersonal and Communication Skills: Residents must be able to demonstrate interpersonal and

communication skills that result in effective information exchange and teaming with patients, their patients' families and other health care providers. Specifically, residents will:

1. Create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
2. Use effective listening skills in interactions with patients, their family members and other health care providers.

Professionalism: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population. Specifically, residents will:

1. Obtain informed consent for psychiatric treatment plans, including for the use of psychotropic medications, and will demonstrate understanding of the ethical principles underlying informed consent.
2. Provide care to outpatients that take into account (a) medical record keeping, (b) risk management and quality assurance issues, (c) confidentiality, (d) collaboration with other providers, agencies and family members, (e) financial and health system issues, (f) legal issues and (g) other ethical concerns.
3. Demonstrate sensitivity and responsiveness to each patient's age, gender, culture, ethnicity, religion and disabilities.

Systems-Based Practice: Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide optimal care to outpatients. Specifically, residents will:

1. Appreciate the model of community-based integrated behavioral health employed at PCN and will understand the difference between this model and others, such as County mental health, and hospital-based practice.
2. Understand how their patient care affects and is affected by other health care providers.
3. Collaborate with health professionals, in particular primary care providers
4. Understand the regulation of outpatient psychiatric treatment, including: (a) patient confidentiality and HIPAA; (b) state regulations regarding involuntary treatment; (c) state regulations regarding guardianship.
5. Advocate for quality patient care and assist patients in dealing with the complex mental health system.

Unique Aspects of This Rotation Training

Primary Care Neuropsychiatry

A. Service Goals

PCN department provides integrated primary care behavioral health model, ongoing follow-up of chronic severe mental illness and consultation services to primary care providers and urgent care. PCN sees a broad range of patients with depression, anxiety, psychosis, mood disorders, co-morbid substance abuse issues and personality disorders. Residents will be supervised and trained to conduct independent assessment, generating differential diagnoses, and multi-axial assessment. Residents are expected to see four new psychiatric evaluations and four primary care consultations during the rotation. They will see 4 patients a day for brief assessment, monitoring for side effects and medication adjustment of already established patients. Residents will be involved in one hour per week in treatment planning meeting and three hours per week with faculty for education and supervision.

B. Service Description

A two-week rotation occurs in the first year, and includes a variety of elements of behavioral medicine, psychiatry, and psychopharmacology. In addition to the specific first year curriculum, behavioral science is integrated into the entire three-year experience at SCHC, in lectures, hospital rounds, clinic "shadowing", "curbside" consulting, and when requested, through elective experiences. During the first year, periodic site visits may be conducted to vital community agencies and mental health programs including time at the SCHC Primary Care Neuropsychiatric (PCN) department. This will provide residents with practice in networking within a mental health community and will provide them with referral and consultation resources. Some aspects of behavioral health training can be best implemented in an experiential manner including Counseling Skills Training, Interviewing Skills Training, Relaxation and Stress Management (for both residents and significant others), psychological testing and behavioral science precepting.

C. Duties

During the first-year rotation, the Resident will spend face-to-face time with mental health professionals and patients in relevant facilities and agencies, and will undergo the various experiential training activities, as described above. Each Resident will have the opportunity to observe and experience the paradigm differences and similarities between the mental health field and the medical arenas to which they have become accustomed. Orientation to a range of mental health disciplines (e.g., psychiatry, clinical psychology, marriage and family therapy, etc.) will typically take place. Residents will also serve as observers or co-therapists, as indicated, in

psychotherapy and counseling sessions. Whenever possible, this will encompass a range of therapeutic modalities, including individual, group, couples, and family, depending upon the availability of cases and resources. Every effort will be made to orient Residents to community referral resources and relevant mental health legal issues.

Residents will be given the opportunity to sit in with and assist practicing psychiatrists as they meet with patients in SCHCs PCN department and in other community settings where available and appropriate. This will not only provide valuable role modeling but will provide practical and focused training in the use of psychotropic medication. Integration of Behavioral Science with general clinic-based outpatient medicine will occur during the rotation (and also during the second and third years of training) through precepting in which Behavioral Science faculty will see patients along with Residents during typical clinic visits.

Each Resident will be evaluated by the Behavioral Science Coordinator with respect to his/her competencies in this domain. Each mental health professional with whom the Resident came into contact during the rotation will also have an opportunity to provide feedback about the Resident. The Resident will also be given feedback and an oral review during a closure session with the Behavioral Science Coordinator.

Psychiatry services at SCHC are available on site with priority given to second- and third-year residents whenever the clinic schedule permits. This is because it will be a more advanced experience designed to assist residents in learning to provide independent, primary care level psychiatric services. However, when a first-year resident is assigned to this training experience, teaching will be focused and guided toward the resident's level of training and experience. The psychiatry clinic is an important training opportunity for all residents because Family physicians are frequently called upon to provide initial psychiatric screening and treatment in both inpatient and outpatient settings. Practicing Physicians provide longitudinal psychotropic medication management for patients whose primary clinical issues are psychiatric and yet are not severe enough that a referral to a psychiatrist is mandated. It is essential for residents to gain experience in handling this level of primary care independently. Services will involve psychotropic medication management, but there will be elements of psychotherapy and counseling, crisis intervention, and coordination of special referrals. The focus of teaching with these cases will be appropriate for primary care physicians, resulting in a better integration of general medicine and psychiatry. This model of integration of mental and behavioral health with overall primary care is a core foundation of care provided in the SCHC medical home model of practice.

A. Service Goals

The primary objective of the Behavioral Science Curriculum is to help Family Practice Residents more fully develop the skills and the knowledge base needed to intervene meaningfully and efficiently in the mental health issues of patients. A large percentage of patients seeking ambulatory care have a psychosocial or cultural issue of significance that if unrecognized or mismanaged seriously impairs the effectiveness of the physician's care. Residents are expected to achieve the full set of Behavioral Science and Psychiatry Competencies through this curriculum (See also Residency Goals and Competencies).

Rationale: Behavioral topics are best learned by residents if they are viewed as practical and applicable to their current or future practice. The timing of the teaching sessions is very important as the residents are more receptive to learning about certain concepts at particular times in the course of their residency. Residents are most teachable when the concepts can be tied into specific patient examples, particularly with their own patients. In order for behavioral concepts to be fully integrated into the residents' patient care, the concepts must be actively taught and reinforced by all family practice faculty members in all teaching activities - hospital rounds, conferences, clinical supervision, etc. This is where the bulk of learning actually takes place. However, the residents must be introduced to certain key concepts in a more didactic manner, through lectures, readings, small group discussions, and other similar teaching modalities. The concepts taught in this manner should be the basic building blocks which then can be expanded and reinforced by the faculty in the more clinically oriented teaching activities.

1. Residents should learn a systems approach to health care, with the ability to intervene at different levels of the system to help patients achieve a higher level of well-being.
2. Knowledge of human growth and development, including both individual and family life cycles is essential for a family physician that will be caring for the entire range of human lifestages.
3. Crisis management is a basic skill for family physicians that help patients daily to deal with stressful life events.
4. Family physicians must be able to identify and treat a broad range of emotional problems and psychiatric disorders in children and adults and seek referral when indicated.
5. Modern health care often requires a team approach, with the family physician as the coordinator. Family practice residents should, therefore, be trained in the utilization of community social, economic and health care resources.
6. The family physician must be a skilled communicator to be effective in developing rapport with patients, gathering the appropriate information, and educating and counseling the patient and family. Family physicians also interact with a broad range of other health professionals. Therefore, the development and refinement of communication and interpersonal skills by the resident is a primary goal for a family practice teaching program.
7. Physicians need to be aware of their own personal and family issues and values in order to deal effectively with the broad range of patients with their own issues and values. Self-understanding leads to a greater understanding of others and should be actively facilitated as part of the behavioral science curriculum.

Objectives

Residents will be able to:

1. Conceptualize health care in terms of the total person, considering the family, social and cultural context in which he/she lives.
 1. Employ the biopsychosocial model in dealing with the entire scope of health problems.
 2. Develop a community and family systems view of health care, utilizing knowledge of systems dynamics to intervene at different levels of the system.
 3. Describe the health beliefs generally held by the different ethnic, religious, and cultural groups most prevalent in this area.
 4. Construct individualized plans for managing patient problems based partly on the patient's family and social situation and his/her health and illness beliefs.

2. Develop increased awareness of him/her as it affects professional performance.
 1. Analyze constructive and destructive patterns of interactions with other people and in various circumstances.
 2. Assess personal attitudes and values and their implications for professional life.
 3. Develop an understanding of his/her family of origin and its impact on present patterns and values.
 4. Detect positive and negative developments in current family life.
 5. Recognize vulnerabilities that limit his/her effectiveness (such as knowledge, skills, substance abuse, social or emotional problems) and resources for dealing with these issues.
 6. Develop plans for preventing or dealing with the sources of stress in various professional situations.

3. Demonstrate skill in interviewing patients and establishing good doctor/patient relationships.
 1. Employ basic communication skills.
 2. Distinguish and utilize various levels of non-verbal communication.
 3. Recognize the influence of the setting and external factors on the doctor/patient relationship.
 4. Demonstrate an appropriate use of interviewing skills, including:
 1. Active listening
 2. Open-ended questions
 3. Silence
 4. Confrontation
 5. Modeling of self-disclosure
 6. Positive regard and empathy
 7. Constructive feedback
 8. Ability to direct a limited interview
 9. Display sensitive, non-judgmental care for a diverse patient population.

4. Provide high quality patient education in practice.
 1. Give patients clear feedback regarding medical or psychosocial problems.
 2. Evaluate patient understanding of information provided.
 3. Describe the utilization of other members of the health care team for patient education.
 4. List the advantages and disadvantages of the various patient education modalities.
 5. Design a plan for providing patient education in clinical practice.

5. Understand the normal process of growth and development.
 1. Describe the stages and milestones of child development.
 2. Screen for developmental problems in childhood using standard testing procedures.
 3. Manage child behavior problems through educating parents in parenting skills.
 4. Describe the stages in the individual and family life cycles.
 5. Cite the major issues and sources of stress for each stage of the individual and family life cycle.
 6. Design a plan for anticipatory guidance to deal with predictable crises in the life cycle.
 7. Describe the stages of grief in preparation for or reaction to death or other loss.
 8. Recognize the patterns of delayed or unresolved grief and intervene appropriately.

6. Utilize a family-oriented approach to patient care, understanding the workings of the family system and its impact on the health of the individual.

1. Demonstrate understanding of the basic principles of family systems theory, including:
 1. Maintenance of homeostasis
 2. Circular causality (a change in one part of a system effects change throughout the system)
 3. Non-summativity (family as a whole is greater than the sum of its parts)
 4. Mechanisms for coping with stress
 5. Apply approach to gathering family data using the genogram
 6. Describe the dynamics producing resistance to change in a family member by the rest of the family system and the importance of this process as a factor in determining patient compliance.
 7. Determine the effect of illness in an individual on the rest of the family system.
 8. Assess the importance of stress in the family system as a contributor to illness in an individual family member.
 9. Identify the values concerning families generally held by the different ethnic, religious, and cultural groups most prevalent in this area.
 10. Describe the transmission of health beliefs and illness patterns in a family system.

7. Demonstrate the ability to diagnose and manage psychiatric disorders.

1. Classify psychological disorders according to the standard DSM-IV system.
2. Perform a complete mental status exam.
3. Gather thorough psychosocial information about the patient and his/her family, primarily utilizing the approach described in 6.
4. Utilize psychological tests appropriately.
5. Diagnose and manage the major emotional disorders including:
 1. Depression
 2. Anxiety
 3. Psychoses
 4. Bipolar Disorder
 5. Personality disorders
 6. Cognitive dysfunction
 7. Organic brain syndrome
 8. Sexual disorders
 9. Alcoholism and substance abuse
 10. Somatoform disorders

6. Diagnose and manage the emotional problems of children, including:

1. Enuresis
2. Encopresis
3. School phobia
4. Attention deficit disorder
5. Learning disabilities
6. Behavioral disorders
7. Autism

7. Demonstrate understanding of the use of psychotropic medications.

8. Demonstrate skill in working with "difficult" patients in the practice, including those who are:

1. Demanding
2. Non-compliant
3. Seductive
4. Angry
5. Overly talkative

6. Late
 7. Dependent
 8. Select and employ the appropriate therapeutic technique to intervene in most psychosocial problems seen in practice.
9. Utilize a family systems approach to deal with family issues, as outlined in Section 6.
10. Counsel patients concerning desirable lifestyle modifications, and utilize patient education classes, including:
 1. Smoking Cessation
 2. Weight loss and other dietary changes
 3. Exercise programs
 4. Use of seatbelts and car seats
 11. Construct a format for anticipatory counseling to deal with predictable sources of stress from the life cycle, as in Section 5.
 12. Discuss the use of alternative stress reduction techniques such as bio-feedback, relaxation techniques, yoga, meditation, and hypnosis
 13. Develop a format for crisis management, including:
 1. Define a crisis
 2. Identify the factors that produce a crisis
 3. List the coping mechanisms by which people deal with a crisis
 4. Identify the stages of a crisis
 5. Describe a scheme for crisis intervention
 6. Demonstrate the ability to conduct short-term supportive counseling sessions.
 7. Demonstrate the ability to counsel patients concerning sexual problems.
 8. Develop guidelines for referral of patients or families requiring more intensive therapy.
8. Manage situations of social and family violence which may arise in clinical practice.
 1. Discuss the dynamics of child abuse, spouse abuse, and incest.
 2. Recognize patterns in families which tend to produce child abuse, spouse abuse and incest.
 3. Counsel rape victims in a sensitive, supportive fashion, dealing with the medical, legal, and psychological problems.
 4. Utilize community resources for victims of child abuse, spouse abuse, incest, and rape.
 5. Describe the dynamics of suicide.
 6. Determine the risk of suicide in depressed patients.
 7. Construct a suicide contract to prevent suicide until definitive treatment can be obtained.
 8. Use crisis intervention techniques in dealing with all the above situations.
 9. Utilize community resources and other disciplines as part of the health care team.
 1. Describe the use of nurse practitioners and physician's assistants in a physician's office.
 2. Discuss the use of social workers, family therapists, nurses, and office staff as part of the team.
 3. Utilize community resources in the care of patients, including:
 1. Home health support system
 2. Nursing homes
 3. Government agencies for aiding indigents

4. Mental health centers
4. Assess the patient's family economic and social resources in formulating the plans for treatment on discharge from the hospital.
5. Discuss the various third-party payment systems, including:
 1. Medicare
 2. Medicaid
 3. Private health insurance
 4. Pre-paid health care system
 5. Possible future reimbursement systems.

RURAL FAMILY MEDICINE

Year: PGY1, PGY2, PGY3

Rotation Name: Rural

Location: Private offices and hospitals

Preceptor: varies, Dr. Davainis oversees this rotation

Duration: 2 weeks

- **During Rural**
- **Located at private offices and hospitals**

A. Service Goals

Each resident will experience rural family medicine in order to understand the unique challenges of such practice (clinical and operational) and to be able to better decide if a rural practice fits their career interests. At the completion of residency training, a family medicine resident should:

- Be able to discuss the issues of social determinants of health, health equity, social justice, and US policy impacts in the distribution of health services in low-resource settings. (System-based Practice)
- Assess the health care and public health needs of communities and make evidence-based decisions about resource allocation and the delivery of population health services. (Medical Knowledge, Patient Care)
- Demonstrate knowledge of effective advocacy strategies for health systems improvement within the rural context. (Interpersonal and Communication Skills, System-based Practice)
- Tailor health outreach and clinical interventions by taking into consideration local socioeconomics, politics, health disparities, and cultural influences. (System-based Practice)

- Demonstrate the ability to communicate effectively and collaborate with the patient, the patient’s family, and the patient’s caregivers with sensitivity to sociocultural and health literacy issues so that the diagnosis and plan of care are clearly understood and pertinent to their specific situation. (Interpersonal and Communication Skills)
- Demonstrate the ability to use interpreters when the physician and patient cannot speak the same language. (Interpersonal and Communication Skills)
- Create treatment plans based on knowledge of rural influences, utilizing resources that include local, state, and federal agencies as applicable. (System-based Practice, Practice-based Learning and Improvement)
- Recognize his or her own practice limitations and seek consultation with other health care providers and systems resources to provide optimal care within a rural construct. (Practice-based Learning and Improvement, System-based Practice)
- Develop the following general competencies in rural medicine including:
 - a. Adaptability – how to shape one’s skill set to the needs of the rural community
 - b. Improvisation – how to deliver quality care within the resources and skills you have available in the moment
 - c. Life-long learning – how to continually acquire additional knowledge and skills as needed
 - d. Collaboration – how to get help from others and work together
 - e. Endurance – how to sustain oneself in rural practice

B. Service Description:

Residents have the opportunity to request their location for this two-week rotation. To broaden experiences and exposure to various practice sites, two separate locations may be selected during this rotation, though not required.

These sites include:

1. Seneca Health Care District (Chester/Lake Almanor)
2. Mayer’s Memorial Hospital (Fall River Mills)
3. Weaverville
4. Northeastern Rural Health Clinic (Susanville)
5. Alturas
6. Mercy, Mt. Shasta

7. SCHC- Anderson Family Health Center

Residents will be scheduled in their own continuity clinic in the Residency Department at SCHC on the first Monday and last Friday (1/2 day for PGY1 and all day for PGY2/3) of the rotation. For an enriched experience of rural medicine, it is suggested that the resident stay locally rather than commute to the site. The resident should plan to spend Tuesday through the following Thursday (10 days and 9 nights) at the rural site and be available for some weekend call experience if the opportunity is available. Reimbursement for accommodation of the resident is available to those who do stay around their rural site. Please speak to the Residency Coordinator regarding stipends. Accommodation should be arranged in advance by the resident. For those choosing an SCHC Satellite Clinic, reimbursement is available for mileage only. As all remote locations are located in the mountains where snow is possible, rotations are scheduled during typically non-snowfall months. Exceptions to this timing may be granted by the Program Director on an individual basis.

C. Duties:

Residents see patients in the ambulatory practices and in the hospitals serving those practices under the supervision of the attending family physicians. Residents will see patients and present to the attending, as well as perform procedures as deemed appropriate. Residents may be able to take call, cover the ER, or nursing home, and attend surgeries as first assist depending on the rotation site at their preceptor's discretion.

Reimbursement limit is \$1400.00 for rural rotations.

Additional Learning Resources from COMPADRE:

[Rural Primary Care: Working Outside the Comfort Zone](#)

[Rural Ethics Article](#)

[Overlapping Roles of the Rural Doctor](#)

[Why Rural Matters Video](#)

SURGERY ROTATION

Year: PGY1, PGY3

Rotation Name: Surg

Location: Private offices and hospitals

Preceptor: Dr. Gonzales, various others

Duration: 2 weeks

A. Service Goals

The surgery rotations in the first and third years are intended to provide the family practitioner with appropriate diagnostic and management skills to recognize and appropriately refer the surgical patient in a timely fashion and to manage the medical and social issues of the surgical patient. The resident will have flexibility in determining the preceptors for these rotations, utilizing self-assessment of the Surgical

Competencies Curriculum, which must be successfully completed. At the completion of residency training, a family medicine resident should:

- Be able to perform a surgical assessment and develop an appropriate treatment plan. (Medical Knowledge, Patient Care)
- Coordinate ambulatory, in-patient and institutional care across health care providers, institutions, and agencies. (Systems-based Practice, Patient Care)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure that the diagnosis and treatment plan are clearly understood. (Communication)
- Demonstrate the ability to communicate effectively with the surgeon supervisor/consultant about the patient's symptoms, physical findings, test results and proposed plan of care. (Communication, Professionalism)
- Recognize his or her practice limitations and seek consultation with other health care providers when necessary to provide optimal care. (Professionalism, Practice-based Learning)
- Demonstrate knowledge of the principles of ethics as it applies to medical research. (Professionalism)

B. Service Description

Each resident will rotate on the surgical service for one month during various years. The resident will be assigned to one surgical preceptor during the rotation. Their primary responsibility is to accompany and assist the surgeon with clinic and inpatient responsibilities. Surgical assisting is a valuable component of the rotation, but the extent will be determined in part by the resident's future practice and the surgical privileges desired. The resident's call responsibilities will be the same as other residents scheduled for inpatient call. Depending on the surgical attending, residents may participate in trauma call with the surgeon. Residents will also rotate at SRMC per attending preferences.

C. Duties

1. Provide surgical assistance to their respective preceptors.
2. Accompany the surgeon in both outpatient clinic and inpatient rounds.
3. Attend SCHC continuity clinic, noon conferences and post-call time off.
4. Continuity clinic as scheduled.

UROLOGY

Year: PGY2, PGY3
Rotation Name: EUOC
Location: Private offices, VA
Preceptor: varies
Duration: 2 weeks

A. Service Goals:

Family Physicians commonly care for patients with urological complaints and disorders. Family Physicians actual practices may vary to the extent that they provide care and procedural options for their patients. This portion of the curriculum is designed to provide residents with the skills and expertise expected of family physicians with active practices involving this area. This rotation will provide a concentrated experience in the care of patients with urological disorders and will be the intensive experience in this area. At the completion of residency training, a family medicine resident should:

- Have an understanding and working knowledge of the incidence, predisposition, and impact of diseases affecting men of different age groups, demographic groups, and geographic distributions. (Medical Knowledge)
- Understand the attitudes toward general health and preventive services that prevail in the male population. (Medical Knowledge, Patient Care)
- Be able to take a comprehensive men's health history, including occupational, behavioral, relational, and sexual history. (Medical Knowledge, Patient Care, Interpersonal and Communication Skills)
- Be proficient and comfortable performing a comprehensive male physical examination, including a urogenital, rectal, and prostate examination. (Patient Care)
- Be proficient in communicating in a sensitive and cogent manner with the patient and others involved in his care (when appropriate) all aspects of diagnosis and treatment. (Interpersonal and Communication Skills, Patient Care, Medical Knowledge)
- Understand and be able to communicate appropriate and relevant recommendations regarding screening guidelines, health maintenance, preventive services, and health system access in a way that is appropriate to male patients. (Patient Care, Interpersonal and Communication Skills, Systems-based Practice)
- Be knowledgeable about local resources that are available to assist in assuring appropriate services to male patients. (System-based Practice, Patient Care)

- Be open to feedback and willing to modify one’s approach in order to provide a more male-friendly practice. (Practice-based Learning and Improvement, Interpersonal and Communication Skills, Patient Care)

B. Service Description:

The urology rotation is integrated into 6 weeks in the third year of residency along with ENT, Cardiology and Ophthalmology (EUOC) and is designed to expose residents to the evaluation and management of common urological conditions that present in the ambulatory setting. The experience is based in an urology office practice. Where appropriate to accomplish educational goals, residents may accompany urology preceptors into the hospital setting to assist or observe surgical procedures. This rotation represents one component of a residents training in urology. Substantial training is provided in the primary care of patients with common urological conditions. Responsibility for the medical management of inpatients with urological complaints occurs throughout residency training.

C. Service Duties:

Attendance at the urology office is required. If approved by the urology attending, you may also join them at other practice locations. During this time, you will work one-on-one with an urologist. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/week. A syllabus of relevant readings on the primary and hospital care of common urology conditions is available on our residency website as well.

LONGITUDINAL CONTINUITY EXPERIENCE

THE FAMILY MEDICINE CLINIC

Shasta Community Health Center Family Medicine Residency Program will provide outpatient training in the Family Medicine Center at SCHC.

The resident physician will provide continuity medical care to an assigned and diverse group of patients under the supervision of qualified faculty. During the three years of their training, residents spend progressively more of their training time weekly in the SCHC Family Medicine Center.

The patient care and educational activities in the center are designed to meet or exceed all of the ACGME Program Requirements for Graduate Medical Education in Family Medicine. As such, the goal of their training is to require graded and progressive responsibility in providing patient care. Appropriate supervision ensures safe and effective

care for the individual patient; and assures the development of skills and knowledge for each resident to prepare each resident for the unsupervised practice of medicine.

SCHC Family Medicine Residency Clinic: This is the smaller of the two clinics and exists within Shasta Community Health Center. It is a separate patient care unit of the health center but draws its patients from the same population base as the main center. Only SCHC residents will obtain their continuity training here. Some specialty training will occur within the Residency Clinic and in other areas of SCHC.

Mercy Family Health Center: This is the model Family Medicine Center for the Mercy Redding Family Practice Residency Program and is the larger of the two centers. Participation at this center allows maximum interaction with a large number of experienced faculty and other residents. This well-established center has a number of specialty clinics, in addition to providing continuity medical services. These clinics include: Dermatology, Orthopedics, Allergy, Colposcopy, Renal, Pain Management and Gynecology.

Supervision: Supervision of residents will occur under the control of the Program Director by qualified Family Medicine Physicians. An appropriate ratio of supervising physicians to residency physicians will always be provided. Supervising physicians will encourage progressively increasing responsibility by residents while giving appropriate educational direction and feedback to residents. Supervising physicians are responsible for ensuring safe and quality care for the individual patients.

A list of procedural competencies has been developed for all residents to master during their training. A documentation process will document the type and number of specific procedures. Additional procedural training will be available for interested residents. This may include training in: Colposcopy, LP, Paracentesis, LEEP, Vasectomy, OB Ultrasound, and a variety of minor procedures.

Patient Population: The patient panels for each resident will mirror the patient population of the individual Family Medicine Clinic. The resident panels will include a full range of patient ages from newborns through geriatric patients and include a broad range of medical issues. The number of patient encounters for each resident and nature of the medical issues treated will be tracked and documented. Inquiries for current patient encounter numbers can be made through the Center Manager.

Facilities / Support Staff / Equipment: Each Family Medicine Clinic provides clean, modern, up-to-date examination areas and equipment. Each resident is provided with at least two examination rooms for use during clinic time. Adequate front office, nursing, billing, and other staff is provided to support the resident in developing the skills to work effectively in an outpatient setting. A separate and private consultation area is provided to discuss cases with the Supervising Physician. A library with written and online resource materials is available. Each resident has a secure area for personal belongings. Appropriate equipment for diagnostic testing is available in the lab. A

laboratory for C.L.I.A waived testing is within each Family Medicine Clinic. Residents receive training and competency training to perform these tests. A laboratory draw station is located within the main clinic. X-Ray facilities are located within SCHC and nearby Mercy. Computerized X-Ray viewing is available at each site.

Record Systems: Residents will be educated and evaluated on appropriate documentation of patient care. Mercy Family Health Center currently uses Cerner EMR.

The SCHC Family Medicine Residency Clinic uses existing and well established NextGen EMR system currently used by SCHC for all clinical documentation, scheduling, and billing.

Patient Centered Medical Home: The SCHC Family Medicine Residency Clinic will be striving to meet all established guidelines for being a Patient Centered Medical Home (PCMH.) All other SCHC clinical sites are working toward this designation. This will include: an open scheduling system, a patient focused approach, availability of case management services, integration of Mental Health Services, and online patient access availability through the patient portal for patient scheduling, education and interaction. SCHC is constantly updating the clinic in order to meet meaningful use criteria. Shasta Lake City and Anderson sites are currently level 3 PCMH.

Continuity of Responsibility: Continuity of care is a priority in our program. At each Family Medicine Center, each resident will be assigned a panel of patients that represents the breadth of family medicine. These patients will cover a full age range and have medical issues that reflect the full scope of our specialty. Great efforts will be taken to ensure that residents see their own patients within the center whenever possible. The percentage of visits for which the resident provides care to his/her assigned patients will be tracked.

Residents will be assigned a minimum of seven obstetrical patients that they will see for their prenatal, delivery and postnatal care. Care for the “maternal/child unit” will be provided by the resident.

When one of the resident’s continuity panel patients requires hospitalization, home care, urgent or emergency care, long term care or specialty consultation; the resident will be notified and will be involved in this care as much as possible. Specially, when one of these patients requires hospitalization, the resident will be expected to round on the patient and participate in care decisions and coordination whenever practical. Residents will see at least two continuity patients in nursing homes during their training. Each resident will also perform at least two home visits with at least one being an older adult continuity patient.

Core Competencies

1. Patient Care: Residents will be trained and receive experience in providing compassionate,

appropriate, culturally competent, and effective medical care to a broad range of patients.

2. **Medical Knowledge:** Residents will be trained in and demonstrate the knowledge required to make appropriate and effective medical decisions regarding their patient's care. This knowledge will encompass the breadth of the specialty of Family Medicine.
3. **Practice-Based Learning and Improvement:** Residents will be expected to use written and digital resources effectively to provide timely evidence-based medicine to their patients. They will be trained in and evaluated on their ability to locate, appraise, and utilize evidence from scientific studies as this information relates to their patient's health. Digital resources will be available directly through the EMR (i.e.: Up To Date, Epocrates.)
4. **Interpersonal and Communication Skills:** At every step of their education, residents will develop and demonstrate interpersonal and communication skills that facilitate effective care for their patients. Emphasis will be on honesty, integrity, empathy, and effective listening skills. The residents will receive frequent feedback on the effectiveness of these skills.
5. **Professionalism:** Residents are required to demonstrate the highest level of commitment to the professional standards of their profession, including demonstrating ethical personal behavior, sensitivity to diversity within the patient population, maintenance of confidentiality, work ethics and compliance with SCHC and hospital rules.
6. **System-Based Practice:** Residents will receive training and develop an understanding of how the care they provide to patients fits into the health care of the community. The importance of a team-based approach and coordination of care between different providers and disciples will be emphasized.

Clinical Competency Chart Audit

This is the process/policy that allows licensed second-year resident physicians to be able to see patients in the clinic without necessarily presenting them to the preceptor at the time of the visit. Also, the preceptor does not need to physically see all patients under certain circumstances.

The process, basically, involves each core faculty reviewing 3 resident charts that the faculty member selects at random. The Resident Clinical Competency Chart Audit Form is then used to report on this chart review. If deficiencies are noted during this chart audit, feedback should be given to the resident and another audit should be done on a separate day. Once this chart on it is excessively completed, the core faculty member will then make any

pertinent comments and recommendations on whether they feel this resident is competent to see patient's more independently and clinic. The attachment above gives more details about the process and also outlines the changes in supervision possible after the resident completed since process.

This process should be initiated by the resident physician when he she is interested. The resident should ask each core faculty to complete the chart audit. The completed forms should be returned to the residency coordinator. Once all core faculty have given their positive recommendations, the resident can start seeing patients under the new supervision requirements.

RESIDENT CLINICAL COMPETENCY CHART AUDIT FORM

Resident: _____ Preceptor: _____

Date: _____

To Pass, each item in chart listed below must be 100% appropriate.	<input type="checkbox"/> Pass Chart # _____ Date _____	<input type="checkbox"/> Pass Chart # _____ Date _____	<input type="checkbox"/> Pass Chart # _____ Date _____
Was the chief complaint addressed?	Y N N/A	Y N N/A	Y N N/A
Was the physical exam appropriate for chief complaint?	Y N N/A	Y N N/A	Y N N/A
Were appropriate studies ordered?	Y N N/A	Y N N/A	Y N N/A
Was the diagnosis clearly noted?	Y N N/A	Y N N/A	Y N N/A
Was the treatment appropriate?	Y N N/A	Y N N/A	Y N N/A
Was patient education documented appropriately?	Y N N/A	Y N N/A	Y N N/A
Follow-up noted with proper interval?	Y N N/A	Y N N/A	Y N N/A
Was the Problem List updated?	Y N N/A	Y N N/A	Y N N/A
Was the Medication List updated?	Y N N/A	Y N N/A	Y N N/A
Was HCM addressed appropriately?	Y N N/A	Y N N/A	Y N N/A
Have all drug allergies and adverse reactions been entered on the med sheet?	Y N N/A	Y N N/A	Y N N/A
Were medications appropriate for the condition(s)?	Y N N/A	Y N N/A	Y N N/A

Were medication dosages and frequency documented?	Y	N	N/A	Y	N	N/A	Y	N	N/A
Was electronic prescription written appropriately including legibility, dose and frequency?	Y	N	N/A	Y	N	N/A	Y	N	N/A
Have all abnormal findings and tests been followed adequately?	Y	N	N/A	Y	N	N/A	Y	N	N/A
Were appropriate abbreviations used?	Y	N	N/A	Y	N	N/A	Y	N	N/A
Was appropriate billing completed?	Y	N	N/A	Y	N	N/A	Y	N	N/A
Was checkout process utilized appropriately?	Y	N	N/A	Y	N	N/A	Y	N	N/A

RESIDENT CLINICAL COMPETENCY PROCESS AT SCHC RESIDENCY CENTER

To assure proper patient care and clinical documentation, unlicensed residents will go through a process to certify clinical competency before transitioning to more independent status. Currently, all unlicensed residents must verbally present patients in detail to the preceptor at SCHC. These patients must be physically seen and evaluated by the preceptor with care documented in the chart. Licensed R2s and R3s must also follow the same supervisory requirements unless they meet the exclusion criteria, listed below*. If the exclusion criteria are met, licensed residents must still review patient care with the preceptor during or immediately after each visit, but patients need not be seen by the preceptor.

The process of certifying clinical competency will begin once a resident achieves licensed status. Residents who have been licensed for many months will also need to participate in the process until they are certified. The process will involve core faculty members scheduled specifically for this task. Community preceptors will be notified of each resident’s status but will not be involved in the certification process. The process is described as follows:

1. The Preceptor will review 3 randomly selected charts from previously seen patients.
2. The core faculty member will review and sign the chart audit form, after verifying completion.
3. The certification process will continue until the resident demonstrates clinical competency by chart audit and appropriate clinical care for level of training. Each core faculty member must complete this review and recommend and approve clinical competency.

The decision to allow work independent status will be made after discussion with all Core Faculty.

If after going through the process a licensed resident is not performing to the expected standards as above, they _____

may be required to go through the same process again, as determined by the core faculty.

* For licensed R2s and R3s, all patient care must be reviewed with the preceptor during or immediately after each visit. E/M codes 99201, 99202, 99212, 99203, and 99213 qualify for an exception and need not be seen by the preceptor unless clinically warranted. The preceptor must see all patients seen by residents on visits with E/M codes 99204, 99214, 99205 and 99215. The preceptor must directly supervise all procedures. All Medicare Patients must be seen by preceptor.

OBSTETRICAL CONTINUITY EXPERIENCE

A. Service Goals:

Managing a family practice OB patient is considerably different than managing patients that aren't your own and following that patient and their child is part of what makes family medicine OB unique. This experience is intended to acquaint the resident with a continuity OB experience from prenatal care through labor and delivery and the post-partum period. The bio-psychosocial elements of a "normal" pregnancy are important aspects of this experience

B. Service Description:

Basic Maternity Care: The residents will follow and deliver a minimum of 3 family medicine patients over their three years of training. The continuity credit only counts if patients have been seen antenatal, intrapartum, and postpartum by the same resident.

Comprehensive Maternity Care: The residents will follow and deliver a minimum of 10 family medicine patients over their three years of training. The continuity credit only counts if patients have been seen antenatal, intrapartum, and postpartum by the same resident.

Patients will be assigned to the residents by clinic staff on a rotating basis as they enter the practice up to a maximum of 15 patients. When a resident's continuity patient becomes pregnant, the patient will be evaluated to make sure she is an appropriate low risk OB patient. The resident will provide the prenatal care if at all possible. If patient is deemed high risk the resident has the option of following along with the OB at the OB clinic and doing the patient delivery. During academic counseling, advisors will provide feedback regarding the number of OBs being cared for and delivered. Inpatient precepting of all deliveries will occur with contracted Family Medicine physicians or with the on-call laborist. All SCHC prenatal patients will have a complete chart audit at approximately 28 weeks gestational age. The interesting or teaching cases will be presented at the OB Conference by the continuity provider or the OB back up partner. The OB Conference is

held every other month.

C. Duties

Residents following patients for their prenatal care at the residency clinic are expected to deliver these patients and follow them post-partum.

Residents should establish backup with one or two fellow residents, so that they can cover for each other in the event of away electives, vacations, etc. The backup resident should meet with and establish a relationship with the patient at some point during prenatal care, preferably during the first or second trimester. The backup's name should be noted in the chart so that he/she can assume responsibilities for the patient in the absence of the primary resident.

Prenatal patients who become high risk or with whom questions arise should be appropriately discussed with an OB attending and/or referred to Shasta Maternity Clinic for care as appropriate.

Summary of SCHC OB Program

The SCHC resident physicians are all assigned continuity OB patients starting at approximately the middle of their first year of training. These patients receive their prenatal care in the SCHC Residency Center and deliver at Mercy Hospital under the supervision of Dr. Davainis, Dr. Mooneyham and laborist. All of these patients are established patients at Shasta Community Health Center and are not Shasta Maternity Clinic patients. There is no arrangement for Mercy Resident physicians to be involved in their care, unless the OB on call is involved with the delivery (see below explanation).

In the event that Dr. Davainis or Dr. Mooneyham are not available, there is a contractual arrangement with the Mercy On-call Obstetrician to provide backup physician services. A monthly call schedule listing of who are on call for SCHC continuity patients is posted in Labor and Delivery, in the SCHC Residency Center.

SCHC Resident OB Continuity

GOALS:

1. As Family Medicine encompasses "birth-to-death care", Residents are expected to do prenatal care and deliver at least 3 pregnant patients during their three-year residency for *basic maternity care* track or 10 pregnant patients for *comprehensive maternity care* track. Ideally, each Resident will deliver their own patient. Credit for delivery will be given to the Resident who completes antepartum, intrapartum, and postpartum care for the same patient per ACGME requirements. The delivering Resident must notify the

Center Manager (Randi) of the newborn's birth information.

2. To experience private & group practice model responsibilities with regard to OB care.

METHODS:

1. Patients should be seen regularly by their primary OB providing Resident.

2. To extend continuity, each Resident will pair with his/her SCHC Resident counterpart (usually a resident within their cohort) who will cover the patient's medical needs should their primary Resident be unavailable. If all of the Residents within a cohort will be unavailable, then coverage by one of the other SCHC Residents must be arranged by their primary Resident. All of the physician care, except that provided by ER or specialty care, ideally will be provided by one of the SCHC Residents. With an average expectation of less than 1 continuity delivery per 2 months it is anticipated that the need for the Resident to be contacted for continuity care will be rare. Each Resident will be available by pager, or their cell phone if preferred, for their OB patient's needs after 20 weeks gestation. That contact should occur through Labor and Delivery.

3. After hours phone triage will be done by the L & D Resident on duty and may involve the patient's SCHC OB Resident provider at the discretion of the L & D Resident. However, if the patient presents physically to L & D, then the patient should be treated as a private patient of the SCHC Resident practice. After the OB RN evaluation on L&D, that patient's SCHC Resident will be called to direct further care. All care should be handled by the patient's primary SCHC Resident or by that Resident's covering partner. This care may be by phone when appropriate but must still be presented to the SCHC OB Attending of the day. The monthly SCHC OB Attending call coverage schedule is kept on L&D.

4. The hours needed to provide coverage of continuity OB patients may occasionally be a duty hour violation of work hours, but it is an acceptable exception that needs to be noted in New Innovations. Resident will notify the Residency office if continuity OB care violates a duty hour. This is also a time when one's Resident partner could direct care.

5. Resident partners may also be relied upon to cover patient care needs if the primary Resident is ill or otherwise unavailable to provide care. It is suggested that Residents communicate clearly with their partners when planning to be unavailable and notify L&D of this coverage.

6. All Resident - OB patient encounters will be presented to the SCHC preceptor: Dr. Mooneyham, Dr. Davainis or the laborist on call.

THE BOTTOM LINE:

The on-call L&D Resident will cover phone triage after hours, but all physical patient encounters and

physician contact should be by primary Resident, their cohort resident/partner or prior arrangements with another SCHC Resident.

When supervised by a SCHC preceptor, the mother and baby's care will be provided as a couplet by the SCHC preceptor and the involved SCHC resident physician. The infant will not be routinely cared for by the Family Practice Service. The infant may be listed on the family practice list with the notation that they will be rounded on by SCHC preceptor and the SCHC Resident.

If the SCHC resident is supervised by the Obstetrician on call, the patient is then automatically transferred to the status of a Shasta Maternity Clinic patient. Then, Mercy Residents can be involved in their care. In this case, the baby would be added to the family practice service and rounded on by the Family Practice Attending. If there are any questions about how these patients should receive their hospital care, please contact Randi Holscher (246-5940) the SCHC Residency Center Clinical Director.

SKILLED NURSING FACILITY VISITS (SNFs) – LONG TERM CARE FACILITY

Each second- and third-year resident is required to follow a minimum of two SNF patients. Dr. Doug McMullin will coordinate the patient assignments and SNF patients should be seen each month at their facilities. These visits are to be documented in New Innovations. Dr. McMullin, Dr. Nicora, and Dr. Lupeika will co-sign notes in the SCHC Nextgen EMR.

Lines of Clinical Responsibility / Authority in Supervision of Patients

The direct line of authority for Skilled Nursing Facility care rests with the faculty member formally tasked to oversee resident care of the patients.

General Goals:

1. Provide continuity experience in care of Long-Term Care patients over a period of 30 months
2. Understand the medical problems, facility and community resources, communication lines, and team structure involved in the care of patients in Long Term Care facilities
3. Understand medical problems unique to and care for geriatric and non-geriatric patients in Long Term Care facilities.

Competency – Specific Objectives

Patients residing in Redding Long Term Care (Skilled Nursing Facilities) receive care via Shasta Community Health Center (SCHC). These patients are also registered as SCHC patients for medical record and billing purposes. They receive continuity care by the designated resident providing:

- 1) an annual history and physical exam
- 2) an on-site evaluation and physical assessment monthly
- 3) timely provider response and communication via phone, fax or other for orders, questions, and nursing staff inquiries
- 4) after hours care available from the Mercy Medical Center – Medical Resident on-call.

B. Resident physician will be assigned two LTC patients at month #6 of their residency experience to be followed for the subsequent 30 months of their training. They will become familiar with the patient’s medical and behavioral conditions, social and insurance concerns, family issues, etc. In the event of the death of a patient, another LTC patient will be provided.

C. It is expected that the resident will use their designated free-noon hour monthly for LTC visits and will perform a thorough and appropriate history and physical exam. The resident will enter the details of the encounter into SCHC electronic records (NextGen) and task the attending physician to review and cosign the LTC encounter note. Nursing staff will fax the signed EMR encounter to the LTC facility for their records.

D. The attending physician will also perform an assessment and physical examination of each assigned LTC patient monthly. This visit need not be the same day as the resident encounter. It is desirable that the attending evaluation occur within several days of the resident encounter for continuity and consistency. There will be accessible and frequent communication between resident and attending regarding each LTC patient and their conditions.

E. Residents should review and study journal articles on the SCHC Residency Website filed under: Learning Resources and Rotation Information: Nursing Home and Long-Term Care. Residents should study and understand medical, psychological, and social conditions specific to and frequently encountered in LTC and geriatric patients and the appropriate treatment of, and use of community and facility resources to manage those conditions.

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Competency – Specific Objectives (K=Knowledge, S=Skills, A=Attitude)

A. Patients residing in Redding Long Term Care (Skilled Nursing Facilities) receive care via Shasta Community Health Center (SCHC). These patients are also registered as SCHC patients for medical record and billing purposes. They receive continuity care by the designated resident providing:

- 1) an annual history and physical exam
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- 3) timely provider response and communication via phone, fax or other for orders, questions, and nursing staff inquiries
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C. It is expected that the resident will use their designated free-noon hour monthly for LTC visits and will perform a thorough and appropriate history and physical exam. The resident will enter the details of the encounter into SCHC electronic records (NextGen) and task the attending physician to review and cosign the LTC encounter note. Nursing staff will fax a hard copy of the signed EMR encounter to the LTC facility for their records.

D. The attending physician will also perform an assessment and physical examination of each assigned LTC patient monthly. This visit need not be the same day as the resident encounter. It is desirable that the attending evaluation occur within several days of the resident encounter for continuity and consistency. There

will be accessible and frequent communication between resident and attending regarding each LTC patient and their conditions.

E. Residents should review and study journal articles on the SCHC Residency Website filed under: Learning Resources and Rotation Information: Nursing Home and Long Term Care. (K,S,A) Residents should study and understand medical, psychological and social conditions specific to and frequently encountered in LTC and geriatric patients and the appropriate treatment of, and use of community and facility resources to manage those conditions.

RESIDENT PRESENTATIONS AND SCHOLARLY ACTIVITY

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Demonstrate the ability to ask answerable questions applicable to the direct clinical care of their patients. (Medical Knowledge)
- Demonstrate the ability to search, find, and appraise both primary and secondary information sources for answers to these clinical questions. (Practice-based Learning and Improvement)
- Demonstrate the ability to apply this information to the care of patients. (Patient Care)
- Design a quality project to improve care at SCHC. (Patient Care, Practice-based Learning and Improvement) Present quality project to the clinical leadership committee at SCHC.
- Participate in Morning Report, Journal Clubs, and Grand Rounds presentations. (Medical Knowledge, Patient Care, Practiced-based Learning and Improvement)

ACGME Program Requirements stipulate: Each program must provide opportunity for residents to participate in research or other scholarly activities. Instruction in the critical evaluation of medical literature, including assessing study validity and applicability of studies to the resident's patients must be provided.

The participation of each resident in active research program should be encouraged as preparation for a lifetime of self-education after completion of formal training.

Other acceptable forms of scholarly activity include presentations at national, regional, state, or local meetings, and presentation and publication of review articles and case presentations. These may be given in lieu of Grand Rounds.

Our program meets this requirement through the following means:

Critical Evaluation of Medical Literature: During all three years of residency training, residents receive instruction in the critical evaluation of medical literature during the monthly Journal Club. Residents take turns presenting articles and providing critique with the support of the residency faculty.

Resident Presentations: Our program requires two normal presentations and multiple informal presentations of each resident during their training as part of scholarly activity. This is in addition to service-related presentations, such as Perinatal M&M and inpatient teaching activities. Other options for scholarly activity are found below. Faculty advisors are available to assist residents in the preparation for their formal presentations. The core faculty physicians will evaluate the presentations in terms of relevancy and quality. Presentations that score marginally or do not adequately meet the objectives as outlined below may result in the need for an additional presentation at the discretion of the program director.

Senior Grand Rounds: All third-year residents must prepare and present a Grand Rounds lecture to the hospital medical staff. Their academic advisor or alternate faculty member will provide assistance and consultation for the presentation.

1. Presentations must include a thorough and critical review of the medical literature with at least 10 references cited in the bibliography.
2. As appropriate during the presentation, the resident will make references to studies in the medical literature that support or refute assertions made during the talk.
3. The resident should prepare a handout, consisting of at least an outline to provide a reference for attendees.
4. The presentation should be done on Power Point.
5. Technical assistance is available through the hospital library and/or faculty advisors.
6. Grand Rounds at Mercy Medical Center Redding occurs on Friday at noon.
7. Residents will coordinate the date for their Grand Rounds presentation with Dr. Namihas late in the second year or beginning of the third year.

Morning Report: This is a case presentation by a resident with subsequent discussion on evidence-based treatment and management of the disease presented. Attendings and residents attend this weekly conference and CME is given to faculty attendees. Residents are asked to attend morning report which happens weekly at Mercy Medical Center in the lower-level conference room on Wednesday from 7:15 – 8:00 am. Residents will be assigned presentations of cases throughout the year by the Chief Residents. The cases will be assigned based on topic, such as Peds, Medicine, OB, and ER. Residents will present case and summarize teaching topic. PowerPoint presentations are not expected, but summary teaching points are encouraged based on evidence-based guidelines.

Providing board review practice questions is encouraged as well.

Alternative Scholarly Activities:

- 1. Research.** As an alternative to presenting to the hospital medical staff, a senior resident with prior approval from the program director may participate in an active research program which gives the resident an awareness of the basic principles of study design, performance, analysis, and reporting, as well as of the relevance of research to patient care.
- 2. Presentation at a national, regional, state, or local meeting.** This must involve a medical audience of larger scope than just the residents and faculty members. Such presentations must be approved ahead of time by the program director and attended by the academic advisor or his/her designee. Presentations must include a thorough and critical review of the medical literature concerning the topic, with at least 10 references cited in the bibliography.
- 3. Quality Project.** All SCHC residents are expected to complete an internal quality improvement project. Residents will meet with the Director of Quality Improvement, and come up with a project. This project will serve as a potential poster presentation at the yearly UC Davis Education Conference. There will be an introduction to various QI tools, such as 5 Why's, Fishbone, Logic models, SMART goals, and PDSA cycles. SCHC participates in ResPIP (Residency Performance Improvement Program), which means that QI projects can be submitted for ABFM Performance Improvement credit, which you need to sign up for ABFM Exam by December before graduating.

RESEARCH

Research is essential to advancing primary care. Residents are encouraged to develop research projects and may use elective or CME time for this purpose as approved by the Program Director. Assistance can be obtained from core faculty. Financial support can be arranged in some cases. Papers can be submitted to appropriate journals.

III. Policies and Procedures

For personal policies and procedures for rotations and employment at Shasta Community Health Center please go either to the SCHC Human Resources Office in Administration or go to “PolicyTech” which can be found on the SCHC Intranet and click under “Policies”. Using your name and password you can find the HR policies and procedures as well as all SCHC Board approved policies and procedures.

For general personnel policies and procedures for rotations at Mercy Medical Center Redding refer to the North State Service Area Human Resources Policy Manual. Copies of this manual may be located in the Human Resources Department, Mercy residency office, or online at <H:\Mercy\Redding\Manuals\HR> Policy Manual.

Policies relating to residency training may be modified to meet requirements and policies of the American Board of Family Medicine and the American College of Graduate Medical Education.

ACADEMIC COUNSELING

The residency program believes strongly in the partnership for learning approach between faculty and residents. Feedback to the residents on their performance, their accomplishments, and the areas of needed study is an important part of that partnership. Each resident has an Academic Advisor who is a member of the teaching faculty at Shasta Community Health Center. You will meet with this advisor throughout your three years of training, and they are committed to making your experience here the most productive possible. Your advisor will also be your advocate and someone to turn to if you are encountering problems during your time with us.

Goals of academic counseling are:

- To improve communication between residents and faculty
- To allow residents an opportunity to voice concerns about their own educational needs and about residency teaching
- To provide feedback to residents on their progress and performance
- To provide a regular format to discuss problems and develop plans to correct these.

Process: Each resident will meet with the assigned faculty person two times during the year. Meetings will be scheduled in advance at a mutually acceptable time and should last about an hour. A summary of the meeting written by the faculty person using the Academic Counseling Report will be entered in the resident's file after being read by the resident. The resident may also wish to write a short statement to be included. Items to cover may include:

- Review of preceptors' evaluation of resident including core competencies
- Discussion goals and plans after residency
- Discuss elective planning and opportunities
- Review of resident's procedure log and intern checklist (for first years)
- Review family practice clinic data including individual and clinic productivity, financial performance continuity of care data including obstetrical care, SNF visits, home visits and medical records chart audit
- Discuss moonlighting policies and opportunities
- Review on-going leadership experiences
- Review of ABFP In-Training Exam scores (including plan of study for identified areas of deficiency)
- Discussion of academic problems residents may be encountering
- Summarize areas of needed improvement
- Provide an overall performance evaluation of satisfactory, unsatisfactory, or marginal
- The information discussed will be presented to the CCC (Clinical Competency Committee) for review.

Mentoring:

We have also instituted a mentor relationship with senior to junior residents, which are assigned at the end of PGY1 year for incoming residents. The goal is to assist with transition to Redding area and residency. Most will find their natural mentoring relationships outside of these assigned mentors once settled. We encourage everyone to have lunch or dinner with their mentors every 6 months and SCHC will reimburse the cost.

The reimbursement rates are: Breakfast \$13, Lunch \$15 and Dinner \$26

*Please note that we do not reimburse for alcohol.

ACCOMMODATIONS FOR DISABILITIES

Shasta Community Health Center has a specific policy in the Employee Handbook in PolicyTech.

ADMITTING PROCEDURES

Admission and medical record requirements may be found in the Mercy Medical Center Redding Rules and Regulations of the Medical Staff on hospital computers at: H: Mercy: Public: Medical Staff: Bylaws or Start: Application Launcher: Mercy Redding: Everyday Use: Redding On-Line Manuals: Patient Care Manual: Section V: Continuum of Care.

Every effort should be made to determine the patient's primary care physician at the time of admission. The primary care physician and the continuity resident as appropriate (both referred to as the PCP) should be advised of every admission to a residency service within the first day of hospitalization. Once this is accomplished, the following flow chart should be your guide:

- Mercy Family Health Center Admissions: All SCHC Resident continuity patients will be admitted to the Mercy Family Practice Service. Mercy Family Health Center patients are also admitted to the Family Practice Service. SCHC residents are expected to round on their continuity patients on the Family Practice Service.
- Shasta Maternity Clinic: see SMC Policy and Procedures
- Newborn Nursery: When delivered by a resident's continuity OB, patient goes to the Family Practice Service, the FPS resident has the overall responsibility for the newborn, but the primary care physician (PCP) is expected to see his/her patients and write a note daily while they are inpatient and see the mother with on-call laborist. Exceptions will be made for out-of-town rotations, vacations, and weekends when not on call. Newborns delivered on OB service that are unassigned, go to newborn service to be managed by the Pediatric team.
- Unassigned admits from the ED: When the service is open to admissions, approximately every other medicine admission of an unassigned patient from the ED will go to the Residency Service Pediatrics and OB admissions will go to the services as appropriate. Surgical specialty patients who are unassigned will not go to the Residency services.

The supervising attending should be notified as soon as possible regarding the admission, and immediately if patient is in any way critical or will be admitted to ICU or CCU. Resident physicians will be called to the Emergency Room to admit patients whom the ER physician has determined are candidates for admission. If the resident determines that in his/her opinion the admission is not necessary, the patient may not be discharged from the Emergency Department until having been personally evaluated by the resident's supervising preceptor. The preceptor is required to communicate that decision directly to the ER physician on duty. Transmit orders in a timely fashion.

With the increasing volume of ED patients, and the occasional need to be On Diversion, a timely assessment of the admission in the ED is essential. The ED may choose to transfer the patient to the floor with Holding Orders if the resident is unable to assess/workup the admission in the ED in accordance with how busy the ED happens to be. Holding orders need to be approved by the attending physician prior to transfer.

ADVANCE DIRECTIVES, NO CODE/NO CPR/DNR ORDERS:

The SCHC policy can be found on the SCHC Intranet, via **PolicyTech** under **Title: M – Advance Health Care Directive**.

These hospital policies are located in the Mercy Redding Patient Care Manual, Section II: Patient Rights and Organizational Ethics. This may be found on hospital computer at:

Start: Application Launcher: Mercy Redding: Everyday Use: Redding On-Line Manuals: Patient Care Manual: Section II: Patient Rights and Organizational Ethics

APPEARANCE

A Physician's appearance has a significant impact on how others gauge professional competence and judge the residency and hospital. Residents will present a professional appearance during working hours in compliance with both the both Mercy Medical policies as well as the Policies of Shasta Community Health Center as found in SCHC's HR Policies available on-line through SCHC PolicyTech. All attire must be clean, pressed and in good condition. Professional white coats are provided to all Residents. Close-toed shoes are strongly suggested for safety reasons. Open-toed shoes may only be worn with socks or stockings. Hair must be neat, and fingernails must be an acceptable length and unpolished for appropriate patient care. No strong perfume or cologne, no low-cut blouses or tops and no sweatshirts or T-shirts. No blue jeans unless approved by CEO in advance at SCHC. Dress and skirt lengths must be appropriate. Men are expected to be clean-shaven or have moustaches and beards that are neatly trimmed. Ties are optional. Nametags must be worn while on duty and above the waist per protocol.

SCHC has a dress code in PolicyTech that must be followed.

AUTOPSIES

Every member of the medical staff is expected to be actively interested in securing autopsies. No autopsy will be performed without proper consent. The "Request for Autopsy Consultation" form must be completed. The autopsy is a very important facet of medical investigation, as the amount of information to be gained at the autopsy table is considerable under the appropriate circumstances. It is never pleasant to make the request for autopsy, but next of kin are usually more reasonable than one might anticipate if the request is made in a kind, understanding fashion. Additional information and criteria for requesting an autopsy may be found at:

H: Mercy: Public: Medical Staff: Bylaws

Start: Application Launcher: Mercy Redding: Everyday Use: Redding On-Line Manuals:

Administrative/Governance: Section VIII- Medical Staff Bylaws Accessory Documents Start:
Application Launcher: Mercy Redding: Everyday Use: Redding On-Line Manuals:
Administrative/Governance: X.C.4 – Autopsy Permit Procedure and Notification.

SCHC does have case review of all unexpected deaths of SCHC patients.

BALINT GROUP/ RESIDENT SUPPORT/ INTERN CONFERENCE:

“Programs must have formal mechanisms specifically designed for promotion of physician wellbeing and prevention of impairment. There also should be a structured and facilitated group designed for resident support that meets on a regular basis.” -ACGME Program Requirements for Family medicine

All interns meet every 1-2 weeks during the first 6 months and 1-2 times per month for the last 6 months with Dr. Mooneyham and Christine Woroniecki at Mercy Hospital for a one-hour conference. Every other session is devoted to clinical topics as part of the program’s commitment to achieving PGY 1 clinical competencies. These topics include common outpatient clinical diagnoses and care management issues including health care maintenance, diabetes care, hypertension, asthma/COPD, respiratory infections, hyperlipidemia, pharmacology, and prescriptions, cost effective healthcare, etc. These sessions help orientate the first-year residents to a comprehensive approach to health care and promote the resident identify as a family physician. The other conferences consist of a modified "Baliant" group discussing issues that affect all of us as physicians, but especially interns. Examples would include the "difficult" patient, death and dying, frustrations and sources of satisfaction as well. The purpose is to develop a forum for sharing and understanding, not correcting, or advising! All discussions are held in strict confidence among the participants.

ACGME requires programs to "have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment". This is accomplished through various means, including academic advisor meetings, monthly meetings involving the residents, program director, and clinic staff. Residents also receive training on fatigue, well- being, and impairment during their Annual Hospital Staff Education and lectures provided by Behavioral Science Coordinators: Dan Rubanowitz, PhD at MMCR; Dr. Khan at SCHC. Other regular lectures include Communicating with Compassion (Dr. Lupeika), Progressive Muscle Relaxation / Stress Management (Dr. Rubanowitz) and Dialogue with Duane and Debbie (Informal monthly meetings with MRFPR and SCHC program directors.) The interns also have exposure to Mind-Body Medicine curriculum with Christine Woroniecki as a facilitator.

The ACGME also requires a structure and facilitated group designed for resident support that meets on a regular

schedule. For the first-year residents, this is accomplished in the regularly scheduled intern conferences. For second- and third-year residents, a support group facilitated by Behavioral Health Consultants with SCHC meets on a regular basis. This group is specifically designed for resident support, promotion of physician wellbeing, and prevention of impairment. Dr. Rubanowitz also coordinates an Annual Wellness Screening and Consultation for all residents. This involves assessing the individual resident's score on the Professional Quality of Life Scale, filling out a Wellness and Physician Impairment Prevention check list, and participation in facilitated discussions. This occurs on an individual basis in PGY1 and via group session during PGY2-3 (with an option for individual sessions).

Resident wellness is also promoted through Shasta Community Health Center's Employee Assistance Program (EAP), an excellent benefit for all SCHC employees. Through the EAP, employees can access free services including:

- Counseling for marriage and family conflicts, substance abuse, stress management, emotional challenges, health concerns, grief and loss
- Childcare referrals
- Eldercare referrals
- Legal consultation including these areas: landlord/tenant/real estate, custody/visitation, wills/trusts, family law, and more
- Financial consultation, including credit issues, retirement planning and more

Contacting EAP is confidential which means no personal or identifying information gets back to the company. SCHC provides the EAP to promote early intervention, reduce absenteeism, and show their commitment to employee wellbeing. The Employee Assistance Program can be accessed by calling: 1-800-834-3773

The following website can be used for EAP: <https://www.claremonteap.com/>

BILLING AND DOCUMENTATION

All patients charting and billing must be completed by end of clinic at approximately 5 pm. When in SCHC or connected to SCHC EMR where electronic billing is required, residents are to follow established documentation policies and may only bill in accordance to allowable FQHC billing regulations. Preceptors may also assist in selection of billing codes.

Medication and Problem Lists are to be updated with each visit, including the dose and quantity of medication prescribed. CHARTS ARE NOT TO BE TAKEN OUT OF CLINIC.

SCHC uses an EMR and with proper authentication and secured connections, SCHC residents may access records for documentation purposes 24 hours a day, seven days a week, and even from a select number of remote locations. Do not attempt to enter the building after normal business hours as the alarms will sound.

CCC (CLINICAL COMPETENCY COMMITTEE)

Purpose:

SCHC Residency Program regularly collects information on residents in the clinical setting for the purpose of performance improvement and to ensure delivery of safe patient care. This information is reviewed by the Clinical Competency Committee (CCC). The creation of the CCC is mandated by the ACGME as part of the milestone evaluation process. The members of the CCC make a consensus decision on the progress of each resident using multiple sources of resident assessment data and faculty member observations to inform their evaluations of residents. The CCC offers the resident evaluation process the insight and perspectives of a group of faculty members. It determines how well a resident is meeting program standards, including patient care, or if a resident fails to progress along the appropriate educational trajectory. This process provides an opportunity for early identification of competency issues and helps to shape resident performance improvement and remediation plans. As such, the CCC meets criteria for peer review and therefore any materials, proceedings, or documents maintained by the CCC are fully protected from discovery by State statute. The CCC will meet every six months in December and May to fulfill the ACGME deadline for submission to ADS and after the semi-annual resident assessments. The Residency coordinator will provide the CCC with any necessary materials and administrative assistance as needed.

Membership:

1. The CCC has at least four members, including the following:
 - a. Program Director: A non-voting member
 - b. CCC Chair: A core faculty member who is not the Program Director
 - c. Core Faculty and Academic Advisors
 - d. Others as assigned by the Program Director to include Residency coordinator, Residency clinic nurse manager, non-core faculty and non-physician members of the healthcare team
2. A member must recuse themselves from the CCC discussion if a near relative or other potential conflict of interest exists.

Roles and Responsibilities of CCC:

1. Proceedings of the CCC are confidential and for the purpose of peer review.
2. CCC members will conduct themselves in a professional and respectful manner and provide honest, constructive evaluation and feedback for all residents.
3. The environment of the CCC must be such that faculty can speak freely and openly.
4. Decisions will be made by consensus. If consensus cannot be achieved, the issue will be referred to the Program Director for resolution.

5. The CCC and Program Director can expand tasks of the CCC as necessary.
6. Review all resident evaluations semi-annually (ACGME V.A.1.b.1.a)
7. Semi-annual review deadlines for the Milestones are in January and July of each calendar year.
 - a. Residency coordinator will collate each Resident file to have available for the CCC and each CCC member will have a Resident they are responsible for discussing at the meeting. Usually the Academic Advisor will be the reviewer of the Resident.
8. Prepare and assure the reporting of Milestones evaluations of each resident are done semi-annually to the ACGME (ACGME V.A.1b.1.b)
9. Advise the Program Director regarding resident progress, including promotion, remediation, and dismissal (ACGME V.A.1.b.1.c)

Performance Measures for CCC:

The CCC will use explicit assessment data in measuring resident performance including:

1. Direct and indirect observational tools
2. Rotation evaluations through New Innovations
3. Quality Project, Grand Rounds and Morning Report peer evaluations
4. ITE scores
5. New Innovations and Google Docs procedure and patient encounter logs
6. Patient satisfaction surveys and 360 evaluations by staff
7. Scholarly activity
8. Self-assessments as available
9. Peer review and chart audits
10. ABFM and Maintenance of Certification
11. Board Exams-Step 1, 2, 3
12. Life support training up to date: ACLS, ALSO, BLS, NRP, PALS
13. Academic advisor semi-annual summative evaluation
14. Mercy Medical Center PGY-1 hospital checklist
15. SCHC clinic checklist

CCC Reporting:

The CCC will take data from the evaluations and apply them to the Milestones to mark the progress of Residents by filling out the standardized CCC reporting form. This form will be used by the Program Director and Residency coordinator to report to the ACGME in ADS as mandated. Utilization of the milestones will involve comparisons to a resident's peers in a given program, as well as national benchmarking data when available and thresholds will be set by the CCC for performance improvement interventions.

The CCC will recommend interventions for performance that suggests the need for specific areas of improvement:

1. Interventions to consider:
 - a. Assigning a mentor with expertise to coach resident in area of deficiency
 - b. Additional required readings, questions, case presentations as needed
 - c. Sessions with faculty to improve certain skill sets
 - d. Additional rotations in a given area of deficiency
2. If after remediation a resident still fails to advance sufficiently on one of more Milestones, a CCC might consider extending education or other adverse actions or increased counseling. The CCC recommendations are discussed and reviewed in the promotions committee when determining resident advancement.
3. Resident will be informed of the CCC actions either through a formal letter from the Program Director or verbal feedback from the Academic Advisor depending on the situation. The Promotions committee will always send out a formal letter from the Program Director with promotion specifics per resident.

CHIEF RESIDENTS

The Assistant Chief and Chief Resident are key members of the residency program whose leadership, advice to the faculty and program director, and hard work makes the program strong. As a representative of the residents, the chief resident deserves the respect of both faculty and residents. At times, the chief resident may participate in confidential discussions involving residents or faculty. Examples include participation in the weekly faculty meetings and discussion of an individual resident's performance and progress and how this may affect his/her responsibilities and the residency program schedules. The assistant chief and chief roles will be determined by Faculty and Resident input with ultimate decision by the Program Director. Please see Chief Resident job description for the selection criteria and peer-selection process to become an assistant chief and chief resident.

Ideally, there are two overlapping terms of chief resident office: July 1-June 30 and January 1 –December 31. At times, this term may be shorter or longer due to various resident circumstances. The Chief must be a PGY2 or PGY3 in good standing with final approval by the program director. Not all Residents will qualify for the assistant chief or chief role. If a resident is on academic remediation, they will not qualify. There may be times when the chief will do two consecutive terms based on Resident issues. The assistant chief and chief position are peer selected and approved by faculty and the Program Director.

Chief Resident Duties:

- The SCHC and Mercy chiefs share the duties, with responsibility for the schedule shared with the Mercy Chief Residents.
- Administrative representative of residents (provided with appropriate administrative time to accomplish his/her duties)
- Coordinator of resident complaints and report to appropriate chain of command
- By example, foster the public and professional image of family practice and our program
- Residency meetings as invited by Program Director for both SCHC and Mercy Residencies.
- Assists in the preparation of the Master Schedule with input from residents, health centers, and residency coordinator with final approval by the Program Directors of Mercy and SCHC.
- Helps prepare the call schedule with input from residents and core faculty
- Provides first contact with acutely ill residents to facilitate coverage
- Oversees the jeopardy call system with the Mercy Chief Residents
- SCHC Chief will develop the Morning Report schedule every 6 months and coordinate with the Mercy Chief.
- Act as liaison between SCHC residents and SCHC faculty.
- Act as liaison between faculty and staff, between MFH/SCHC staff and MFH Chief Residents and SCHC staff--especially with communicating call schedules, resident request for days off, resident request for emergent issues, academic issues, curriculum issues or recommendations, moonlighting hours, being informed of any violation of hours, communicating these issues with Amy/Randi.
- Administrative duties: attend monthly faculty meeting (represent SCHC residents in making decisions about curriculum changes/procedure requirement changes/and any new ideas that come up as there are constant changes), faculty retreat (represent SCHC residents), resident retreat (assist in leading the retreat with the MFH Chief resident), leading intern orientation at the end of the year with the MFH Chiefs, attending UC Davis Chief Resident Network meetings--either online through teleconference (to receive support from other Chiefs of common resident issues) and end of year UC Davis Chief Resident Handoff meeting, attend UC Davis Education Conference, attend other conferences to represent residency (National AAFP conference in Kansas, CAFP conference, etc...) Attend Mercy Faculty meetings and Annual Planning meeting.
- Work with the SCHC assistant chief by knowing when to delegate duties: morning report schedules/email reminders, communicating and updating each other regarding issues that arise within the residency, helping each other with attendance of meetings
- Provide support for SCHC residents: morale, difficult interactions/issues/discussion that come up between MFH/SCHC residents if any, academic improvement recommendations from SCHC residents

to faculty

- Meet with Mercy Chief Resident/Assistant Chief Residents to discuss/update on new issues within the residency.
- Communicate with Dr. Lupeika and Amy frequently to stay abreast of all duties and on-going changes within the residency. Communicate with the Mercy Program Director and coordinator on relevant issues.

The Chief Resident may schedule 4 hours of administrative time per four-week rotation.

Assistant Chief Resident Duties:

- Work with the SCHC Chief with duties of: morning report schedules/email reminders, communicating and updating each other regarding issues that arise within the residency, helping each other with attendance of meetings
- Assist in interactions with MFHC Chief, stay in constant communication as much as possible
- Provide support with the Chief resident in all of the above!

CLIA OUTPATIENT LABORATORY PROFICIENCY TESTING

All providers at SCHC and MFHC are required to undergo yearly outpatient laboratory proficiency testing according to the Clinical Laboratory Improvement Amendments (CLIA) established by US Department of Health and Human Services. This is accomplished during a noon conference review and test. Review materials are provided ahead of time.

CLINIC LIBRARY

A library is available in the SCHC and MFHC clinics with reference texts and computer resources. Please use it and feel free to suggest new acquisitions. All library resources must remain in the clinic.

CONFERENCES

Noon conferences occur Monday - Friday on non-holidays, from 12:30 - 1:30 pm., in conference room LLCR, unless indicated otherwise in the monthly schedule. The schedule is available through the Mercy Google Calendar. The schedule indicates the topic, speaker, location and whether lunch is provided. If lunch is not

provided, residents may obtain their lunches from the cafeteria and bring them to the conference.

The noon conference curriculum features talks covering a variety of medical specialties on a one to three year rotating schedule. Other conferences include the following:

Resident Wellness conference	Monthly at Mercy
SCHC Monthly CME	Second Tuesday during lunch
SCHC Resident/Faculty Meeting	Bi-Monthly
Resident Meeting	Monthly
FHC Resident/Staff Meeting	Bi-Monthly
Perinatal (OB and Peds) M&M	Monthly with resident case presentation
SCHC Residents / Staff Meeting	Monthly
FP Clinic OB Education	Bi-Monthly
Senior Resident Grand Rounds	One for each senior resident/year on Fridays
Primary Care Case Presentation	Monthly given by R2s and R3s from Mercy Prog.
Dialogue with Duane & Debbie	Monthly with residents and Drs. Bland & Lupeika
Journal Club	Monthly at Mercy
Morning Report	Weekly on Wednesdays at MMCR
Senior Conference	Monthly on Thursdays at Mercy
Intern Conference	Bi-Monthly on Thursdays at Mercy

Although residents may need to attend to urgent patient care needs, prompt and regular attendance of noon conferences is expected for all residents. Most speakers have put a great deal of effort into preparing their talks and their time should be respected. Residents who attend less than 70% of conferences over a four-month average will be assigned to provide a talk for Residents. The 70% rule takes into account excuses which residents must submit by contacting the Residency Coordinator's office within 48 hours. Acceptable excuses include post call, out of town rotations, vacation time, personal and family emergencies, and urgent patient care needs.

Residents and faculty members may offer suggestions for conference topics to the noon conference coordinator, Steve Namihas, MD at Mercy.

CONTINUITY POLICY

The Shasta Community Health Center Family Medicine Residency Program considers continuity care to be an integral component of family medicine and residency education. As health care team members, we also recognize that coverage for colleagues who are unavailable (due to illness, vacation, etc.) is imperative for timely and appropriate patient care. The following continuity policy has been established taking into consideration PTO, away electives and coverage for colleagues.

1. Clinic Continuity:

- a) The program strives to schedule residents with their own continuity clinic patients. FPS, C1 and C2 resident rotations see a greater number of work-in patients, which may include non-continuity patients.
- b) The resident will be encouraged to take new patients into their clinic from hospital rotations as well from SCHC Urgent Care and from the general patient pool of otherwise new and unassigned patients requesting access to SCHC. Residents will also have the opportunity to assume appropriate patients from any redistribution of assigned patients authorized by SCHC CMO, Program Director and Residency Medical Director.

2. Hospital Continuity:

- a) The program has set a hospital continuity goal of at least 80% for each resident who has continuity patients in the hospital receiving care on the Family Practice Service. Residents will be excused if out of town.

COUNTERSIGNATURE REQUIREMENTS FOR RESIDENT CHARTS:

In addition to the preceptor's own written notes, resident charts require faculty preceptor countersignature on the H&P, Discharge Summary, and any Operative/Procedure Notes dictated and put into EMR. The format needs to comply with Mercy Medical Center Staff Bylaws. The H&P needs to be countersigned by the faculty attending on service at the time of the patient's admission. The resident will note on the progress note in EMR or in dictation itself, which that attending is. For example, for a nighttime pediatric admission, the attending responsible to countersign the H&P will be the on-call pediatrician whom the resident contacted at the time of the patient's admission.

The Discharge Summary needs to be countersigned by the faculty attending involved the day of discharge. The resident will note on the progress note in EMR or in dictation itself, who that attending is. The resident will also note to whom the patient is being sent for further care. This could be an individual physician or a facility (e.g. SCHC). This information should also be placed on the discharge order since many individuals and agencies need this information shortly before or after discharge.

The “surgeon” of record should countersign operative reports dictated or in the progress note in EMR by residents. The attending physician listed by the resident in the note should countersign procedure notes. First-year resident and unlicensed Resident orders for discharge medications require the countersignature of a licensed physician (resident or attending).

Policy: SCHC Countersignature requirement for resident clinic chart notes

Purpose: SCHC strives to be compliant with all ACGME rules regarding supervision and documentation requirements for residency training and to remain in compliance with applicable laws for billing purposes.

Procedure:

1. SCHC has a fully functional EMR system through NextGen.
2. Residents will send all clinic chart notes to their attending preceptor electronically for sign-off after they have verbally discussed each patient with their attending preceptor.
 - a. It is expected that residents complete their chart note prior to leaving clinic.
 - i. Preceptor reviewed charts do, on occasion, get sent back to the Resident for revision. Due to the timing this takes to revise the note, the initial note must be submitted to the preceptor by the end of the clinic day with rare exceptions granted for extenuating circumstances (ie-hospital issues, family emergency, patient care emergency) with the note required within 24 hours (12:00pm for morning clinic and 5pm for afternoon clinic).
 - ii. For compliance with billing laws, the preceptor must co-sign the note prior to the note being billed. Clinic notes must be billed within 72 hours. All Resident notes are billed under the preceptor and thus preceptor co-signature is needed within 72 hours, or the clinic encounter cannot be billed appropriately and is in violation of SCHC policy.
 - iii. An automated 48-hour report will be sent to the preceptor on any resident notes that are created but not signed off by the preceptor. The expectation is that the preceptor will sign off the note within 72 hours.
 - iv. Changes in up or down coding of the resident note will need to be indicated in the Provider sign-off comment section.
 - v. The SCHC billing department will receive a 72-hour report that includes any encounters without a note or a preceptor sign-off to prevent billing being sent without a preceptor co-signature.
 - vi. SCHC will track resident notes that are not completed within 24 hours.
3. The SCHC staff will track delinquent charts as noted above.
4. Residents who fail to complete their charts within 24 hours will be assigned to a weekend jeopardy call on a prorated basis: 1-4 charts-1 call; 5-8 charts-2 calls; 9+ charts-3 calls. The jeopardy call consequence will be implemented only after the resident has failed to complete their charts after 3 clinic shifts. After 3 clinic shifts of failing to complete their charts within 24 hours, the extra jeopardy call will be added per above. The clinic nurse manager will monitor resident compliance with note completion in conjunction with the Residency Medical Director.
5. Residents who are repeatedly delinquent will be required to meet with their advisor to review their clinic flow and documentation. Residents will be given a verbal warning and potentially placed on suspension until the charts are completed.

Sample E H R Preceptor Sign off
Preceptor Supervision

In addition to concurrently monitoring the patient care through appropriate telecommunication technology, I was present during the telecommunication encounter. I agree with the findings and the plan of care as documented.

EHR Supervision Guidelines and Expectations of Resident entry into Medications Module in the NextGen EMR:

Purpose: To allow Residents who are licensed /unlicensed Physicians to enter medications into the Medication Module of the NextGen EMR under the oversight of the supervising Physician(s). Residents are Physicians in training who are learning how to prescribe medications to patients. Resident Physicians will enter medications into the Medication Module utilizing the *Prescribe New* button.

The Resident will follow the listed protocol to prescribe medications.

- Verify Preceptor of the day
- Verify Pharmacy
- Utilize *Prescribe New* button
 - Select medication, drug name and dosage through the search function
 - Select sig and drug usage information (ie: oral, inhalation, IM, daily, BID)
 - Select dispense quantity and specific units
 - Select number of refills
 - Select Diagnosis Code under “view”
 - Add any addition comments into the “Comments” box
 - Select stop date, if necessary (ie: antibiotics, pain medications)
 - Accept/Acknowledge any contraindications
- All outbound prescriptions from the Resident will be reviewed by the Preceptor
- The Supervising Preceptor will review each medication and confirm that the above steps are correct, and the protocol has been properly followed.
- After the proper medication entry protocol has been followed and reviewed by the licensed Supervising Preceptor, the Resident may then send the prescription via ERX, fax, print
 - If the prescription has been printed, then the Resident and Preceptor will both sign the Rx.
- After Resident is licensed and has been signed off by Supervising Preceptor to work independently, then Resident may send prescriptions by following the medication entry protocol, without review by the Supervising Physician.
- A weekly medication prescription by resident’s report is generated and sent to the Residency Medical Director and Program Director to review all resident generated prescriptions.

CONSENTS AND RELATED MATTERS:

Up to date information of consents may be found in the Hospital Consent Policy and/or California Hospital Association (CHA) Consent Manual located in Risk Management Services, Health Information Management, Emergency Departments, and Mercy Family Health Center. For services rendered within the four wall of Shasta Community Health Center or its programs, consents can be obtained on the SCHC Intranet with corresponding policy and procedures associated with specific consents on Policy Tech, also found on the SCHC Intranet.

CRITERIA FOR ADVANCEMENT/PROMOTION OF RESIDENTS IN FAMILY MEDICINE

- A. The decision to promote a resident each year shall be determined by the Residency director with the advice of the CCC, promotions board, and faculty (See Clinical Competency Committee (CCC) Policy). The method of evaluation shall consist of direct observation of the resident as well as by indirect observation through videotapes, rotation evaluations, and written examination (National Boards, In-Training Exams, etc...). It is expected that residents will participate in all aspects of the curriculum, as well as in the periodic evaluation of educational experiences and faculty through ACGME and New Innovations Survey. It is further expected that residents will complete all administrative responsibilities of a resident, including medical records, licensure, credentialing, etc. in a timely fashion (See SCHC Licensed Healthcare Professionals-Supplement to Handbook). Incorporated into the criteria for advancement are the ACGME's six core competencies. These are specifically included in the attending rotation evaluations and include:
1. Patient Care
 2. Medical Knowledge
 3. Practice-based Learning/improvement
 4. Interpersonal/Communication Skills
 5. Professionalism
 6. Systems-based practice
- B. The ACGME monitors and tracks each resident in a national evaluation system called the Milestones Criteria. The Milestones have been incorporated into the SCHC and Mercy evaluations.
- C. All residents obtain their California PTL (post-graduate training license) within 180 days of starting their intern year on July 1st. This license will be valid during their residency training and will expire during their PGY2 or PGY3 year. If a resident extends their training time beyond 36 months, the Medical Board of California will be

notified by both the residency program and the resident. All residents must obtain their California Physician and Surgeon license prior to their PTL expiration or cease all residency training activity. US grads must obtain their license during their PGY2 year and IMG must obtain their license during their PGY3 year.

- a. To be promoted from the PGY1 to the PGY2 year, the resident must meet the promotions criteria outlined below, perform at a competency level adequate to maintain licensure in California, act with limited independence, and perform at a competency level to supervise junior residents and students. These criteria are applied to both United States Medical School Graduates and International Medical Graduates.
 - b. For promotion from the PGY2 to PGY3 year, residents continue to meet the PGY2 competency requirements listed above and meet the promotions criteria outlined below, as well as achieve appropriate milestones.
 - c. To graduate, the resident must continue to meet the PGY2 and PGY3 competency requirements, meet the promotions criteria outlined below, and be judged to have demonstrated sufficient professional ability to practice competently and independently as a family practice physician. After the resident completes 36 months of residency, the program director certifies that they are competent to work as an independent physician, and they satisfy all ACGME requirements for graduation.
- D. Twice per year, the CCC will meet to discuss each resident and monitor progression through the Milestone stages. The Clinical Competency Committee (CCC) is composed of voting members and shall include three faculty members, the Residency Program Director, the Residency Coordinator/Manager, and other members as deemed necessary. SCHC will seek input from the Mercy Medical Center Redding Residency Program Director and Chief Residents if needed to determine milestone competencies.
- E. The Chief Resident will sit on the Promotions Committee but not the CCC. Resident input on the CCC will be solicited as needed prior to the meeting. The CCC meets annually in December and June to review each resident and recommend to the Promotions Committee and the Residency Program Director for or against promotion to the next level of training. The Promotions Committee meets yearly in February to discuss resident promotion and criteria for advancement. The February meeting time allows for any resident notification of extension in sufficient time prior to the next academic year. The following criteria are used by the Promotions Committee in their deliberations.
1. Major criteria: These criteria must be met to be promoted to the next year of training:
 - a. Receive a performance rating at the appropriate PGY level on Milestone evaluations. Approximate Milestone levels are 1-2 for PGY1, 2-3 for PGY2, and 3-4 for PGY3.
 - b. Meet the following licensing requirements:
 1. Pass USMLE or NBOME Step 3 before the end of PGY1. All residents must have their PTL within 180 days of starting their PGY1 year.(Please see separate Licensure section

- for policies on reimbursement, etc.)
2. Exceptions to Step 3 testing or license requirement can be made due to emergencies with Program Director approval.
 - c. A favorable Faculty Advisor's report. Faculty Advisors shall meet with all residents every six months (October and April) and more often if needed. If satisfactory progress is not noted, or if problems are identified, additional meetings may be scheduled on a more frequent basis with regular reports to be submitted to the Faculty Committee and Residency Program Director.
 - d. Completion, or evidence of progress, of the resident's third year grand rounds presentation or other Scholarly Activity approved by Program Director. Determination of progress will be the decision of the resident's faculty advisor. Satisfactory participation in all required activities of the training program; including nursing home visits, Residency resident/staff meetings, noon conferences, continuity care of patients admitted to hospital, morning report presentations, committee attendance, etc.
 - e. Attend all rotations as scheduled with satisfactory evaluations.
 - f. Be competent to function independently and in a supervisory role with junior residents. The faculty committee will make this determination at the end of the PGY1 year during the June CCC Meeting.
 - g. For graduation, demonstrate sufficient professional ability to practice competently and independently as a family medicine physician. The faculty committee and Program Director will make this determination.
 - h. Abide by standards consistent with expected professional and ethical behavior (See [Compliance Program, Section 5- Code of Conduct.](#))
 - i. Meet with Director of Quality Improvement to establish and complete quality projects by the end of PGY3 year.
 - j. PGY3 residents are to sign up for April ABFM Board Exam unless discussed with the Program Director. Residents will receive full reimbursement for the ABFM Certification Exam if the resident takes the exam during residency. No reimbursement will be given if the resident takes this after graduation or needs to retake the exam.
2. Minor Criteria: These criteria will also be considered by the CCC and Promotions Committee in determining a resident's readiness for promotion. They are not necessarily required for promotion but may affect promotion based on individual circumstances the achievement of other major and minor criteria.
- a. In-training Assessment Examination composite score at or above the 90th Bayesian Score Predictor for post graduate year. If this score level is not obtained, then an appropriate study plan and repeat of the test until this score is obtained. Moonlighting privileges will be suspended until this score level is achieved. Elective time may be used to allow study and preparation time to complete the test.
 - b. Satisfactory evaluations by Residency Clinic nursing, patients, office staff and peers. Residents must receive passing evaluations on non-family practice services and community rotations.

DEATH RELATED ISSUES

Information and SCHC internal policies regarding the post-mortem process can be located on **PolicyTech** under **Title: R – Post Mortem Audit Process.**

Information and hospital policies on Deaths and Autopsies may be found at:

Start: Application Launcher: Mercy Redding: Everyday Use: Redding On-Line Manuals: Administrative

Governance: Section X – Risk Management:

- Legal: X.C.0 – Deaths
- X.C.2 – Determining Deaths
- X.C.4 – Autopsy Permit Procedure and Notification. Information specific to fetal loss and newborn deaths may be found at: Start: Application Launcher: Mercy Redding: Everyday Use: Redding On-Line Manuals: Policies and Procedures: Procedures: Perinatal Loss Procedures

Residents must be licensed senior residents in order to declare death. *When making a death pronouncement, the physician should also indicate in a physician's order the doctor who will be responsible for completing the death certificate.*

- DO NOT PUT "CARDIO-RESPIRATORY FAILURE" or, "Cardio-respiratory collapse" for the cause of death.
The first line of the "Cause of Death" section is the disease or trauma that caused the death, e.g., myocardial infarction, NOT common final pathways like cardiopulmonary failure, etc.
- The second line is for secondary causes, e.g., Atherosclerotic Cardiovascular Disease, trauma
- The third line is for tertiary causes, if any. The contributing factors can include things like smoking or diabetes. Please be sure there is documentation for the cause(s) mentioned, and touch base with any faculty person if you have any question about what to include in the certificate, your attending or Dr. Nena Perry will be happy to help you with any questions.
- Dr. Ron Sand leads the palliative care and hospice rotation where Residents will get experience filling out death certificates.

DISASTER ISSUES

Shasta Community Health Center has a Disaster Recovery Plan in PolicyTech. Please see full policy for further details.

There is a GME Disaster Policy that covers any situation that could cause significant alteration to the Residency experience. Please see PolicyTech for the full policy.

DOCUMENTATION OF RESIDENCY EXPERIENCE

A comprehensive documentation of your residency experience is important to your future practice as a family physician. The information you collect will provide a basis of documentation when requesting hospital privileges and malpractice. Educational content of your training, board certification, as well as experience with specific diagnoses and

procedures will all be considered when medical staff membership is granted. For those of you with an interest in outcome analysis, documentation of patient contacts provides an invaluable database. All residents are required to document procedural experiences using the New Innovations procedure log. In addition, this program should be used to document patients seen in the sports medicine event, ICU, SNF, and home visits. This will be used as a source of information for future reference letters, which may be requested by places of employment and hospitals from the residency program. It will also be used to provide data to regulatory bodies such as the ACGME and ABFM to confirm we are meeting the requirements for residency education in family medicine. Through the SCHC NextGen EMR, residents can provide outpatient documentation of diagnosis, procedures and patient numbers. Residents will monitor all inpatient encounters through the online Google Docs system. Please refer to the Wecker Report and Suazo Video for guidance on how to do this. It is expected that all inpatient meaningful patient encounters be tracked per ACGME guidelines. Academic advisors will monitor Resident progress.

DUE PROCESS PROCEDURE FOR RESIDENCY PROGRAM

A. Introduction:

1. A number of administrative actions may affect the continued participation of a resident in the residency program. These include but are not limited to: periodic evaluations; letters of counseling, warning, admonition, reprimand, and censure; probation; reduction of privileges; suspension from the residency program, which may include suspension of clinical privileges for medical record delinquency, or for other reasons; and dismissal.

B. Grounds for Disciplinary Action:

1. Grounds for disciplinary action include, but are not limited to, the following:
 - a. Failure to rectify deficiencies of which the resident has been notified in one or more letters of warning, censure, probation, or suspension.
 - b. Incompetence or conduct adversely affecting quality of patient care.
 - c. Unethical or illegal conduct.
 - d. Violation of standards of the residency program, or of the Bylaws or the Rules and Regulations of the Medical Staff of Mercy Medical Center and/or violations of the Shasta Community Health Center Clinical Code of Conduct.
 - e. License removal or non-renewal of medical licensure is cause for immediate dismissal from the Residency Program

C. Medical Record Delinquency:

1. Suspensions of clinical privileges, which arise from medical record delinquencies under the provisions of the _____ Bylaws of the Medical Staff of Mercy Medical Center, shall automatically result in a like suspension of _____

participation in the residency program, without right of hearing or appeal. Participation shall be reinstated upon reinstatement of clinical privileges pursuant to the Bylaws of the Medical Staff of Mercy Medical Center. Continued medical record delinquency may be cause for other disciplinary action.

2. In addition, medical record delinquencies of SCHC patient records in violation of SCHC medical records policy (See Clinician Coding and Documentation) can also result in suspension of participation in the residency program immediately until chart deficiencies are fixed.

D. Letters:

1. Letters of counseling, warning, admonition, reprimand, and censure shall be issued by the Residency Program Director when a resident's performance fails to meet the standards set by the training program.

2. Receipt of such a letter requires that the resident physician correct the deficiency as presented within the letter.

3. The letter shall stipulate the specific reasons for any actions noted and the recommended course for correction. If patient care activities are involved within Mercy Medical Center Redding, a copy of the letter will be submitted to the Residency Program Director of the Family Medicine Residency Program and the Medical Director of Mercy Medical Center.

4. In either case, a copy of that letter will be provided to SCHC's CMO. Continued failure to correct the deficiencies may result in suspension or dismissal from the residency training program. Such a letter shall not give rise to a right to a review hearing or to appeal.

5. Dismissal from the Residency Program will be initiated by the Residency Program Director in coordination with SCHC's Human Resources Department.

E. Temporary Suspension:

1. A resident physician may, without right to a review hearing, be temporarily suspended, for a period not to exceed ten (10) days, from participation in the residency program.

2. This includes loss of clinical privileges, at any time upon the written, specific recommendation of a faculty member to the Residency Program Director.

3. If, after review, the Program Director, in his/her sole judgment and discretion, determines that patient care has been compromised or that the resident physician is involved in activity not otherwise appropriate to the program.

4. During the period of temporary suspension, the Residency Program Director may review the resident's performance and determine whether or not additional disciplinary action should be taken against the resident.

5. The Residency Program Director may determine that suspension of a resident's privileges should remain in effect for a period in excess of ten (10) days. In that event, the resident shall be entitled to a review hearing

and appellate review if requested by him/her in the manner prescribed.

6. The Residency Program Director may also determine that privileges should be suspended pending the review hearing and appeal process.

a. In this event, the resident shall be entitled to a preliminary review of that decision as soon as it can be arranged before the Chief Medical Officer of SCHC.

b. If the event occurred at Mercy Hospital the Mercy Residency Program Director, SCHC Residency Program Director and SCHC's Chief Medical Officer will determine if suspension should remain in effect pending a review hearing and appeal.

c. The Mercy Residency Program Director may involve either the Mercy Medical Director or the Chief of Staff of Mercy Medical Center in that review if the issue is hospital related. The decision of the SCHC CMO and SCHC Residency Program Director as to whether or not suspension should remain in effect pending the review hearing and the appeal process shall be final and conclusive upon the resident.

F. Other Disciplinary Actions: Disciplinary action other than or in addition to, temporary suspension or letters described in Section 4, may be recommended at any time by the Residency Program Director. The Residency Program Director shall notify the resident, in writing, of the proposed action which has been recommended, the reasons for the recommendation, and a summary of the resident's rights under the provisions of this due process procedure. Upon notification of the recommendation for disciplinary action by the Residency Program Director, the resident, within a period of ten (10) days, may request a review hearing by written request delivered to the Residency Program Director. In the event that the resident fails to request a review hearing, the recommendation of the Residency Program Director shall be submitted to the Graduate Medical Education Committee for action, whose decision and judgment on the matter shall be final and conclusive.

G. Review Hearings: Upon request by the resident for a review hearing, a Review Panel shall be convened within twenty (20) days. The resident shall be notified of the hearing date not less than (10) days prior to the review hearing. The notice of hearing shall include a list of the witnesses to be called in support of the recommendation of the Residency Program Director. The Review Panel will consist of five individuals, all of whom shall be faculty members of the residency program. If the issue is Mercy hospital related, SCHC CMO may decide to permit The Mercy Redding Program Director or the Medical Director of Mercy Medical Center to select four members of the panel and the affected resident shall select one. At the hearing, the Residency Program Director on the one hand, and the affected resident on the other, will each have the right to call witnesses and present relevant verbal and written evidence of the sort that responsible persons are accustomed to rely on in the conduct of serious affairs. Evidence need not conform to common law or statutory rules, which might make it inadmissible in a court of law. The resident will be afforded the opportunity to present a personal statement in his or her own defense. The statement may be presented orally or in writing. The review hearing will be closed and the proceedings shall be recorded by a court reporter or by other means approved by the panel. Legal counsel may be consulted to assist in

preparation for the hearing, but may not directly participate in its proceedings. The Review Panel shall render a recommendation, in writing, to the Graduate Medical Education Committee within ten (10) days of the hearing. The recommendation shall include the reasons supporting the decision. A copy of the recommendation shall be delivered to the affected resident and to the Residency Program Director.

H. Appeal: Following receipt of the Review Panel's decision, the resident may appeal that decision, in writing, to the Graduate Medical Education Committee. To exercise that right, he/she shall give written notice of his/her intent to appeal to the Residency Program Director within ten (10) days following delivery of the decision to him. Failure to give notice in the manner and within the time provided shall constitute a waiver of the right to appeal. Notice of the time and place of the appearance before the Graduate Medical Education Committee, that will be scheduled not less than twenty (20) days following the request for the appeal, shall be given to the resident not less than (10) days before the time scheduled. The proceedings on appeal shall be in- the nature of an appellate review, based upon the record of the hearing before the Review Panel. However, the Graduate Medical Education Committee, in its sole judgment and discretion, may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Review Panel Hearing. The resident and the Residency Program Director shall each have the right to present oral and written statements and authorities at any time prior to submission of the matter, in support of his or her position on appeal. The Graduate Medical Education Committee may affirm, modify, or reverse the recommended action of the Review Panel or may, in its sole judgment and discretion, refer the matter for further review and consideration. The decision of the Graduate Medical Education Committee shall be final and conclusive.

I. Medical Staff Proceedings: Nothing in this due process procedure shall be construed to prohibit the Medical Staff of Mercy Medical Center from taking disciplinary action against a resident in accordance with the provisions of the Medical Staff Bylaws. Suspension of the privileges of a resident or termination of his membership on the Medical Staff by reason of proceedings taken by the Medical Staff in accordance with the Medical Staff Bylaws of Mercy Medical Center, shall result in like suspension or termination from the residency program without any right to appeal, or without any right to review or appeal under this due process procedure.

J. Error in Procedure: The Graduate Medical Education Committee, in its sole judgment and discretion, shall determine whether or not any failure to follow the procedure outlined in this document has deprived a resident of due process, and should constitute grounds for a new review hearing and appeal or for other remedial action. Its determination with regard to that matter should be final and conclusive.

EVALUATIONS

Evaluation and feedback are essential to knowing if we are meeting our intended goals. In the residency program, this is true for resident performance, teacher performance, curriculum composition, rotation performance, conference quality, and significantly, graduate assessment of the effectiveness of their training. Evaluations may

be formative, where feedback is given at the time of performance and helps to correct, or confirm, the appropriateness and effectiveness of the performance (e.g., you did that circumcision just right. The block could be improved by using a little more anesthetic). Evaluation may be summative, which occurs following input of all evaluation information and results essentially in a grade.

Resident Evaluations: Attending Evaluation of the Resident - On each rotation, the appropriate attending(s) will complete the Milestone and competency-based evaluation. The attending evaluation will be summative and will also indicate a final recommendation based on the current level of training. These evaluations are performed using New Innovations.

Procedure Competency: Procedural competency evaluations are provided by the precepting attendings using New Innovations (see Procedural Competency section below).

Peer Evaluations: Residents have the opportunity to evaluate each other on the Medicine and Pediatrics/Ob services using the New Innovations on-line evaluation system. Junior residents evaluate senior residents in the areas of knowledge base/procedure skills, service management, teaching effectiveness, and interpersonal skills. These evaluations are anonymous. Senior residents evaluate junior residents in the areas of knowledge base/data gathering, problems solving/case management, interpersonal relations, work habits and overall performance. The senior residents are encouraged to review their evaluations directly with junior residents in addition to using the New Innovations on-line evaluation system.

Presentation Evaluations: Morning Report evaluations are given after each presentation. Any other lectures given by the Resident will be evaluated through verbal and written feedback. Third year Grand Round presentations are evaluated by core faculty in addition to a general audience evaluation performed by the Mercy Medical CME department.

Rotation Evaluations: Rotation strengths, weaknesses and opportunities for improvement are incorporated into the attending evaluations. With New Innovations, this collated data will now be available for the annual spring faculty and chief resident planning meeting and annual planning evaluation committee. During this retreat, modifications are made to the upcoming academic year taking into consideration such things as rotation feedback and changing ACGME requirements. Action plans with goals and timelines will be developed for the upcoming year. Prior year action plans and goals will be reviewed and evaluated.

Family Health Center Evaluations: SCHC conducts a health center evaluation annually and daily through New Innovations Shift Cards. Issues such as clinical material, office design and function, procedures and protocols, teaching and reference materials are included in this evaluation. In addition, there are health center

management meetings held throughout the year with resident participation, to discuss important issues.

Conference Evaluations: Conferences which are designated CME will include an evaluation form completed by the participants to track the quality and relevance of the material presented. These evaluations help determine the quality and relevance of lectures and the need for modification. Morning Report, Grand Rounds and Journal Club presentations provide CME. SCHC also provides CME to our Clinical Staff.

American Board of Family Practice In-training Assessment Exams: In-training Assessment Exams are given to all residents in October or November, and residents must take the exam. If vacation or away electives have been scheduled for the same time, the resident must make appropriate arrangements with the Residency Coordinator to take the exam elsewhere or return to Redding. Exams are similar to Board exams in content and format. If the overall score is below the 20th percentile, moonlighting privileges may be forfeited pending improved performance on the next In-training Exam and/or a period of restudy and repeat examination. The scores will be another instrument for review and feedback on the resident's progress as well as on the overall performance of the program in order to identify any areas of program weakness.

Graduate Evaluation: Every year, graduates who have been out 1 and 5 years will be surveyed concerning the quality and relevance of their training. This is being done in conjunction with the UC Davis Family & Community Medicine Network of Family Practice Residencies so that we are also able to compare program success. This information is vital to keeping our program relevant in our changing world of medical practice. These evaluations will be reviewed at our annual planning meeting and relevant curriculum changes may be made based on this data.

Informal and formal discussions: Informal discussions with the Program Director, faculty advisors, faculty and peers are valuable ways to improve the partnership of teachers and learners, and to improve the quality of care we deliver to our patients. Residents have the opportunity to provide feedback at regularly scheduled resident/faculty meetings, clinic staff resident meetings, and Dialogue with Director meetings.

EXPENSES AND REIMBURSEMENT

Purpose:

There are times when an individual resident is asked to travel and attend various functions as related to their duties as a resident of the Shasta Community Health Center (SCHC) Family Medicine Residency Program.

1. **Travel expenses related to Residency for required rotations.**
 - a. Away rotations are not reimbursed by SCHC and are entirely the resident responsibility for all expenses.
 - b. Rural rotations will be reimbursed up to a maximum of \$1400 per resident per rural rotation to pay for housing, travel mileage and meals at per diem rates.
 - c. Pediatric ER rotation in Sacramento will be reimbursed up to a maximum of \$2100 per resident one time during their residency training to pay for housing, travel mileage and meals at per diem rates.
 - d. Two residents per year will attend the Helping Babies Breathe Global Health rotation and will be reimbursed for hotel, airfare and travel expenses related to teaching activities. No meals are covered during this rotation. Not all residents will participate in this rotation. A maximum total of \$20,000 per year is budgeted for this rotation which includes resident expenses as noted, faculty expenses and equipment costs.
 - e. Local rotations deemed required (St. Elizabeth Hospital in Red Bluff, Anderson, Shasta Lake City) will be reimbursed for travel at the federal mileage rate which changes annually.

2. **Travel expenses related to Residency required conferences for leadership training and recruitment.**
 - a. Travel to conferences required by the residency will be reimbursed for housing, airfare and/or travel mileage and meals at per diem rates.
 - b. Examples of Residency required conferences for recruitment and meetings:
 - i. CAFP meeting in LA each Fall.
 - ii. AAFP National Resident and Student Conference in Kansas City each summer.
 - iii. UC Davis recruitment conferences and chief training meetings in Sacramento 2-3 times per year.
 - iv. Other Medical school recruitment events determined by the Residency Faculty to be useful for recruitment purposes.

3. **Travel expenses related to Residency Scholarly activity and presentation of quality project and scholarly work at conferences.**
 - a. Travel to Scholarly activity and conferences representing the residency program will be reimbursed for housing, airfare and/or travel mileage and meals at per diem rates.
 - b. Conferences related to Scholarly activity and conference presentations need to be approved by the Program Director and DIO.
 - c. Examples of Residency Scholarly activity and conference presentation events:
 - i. Medical school procedure workshops and events at various venues (UC Davis, UCSF, Nevada, etc...)
 - ii. Presentation of resident quality project or scholarly work at conference (ie-UC Davis Education Conference, STFM, etc...)

4. **Expenses related to Mentoring of Junior Residents**
 - a. Each Senior resident (PGY2, PGY3) will mentor 1 Junior (PGY1, PGY2) resident.
 - b. Mentor meetings will be reimbursed for meals at per diem rates for Redding, CA for lunch or dinner limited to once a quarter.

FAMILY OR FRIENDS VISITING RESIDENTS AT HOSPITAL

Issues such as professionalism, hospital policies, privacy, and HIPAA must be considered when residents have

family members or significant others visiting for meals or during breaks on call. These visitations must be limited to non-clinical areas (i.e., cafeteria, physician offices, and resident lounge). Discussion of patient care issues should be avoided in their presence. While family members may visit, their presence should not interfere with the resident duties. In addition, family members and significant others must not sleep or nap in resident lounge or call areas.

FNP/PA AND MEDICAL STUDENTS AND FELLOWSHIP

Students enrolled at Mercy Medical Center and SCHC from UC Davis, Touro, Western, and Rocky Mountain College shall be under the direct supervision of an attending physician and comply with the affiliation agreement guidelines.

There is a PA/FNP Fellowship at SCHC that Residents will learn how to interact with mid-level providers. Please see website for Fellowship description.

GRADUATE MEDICAL EDUCATION COMMITTEE

The Graduate Medical Education Committee (GMEC) has the responsibility for monitoring and advising on all aspects of residency education. The committee will meet at least quarterly. A standard agenda with committee members and standing agenda items is included below:

GENERAL SESSION AGENDA

Dates to Remember

New Business Standing

Agenda Items

- A. ACGME Communications (including accreditation, change in resident numbers, Clinical Learning Environment Review Reports, Annual Resident Survey, Annual Faculty Survey, WebADS)
- B. Quality of Learning/Working Environment
- C. Quality of Education Environment (see also D.)
- D. Annual evaluation and Improvement Activities
 1. Annual Institutional Review (AIR)
 - i. Self-study Visit Results
 - ii. ACGME notification of accreditation status and self-study visit
 - iii. ACGME Annual Survey of Residents
 - iv. ACGME Annual Survey of Core Faculty
 2. Annual Institutional Review (AIR) Action Plans
 3. Program Evaluation Committee & Written Annual Program Evaluation (resident performance - Milestones, faculty development, program quality including confidential resident and faculty program evaluations, graduate performance including ABFM performance & graduate survey, resident attrition, annual action plans, progress report on previous years' action plans)
- E. Institutional GME Policies & Procedures
- F. Annual Recommendations RE; Stipends and Benefits
- G. Major Changes in program structure
- H. Response to Clinical Learning Environment Review (CLER) reports
- I. Change in participating sites
- J. Changes in faculty/PD
- K. Student Learners

SCHC GMEC members include: SCHC Residency Program and Assistant Program Director, Chief and Assistant Chief Residents, Clinic Center Nurse Manager, Behavioral health Faculty, Pediatric Faculty, CMO, CEO, DIO, COO, Clinic Quality Director, CFO, Clinic IT Director, Clinic Planning Director, Satellite Faculty, Core Faculty and Residency Coordinator.

In addition, the SCHC Residency Program Director will attend and participate on the GMEC at the Mercy Family Medicine Residency Program. At this meeting, the standard agenda will be similar to the above SCHC agenda and include department chair representation from all of the inpatient services including: Mercy Program Director, Mercy Chief Resident, Mercy Maternity Center Manager, ER, FP, Internal Medicine, OB/Gyne, Pediatrics, Surgery, Medical Executive Committee member, and Hospital Administrator representative/V.P., Medical Affairs.

GRIEVANCES AND COMPLAINTS

There may be experiences during the residency when the resident is placed in difficult positions that may, or may not, be related to any action on his/her part. Often such issues can be resolved by talking them through with the involved parties with or without a neutral third person, but sometimes they cannot. The program is committed to being supportive and fair in its response to problems and utilizes its recommendations and the resources of SCHC Human Resources Department and its official Policies as needed to reconcile the problem. We recommend the following first steps:

- First, discuss with the Chief Resident for SCHC or Mercy.
- Decide with him/her how to proceed.
- Check our Grievance Policy, contact academic advisor if pertinent
- If in doubt, contact the SCHC Residency Director, Debbie Lupeika, MD or Dr. Duane Bland, Mercy Residency Director

Where not to air grievances:

- Nurses in public areas
- Medical students in public areas
- SCHC or Mercy Hospital's Medical Director or Administration, even if the problem seems to be their responsibility
- Patients, especially in public areas

If you believe a significant issue exists that impacts the safety and quality of patient care, a written report should

be made so that the appropriate analysis and corrections are made by the relevant clinical supervisors (e.g., nursing, radiology, lab, OR, etc.) See section on Incident Reports.

HARRASSMENT

Shasta Community Health Center has a specific policy covering sexual and other forms of harassment. Please see Employee Handbook and PolicyTech. Residents can resolve complaints in a safe and non-punitive environment.

IN-TRAINING EXAMINATION

The In-Training Exam (ITE) developed by the American Board of Family Medicine and administered by all residency programs in October or November provides one of many gauges of resident training and progress. Our program uses as a passing score above or equal to the 90% predicted pass rate (based on the ABFM Bayesian Score Predictor). Given that the ITE simulates the board exam, the program takes specific action for residents who score below the 90% predicted pass rate. Retaking the ITE should be scheduled in a timely manner on an outpatient rotation to avoid changes to the master schedule. including the following:

- No moonlighting privileges for that resident*
- Resident meets with academic advisor and develops written plan for study and retesting
- Academic Advisor meets with resident on a regular basis to monitor progress
- Resident takes ITE (retest) and academic advisor makes recommendations to program director based on results
- Program director considers reinstating moonlighting privileges

*Exception: In consultation with academic advisor, the program director may consider continuation of moonlighting under the following circumstances:

- Composite Score of 90% of the predicted pass rate
- Good performance on residency clinical rotations
- Moonlighting occurs at a site that has a residency faculty member (community preceptors or core faculty) who has been informed by the resident of plans for study and retest due to a low score on the ITE.

LEAVE POLICIES:

Refer to Human Resources Policies and Procedures and Employee Handbook on the SCHC Intranet: Policy Tech.

LEAVING THE HOSPITAL AGAINST MEDICAL ADVICE (AMA):

Should a patient insist upon leaving the hospital without approval of the attending physician, the hospital has absolutely no right to detain them, unless he/she is a minor or under legal commitment. The hospital must avoid, as far as possible, permitting the patient to jeopardize his safety and must protect itself from possible slander and lawsuits. The following procedure must be carried out, and this is the responsibility of the CHARGE NURSE ON THE FLOOR on which the patient is staying:

- Notify the attending physician of the patient's intention.
- Warn the patient of the possible risk incurred in his leaving against medical advice.
- Request the patient to sign "Release from Responsibility, Leaving the Hospital against Doctor's Advice" form.
- If the patient refuses to sign, be sure to make a notation on the nurse's notes, and have at least one witness to the patient's verbal refusal to sign.
- Complete a Notification Form

LEGAL ISSUES

Legal Procedure for court summons for cases involving residents:

- a) Resident signs and dates when the summons is received
- b) Deliver the summons to the SCHC Residency office or SCHC Administration as soon as possible to determine next steps including a risk management assessment and potential legal review. SCHC has legal counsel and they will be consulted, along with the CEO and CMO, as needed.

LICENSURE

Shasta Community Health Center will pay for the PTL (Postgraduate Training License). After the Match each year, incoming interns will apply for their PTL. This PTL must be obtained within 180 days of starting Residency. It is recommended that incoming interns apply while still in medical school to ensure a timely response from the California Medical Board. In order to qualify for reimbursement of payment, resident must submit license application by July 15th of their PGY1 year unless circumstances prevent taking of the test and

this is approved by the Program Director. If license renewal is required during residency training, the reimbursement will be prorated to reflect the time left in the program. Each resident is responsible for scheduling and completing the Step 3 of USMLE or COMLEX in a timely fashion. All license application forms need to be ready to send completed application in July of PGY1 year. Please do not schedule Step 3 during inpatient or night float rotations. Step 3 of USMLE or COMLEX needs to be done prior to PGY2 year. In order to advance to PGY2 year, all residents must take and pass Step 3 during PGY1 year. If the resident does not pass Step 3 during PGY1, then resident will be put on remediation in order to pass Step 3 and not advance to PGY2 until test is done and passed. This remediation might delay the resident graduation date and elective time will be used in order to remediate. Time off for the exam is considered residency time (not PTO), but it MUST be scheduled in advance through the residency office so that the call, service, and FPC schedules can be adjusted accordingly. If the resident has not completed this material as required, SCHC may not pay the fees. If the license is renewed during the residency, SCHC will pay the fee prorated to the amount of time the resident has remaining in the program. The residency office will provide residents with application packets from the California Board of Medical Examiners, but it is the full responsibility of each resident to process his/her application and deal directly with the California Board for any questions about Board policy and procedures.

After licensure, residents must apply to the US Drug Enforcement Agency for controlled drug prescribing privileges (DEA license). After obtaining a DEA number, the resident will notify the Residency Office. A DEA license is needed to prescribe class II- IV medications. Please see the Residency Office for application information. SCHC will assist the Resident in the cost of application for DEA licensure.

Residents will also be asked to sign up for the CURES website to monitor patient prescriptions. SCHC administration will help with this sign up as soon as a DEA license is obtained.

MAIL AND MESSAGES

Mailboxes in the preceptor room at SCHC, email and Inbox/PAQ in EMR should be checked frequently, and action taken expeditiously when needed. Residents are provided with pagers. Notify the Residency Office, if your pager seems to be malfunctioning. Please attempt to keep your pager from dropping into puddles, toilets, or rivers and please safeguard it from loss or theft.

MALPRACTICE

The program provides ongoing malpractice insurance to all residents. If you encounter any situation that you think might involve legal action, notify the Program Director at once. This includes receiving legal documents asking for patient records; a bad clinical outcome, which could in any way be construed to involve negligence

or other malpractice; or threats of suit from an angry patient or family member. The health center also provides a "Tail" coverage, which means you are covered for events while a resident after you leave. If after graduation you are ever named in a lawsuit involving a patient at Mercy or SCHC, contact the Residency Program immediately so that we may involve our Risk Management and assist you as appropriate. NEVER "GO IT ALONE." Please note SCHC is primarily covered under a Federal program called the "Federal Tort Claims Act" or FTCA. This process can take time and requires the Resident's complete cooperation. While more complicated, FTCA coverage is much more comprehensive than regular commercial professional liability coverage. Secondary malpractice coverage is obtained for the Residency Program. This information is available to the Residents. Please note, FTCA coverage is only available for those services/procedures and locations for which SCHC is authorized to serve (called our Federal Scope of Project). If you feel pulled to go outside the norm of service or geographic area, please consult with the Residency Director who will seek out the CEO for determination of liability coverage.

MEDICAL MARIJUANA

In agreement with Federal Law, SCHC providers will not write prescriptions for medical marijuana.

MEDICAL RECORDS/HEALTH INFORMATION SERVICES

Mercy Medical Center Medical Center and Shasta Community Health Center medical records policies may be found on, in the case of Mercy, the hospital computers at:

- (1) Mercy: Public: Medical Staff: Bylaws

Start: Application Launcher: Mercy Redding: Everyday Use: Redding On-Line Manuals:
Administrative/Governance: Section VIII- Medical Staff Rules and Regulations.

And in the case of Shasta Community Health Center -

- (2) Shasta Community Health Center: Medical Staff Manual and Clinic Policy Manual

Start: by launching in "Policy Tech" using your assigned password. All SCHC currently approved policies, including clinical, medication, risk management, quality improvement, etc., policies can be found.

Completion of medical records is important for multiple reasons including communication of patient care between providers, patient safety, billing, and regulatory requirements. In the hospital, the medical staff rules

regarding timely completion of charts apply to residents, even though they are not official members of the medical staff and do not have admitting privileges; they work under the privileges of the attending preceptor. Residents placed on "suspension" for incomplete medical records must remedy this within 24 hours. If records are not completed, the resident will be pulled from their rotation. If the suspended resident is on an in-patient service, another resident on an elective or other available rotation will be pulled to cover. This resident will be paid back. If the "suspended" resident is scheduled for call, the Jeopardy resident will replace them. This resident will be paid back. A copy of medical records suspension will be added to the resident file for reference. A residence that has been on 90 days of suspension will be suspended from the residency program for 10 days resulting in delayed graduation and documentation in the resident file. Likewise, Shasta Community Health Center also has mandatory requirements for timely charting (please see SCHC medical staff manual in Policy Tech). Residents who fail to complete their charting to the satisfaction of the preceptor/faculty member and consistent with the standards acceptable to SCHC, will be notified of such and will have 24 hours to remedy the situation. Likewise, a progressive suspension from service within SCHC will be invoked until such charting is adequately completed. Such suspensions will be noted in the residents file that could result in delayed graduation and if egregious enough, suspension from the residency program.

Electronic Charting: Residents will be trained in the use of the SCHC approved EMR system (presently NextGen EMR). The system will be set up to allow for direct charting in the EMR by the resident and once completed that chart note will be sent to the supervising faculty member for review. The completed chart, note or order will show up in the Faculty members PAQ (Provider Approval Queue) and subject to review and request for modifications or further documentation by the supervising faculty member. If no changes are required, once the supervising faculty member approves these documentation/orders the chart will be electronically filed as complete. If further corrections/modifications are necessary, such instruction will be sent by the supervising faculty member to the resident where the resident will find that information request as an electronic "task" in their own inbox in the EMR. Once completed to the satisfaction of the supervising faculty member, the documentation will show itself as having been reviewed and being approved. The system also provides for a secure "audit trail". It is an expectation that residents will complete their clinic charts on the day of their clinic. Faculty need to review and sign off charts in a timely manner and this is ideally done on the same day. Residents will be provided charting assistance as necessary, including scribes and dragon dictation.

MEDICAL STAFF BYLAWS / RULES AND REGULATIONS OF THE MEDICAL STAFF

Mercy Medical Center Redding Rules and Regulations of the Medical Staff may be found on hospital computers at:

MERCY MEDICAL CENTER PERSONNEL POLICIES:

For on-the job injuries occurring at Mercy Medical Center Redding SCHC employees should be seen at Mercy's Employee Health (6193) during the day or at the Emergency Room (7200) during off-hours. You must report even minor injuries that are incurred while working for either Mercy Medical Center or at Shasta Community Health Center. In the case of on the job injuries at SCHC, you must report such injuries to the Clinic Nurse Center Manager in your Residency Department who will know what steps to take next. Regardless of where the on the job injury happens, the reporting of such injuries (which may incur considerable expense and loss of work) are covered by Workman's Comp, not by your regular health insurance so it is imperative that it be reported early to SCHC's HR Department and that you follow the instructions given. Failure to report can have significant negative consequences for you personally.

For general personnel policies and procedures please refer to Shasta Community Health Center Human Resource Policy Manual. Copies of this manual may be found on the SCHC Intranet with hardcopies available at SCHC's HR Department.

MOONLIGHTING POLICY

Moonlighting is an optional activity and not required by our program but is subject to ACGME duty hour restrictions. All hours spent moonlighting must be documented in New Innovations. Residency training is considered a full-time position. We recognize both the importance of rest and reading time as well as the value of moonlighting for some residents. Consequently, moonlighting is a privilege permitted only to the extent that it does not interfere with a resident's performance in the program, complies with the ACGME guidelines on Duty Hours (we include all moonlighting hours towards the 80 hour work limit rule, not just moonlighting in the health center and/or hospital), and has the Program Director's approval which takes into account the resident's performance in the program and readiness to assume the responsibilities of the moonlighting experience. Every resident must complete the intention to moonlight form available from the residency office prior to starting moonlighting. Licensed PGY2 and PGY3 residents in good standing may be granted moonlighting privileges effective through the remainder of their residency unless evidence of inadequate progress becomes apparent. We recommend limiting moonlighting to a maximum of one time per week and one time per weekend and preferably an evening or Saturday shift. It is also recommended that Moonlighting not be done during an inpatient rotation

due to service commitments. Moonlighting on post-call days is not permitted. If moonlighting activities detract from the residency experience, then the program director will take further action. Issues that may affect moonlighting include excessive fatigue, not being available to family medicine OB patients or resident service duties, excessively delinquent medical charting, and poor performance on the In-Training Assessment Exam as defined by less than 90% on Bayesian Score Predictor (see [In- Training Assessment Exam](#) section for more details). Potential consequences of not following the restrictions for moonlighting include:

- No moonlighting permitted.
- Failure to be certified as board eligible by successful completion of the entire prescribed curriculum.
- Recommendation of remedial rotations, substitution of core for elective rotations, or a delayed Graduation date.

No moonlighting is permitted during residency duty hours at any time including daytime rotations or on-call periods. There is no exception to this policy and any violation will result in suspension.

It is important to emphasize also that clinical services rendered while moonlighting outside of Shasta Community Health Center are NOT covered by the residency liability-malpractice policies including those under FTCA. You are on your own for coverage when moonlighting. Be sure that any moonlighting agreements you make clearly document liability coverage.

Residents must document the number of moonlighting hours worked during each block rotation on New Innovations and records of this are kept in the residency office. The Residency office will be alerted by the New Innovations system if duty hours are exceeded.

Please see SCHC moonlighting form on the following page.



Residency Program Director:

This is to advise you that I am considering outside employment at:

I acknowledge that such employment must be approved by the Residency Program Director, and that approval is subject to the conditions listed below:

1. My outside employment does not conflict with, or affect my performance as a resident in the Shasta Health Center Family Medicine Residency Program.
2. Outside employment is not to be undertaken during any period of time when I am on call at Mercy Medical Center, regardless of whether that call takes place at Mercy Medical Center or on pager. No moonlighting allowed during inpatient rotations to prevent duty hour violations (FPS, OB, Peds, Med, Night Float).
3. It is understood that my outside employment is not within the scope of my University duties, or my employment by Shasta Community Health Center. Neither the University nor Shasta Community Health Center will provide professional liability coverage to me, or to any other person or entity, for any claims that arise from my outside employment or activities. I am not to undertake any outside employment as a physician unless professional liability coverage is provided either by me or by my employer, and reasonable evidence of this coverage is provided to the Residency Director upon request.
4. Outside employment may be denied for residents who score below the 90% Bayesian Score Predictor on the ITE exam.
5. This approval is subject to revocation at any time. It constitutes only as consent to the outside employment indicated above, and does not constitute an endorsement of recommendation of the outside employer.
6. This approval shall be effective only when I sign, date, and return this form to the Program Director's office; and I then receive notification of the approval from the Program Director.
7. I have read and will comply with all aspects of our residency program's moonlighting policy. I will not allow my moonlighting to interfere with my education. I will submit to the Program Director during each block rotation a specific log of my moonlighting hours in New Innovations for tracking of duty hours.

Resident's Signature: _____

Date: _____

Print Name: _____

Approved by: _____

Date: _____

Program Director

NURSING ORDERS

Verbal nursing orders should only be used in emergency situations. After completing the order, the nurse will task the provider. SCHC has a fully functional EMR and nursing orders will be reviewed with SCHC residents. All nursing orders will be placed via the EMR per SCHC protocol.

ORIENTATION

The goal of orientation is to prepare incoming residents for the administrative and patient care requirements for being a family resident at Mercy Medical Center and Shasta Community Health Center. For each academic year orientation begins in mid-June. The following topics, didactics, and courses are covered during orientation.

<i>Topic</i>	<i>Responsible Party</i>
Employee Physical - Scheduled Prior To Orientation	Human Resources
Photos At Our Office	Human Resources
Forms and Information / New Hire Paperwork	Human Resources
Mission and Values/ Ethics & Compliance / HIPAA	COO / Privacy Officer
Welcome From Director	Dr. Lupeika & Dr. Bland
Chief Orientation Part 1	Current Chief
Employee Benefits	Human Resources
Personnel Policies/Corporate Integrity	Human Resources
Compassion in Medicine	Dr. Lupeika
Orientation - Hospital	Mercy Staff
Standards Of Conduct and Privacy Video	Privacy Officer
SCHC Intro & General Introduction	Dr. Lupeika., Dr. Nelson CMO
Computer	Chief Information Officer
Administration	Chief Operating Officer
Front Office	Randi Holscher, RN
Nursing & Clinic Tour	Randi Holscher, RN
Infection Control	SCHC Staff
Social Services Care & Coordination	Mercy Staff
BLS	SCHC Credentialing or Enterprise Training Center
OB Orientation	Dr. Davainis
Pediatric And Neonatal Services	Dr. Smith
OB Clinic Information	Director of Clinical Operations
Tour Of Labor & Delivery and Nursery	Dr. Skipitis, Dr. Mooneyham
Ob Sterile Technique	Mercy Staff
Mock Delivery	Dr. Skipitis, Dr. Mooneyham, Mercy Staff
PWC / Cerner System	Mercy EMR Staff
Pals	CEEMED
ACLS	CEEMED
NRP	Education Staff Mercy Hospital

Home Care	Dignity Health Staff
Procedure raining	SCHC & Mercy Faculty
Episiotomy Clinic	SCHC & Mercy Faculty
Health Information HPF Training	Dignity Health Staff
Health Information Tour	Mercy Staff
Orientation To Inpatient Services	Residents and attendings
Pharmacy	Pharmacy Staff
PACS Radiology	Radiology Staff
CLIA Testing	Dr. Namihias
ED Orientation	ER Director

OTHER EMPLOYEE BENEFITS

- Employee Assistance Program: Confidential professional counseling and referral service for you and your family
- Parking: Residents should obtain badges from the Medical Staff Office for entering the Doctor's Parking Lot at MMCR.
- Meals: Food will be free from the Mercy Medical Center cafeteria for residents on duty.
- Sleep Room: A room with telephone in the hospital will be provided for residents on night and weekend call.
- Immunizations: Residents may receive immunizations for Flu, COVID, rubella, hepatitis B, and diphtheria-tetanus via Shasta Community Health Center Employee Health program nurse. The program encourages staff members to be fully protected against these potential occupational hazards.
- Book Allowance: A book allowance for up to \$300 per year may be used to purchase medical texts, journals, computer software or other educational items as approved by the program director. Residents should purchase books and return original receipts to the residency office.
- Pager: The program will provide use of one pager plus one replacement pager for loss or breakage that occurs during residency training. The resident will be financially responsible for the cost if more than one replacement pager is needed.
- Every resident is provided with a computer from SCHC with access to Up-to-date, and other resources.
- Membership on the AAFP for all three years.
- Cost of California medical license while in our residency (to qualify: license paperwork must be submitted by July 15th of PGY1 year). If license renewal is required during residency training, the reimbursement will be prorated to reflect the time left in the program.
- Cost of DEA certificates while in our residency
- Expense Reimbursement: Residents may be reimbursed for certain expense such as mileage for the rural rotations and expenses for attending approved meetings or residency fairs. To be reimbursed for

expenses, residents must follow the SCHC approved Travel Expense Policy and use the approved SCHC Travel Expense forms (both found on the SCHC Intranet) and provide the residency office with original receipts and documentation of the expenses within 30 days of when the expense is incurred. If the resident is attending a residency fair, conference, or meeting at the request of the program, the resident must complete a "Request for Permission to Attend Workshop, Seminar, Institute, etc." form. This form must be approved by the Program Director prior to the event. Expenses for electives and away electives are not covered by the Residency program.

- Advance payments for travel expenses: In certain cases, the Residency Office can obtain advance payments for expenses incurred on behalf of the residency. To obtain an advance, the resident must provide an approved; Request for Permission to Attend Workshop, Seminar, Institute, etc. form and other requested documentation to the Residency Coordinator at least 2 weeks before the money is needed. The resident must also specifically request an advance payment of expenses, as one will not automatically be given.
- Residents will be paid for orientation and given a \$1,000 moving allowance with moving receipts are required.
- Residents on travel pertinent to Residency business will be given per diem meals only.
- Some cost for the ABFM Board exam is covered – please see the Residency office for details.

OUTSIDE TELEPHONE CALLS

All outside telephone calls should be directed to the resident on call at Mercy. Accept outside calls only from these patients:

MFHC patients

Advice given over the telephone should be limited and treated with considerable caution, given the absence of medical records, no prior knowledge of the patient, and inability to perform a physical exam.

All conversations with patients should be dictated using the stat line (01), with a copy sent to the clinic providing the patient's care. The dictation should also include the following:

- a. Your name, the doctor dictating the note (who took the patient's call)
- b. Patient's name (use for acct #9999999)
- c. Patient's DOB
- d. Date the of the telephone report
- e. Presenting problem or question
- f. Any discussion
- g. Impression
- h. Instructions given to patient

Consider concluding all conversations and documenting in your report that you *advised the patient that ability to* _____

provide medical care over the phone is limited. Therefore, the patient must go to the Emergency Department for further evaluation of urgent conditions. If the decision is made for the patient to see their own doctor for follow-up, have them set up the earliest possible appointment and to seek care at the Emergency Department if the problem persists, or worsens.

If the patient needs a refill for pain medications or other controlled substances, have them follow-up with their private physician or go to the ED. In very rare circumstances, using your judgment, you may fax to their pharmacy a refill prescription with a limited amount of medication to last until their clinic re-opens.

PATIENT DELIVERED PARTNER THERAPY

Although it is ideal for the partner to be seen by a medical provider before receiving antibiotic treatment, groups such as the AMA recognize the benefits of patient delivered partner therapy (PDPT). The effectiveness of this practice was published in the New England Journal of Medicine: Golden MR, Whittington WL, Handsfield HH, et al. Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or Chlamydia infection [N Engl J Med 2005;352:676-85](#). Be sure if you choose to write a prescription for PDPT at SCHC, please make sure that a separate prescription is written for the patient's partner. Do not add extra pills onto the patient's prescription. A patient handout to give to a partner explaining Chlamydia and its treatment can be found in the Patient Education file on the EMR at SCHC.

PEC (PROGRAM EVALUATION COMMITTEE)

Purpose:

1. Each Residency will establish a Program Evaluation Committee (PEC) which will:
 - a. Plan, develop, implement, and evaluate the educational activities of the program.
 - b. Review and make recommendations of revision of competency based curricular goals and objectives.
 - c. Address areas of non-compliance with ACGME standards and citations.
 - d. Annually assess the effectiveness of the program's education of residents using evaluations of faculty and residents.
2. The PEC will be appointed by the Program Director and include at least two faculty and at least one resident. The composition will include all faculty along with the chief and assistant chief residents.
3. The PEC will meet annually at the Annual Planning Meeting and more often as necessary to determine curricular changes.
4. The PEC must document formal, systematic evaluation of the curriculum and is responsible for

rendering a written Annual Program Evaluation (APE).

5. The PEC must evaluate and comment on each of the following areas:
 - a. Resident performance
 - b. Faculty development
 - c. Graduate performance, including performance of program graduates on the certification examination
 - d. Program quality which includes confidential written evaluations of the program by residents and faculty
 - e. Progress on the previous year's action plans
6. The PEC must create an action plan for each academic year.
7. The Program coordinator will be responsible for gathering all data for the PEC, coordinating, and documenting the meeting minutes and assisting in developing the APE.
8. The APE will be developed by the PEC at the Annual Planning Meeting and presented in the form of a summary, meeting minutes and Action Plans to the GMEC for approval. These approved documents will be presented to the SCHC Board of Directors by the DIO for review.
 - a. During the meeting the following will be reviewed and discussed:
 - i. Previous Action Plans
 - ii. Citation corrections and review
 - iii. Program goals and objectives with the Residency Aim and SCHC mission and vision statement
 - iv. Residency curriculum
 - v. Faculty and resident written evaluations summary which was reviewed by academic advisors at their twice-yearly reviews
 - vi. Graduate performance on Board exams
 - vii. Faculty development
 - b. Data will be reviewed at the future Faculty meetings and GMEC meetings.
9. The Annual Planning meeting will include the following which will be collected and coordinated between the Program Director and the Program coordinator prior to the meeting:
 - a. Residency Aim with the SCHC mission and vision statement
 - b. Overall Program Goals and Objectives
 - c. ACGME citations and reviews
 - d. Previous academic year Action Plans
 - e. ITE scores
 - f. New Innovations and Google Docs procedure and patient encounter logs
 - g. Resident scholarly and Quality improvement activity and projects
 - h. Milestones summary data

- i. Faculty Development Activities summary
 - j. Review of Resident Review of Faculty
 - k. Review of Duty Hours and New Innovations documentation
 - l. ACGME and local resident survey
 - m. ACGME and local faculty survey
 - n. Current Resident Curriculum
 - o. Residency Performance Index report
 - p. Match Data as pertinent
 - q. Graduate survey
 - r. Board Take/Pass Rates
 - s. Hospital reports as needed and Mercy coordination reports
10. The Annual Program Evaluation and Action Plans will be developed after the Annual Planning meeting which will include the following:
- a. A review of last year's Action Plans
 - b. A summary of Resident Performance
 - c. A summary of Faculty Development
 - d. A summary of Graduate Performance
 - e. A summary of program and clinical quality
 - f. An Action Plan for the upcoming Academic Year, which will delineate what areas of improvement are to be addressed, who the responsible party is, and timeframes of each action item.
 - g. The final report will be presented at Faculty meetings and the GMEC meeting.
 - h. The report will be presented to the SCHC Board of Directors by the DIO and shared with residents, the residency department and the Mercy Program Director

PHONE MESSAGES AND RESPECTING PRIVACY - HIPAA

The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care at their homes, whether through the mail, protected email, by phone, or in some other manner. In addition, the HIPAA Privacy Rule does not prohibit healthcare providers from leaving messages for patients on their voice mail or answering machines. However, to reasonably safeguard the individual's privacy, covered entities should take care to limit the amount of information disclosed on the answering machine, voice mail or answering service. The HIPAA Privacy Rule permits health care providers to leave a message with a family member or other person who answers the phone when the patient is not home, and to disclose only limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present. There is a HIPAA template on the NextGen EMR that contains the disclosure contacts.

Healthcare providers should also use professional judgment to assure that such disclosures are in the best interest of the individual and limit the information that is disclosed.

- **Don't** - Leave a message with a third party that provides any identifying details about the patient or his condition, whether speaking on the phone to an individual, via voicemail or an answering machine. This is a breach of confidentiality. When calling a physician about a patient, never leave a message with a third party, on voicemail or an answering service that provides any identifying details about the patient or their condition.
- **Do** - Leave a brief message requesting a call back from the patient. Leave a message for the physician requesting a call back (urgent or not urgent) regarding a patient matter.
- In situations where a patient has requested that the healthcare provider communicate with him in a confidential manner, such as by alternative means or at an alternative location, the healthcare provider must accommodate that request, if reasonable. For example, the U.S. Department of Human Services (DHS) considers a request to receive mailings from the healthcare provider in a closed envelope rather than by postcard to be a reasonable request that should be accommodated.
- Similarly, a request to receive mail from the healthcare provider at a post office box rather than at home, or to receive calls at the office rather than at home are also considered to be reasonable requests, absent extenuating circumstances.

PRODUCTIVITY AND PATIENT PANELS

According to the ACGME program requirements: Residents' clinic assignments over the course of 3 years of training must include progressive responsibility for increased patient visit volume and visit efficiency. The 3-year FMC experience for each resident must include a documented total of at least 1650 patient visits.

The number of patient visits from resident participation at a second FMC and/or from other longitudinal clinics may be counted toward the total number of patient visits if these visits are supervised by family physician faculty and if it can be documented that these patients are seen in continuity by the residents.

Since continuity requires following patients to other settings, the continuity visit numbers may also include patients from the resident's panels who are seen at home, at long-term care sites, satellite, and department SCHC clinics, and patients seen in an OB continuity care setting. Please be sure to add name to clinical encounter under "Encounter Indicator" to better track these numbers.

PHYSICIAN IMPAIRMENT

See Wellness Section in Resident Handbook, and the professional and prohibited conduct in Employee

PRECEPTOR RESPONSIBILITIES

- May supervise no more than four residents (or other students) at any given time.
- Must be on site and immediately available.
- Must assume responsibility for care given by residents.
- Must have no other responsibilities at the time of teaching (including supervision of other personnel or clinical duties). An exception will be made when there is only one resident in clinic, during which time the preceptor may see one patient per hour.
- Must review each patient's care with each resident in a timely manner and appropriately document the extent of his/her participation in the review and direction of care.
- The preceptor must be present during all critical and key portions of all procedures.
- Must document his/her role in supervision on the resident's chart note.
- Additional preceptor responsibilities include reviewing resident's charts for proper completion of the Medication List, Problem List, HCM, and Billing.

PRESCRIPTIONS

Hospital Discharge: A licensed resident preferably writes discharge orders and prescriptions, using his/her name and license number. If an unlicensed resident writes discharge orders, then the attending physician must sign the orders and the attending physician's name and number are used. The resident must indicate on the discharge order the name of the attending and the date of discharge as this is used both for medications and a variety of other health care agencies (e.g. —Discharge from the Service of Dr. <attending>. Follow-up with Dr. <attending> or with <clinic>")

The following items will apply to prescriptions for controlled substances effective 1-1-05:

Schedule II drugs:

- These drugs must be written using a controlled substance prescription script or E-prescribed and signed by the physician specific for that prescription pad, whether it is an attending or licensed resident with a DEA number. Scripts can be printed on the secure printer.
- Schedule II drugs may be written for terminal patients using standard prescription pads if the physician writes on the prescription "11159.2 Exemption"
- Schedule III and IV drugs
- These drugs may be written by a licensed resident or attending physician using his/her DEA

number and the controlled substance prescription pad or E-prescribed specific for that physician. Alternatively, a schedule III or IV prescription may be written using a standard prescription, or E-prescribed if it is faxed or called into the retail pharmacy by telephone, using the prescriber's DEA number.

Residents must be licensed and have a DEA number to write for controlled substances.

Outpatient: When unlicensed residents write outpatient prescriptions, the prescription must be co-signed by the preceptor. Licensed residents do not need co-signatures. Prescriptions are done through the EMR and residents should follow the approved EMR workflow for approving prescriptions. Prescriptions for controlled substances can only be written and signed by a licensed physician using his/her "triplicate." A script is generated through the secure, locked printer. SCHC controlled prescriptions can also be e-prescribed by designated providers. Please see SCHC IT department for e-prescribing protocol once license and DEA are obtained.

Helpful Hints to reduce medication errors:

- Include patients name and date of birth on all prescriptions
- Create a clear, consistent, and standard way for you to write every prescription. For in-patients, this could be: Drug, Strength, Form, Route, Frequency, and Duration. (Example: Amoxicillin 250mg/tab, one tab p.o. q6h X 7days.)
- An out-patient prescription should also indicate the number to dispense and refills. (Example: Amoxicillin 250 mg tabs. Disp: #28. Sig: One tab po q6h X 7 days. NoRefill.)
- Refrain from using abbreviations such as: "u" for units, "iu" for international units "pen" for penicillin, "QD" for daily, "QID" for 4 times daily, "QOD" for every other day, "MS" for Morphine Sulfate, "MSO4" for Magnesium Sulfate, or apothecary symbols for drams, minims, or ounces. These words should be written out instead. Write "ml" not "cc"
- Eliminate the use of "trailing zero's" – use 2mg instead of 2.0mg (easily mistaken for 20mg). Always use "leading zero's" – use 0.125 rather than .125.
- Order medications by "mcg," "mg," or "g" strength when possible. Example: Tylenol 650 mg instead of Tylenol 2 tabs (Tylenol comes in different strengths).
- Be aware of potential look-alike and sound-alike drugs
- Do not write "Resume previous orders."
- When in house, write the order, don't make it a verbal order to the nurse on the floor. Don't give phone orders whenever possible.

EMR Workflow

EHR Supervision Guidelines and Expectations of Resident entry into Medications Module in the NextGen EMR:

Purpose: To allow Residents who are licensed /unlicensed Physicians to enter medications into the Medication Module of the NextGen EMR under the oversight of the supervising Physician(s). Residents are Physicians in training who are learning how to prescribe medications to patients. Resident Physicians will enter medications into the Medication Module utilizing the ***Prescribe New*** button.

The Resident will follow the listed protocol to prescribe medications.

- Verify Preceptor of the day
- Verify Pharmacy
- Utilize ***Prescribe New*** button
 - Select medication, drug name and dosage through the search function
 - Select sig and drug usage information (ie: oral, inhalation, IM, daily, BID)
 - Select dispense quantity and specific units
 - Select number of refills
 - Select Diagnosis Code under “view”
 - Add any addition comments into the “Comments” box
 - Select stop date, if necessary (ie: antibiotics, pain medications)
 - Accept/Acknowledge any contraindications
- All outbound prescriptions from the Resident will be reviewed by the Preceptor
- The Supervising Preceptor will review each medication and confirm that the above steps are correct and the protocol has been properly followed.
- After the proper medication entry protocol has been followed and reviewed by the licensed Supervising Preceptor, the Resident may then send the prescription via ERX, fax, print
 - If the prescription has been printed, then the Resident and Preceptor will both sign the Rx.
- After Resident is licensed and has been signed off by Supervising Preceptor to work independently, then Resident may send prescriptions by following the medication entry protocol, without review by the Supervising Physician.

PROCEDURE COMPETENCY

The program uses a method by which all procedures will be supervised and evaluated and kept in an online database called New Innovations. The program has devised a credentialing process to establish whether or not a resident is competent to perform specific procedures. Residents will document their procedural experience, including the name of the procedure, age and gender of patient. The supervising physician will document the level of performance (e.g., progressing toward independent performance). Procedural teaching includes didactic presentations, indications and contra-indications, risks and benefits, informed consent, appropriate coding and charging, management of aftercare and complications, and acquisition and maintenance of skills. The academic advisor will review their assigned resident's procedure log bi-annually and discuss the progress of their training.

The following includes the procedural competencies for each area of residency training along with the number of procedures required prior to completion of the residency program. Also listed is the number of procedures required before independent status is granted.

Preceptors will use New Innovations to document the supervision of each procedure and to rate the level of resident performance using the following code: 1= required significant assistance; 2= required minimal assistance; 3= procedure performed satisfactorily without assistance. Resident must perform the minimum number of procedures as outlined below and demonstrate level 3 performance on at least 2 occasions to be considered competent.

After a resident demonstrates proficiency, a preceptor will still need to observe future cases during the key part according to Medicare supervision guidelines for billing purposes.

PROCEDURE REQUIREMENTS AT SCHC

Prior to performing procedures at SCHC, providers will perform and document in the clinic note the following:

1. Review the patient's past medical history and comorbidities and perform a physical examination to assure no contraindications for the procedures.
2. After discussing and reviewing risks, benefits, and alternatives of the procedure with the patient, write an order in the chart requesting the nurse to have the patient sign a consent form for the procedure(s). The order will specify the name of the procedure(s) and the site(s), if applicable.
3. Perform a surgical "time out" to confirm the following: the patient's identity using two identifiers, the correct procedure, the correct site and side (if applicable), the correct position of the patient, and the correct equipment available in the room. All members of the healthcare team must be in agreement and their names will be listed on the Procedure Note.

4. Document the following in the procedure note: the date, time, pre- and post-procedure diagnosis, attending, resident, anesthesia, findings, complications, EBL, and informed consent, including risks, benefits, and alternatives. If applicable, it will also include sedation, drains, and specimens.

Please see SCHC Procedure Requirements for Graduation on the following page.

**Procedure Requirements for Graduation and Initial Appointment of Hospital Privileges
SCHC Family Medicine Residency Program**

Procedures	Minimum required to graduate	MMCR required for Privileges	SCHC privileges	Resident's # to Date
Critical Care				
ICU Management	10	30		
Arterial catheterization		15		
Central venous catheters		25		
Chest tubes		10		
Intubation or extubation		15		
Paracentesis		10		
Lumbar puncture (adult)		5		
Thoracentesis		10		
Ventilator care, uncomplicated		15		
Newborn Care				
Newborn care	40	10		
Newborn lumbar puncture		5		
Circumcision (any technique) MUST LEARN	5	20	10	
Obstetrics				
Continuity OB Care	3 or 10	0		
vaginal Delivery MUST LEARN	40	25		
Repair of perineal lacs (1st or 2nd degree)	5	*		
Amniotomy/IUPC/Fetal Scalp Electrode		*		
Foley bulb labor induction		*		
Vacuum Assist Delivery		2		
Dilatation and curettage		10		
<i>*Items above with asterik are included in OB Management Privileges</i>				
Musculoskeletal Medicine and Outpatient Procedures				
Abscess I & D/packing MUST LEARN	2	*		
Anoscopy	1	*		
Bartholin cyst management		5	3	
Casting/Splinting	4	*		
Colposcopy	1	*(5)	5	
Ear lavage/cerumen impaction				
EKG Interpretation MUST LEARN		ACC Module		
Endometrial Biopsy	1	5	3	
Foreign body removal				
IUD			3	
Joint Injection or aspiration MUST LEARN	2	*		
Joint reduction				
LEEP		*	5	
Nail Removal	2	*	3	
PAP Smear MUST LEARN		*		
Skin-Cryotherapy (destruct lesion)	2	*		
Skin-Excision of lesion	2	*	3	
Skin-Laceration Repair	2	*		
Skin-Punch Biopsy MUST LEARN	2	*		
Skin-Shave Biopsy MUST LEARN	2	*		
Trigger Point Injection	2	*		
Vasectomy			5	
Surgery first assist	10	10		
*Considered Risk Group 1 procedure - need 20 of group				

Last updated: 3/1/22

PROFESSIONALISM

ACGME requires that programs provide educational experiences as needed in order for their residents to demonstrate compassionate, appropriate, and effective patient care, Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals; and a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds. Residents will receive training in professionalism through lectures, and longitudinally during each of their clinical rotations.

Competency in this area will be assessed during the evaluation process and reviewed during academic counseling. Examples of these areas include:

- Integrity
- Respect for Others
- Altruism
- Communication – appropriate and timely
- Commitment
- Honesty
- Teamwork Milestones
- Personal Hygiene/ Dress/ Composure
- Patient Care
- Administrative Tasks
- Rotation Attendance and preparedness
- HIPAA Compliance
- Work Hour Compliance
- Appropriate use of social networking

Failure to Show for Assigned Rotation

For professionalism standards, it is very important that you follow your assigned daily schedule. Any deviations must be reported to the residency office. Your schedules are used to document cost reports for federal reimbursement and to confirm your training requirements for the ACGME and the ABFM. The residency staff spent considerable time arranging your rotations and community faculty expect your presence. Missing the rotation assignment without communication is disrespectful to the staff, the preceptors, and your fellow residents. If there is a legitimate reason for you to miss an assigned rotation, please let the office know so we can adjust your schedule, communicate with the attending, and adjust our records. Failure to show for an assigned rotation the first time is a verbal warning.

Subsequent failure to show for assigned rotations will result in the time being counted towards vacation, an equivalent time removed from upcoming vacation (or a delayed graduation date if vacation time is used up), additional call, and a letter of warning to the academic file.

Medical Staff Expectations for Professional Behavior

Residents are also asked to sign the document “Expectations of the Medical Staff & Allied Health Professional Staff” which is a medical staff requirement prior to medical staff appointments. A copy of this document can be found through the Mercy Redding Family Practice Residency Program.

All practitioner behavior and actions are consistent with Shasta Community Health Center’s core values of:

- Caring and Compassion – We treat those we serve and one another with concern, kindness and respect.
- Honesty and Integrity – We act openly and truthfully in everything we do.
- Teamwork – We work together cooperatively, recognizing the power of our combined efforts exceeds what we can accomplish individually.
- Community – We acknowledge our vital role in local communities, and we seek to understand and serve their needs.
- Excellence and Quality – We are committed to quality and to adding value in every aspect of our work, and we strive to exceed the expectations of our customers/patients.
- Education, Teaching and Training – We strive to create an educational environment for our patients, our Employees, and for the training of medical professionals dedicated to servicing the disadvantaged.

Quality care: Each member of the staff is expected to provide the best possible care for his or HER patients.

This includes maintaining the necessary skills, obtaining adequate continuing education, exercising good judgment, and communicating effectively with other practitioners and staff.

Behavior (verbal or physical abuse, sexual harassment): Quality medical care is a team effort involving physicians, nurses, and other interdisciplinary staff members. We expect all staff members to behave in a professional and respectful manner toward members of the healthcare team. Verbal abuse destroys the effectiveness of the team and adversely affects patient care. Verbal abuse—yelling, swearing, insulting, or threatening anyone—is unacceptable and will result in disciplinary action by the medical staff. Similarly, inappropriate physical behavior—throwing or slamming objects, damaging hospital property, violent gestures—will not be tolerated. Sexual harassment—unwanted advances, inappropriate touching—is equally unacceptable.

Medical record completion: The medical record is an important tool of documentation and communication. It is

expected that each staff member will enter data in the EMR correctly using the appropriate templates and/or write legibly, complete dictations and sign their charts in a timely fashion, according to the medical staff rules. Residents are expected to complete their SCHC EMR notes prior to leaving clinic. Hospital EMR notes are expected on the same day in a timely manner, before 5pm.

Participation in peer review: Meaningful peer review is vital to maintaining quality care in the hospital. All members of the medical staff are expected to participate in peer review, as defined by their respective division.

Practitioner impairment: All practitioners need to be physically and mentally able to perform their patient care duties. Any condition that might affect his or her ability to provide care for patients must be reported to the SCHC Chief Medical Officer.

Maintaining Professional Boundaries and Respecting Patients' Privacy during Patient Examinations

AMA Statement on Professional Boundaries: The American Medical Association Council of Ethical and Judicial Affairs (1989) addressed professional boundaries and stated that sexual misconduct violates the trust that a patient places in the physician and is unethical. ^[3] This position was further modified in 1991 to add that a sexual or romantic relationship with former patients is unethical if the practitioner uses or exploits trust, knowledge, emotions, or influence that was derived from a previous professional relationship.

Addressing Patients' Perceptions: Patients may perceive misconduct if proper communication does not occur, or if extra measures are not taken to protect their privacy. The California Medical Board has received numerous complaints regarding improper physician conduct that could have been avoided with proper communication and use of safeguards, including the following:

- Proper explanation ahead of time regarding the scope, nature, or necessity of examinations which included touching private body parts.
- Allowing adequate private time for the patient to undress and cover properly.
- Limiting examination to required areas of focus based on patient complaint and insuring adequate covering during the examination.
- Using appropriate chaperones during examination of private body parts, especially during breast, rectal and pelvic examination.
- Carefully considering language and questions during the interview and examination.
- Behaviors should not be pursued that would not pass the colleague disclosure test.

Addressing Sexual Tension: Erotic undercurrents may occur between patients and physicians and need not end the physician– patient relationship. Although sexual undercurrents are not uncommon in the doctor–

patient interaction, sexual behaviors are always inappropriate and may result in disciplinary actions for sexual misconduct. Ways to address sexual tension include:

- Explaining reasons for sexually related examinations or questions and encouraging patient questions, while maintaining appropriate boundaries.
- Responding to patients who express erotic feelings in a matter-of-fact manner, emphasizing the doctor/patient relationship, the importance of objectivity, and the physician's desire for it to remain that way.
- Explaining that rejection of the patient's inappropriate requests or comments does not mean the physician does not care for the patient or does not wish to work with them.
- If a patient persists with inappropriate requests, or comments, or becomes extremely angry, the physician should respond calmly and with sincere regret that this behavior will cause termination of the relationship.
- Physicians should seek to understand their personal reactions and attitudes toward sexual issues.
- Patients who persist in acting out erotic feelings should be transferred to another physician and, pending transfer, sexually related issues should be avoided.
- The physician should explain the change as related to the persistence of the behavior and the physician's decision that it is in the patient's best interests not to continue.
- Admitting attraction or other feelings for the patient is discouraged as inappropriate disclosure on the part of the physician.

Key Points

- Boundaries between physician and patient permit the unique intimacy of the physician– patient relationship.
- Sexual contact crosses these boundaries and violates the relationship.
- Erotic feelings are signs of potential boundary crossings.
- Physicians and patient erotic feelings and behaviors can be constructively managed.
- It is highly recommended to consult with a faculty member or trusted colleague when potential boundary issues of any kind are detected, and to practice prevention before problems emerge.
- Male providers are required to have a female chaperone present for female breast, pelvic, and rectal examinations. Female providers are required to have a chaperone present for male genital and rectal examinations. It is also recommended that female providers have a chaperone during breast and PAP exams, and that male providers have a chaperone during male genitalia exams.

Link to ABFM professionalism guidelines: <https://www.theabfm.org/sites/default/files/PDF/ABFMGuidelines.pdf>

PSYCHIATRIC TEMPORARY CUSTODY (5150):

Effective June 2003, Residents no longer write 5150's. Any discussion about a 5150 for an inpatient needs to occur between the patient's attending physician and the Shasta County Mental Health Department or the Redding Police Department (police have the 5150 privilege). If the patient is a regular patient of Shasta Community Health Center, residents are advised to consult with SCHC's Psychiatrist for further direction.

REFERRAL PROTOCOL

In the past, we have received complaints from consultants regarding the lack of pertinent information when patients are referred from SCHC. Because of this problem, many consultants have refused to accept referrals from our clinic. To address this issue, we have referral protocol, which all clinic providers must follow when obtaining consultation outside of the residency clinic.

1. Resident cases must be discussed with the clinic attending physician prior to referral.
2. Residents must complete the referral template and also generate a detailed a note so the consulting physician will have pertinent information when seeing the patient.
 - a. The referral note may be in the form of a clinic note.
 - b. SCHC has an EMR and a generic letter available in the Document Library.
 - c. Use the stat dictation line (01) for urgently needed referrals through Mercy Hospital.
3. The referral note must include the following *pertinent* information:
 - a. The patient's general medical condition and current medical status
 - b. Past medical information
 - c. Medication list
 - d. Prior studies, treatments, and procedures
 - e. Any other information that would assist the consultant

REPORTABLE CASES: see SCAN Protocol

California law mandates that all health care practitioners make a formal report to the relevant authorities when encountering cases in which there is:

Suspected Child Abuse: (physical, emotional, neglect, etc.): A telephone report is required immediately or as soon as practically possible to the Child Protective Services Agency of Shasta County, and a follow-up written report is to be made within 36 hours.

Suspected Dependent Adult/Elder Abuse: (physical, neglect, abandonment, fiduciary, etc.): A telephone report is required immediately or as soon as possible to the Adult Protective Services Agency of Shasta County, and a follow-up report is to be made within two (2) working days.

Suspected Violent Injury: (homicide, assault, gunshot, stab wound, choking, lacerations, bruises, etc): A telephone report of previously unreported injuries must be made immediately or as soon as practically possible to the law enforcement agency (i.e. police) in the jurisdiction in which the injury occurred, and a follow-up written report is to be made within two (2) working days.

Others include:

- Sexual assault/rape
- An injury or condition resulting from neglect or abuse in a patient transferred from another health facility resulting from neglect or abuse

Additional information or reporting requirements may be found in the California HealthCare Association Consent Manual; these are available for review at SCHC, Mercy OB clinic, Hospital Administration, and from departmental nursing supervisors.

Note that simple, standardized forms are available in the family health center (SCHC) and in the hospital (obtained from the nursing staff) for use in fulfilling the written reporting requirements described above. All residents should feel welcome and comfortable obtaining guidance and assistance from a faculty member or attending in any case in which potential reporting requirements exists. Consulting and coordinating in these situations are often indicated in order to ensure that sensitive legal and ethical requirements are fulfilled.

Reportable Diseases and Conditions: (communicable diseases, STDs, Hepatitis, TBC, etc.): Telephone, fax and/or written reporting of certain diseases to the Shasta County Public Health Department are mandated. A reporting form is available in each family health center and in the hospital that delineates the specific reportable diseases and provides a listing of the required reporting modes (e.g., some diseases require immediate telephone reports, other require reports by phone and by mail, etc.).

RESIDENCY DEPARTMENT COVERAGE POLICY

The SCHC Residency Department will have policies and procedures in place to ensure that all clinical activities by all department primary care clinicians, including follow up on test results and questions from patients, will be accomplished in a timely and appropriate manner. This will occur on a continual basis, even when the individual provider is not available. This policy includes means and methods to monitor and respond to laboratory and radiology test results, questions from patients and other entities regarding patient care, request for medication refills and other patient related follow up activities. The policy shall include the responsibilities of individual clinicians, the responsibilities of nursing and ancillary staff and a specific responsibility of clinicians assigned special covering duties.

INDIVIDUAL CLINICIANS' RESPONSIBILITIES

Each clinician, including resident physicians will daily check their EHR "task list" and "PAQ" for patient care issues which require immediate attention. Whenever possible, these lists should be checked several times daily, with appropriate action and work assignments made in a timely manner. When physically in the clinic, the clinician will also check physical inboxes for documents requiring action.

When a clinician is scheduled to be away from the clinic for more than one clinic today, the physician assigned to covering duties will handle these matters. Informational items which did not require action may be left for the primary clinician.

RESIDENT PHYSICIAN RESPONSIBILITIES

Each resident physician, while on "in-town" rotations shall daily check their EHR "task list and PAQ" and take appropriate and timely action. It is an expectation that each resident will use their assigned laptop computers or tablets to remotely sign on to the EHR on a daily basis and take care of in direct patient care issues on their continuity patients. When on vacation or an away elective, coverage issues are taken care of by the covering clinician.

During each resident continuity clinic, all items in the task list, PAQ and physical in box should be taken care of with the assistance of the preceptor of the day.

The covering clinician of the day may be consulted anytime on how to take care of issues.

Follow up issues directed to nursing should be “tasked” to the nurse working with the Resident that day, or, if not during a clinic, to their assigned nurse, then lastly to the nursing task group using the telephone template.

COVERING PHYSICIAN RESPONSIBILITIES

On days when assigned to be covering clinician, the physician will take care of urgent or timely issues presented or task to them. These issues may be for residency faculty or residents that are physically not present in clinic or on vacation.

The covering clinician will check at least once daily and preferably several times daily, review the “task list and PAQ” for Department faculty who are not present in the clinic during regular scheduled workdays. If the clinician’s anticipated absence will be brief, the covering clinician will review clinical information or requests and decide to either take action or save for the clinician to address on his or her return. But, if the absent clinician is to be gone for an extended period of time, perhaps over a week, then definitive action should be taken on all patient care issues.

Nursing follow up on covering and she should be directed to the nursing task group.

DUTIES OF THE CLINIC I DOCTOR

During this rotation the resident will be in clinic from 8:00 a.m. to 5:00 p.m. daily, Monday - Friday. The resident will be responsible for specialty clinics as scheduled.

When not scheduled for a specialty clinic, the resident will see his/her continuity patients and/or work-ins. When post-call, the resident will have the afternoon off. Other health center responsibilities vary according to the Track and may include checking charts, daily lab, and prescription refills of those residents on away electives and vacation, as outlined below.

1. Review SCHC lab reports through your PAQ and Inbox.
 - a. C1 will review SCHC Inbox/PAQ daily from 8-9am (time is allotted for this).
 - b. C1 will review for any potentially serious abnormal lab and make sure appropriate f/u is done.
 - c. When C1 reviews lab and finds an abnormal result, he/she may contact patient, schedule f/u visit with PCC or refer the result to the PCC.
 - d. C1 will take care of the resident’s abnormal lab while they are on vacation or on “out of town” elective or on Night Float Rotation.

- e. If abnormal PAP, complete the PAP worksheet electronically.
- f. If f/u visit needed for any reason, alert front office via task in EMR VC Scheduling group to contact the patient to schedule an office visit with PCC.
- g. Coumadin patients are tracked through the Coumadin Clinic, to assure appropriate f/u by patients.

2. Review and Refill Prescriptions

- a. All prescriptions for residents on vacation or out of town elective or night float rotation need to be reviewed.
- b. If unable to renew prescription for any reason, please note on refill from pharmacy or contact patient, i.e. too long since last visit, needs f/u evaluation, narcotic issues, unclear from chart review what medications patients are taking.
- c. Do not just authorize refills blindly (see examples in b)

3. Chart Review

- a. Occasionally there is paperwork that cannot wait until PCC returns from vacation or out of town elective or night float rotation. Complete if needed.
- b. If unable to complete immediate paperwork because of time constraints or lack of documentation in chart, have front office schedule patient for an appointment.

4. Specialty Clinic

- a. Attendance required at all specialty clinics.

5. Clinic Practice Management.

- a. Must complete all C1 responsibilities prior to leaving clinic (last work-in can be scheduled up to 4:45pm).
- b. Collaboration/teamwork important. Front Office and nursing staff look to C1 for direction (i.e., responsibilities, attitude)
- c. Role model for other residents on C1 protocol.
- d. Complete C1 evaluation at end of rotation.

6. Clinic Doc will see work-in and fill in appointments as needed.

7. Specialty clinics that start @ 8am include Minor Surgery, Ortho, and Colpoclinic.

The name of the covering clinician will be noted on the front office informational white board.

Daily notification will be made to the covering clinician as a reminder of his/her cover responsibilities. A reminder should be made of who they should be covering for.

Clinical issues or questions should be routed to the access nurse for review.

Nursing Responsibilities

Nursing should monitor absent clinician's in boxes for clinical activities that need action taken. These issues should be presented to the covering clinician in a timely manner dependent upon the urgency of the request/issue.

Nursing staff should frequently check the nursing call group task list and take appropriate action.

Access Nurse Responsibilities

The assigned access nurse will triage clinical issues and present these issues to the covering clinician either in person or via telephone communication within the EHR.

RESIDENT IMPROVEMENT PLANS AND RESIDENT CONFIDENTIALITY

In the event that a junior resident requires additional training and supervision in one or more area, the senior resident(s) supervising the junior resident will be informed by the Program Director or another faculty member. With the intent of promoting better education and patient safety, this briefing will include the aspects of the junior resident's improvement plans as it relates to senior residents function as the supervising resident.

In addition, residents may be involved in confidential discussions about other resident's performance when serving in their role as the chief resident or assistant chief resident, or as a member of the promotions committee.

RESTRICTIVE COVENANTS

Shasta Community Health Center prohibits restrictive covenants. Please see PolicyTech for full policy.

SAFETY

Safety is very important at SCHC. All employees are required to do yearly Relias training on the computer, along with participate in safety drills as scheduled by the organization. Monthly Safety Shorts are emailed out to all employees

on subjects such as evacuation, fire drills, needle sticks, exposure incidents, emergency drills and personal protective equipment. Safety is an ongoing topic at Medical Staff and Department meetings, along with risk management topics. Please see Policy Tech online for further safety information. Incident reports can be reported on the intranet. The Compliance or Safety Officer for SCHC is available to discuss any safety concerns. There is an anonymous line to report any Compliance concerns that is available to SCHC employees at any time: 1-844-536-9450

SENTINAL EVENTS

For SCHC Residents on duty at the hospital, Mercy Medical Center Redding leadership and staff support a proactive sentinel event management system that addresses both actual and potential events. Details of this program are available on hospital computers at: Start: Application Launcher: Mercy Redding: Everyday Use: Redding On-Line Manuals: Governance/Administrative Governance:

- X.C.5 – Management and Reporting of Sentinel Events
- X.S.0 – Event Reporting Management.

SCHEDULES AND CALL

Notification of Schedule Change Policy

Accurate documentation of residency schedules and communication about changes are important for many reasons. These include: 1) accurate reporting of rotations for grant funding; 2) accurate documentation of your residency experience to assure you are meeting program and ACGME requirements; 3) communication and coordination with community faculty (poor communication can negatively affect our residency reputation and the desire for community attendings, many of them volunteer faculty, to work with our residents).

Any residency rotation schedule changes that deviate from the schedule provided by the residency office must be immediately reported to the residency office. This includes missed assignments or being late for any reason (i.e. illness, transportation issues, cancelled clinics, etc.). Failure to communicate with the residency office will result in a letter of warning to the residency file and possible residency extension with a permanent record stating the reason for the extension.

Any change in your schedule including master schedule (rotations), daily schedule, or call schedule must be reported and/or coordinated with the residency office as soon as possible. Changes in the schedule without approval from the residency office may result in a loss of credit for the rotation.

Call Positions and Duties: A call hierarchy exists in which junior residents have primary responsibility for coverage of the inpatient services. They are supervised by senior residents who are responsible for

overseeing admissions and care of all patients admitted to the resident services. The attending physician is responsible for supervising all resident care, answering questions, and addressing problems. At least two residents are on call each night or weekend, providing 24 hours resident coverage.

WORK HOURS AND CALL DUTIES

PGY 1

Inpatient OB/Peds 6:30 a.m. to 5:00 p.m.

OBPNF 5:00 pm to 6:30 am

Med/FPS 7:00 am to 5:30 pm.

NFM 5:30 pm to 7:00 am

Weekend calls for PGY 1 will consist of 24-hour shifts with additional hours (maximum of 4 additional hours) for finishing notes and signing out to the oncoming team. Services covered include the combination of Medicine and Family Practice Service by one resident team, while the other service will involve OB, Pediatrics, and Newborn Nursery by another resident team.

PGY 2-3

Inpatient OB/Peds 6:30 a.m. to 5:00 p.m.

OBPNF 5:00 pm to 6:30 am

Med/FPS 7:00 am to 5:30 pm.

NFM 5:30 pm to 7:00 am

NFS 5:00 pm to 7:00 am

Call will be done by senior residents throughout the year which consists of weekend call for a 24-hour shift with additional hours (maximum of 4 additional hours) to finish notes and sign-out.

Holiday Call: List will be made following finalization of the master schedule with each Resident coordinating with the Chief Residents to determine the schedule prior to the start of the academic year in July. *Make sure Holiday Call does not occur during scheduled vacation times.*

Sign-Out for Call: It is extremely important that patients are signed out appropriately. Senior residents need to be present at both morning and evening sign-outs during regular inpatient hours and at the regular weekend sign-out time (see times above).

Patient care and precepting must be completed at the residency center prior to returning to the hospital for call. Residents will leave the hospital when their work is completed, and they have adequately signed out.

Admission timing guidelines: While physicians often have their own preferences for defining when an admission goes to the service resident or on-call resident around the sign-out periods, with the number of residents involved, the program must have a consistent set of guidelines to ensure the patient's safe transfer of care to the inpatient service, and to avoid unnecessary resident conflict over who is responsible for this patient. The times listed refer to the time the ED notifies the on-call resident of the admission.

All mornings: The on-call resident will manage Admissions from the ED up to 30 minutes prior to sign-out (OB/Peds 5:59 am, or Med/FPS 6:29 am). After these times, the admission will be held for the incoming resident for the day. Incoming residents may accept patients from earlier if they so choose. If there is an urgent need to see the patient during that interval, then the on-call resident will be responsible. Patient safety always is the major determinant.

Monday through Friday evenings: Admissions from the ED up to 30 minutes prior to sign-out remain the responsibility of the day team (OB/Peds 4:29 pm, or Med/FPS 4:59 pm). After these times, the admission goes to the appropriate on call resident. If there is an urgent need to see the patient during the interval, then the on-call resident will be responsible. Patient safety always is the major determinant.

For patient safety and efficiency, the upper-level resident should always exercise their best judgment when assigning admissions around the change of shift times. That decision may overrule the above guidelines concerning times and which call accepts the admission (e.g., circumstances may make assigning the Peds call resident a medicine admit at 6:45 am). In the event of a disagreement, the upper level resident's decision is the one that applies. Residents may subsequently discuss the issues with the Chief Residents and/or the Program Director, but after the care is rendered and the crisis is over.

Changes to the written call schedule: All resident parties involved must agree upon changes. The resident originally assigned the call remains ultimately responsible for coverage. All changes need to be reported prior to the call day in question to the ER, MMC operator, the hospital wards involved, and the residency office. This is the responsibility of the resident originally assigned the call. In the event a resident is unable to take an assigned call day due to an acute illness, a family emergency, etc., that resident is responsible for contacting the chief resident and the residency office. The chief resident will assist them with arranging coverage.

Changing call cannot interfere with coverage of previously scheduled hours in the residency center or specialty clinics during the post-call period. If the jeopardy call resident takes call, they should immediately notify the residency office and any post call clinics that may be affected. (i.e., SCHC, community preceptors, etc.)

Jeopardy call: Jeopardy call is scheduled as a separate roster. Residents assigned to jeopardy call must be available by pager or phone to cover in the event of illness or emergency that prevents the on-call resident from working. They should remain available to work on a half-hour notice when contacted by the chief resident or acting chief. A

jeopardy call is defined as any call that a resident is unable to perform within 24 hours of the start of the call regardless of the reason. If the jeopardy call resident takes call, they should immediately notify the residency office and any post call clinics that may be affected. (i.e., SCHC, community preceptors, etc.) If a jeopardy resident is unable to do a call and knows this >24 hours from the start of the call, it is that resident's responsibility to find a replacement. A "time for time" trade policy for jeopardy call is in effect.

Thus, if the jeopardy call person is called in to do a call, the resident who called in sick will repay the call later in the year. This reimbursement call is to be arranged between the two residents involved. If they can't agree, the chief resident will assign the call in a future call schedule. If the jeopardy call person is unable to perform a jeopardy call (for any reason) it remains the jeopardy call person's responsibility to find a replacement. Extended sick leave is to be dealt with on a case-by-case basis. Call in those instances will generally be redistributed throughout the residency without payback.

Please note that there is no intern jeopardy call schedule system by resident request. The senior on service will cover where needed.

Senior Call Requirement/Expectations

Beginning of the Year

- Please be cognizant of the fact our interns will all be coming in with different levels of comfort and experience. You will not be able to treat all interns alike.
- Check in with the intern at the beginning of the shift and ask what their experience/comfort level is. Also make sure they know the following:
 - You are there to help them and answer questions. They should always feel comfortable reaching out to you
 - Give them an effective way to get a hold of you. You will need to grab an ASCOM because cell service can be spotty.
 - Part of your job is to make sure that they are not getting overwhelmed and are staying on top of their work. If you notice them getting overwhelmed step up and help. You can
 - Scribe for them on admissions
 - Take admissions and triages yourself
 - Prep/do discharges
 - Help put in orders

Peds

- You should see all newborns that have not been previously seen by a senior resident
- You should computer round on all patients: newborns/peds
- You should round on all Peds patients but ideally the intern should be covering all Peds patients
- You should see all Peds admits with the intern
- All plans for Peds admissions should be discussed with the intern before the attending is called

OB

- Computer round on all OB patients
- Prioritize giving the intern intrapartum and gyn patients (better learning)
- You must be present for *every delivery* unless very special circumstances arise
- Be available to discuss plans for triage patients with intern before they call attending
- Be available to supervise and help interns with AROM, FSE placement, IUPC placement

-Be available and attempt to be present for all ED consults

Medicine/FPS

- Computer round on all patients and physically round on any unstable patients
- Attend all admissions at the beginning of the year
- Review all admission plans at the beginning of the year before intern presents to the attending
- Attend all rapids that are called on patients with intern (intern should also attend all rapids even if it is on a patient the senior is covering)
- Review consult questions and sign out with intern before consultation at the beginning of the year unless consult is emergent

Call Numbers

- The goal for splitting notes and patient care should be roughly 60/40 splits (60% interns and 40% seniors) on regular calls
- Later in the year with super senior service, splitting can base off the size of lists and based off interns' comfort level and at the intern's agreement.
- In general, the split should be close to 60/40 and the amount you take as a senior should really be whatever is required to make sure that the intern is not getting overwhelmed, work/orders/notes are being completed in a timely manner and patient care is not suffering.

Super Senior

- Interns will not be doing solo calls with senior back up as we have in years past but instead will be doing calls with a super senior coverage (two interns with one super senior)
- Your job as a super senior is to make sure that interns are keeping up with workflow and are not getting overwhelmed.
- You should computer and physically round on all unstable patients and any patients the interns have concerns about
- Be present for deliveries
- Discuss all med/FPS admissions with intern even if it is brief
- Be available to answer questions and help if your intern requests help
- Attempt to attend as much of rounds as possible and discuss patient plans of unstable patients with intern after rounds.

Weekend notes will be distributed as follow:

Med/FPS:

Saturday: NFM intern 0%, NFS 0%, Super senior 20%, Intern 80%

Sunday:

OB/Peds:

Saturday: NFS and OBPNF intern 20%

Sunday: The Saturday senior and intern 20%

- Super senior and intern coming off night float services (Saturday), do 20% of notes for OB/Peds for the morning team.
- If the service is busy, the senior can do 20%. The incoming super senior does 20% of medicine/FPS notes.
- The notes will be on patients that are stable. Exam: mom/baby couplets and stable/placement patients on medicine.
- The notes will be signed, not pended.
- Seniors will be expected to see the patients who they are writing notes for but will not be actively managing them.
- You will oversee 4 resident services and must be available for assistance throughout the 24-hour call.
- You will generally not be actively managing patients- interns are responsible for taking all phone calls, doing admits, and managing the patients on their respective services. You are expected to closely monitor the more critically ill/sick patients.
- You do not need to attend all rounds. Attend the ones with sicker patients or more complicated census

WORK HOUR RESTRICTIONS

Residency Work Hours are monitored by the residency office. Residency rotation, clinic, conference attendance, and call expectations are structured to meet the work hour restrictions. The chief resident makes the monthly call schedules which are reviewed by the program director to assure compliance. The Residency program requires

documentation of duty and moonlight hours worked using an on-line program - New Innovations. In the event of a work hour violation, the program director explores the circumstance with the goal of preventing further occurrences.

The Shasta Community Health Center Family Practice Residency Program follows The ACGME Approved Standards for residency work hours effective July 2011:

Maximum Hours of Work per Week: Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.

Moonlighting: Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. PGY-1 residents are not permitted to moonlight. Residency work duties supersede any moonlighting duties. All Residency work must be completed before starting a moonlight shift.

Mandatory Time Free of Duty: Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Duty Period Length: Duty periods of PGY-1 residents must not exceed 24 hours in duration with 4 additional hours in order to complete work duties and sign-out. This change is approved by the ACGME as of July, 2017. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m. is strongly suggested. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must: appropriately hand over the care of all other patients to the team responsible for their continuing care; and document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director and make a notation in the New Innovations system. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Minimum Time Off between Scheduled Duty Periods: PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. Intermediate-level residents [as defined by the Review Committee – PGY-2 for family medicine] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. Residents in the final years of education [as defined by the Review Committee – PGY3 for family medicine] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee – The Family Medicine Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

Maximum Frequency of In-House Night Float: Residents must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night floats, and maximum number of months of night float per year may be further specified by the Review Committee – for family medicine, night float experiences must not exceed 50 percent of a resident’s inpatient experiences.] Night float shifts are Monday through Friday during a two-week block rotation.

Maximum In-House On-Call Frequency: PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third night (when averaged over a four-week period.)

At-Home Call: Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each resident.

The Call Schedule is done by the Chief Resident, with input from residents, and in accordance with the master schedule and our scheduling guidelines. The foremost aims of the call schedules are to be equitable and to provide smooth, uninterrupted coverage of the clinical services, while following the ACGME work hour standards. To assure compliance with residency work hour restrictions, residents must keep a log of hours worked including moonlighting and submit this to the residency program via New Innovations.

MASTER SCHEDULE

The Master Schedule of rotations for all residents and 13 rotations is extremely complex. The Schedule is put together in the spring and must balance the interests of rotations, service coverage, resident requests, health center coverage, and a logical sequence of certain rotations and responsibilities. This schedule has been developed along a variety of pathways in the past, but the bottom line is the appropriateness of the final product. All stakeholders (rotations, health centers, residents) have input in its development and final version. The residency program director has final authority in approving the Master Schedule.

There are events that occur, unpredictably, that impact the Master Schedule such as illness, pregnancy, and personal problems. For such unavoidable reasons, the Master Schedule will be modified by the Program Director in consultation with the Chief Resident, the health center, and the Residency Coordinator using the appropriate Schedule Change Form. There may be less serious reasons for changing the Master Schedule, which may generate a Schedule Change Form and may be considered. However, most changes are complex and will not be made.

HOLIDAYS: For SCHC PGY1 residents, Mercy Family Health Center is closed on hospital holidays. Holiday call is treated as a weekend call. Mercy Medical Center observes these holidays: New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving Day, Day after Thanksgiving, Christmas Day. As relates to call, generally the Mercy Medical Center holiday schedule dictates which days are considered holidays.

SCHC Observed Holidays: The Health Center provides paid time off for the following holidays: New Year's Day, President's Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving and Christmas Day.

Appropriate "leave forms" must be completed and authorized by the Residency Director and the Clinic Manager at least twelve weeks prior to when the leave is effective.

JURY DUTY: Please refer to Shasta Community Health Center's HR Policies that can be found on the SCHC Intranet. Copies of this manual may be located in the Human Resources Department. Residents are not exempt from Jury Duty. You must coordinate with the Residency Office if summoned so that we can arrange appropriate coverage.

COURT APPEARANCE AND JURY DUTY: The Health Center provides up to 10 days paid jury duty or court appearance per year. Please be aware that this may extend the Residency and needs to be discussed with the Program Director.

Schedule - Vacation

Residents take vacation according to the Master Schedule, which is done by the Chief Residents and Program Directors of SCHC and Mercy after obtaining resident requests. The Master Schedule is made in order to balance everyone's request vs. service and clinic staffing needs. Vacation periods may not accumulate from one year to another. Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of the G-2 year and first month of the G-3 year in sequence) and a resident does not have the option of reducing the total time required for residency (36 calendar months) by relinquishing vacation time. Vacation time is broken up into two 2-week blocks. PGY III residents may take one-to-two-week vacation blocks during electives. It cannot be taken the last two weeks of residency. This also is scheduled by the Chief Residents and Program Directors on the Master Schedule.

Changes to scheduled vacation will only be considered for exceptional circumstances and will usually be denied by the program director. This is a reflection of the difficulty of balancing call, service and SCHC coverage. If you do have a request, it must come with a solution to these issues and must be approved by the Chief Resident, the service, Mercy Residency and SCHC.

Further vacation descriptions can be found in the Employee handbook and on PolicyTech.

CLINIC SCHEDULE AND TIMES

Over the three years, residents spend progressively more time in their continuity outpatient clinic, with SCHC residents spending their PGY1, PGY2 and PGY3 years at SCHC and Mercy residents at their own outpatient clinic. The progression of time begins with one or two half-day per week in the first year, two or more half-days per week in the second year, and three or more half- days per week during the third year. While office hours may vary somewhat according to the resident's rotation, it is essential that the resident sign out from hospital duties in time to be in the center for the first appointment. When a resident is not in clinic, a fellow resident or faculty will care for his/her patients.

Residents who are not on vacation or away electives are expected to check their Provider Approval Queue (PAQ) and Inbox in the SCHC EMR daily (this can be done remotely) and during their C1/2 rotations, to complete all prescription refills, review lab results, and attend to any messages from patients, staff, or faculty.

Appointments are scheduled from 8:10 - 11:30 a.m. and 1:50 - 4:30 p.m.; although walk-in patients are seen up until 11:45 am and 4:45 pm. Plan to arrive at 8:00 am and 1:40 pm for the assigned clinic to huddle with

your nurse-scribe team and your preceptor. Residents who have completed all other patient care responsibilities are expected to be available in clinic to see patients up to these times. To assure that all walk-in patients are seen, residents must check with both the preceptor and the desk nurse when leaving the morning clinic before noon or the afternoon clinic before 5 pm. Residents leaving clinic early without checking-out as above will be scheduled for additional clinic time. SCHC has a "Dashboard" system to accommodate patient walk-ins. Residents should check will with their nurse to ensure no "Dashboard" patients are remaining.

We value the huddle process, so residents are responsible to be in clinic 10 minutes before their first patient is scheduled. Please notify Randi Holscher, the residency Center Manager, if you are going to be late so arrangements can be made. The Family Practice Service Resident will be at SCHC Monday through Friday from 10am – Noon to see continuity patients.

Residents will be assigned a number of patients per clinic according to their year of Residency training:

PGY1: 2 - 5
PGY2: 5 - 8
PGY3: 7 - 10

Additional patients may be added to the schedule if residents have less than the maximum number of patients scheduled before the start of their clinic. The front office will continue to schedule these "work-in" appointments until each resident's schedule reaches the maximum amount indicated above, providing the "work-in" patient can be seen by the time the work-in slot is available.

In addition to "work-in" appointments, residents and faculty are expected to see up to one additional "work-in" patient per clinic to accommodate patients with urgent healthcare needs who would have to be sent to the emergency room. As much as possible, the front office staff will schedule these "work-in" appointments during the beginning of the clinic. Residents will not be scheduled for clinic during a post-call day. R1 Residents will not be in Clinic during their night float weeks to prevent duty hour violations.

Preceptors are available in the clinic during all times of resident patient care.

GENERAL GUIDELINES AND EXPECTATIONS

1. Confidentiality: must be maintained by logging off computers when stations are left and keeping discussions about patients confined to the preceptor room.
2. Food and drinks: are not allowed in patient care areas or the preceptor room.
3. Privacy: Knock before entering into any patient's room in clinic and wait for an appropriate response.

4. Sample Medications: SCHC does not have sample medications available and are prescribed through the NextGen EMR.
5. Timeliness: Residents are expected to attend their clinics regularly and in a timely fashion. If late for any reason, residents must notify the Center Manager and/or Residency Program Coordinator.
6. The Procedure Log: Use New Innovations to document all procedures. Reports on patient activity will be generated from SCHC EMR. It is expected that all Residents keep current on logging duty hours, procedures, and patient encounters from Mercy Hospital during rotations. Ideally, this is done on a daily basis. These administrative duties are considered deficient if a Resident is two weeks behind.
7. It is expected that all Residents will finish their EMR notes by the end of clinic. Leaving the clinic before notes are done is an exception. Delay in EMR notes affects patient care, billing, staff time and preceptor time and is considered unacceptable.

SCRIBE POLICY

Scribes are an adjunct to the clinical team at SCHC. Residents and Faculty are scheduled with scribes whenever possible. Scribes are not always available, and thus a priority of scribe assignment is as follows:

1. Faculty and Specialists
2. Night Float Resident
3. Family Practice Resident
4. PGY3 Residents
5. PGY2 Residents
6. PGY1 Residents

When there is a shortage of scribes, the scribe will be assigned to the Physician with the most patients on their schedule taking into consideration the acuity of patients scheduled among everyone in clinic.

SICK LEAVE AND PERSONAL DAYS

Residents are responsible to notify the Residency Coordinator if you are unable to work due to illness or if you have a medical or dental appointment. The coordinator will notify your service and health center for coverage as appropriate. A few hours out during the workday is not considered time off, but you do need to manage the appropriate notifications so your work is covered. After hours and on weekends, the core faculty member on Family Practice Service should be notified in the event of an emergency absence. Sick days are deducted from your sick time. Please refer to section on sick leave in PolicyTech at SCHC. If the jeopardy call resident takes call, he/she should immediately notify the residency office and any post call clinics that may be affected (i.e.

SCHC continuity preceptors, etc.) Sick leave is considered time away from residency training by the ABFM. Residents may be required to use scheduled vacation time to make up for missed rotations if it is clear that they will exceed the allowed 28 days per academic year away from residency training. This is only allowed during the same academic year. Sick time will not be used in these circumstances. If all vacation time has already been used, then the residency training and the resident's graduation date will be extended.

Once a year, however, residents may make one unscheduled clinic change with at least 10 working days' notice so staff can contact patients prior to their appointments. One-time clinic changes may be done for personal time off, or work reasons: CME, interviewing for a future job, or elective rotation time. Additionally, the change must be approved by the Residency Director with notification given to the Center Manager and the Residency Coordinator, to make sure that it will not affect clinic staffing. The residency office has the appropriate paperwork. We ask that you begin the paperwork as soon as possible to make these days as smooth as possible for all concerned.

Residents are only allowed 28 days off per academic year per ACGME requirements before being required to extend their Residency.

Our program encourages Residents to attend to their personal health needs. For personal appointments (dentist, physician, family needs), a resident can take up to 2 hours (including driving time) to attend to these personal needs. If more time is needed, this needs to be approved by the Program Director and Residency office. We ask that these appointments not be deliberately scheduled during an inpatient rotation or call shift unless coverage is secured by the resident. The ideal timing for these appointments is during outpatient rotations and that clinic responsibilities are covered.

SPECIALTY CLINICS

During Clinic I and II rotations, time is scheduled in the specialty clinics held either at Mercy Family Health Center or Shasta Community Health Center. Continuity clinic time is maintained throughout the rotation at the minimum of three half days a week. Specialty clinics include Ophthalmology, QI, Allergy, Dermatology, ENT, Ortho, Peds dermatology, pain management, HIV, practice management, minor surgery, plastic surgery, vasectomy, colposcopy, Gyn, procedure clinic, OMT, circumcision, and renal. See Rotation Core Competencies and Expectations.

SUPERVISION

Supervision of residents is essential to quality graduate medical education and to the safe care of the patients we

serve. Residency is an educational experience that, more than anything else develops judgment and skills and these qualities can only come from responsibility with feedback. Supervision not only involves an assessment of the resident's clinical knowledge and skills, but also interpersonal (professional and patient) skills essential to being an effective doctor. Supervision (and evaluation) is a requirement of the ACGME, which certifies all graduate medical education programs, and is now re-focusing on competency-based curriculum, which this program has embraced. Each rotation has the defined competencies, which family physicians (and at times family practice residents in this hospital) require to be effective and successful.

Supervision also has regulatory components affecting the supervising physician and his/her obligations as described in Mercy Medical Center Redding's Policy below. All issues of supervision policy are determined at Mercy's Graduate Medical Education Committee, which consists of attending physicians, faculty, chief resident, and administrative representatives (including the Vice President of Medical Affairs).

POLICY STATEMENT ON GRADUATE MEDICAL EDUCATION PROGRAM MERCY MEDICAL CENTER REDDING SUPERVISION OF A RESIDENT

1. Attending staff physicians who agree to supervise residents do so under privileges granted to the attending by the medical staff. Residents themselves do not have privileges at Mercy Medical Center Redding. Accordingly, in accepting the attending role, a medical staff member agrees to assume responsibility for appropriate supervision of the residents' patient care. Medical staff members have the option of not participating in resident supervision and/or teaching.
2. The attending physician is responsible to round everyday he/she is on service with the resident team. The attending physician is responsible to review the clinical records of all patients on his/her service, checking the work-up and progress notes of the residents. This monitoring should include attention to the resident's ability to structure a differential diagnosis and diagnostic plan, review of therapeutic options and approval of all medications and therapies prescribed by the resident. The attending physician is responsible for signing off on the clinical records including discharge summaries of all patients admitted to their service. The attending physician will write a brief admission note or co-sign the resident's admission note within 24 hours of admission. H&Ps will be authorized by a preceptor within 24 hours. For all admissions, the attending will review the resident progress notes daily and authenticate or complete a separate note. Individual orders, including order for initiation or renewal of patient restraints, are monitored by the attending physicians. For billing it is the attending physician's responsibility to follow insurance (i.e., Medicare, Medi-Cal, etc.) requirements for supervision and documentation.

3. Procedure performed by the residents must be supervised in accordance with 1st, 2nd, and 3rd year Description of Duties. Obstetrical faculty is responsible to be present for each resident delivery. It is the responsibility of the delivering resident to notify the attending physician of the impending delivery. For billing it is the attending physician's responsibility to follow insurance (i.e., Medicare, Medi-Cal, etc.) requirements for supervision and documentation.
4. The attending physician is responsible for notifying the program director of any deviation from appropriate professional standards by the resident. This includes any behavioral issues that affect a resident's ability to perform his/her duties in an effective manner. The program director has the ultimate responsibility to assure that residents meet the standards set in this regard. In cooperation with the faculty, he will determine a course of action to correct the problem and provide supervision with any remedial help required.
5. The attending physician agrees to provide each resident with a written or electronic New Innovations evaluation at the end of each rotation. This may include a formal exit interview at the discretion of the attending. The program director or the resident's faculty advisor will meet with each resident at least two times a year to review these evaluations and address any perceived deficits.
6. If a resident physician is asked to see a private patient on an emergency basis, the care they provide comes under the supervision of the staff physician responsible for the patient. Staff physicians should approve the resident's involvement whenever possible and resume direct patient care as soon as circumstances permit.
7. The attending physician is responsible to report unexcused resident absences to the program director. The program director is responsible to assure that patient care responsibilities are covered.

Shasta Community Health Center Description of Duties for Residents for PGY1, PGY2, and PGY3

This list represents duties of the resident as delineated in the resident Job Description. Residents are NOT members of the Medical Staff, their duties and responsibilities are determined by the Accreditation Council for Graduate Medical Education and by the Residency Review Committee in Family Practice, Residents always function in the hospital and clinics under the authority and direction of the attending physician as defined in the hospital policies, (Criteria for advancement are contained elsewhere in the resident manual.)

This list is provided for information to the clinical areas.

Procedural Skills: All procedures performed by a resident require the direct oversight and presence of the attending physician, (Ref: MMCR Policy, CHW Policy 9,109, and Medicare Carriers Manual Section 15016 -

Supervising Physicians in Teaching Settings.)

Medical Management and Diagnostic (Cognitive):

1. Performs physical examinations of patients, diagnoses diseases and disorders, and prescribes and administers treatment.
2. Assists in surgical operations.
3. Confers with the attending physician on the examination, care, and treatment of patients, and any substantial change in condition.
4. Confers with relatives of patients concerning condition and treatment.
5. Obtains and records medical histories, physical examinations, and progress notes on all patients examined and treated.
6. Makes rounds of the wards and reports on the condition and progress of patients.
7. Exercises medical judgment in the proper diagnosis, care, and treatment of patients in Mercy Medical Center and SCHC/MFHC.
8. Makes recommendations to the Director of Family Practice Residency on policy matters.
9. Explains the services available at Mercy Medical Center and SCHC to members of the general public.
10. Orders and interprets laboratory examinations, analyses, and x-rays.
11. Writes medication orders.
12. Assists in the instruction and supervision of nurses, technicians, and personnel assigned for special training.
13. Attends and participates in clinics and staff conferences on the discussion of surgical, medical, and mental conditions of various patients and their diagnoses and treatment.
14. Prepares case histories, reports, and related correspondence.

Call Expectations and Supervision Responsibilities PGY1s on weekend call or night float:

1. There is always a PGY2 or PGY3 in house to serve as back-up.
2. PGY1s must notify the senior resident in-house of all admissions, discharges, or change in patient status (use the same guidelines we have developed for notifying your attending).
3. PGY1s must assist with rounding on weekend mornings under the direction of the senior residents (please work with your senior resident to assure that you do not exceed work hour restrictions).

PGY2/PGY3 on weekend call or night float – supervision responsibilities:

1. Monitor all resident admits, discharges, or changes in patient status; this allows you to provide education, back-up, and close the service when necessary.

2. Obtain a brief check out from the senior resident checking out on the opposite service regarding service status (i.e., green – open and not busy, yellow – open and busy, red – closed) and information on unstable patients and patients that the PGY1 may need assistance with managing.
3. Assist PGY1 with patient care if service becomes excessively busy.
4. Recommend closure of medicine admissions from the ED if it is anticipated that either the medicine or Ob service has become too busy for both the PGY1 and PGY2/3 to manage together.

Short Call PGY2/PGY3

1. Round and supervise/manage PGY1s who are rounding
2. Do not leave the hospital until PGY1 coming off call has completed rounding and left

Supervision criteria for senior residents supervising junior residents during low-risk labor: Attending notification guidelines apply to all levels of residency training, PGY1-PGY3. Senior residents will be required to meet specific criteria prior to supervising junior residents during low-risk labor. They will have to successfully complete their intern year obtaining the intern certificate and advancement to second year status. They will also need to complete specific OB requirement. They will need to have completion of and continued ALSO (Advanced Life Support in Obstetrics) certification. They must have a minimum of 30 vaginal deliveries documented. OB rotation evaluations must be overall satisfactory and include by the end of PGY1- competent to supervise first year residents' performance portion to be satisfactory or above.

When first year residents begin participating in the Night Float Obstetrics/Pediatrics rotation, they must work closely with the senior resident on the Night Float Medicine Rotation. For the purposed of resident education, supervision requirements, and patient safety, the following procedures must be followed:

- Senior residents must be notified of all admissions, pending deliveries, or significant change in patient status. Any item that requires attending notification (see below) also requires communication with the senior resident. The PGY1 Resident should provide this notification immediately after evaluating the patient – sooner in emergent or urgent situations
- The senior resident must be notified of all pending deliveries and is expected to present for these deliveries

It is important for both PGY1 and senior residents to follow these procedures. Failure to follow these procedures may result in cessation of the rotation, possible delay in residency advancement, and loss of future elective time while the rotation is made up. It is expected that all residents will continue to follow the usual attending notification guidelines as outlined below:

Attending Notification Guidelines

Attending notification guidelines identify specific criteria that should trigger a phone call by a resident to an attending physician to inform the attending of a change in patient condition. It is expected that the attending will be notified ASAP, following appropriate assessment and stabilization of the patient, if necessary, for the following conditions/ circumstances:

All Admissions

1. Any significant change in condition
2. Critical labs that may change the course of action of patient care
3. Rapid Response Team call, Code, cardiac or respiratory arrest
4. Unplanned intervention or transfer to higher level of care
5. Iatrogenic event: serious complication from medical intervention
6. Initiation of restraints
7. Discharge AMA
8. Unanticipated death
9. At request of staff member, patient, or family member

In Addition, for Obstetrics:

1. All imminent deliveries
2. All non-labor patients after evaluation prior to discharge
3. Any significant or unclear FHT or TOCO that may require urgent evaluation and/or treatment
4. Unexpected blood transfusion pre or post -delivery without prior attending knowledge or instruction
5. Fetal demise

In Addition, for Normal Newborns:

1. Any concern or complication
2. Any potential NICU transfer
3. Note: According to hospital Maternity Service Structure Standards normal newborns must be seen by attending within 18hrs of delivery

SUPERVISION REQUIREMENTS FOR PARTNERSHIP HEALTH

Dignity Health Graduate Medical Education Uniform Policy for California Hospitals

The requirements effective as of 2004 are more stringent than the Medicare billing requirements. We will no longer be able to employ the 6-month Medicare exemption. Instead, we must have the *teaching physician present for all billable patient care services performed by unlicensed residents*. This includes all interns and all

second-year residents who have not received their licenses. More details about supervision guidelines are included below:

FIRST YEAR RESIDENTS

- All patients must be verbally presented in detail to the preceptor.
- *All patients seen by PGY1s must be physically seen and evaluated by the preceptor with care documented in the chart.*
- The preceptor must directly supervise all procedures.

SECOND- AND THIRD-YEAR RESIDENTS

- *All patients seen by unlicensed PGY2s must be physically seen and evaluated by the preceptor with care documented in the chart.*
- For licensed PGY2s and PGY3s, all patient care must be reviewed with the preceptor during or immediately after each visit.
- E/M codes 99201, 99202, 99211, 99212, 99203, and 99213 qualify for an exception and need not be seen by the preceptor unless clinically warranted.

The preceptor must see all patients seen by residents on visits with E/M codes 99204, 99214, 99205 and 99215. The preceptor must directly supervise all procedures

SURGICAL ASSISTING POLICY

The ACGME requires programs to provide all residents with training in basic surgical principles and technical skills to assist the surgeon in the operating room. One of the ways the program provides this training is by having residents assist in the surgeries for surgeons who precept at SCHC. These patients may or may not be seen at SCHC for their primary care. The order of priority for determining which resident might provide this service is as follows:

1. Resident who may be providing primary care for that patient
2. Resident on surgical rotation
3. FPS resident if not the only senior covering inpatient services

At times, the program may not be able to identify a resident who is available to assist surgeons operating on

patients not seen at SCHC. A surgical assistant will be located using the following order of priority if necessary:

4. Primary care provider for that patient
5. Resident on surgical rotation
6. FPS resident if not the only senior covering inpatient services
7. Residents on outpatient rotations

The clinic manager or clinic director will make the final determination in cases that are unclear.

VENDOR INTERACTIONS

Shasta Community Health Center has a policy to ensure that GME activities are not compromised through vendor influence. Please see PolicyTech for full policy.

WARFARIN PROTOCOL

All patients having their warfarin anticoagulation therapy managed at SCHC will be enrolled in a management program to assure proper use and monitoring of this medication. For SCHC residents, these patients can be directed to the Coumadin R.N. who will enroll the patient in the SCHC Coumadin tracking program with the assigned RN following patients using specific SCHC approved protocols. Please refer to the Coumadin template in the EHR.

MANAGEMENT OF SIGNIFICANTLY ELEVATED INR WITH OR WITHOUT BLEEDING⁴

INR 5.0 to 8.9, no significant bleeding:	Omit 1 to 2 doses; reduce dose 10 to 20 percent; monitor frequently. Alternately consider vitamin K 2.5 mg orally.
INR ≥ 9.0, no significant bleeding:	Hold warfarin therapy; give vitamin K 5 mg orally; monitor frequently. Resume at lower dose when INR is therapeutic.
Serious bleeding, any INR:	Hold warfarin; refer patient to the Emergency Department

WELLNESS - RESIDENT

Resident well-being and fatigue management are important skills to learn. There are several opportunities for SCHC residents to practice work-life balance skills. There are wellness hikes, kayak tours, river rafting and various dinner events to promote outside of work activities. SCHC has a wellness counsel that schedules events for employees and there are various online tools that are given to residents. Residents receive yearly didactics on fatigue management, communicating with compassion, burn-out and stress management. SCHC offers EAP (Employee Assistance Program) to all employees if the need arises, and we have Dan Rubanowitz as part of our Behavioral Health faculty to assist residents who are struggling. Interns undergo a mind-body curriculum during their intern conference and participate in regular check-ins.

RESIDENT WELLNESS POST CALL

To promote resident wellness for residents who are too tired to drive home post-call, the residency program has set up the following policy:

- During the week, residents can call or text the residency office at 530-248-3711 to arrange for a ride home.
- During the weekend and after hours, the jeopardy resident can be contacted for a ride home if needed. If the jeopardy resident is unavailable, a resident may call for a taxi and will be reimbursed by the residency office.

MEDICAL STUDENTS

Policy and Procedures for medical students rotating at Mercy Medical Center Redding are coordinated through the Mercy residency office. Mercy only takes senior students, or third year students who have completed all core rotations, from LCME or AOA approved schools. Clerkships are not offered in July. We typically offer 2- and 4-week rotations. SCHC residency program will accept 3rd and 4th year medical students on a case-by-case basis through either the Residency Program Director and/or through the CMO's office for consideration. If the medical student wishes to spend time at Mercy Hospital, they may be required to complete a hospital orientation and should be teamed up with an SCHC Faculty member during their time at Mercy. SCHC participates in the Rural PRIME program through UC Davis. Students will rotate through the Residency Department for 6 weeks and the Pediatric Department for 3-4 weeks periodically throughout the year. Students should always be introduced to the patient by the resident or attending, acknowledging that he/she is a medical student on a clerkship with us, and requesting the patient's consent to have the student participate in his/her care. SCHC students will be acknowledged on the EMR documentation through the alert section.

History and exam findings must always be discussed with, and verified by, the resident and attending. Student chart entries, other than Social History and Review of Systems, are not acceptable documentation in California and require documentation from the resident and attending that reflects the resident's or attending's own personal findings. Scribes may be used to document if they are working directly with the attending. Students may not dictate their chart entries.

TIPS FOR TEACHING MEDICAL STUDENTS

The resident / preceptor should offer guidance prior to the patient encounter by reviewing the problem and drug list in the chart and making any comments about the patient and the focus of this visit.

The student will observe your patient encounters. When considered ready, the student will take the lead role of gathering the data. The student should be observed and guided at all times. Once the preceptor is comfortable with the student's ability, they may then have the student see selected patients before his/her personal evaluation. Introduce the student to the patient and tell the patient you will return.

Students should type on the EMR the encounter using the SOAP format and the preceptor will review and critique the student's note. The preceptor must chart a complete note on the same page as the student and/or dictate on the patient. Feedback should be given to the student on each case and suggestions for improvement made. By the end of the rotation, the preceptors will evaluate and grade the student, using the copy of the school's evaluation form. This should be discussed with the student for their benefit or done after the rotation.

Student rotations for 3rd year students are January – April. Rotations for 4th Year students are August – December. No rotations are offered in June and July at SCHC. There is typically a waiting list, so early contact with the Program Director is essential. Most successful students contact our program by April or May of their 3rd year.

An affiliation agreement with the student's medical school is required before the approval process can begin.

Upon confirmation of the agreement, students will need to submit:

- Dean's letter of good standing
- Medical school transcript (unofficial)
- Board Scores – COMPLEX or USMLE (unofficial transcript)
- Personal statement about their goals and interests in medicine and describe why they would like to specifically rotate at SCHC

EVALUATION OF MEDICAL STUDENTS

Immediate feedback (Formative Evaluation) to the student from the supervising resident or attending is always encouraged as part of the learning process. In addition, the evaluation form provided by the medical school will guide the official feedback process (Summative Evaluation). Dr. Namihias will be responsible for completing Mercy evaluations. Dr. Lupeika and Dr. McMullin will complete SCHC evaluations.

SUPERVISION OF MEDICAL STUDENTS

Student supervision is defined in Mercy Medical Center Administrative Policy VIII.D.0:

Patient care provided by medical students, and FNP/PA students shall be under the supervision of clinical teaching faculty. Such care shall be in accordance with the provisions of the Shasta Community Health Center Program approved by and in conformity with the Accreditation Council of Graduate Medical Education.

All students writing in the medical records will indicate their student status (e.g. MS IV, PA-S, and FNP-S). Student notes do not suffice for adequate clinical documentation. Student notes must be reviewed, corrected and countersigned by the attending or resident physician providing supervision. The only documentation by medical students that may be used by the teaching physician is their documentation of the review of systems (ROS) and past family social history (PFSH). The teaching physician may NOT refer to a medical student's documentation of physical exam findings or medical decision-making in his/her personal note. The teaching physician must verify and re-document the history of present illness (HPI) as well as perform and re- document the physical exam and medical decision-making activities of the visit service. This rule also applies to the documentation by other kinds of students, e.g., physician assistants and nurse practitioners. The attending or senior resident physician must countersign all orders written by medical students before being accepted by the nursing staff. Students may not perform any examinations, diagnostic tests, procedures (including surgical assisting), or therapy on any patients without the approval of the attending physician. An attending physician must directly supervise all procedures.

Students participating in clerkships with the Shasta Community Health Center Practice Residency Program shall be currently enrolled in a school approved by the Liaison Committee on Medical Education, the American Osteopathic Association, or the Commission on Accreditation of Allied Health Education Programs. Medical Students enrolled in schools other than U.C. Davis shall provide certification of malpractice and liability coverage from their sponsoring institution prior to clerkship participation, as well as written approval from the Medical School Dean's Office. The School must provide any evaluation requirements.

Student rotations sponsored by the Residency Program will be coordinated and managed by the Residency Office. All involved attending physicians and nursing units will be notified of students and their dates of rotation at Mercy Medical Center Redding prior to their arrival if such medical students wish to spend time at Mercy hospital during their clerkship or rotation at SCHC. Dr. McMullin and Dr. Lupeika coordinate the student rotations.

MEDICAL STUDENTS APPLYING TO RESIDENCY–CRITERIA

The following information is provided to medical students applying to our residency program and includes criteria for interviewing.

Thank you for your interest in the Shasta Community Health Center Family Medicine Residency Program. Detailed information can be found at: <http://www.shastahealth.org>

SCHC is a member of the University of California, Davis Network of Affiliated Family Medicine Residency Programs. The primary objective of the Family Medicine Residency Network is to provide a rich graduate experience in family medicine which implements the principles of the American Academy of Family Physicians, the Accreditation Council on Graduate Medical Education, and the American Board of Family Medicine.

It is our goal to train high-quality family physicians to meet the health care needs of California, to practice with medically underserved populations, and to be leaders in our medical communities. The UCD Family Medicine Residency Network includes several separate programs: Adventist Health (Ukiah), Mercy Family Health Center (Redding), Mercy Medical Center Merced, San Joaquin General Hospital (Stockton); Shasta Community Health Center (Redding); University of California, Davis Medical Center (Sacramento); and Valley Consortium for Medical Education (Modesto). The affiliated program at Travis Air Force Base does not participate in the NRMP.

Intern Positions: In order to ensure the best interview date, please submit all application materials no later than December. After this date, applications will be individually reviewed for consideration. You need to submit an [ERAS application](#) to each program you are interested in. We only accept applications through ERAS. Interviews are offered directly from the program. All applications are screened, and interviews offered by merit. No other application will be accepted for intern positions. For more information on obtaining an application, please contact your Dean's office. International medical students should contact the ECFMG.

International Medical Graduates

The following items are needed by all International Medical Graduate applicants:

8. A current (within one year) Post Graduate Training Authorization Letter from the Medical Board of California
9. A current ECFMG certificate.

Please note: If you have more than 36 months of post graduate training in the USA, you must have a California Medical License to start a residency in California. (24 months for US Medical Graduates)

Applicants must provide a receipt of application from the medical board before we will consider interviews and

applicants must have the Post Graduate Training Authorization Letter by January 31st to be considered for the match. Keep in mind that it can take up to or greater than 90 days to obtain the Post Training Authorization Letter from the California Medical Board. For further information, please contact the Medical Board of California (916) 263-2499 or visit their website <http://www.medbd.ca.gov/>

Frequently asked questions:

2. What are your minimum score requirements?

There are no minimum score requirements. Each application is reviewed in full. Applicants with more than one examination failure on the USMLE or COMLEX are excluded from the applicant pool.

3. Do you accept IMGs in your program?

Yes.

4. Are there IMG's working the SCHC Residency Program?

Yes.

5. Are there IMGs working in the Mercy Redding Family Practice Residency program?

Yes.

6. Is preference given to Green Card holders?

No preference is given to anyone for any reason. All applications are screened based on merit.

7. Is US experience mandatory for the program?

Yes, US experience including hands-on patient care, writing notes, developing treatment plans, and writing orders is required in hospital based and outpatient settings. Observation alone does not meet these criteria. Experience in family practice or another primary care field is encouraged. Applicants must have recent letter of reference from a physician supervisor in the U.S. documenting clinical performance and level of care. These references should include documentation of experience in hands-on patient care and responsibility for writing notes, developing treatment plans, and writing orders. Applications without clear documentation of this experience will not be accepted.

8. Does the program sponsor Visas?

No.

9. Does your program accept DOs?

Yes, our program accepts osteopathic physicians. In addition, we have core and community osteopathic faculty members.

10. Are both the USMLE and COMLEX needed for DO students?

No. One or the other is acceptable.

11. Where can I get a listing of where your residents attended medical school?

Please take a look at the Shasta Community Health Center Residency Program's website (<http://www.shastahealth.org/schc-family-medicine-residency-center>) for information pertaining to the current residents. SCHC has been a training track in the past, affiliated with the Mercy Family Health Center FMRP and we have graduates of this track who still work at SCHC.

12. When does your program conduct interviews?

The interview season runs from October through January. Please take a look at our website for the most current information. We will coordinate our interview dates with the Mercy Family Health Center FMRP which schedules their interviews through the UCD network in Sacramento.

13. How many years after graduation from medical school do you still consider applicants for an interview?

For the incoming class, applicants must have graduated from medical school within the last two years. For applicants who have not graduated in the past year, significant clinical experience since graduation must be documented along with written letters of reference. Applicants must have recent (the past year) US clinical experience to be considered for an interview.

14. Does your program offer observerships?

No. All students who participate in rotations at our institution must be currently enrolled in a LCME or AOA accredited school.

Approved:

Debra Lupeika, MD, FAAP; Program Director

Date

Amanda Mooneyham, MD, MPH; Associate Program Director

Date

Maria Nicora, MD; Medical Director

Date

Residency Leave Policy

The following policy is established to meet the guidelines and requirements for vacation and leave of absence from the ACGME, ABFM, Medical Board of California, the Osteopathic Medical Board of California, Sponsoring Institutional policies, and applicable laws.

Each resident is allowed six weeks of 100% paid leave of absence during their three-year residency that must meet the qualifying reasons for medical, parental and/or caregiver leave(s) set forth by the institution. Eligibility for this leave begins on the hire start date. Leaves do not have to be continuous - intermittent leave is eligible. A minimum of one week vacation (paid time off) must be reserved for the resident's use outside the first six weeks of leave of absence.

In addition to the paid leave of absence, residents are allotted 200 hours of paid time off per PGY level. 160 of these hours are used for scheduled vacation. 40 of these hours are reserved for sick days. Sick days must be approved and qualify under institutional rules and may require a physician note.

The maximum allotted time away (without continuity clinic defined as leave, vacation, away elective) per year without the need for extension is 12-weeks per 12-month PGY period, or 20-weeks per 36-month residency period. If a resident exceeds limits, they will be required to extend residency.

The determination if a resident will need to extend after a leave is taken will be decided by the Promotion Committee with input from the Program Director and Clinical Competency Committee. If approved, equivalent Elective time or Away Elective time may be replaced with leave. The resident must meet all ACGME requirements and program requirements in order to graduate and this may require program extension. Requirements include 40 weeks of continuity clinic time in each academic year. For residents graduating in 2023, 1650 in-person continuity clinic visits are necessary to meet ABFM certification and graduation requirements; after 2023, residents are required to complete a minimum of 1,000 hours dedicated to caring for continuity patients.

Residents who require a Leave of Absence need to notify the Program Director and Residency Manager as soon as possible and meet with them to determine if the Leave will require an extension of the program.

Residents may take the PNE (Parental Newborn Elective) rotation in addition to the six-week leave time, but this must be approved by the Program Director. The PNE may be taken as an Away Elective (PNEA) or Elective (PNEH). If taken as an Away Elective the resident must still have 40 weeks of continuity clinic per year without the requirement for extension. The combination of PNE and leave time must not exceed 8 weeks. Beginning in 2023, the PNE may be taken for a maximum of two weeks following the rotation requirements including goals and objectives.

LOA - EXTENSION CHECKLIST

To use LOA rather than extend residency, the resident must meet the requirements for ACGME (Accreditation Standards), ABFM (Board Certification), State of California (Licensure), and Program Core Requirements.

If all LOA criteria is met, with promotions committee and program director approval resident may use leave as LOA rather than extend their residency.

RESIDENT LOA / EXTENSION CRITERIA	MEETS CRITERIA	COMMENTS: FORM COMPLETION DATE: _____
Less than 12 Weeks away during current year	<input type="checkbox"/>	
Less than 20 Weeks away during 3-year residency program	<input type="checkbox"/>	
40 Weeks Continuity Clinic per year completed	<input type="checkbox"/>	
Pt visits 1650 Number or 1000 Number of hours in Clinic	<input type="checkbox"/>	
Program requirement Rotations completed	<input type="checkbox"/>	
Amount of Away Elective used to date in residency	_____	
Amount of Elect used to date in residency	_____	
Amount of Flex Time used to date in residency	_____	
Promotions Board Reviewed/Approved Resident training is at appropriate level for PGY year		
Program Director Reviewed/Approved Resident training is at appropriate level for PGY year		

Master Schedule Change Request

Shasta Community Health Center
Redding Family Practice Residency

Changes to the Master Schedule will only be made for special circumstances.

NAME: _____

Changes requested - Rot # ____

Dates: _____

Currently Scheduled: _____

Change to: _____

Changes requested – Rot # ____

Dates: _____

Currently Scheduled: _____

Change to: _____

Justification: _____

Resident Signature: _____

Date: _____

Received: _____
Date

Approvals:

Amy Fahnestock, Residency Coordinator

(Signature) (Date)

Randi Holscher, SCHC Clinic Mgr

(Signature) (Date)

Chief Resident

(Signature) (Date)

Debra Lupeika, Program Director

(Signature) (Date)

Notifications to Resident, Chief Resident, Health Center: _____
Date

Call Schedule Request Form

Name: _____ Date Submitted: _____

Master Schedule Rotation: _____

ADVANCE NOTICE TIME OFF *

Dates Unavailable	Reason

SCHEDULE CALL CHANGE

Call Date	Holiday	Jeopardy	Weekends	Weekdays	Resident Substituting	Date Switched

- Note: Pre-Requested Time Off may count as Time Away per ACGME rules. (i.e. Saturday's may count depending on the situation.) Please clarify with your chiefs, residency office, or PD.

Reviewed by: _____

Date: _____

Approved by: _____

Date: _____

Copies to: _____

Date: _____

REQUEST FOR TIME OFF

Name: _____ Date Submitted: _____

Date Requested: _____ Assigned Service: _____

Is This Date Adjacent to Vacation Day or Holiday? (**Not allowed for scheduled personal PTO**) Yes ___ No ___

Academic Year _____

Previous Personal or Sick Days Taken This Academic Year: _____

Vacation Days Used: _____

REASON:

PTO LOA Sick Jury Duty Bereavement Job Interview Other*

FURTHER EXPLANATION*

Is call coverage needed? YES NO If yes, who will be covering? _____

How will this affect your clinic schedule?

- No clinic scheduled
- Clinic cancelled with approval from Clinic Manager
- Clinic covered by? _____

Coordinator Signature:

Date:

Clinic Manager Signature:

Date:

Chief Resident Signature:

Date:

Program Director Signature:

Date:

SCHC POLICY:

- Residents at SCHC are entitled to 200 hours of paid time off each academic year (per contract).
- Scheduled vacation = 160 hours (4 seven-day blocks).
- 5 additional personal/sick PTO days are available only for emergencies. If these additional days are used, residency must be extended (see ACGME policy below).

ACGME POLICY:

- Maximum time away is 12 weeks including sick, vacation, leave
- Days away from the program in excess of 12 weeks will require an extension in training.
- Residents must have at least 40 weeks per academic year in continuity clinic. If less than 40 weeks then extension is required

Elective time off should be requested three months in advance

Unused sick over 40 hours can be "cashed out" each December

ABFM Board exams or Step 3 days do not count against time away paid