Rio Bravo
Family Medicine Residency Program

POLICY AND PROCEDURES MANUAL

CLINICA SIERRA VISTA

CONTENTS

I. POLICY AND PROCEDURE MANUAL DESCRIPTION

A. Purpose - The purpose of this manual is to set forth the policies and procedures of the Rio Bravo Family Medicine Residency Program (RBFMRP). It is intended that this document be a "living" manual that is regularly updated and actively used as an organizing tool for change and development for RBFMRP.

B. Submission - This Policy and Procedure Manual will be submitted to the CEO of Clinica Sierra Vista on an annual basis or when revised. The GMEC has ultimate responsibility for approval of this Policy and Procedure Manual.

C. Revisions - This Policy and Procedure Manual allows revisions as frequently as needed. RBFMRP reserves the right to revoke, change, or supplement guidelines at any time without notice. Revisions must be approved by the GMEC or designee. Since the information presented in this policy/procedure manual is necessarily subject to changes, it is understood that changes in policy may supersede, revise, or eliminate one or more of the policies/procedures in this manual. These changes will be communicated to faculty, staff, residents and fellows by the Residency Director or designee through official notice or memorandum.

D. Policy Review - This Policy and Procedure Manual will be updated on a regular basis by the Program Director or designee. The revised Policy and Procedure Manual will be distributed for comment and review prior to final approval.

E. Location of Copies - Copies of this Policy and Procedure Manual will be located in the RBFMRP office, and the office of the Executive Director.

F. Relationship of this Manual to Other Policy and Procedure Manuals - This manual is the document of first reference for activities of RBFMRP faculty and residents. RBFMRP educational and clinical responsibilities include activities in other departments and institutions. When involved in extra-departmental activities, the Policy and Procedure Manual of the involved department or institution will be the document of first reference. Areas of conflict involving the RBFMRP and other departments' policy manuals will be promptly addressed. This Policy and Procedure Manual will not be construed to supersede any policies established by Clinica Sierra Vista in the "Employee Handbook," the Residency Employment Contract, or any policies established by health care organizations within which RBFMRP residents and faculty function. This manual does supersede the RBFMRP Residents' Handbook.

II. MISSION

A. Mission - The mission of the Rio Bravo Family Medicine Residency Program (RBFMRP) is to educate and train high quality, culturally competent family medicine residents in rural and underserved community settings with an emphasis on the value of primary and preventative health care. The RBFMRP supports family medicine-centered education, service, and research in the Central San Joaquin Valley. The RBFMRP complies with Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements and the Special Requirements for Residency Training in Family Medicine.

The mission of the RBFMRP encompasses maintaining a high quality residency program, facilitating the development and sustenance of a regional service-education network for family physicians and allied health professionals. The mission focuses on providing a family medicine perspective (both educational and political), developing and supporting continuing medical education activities for practicing physicians and allied health professionals, and serving in a general capacity to facilitate, research, and organize innovative approaches to health care in family and community medicine, with a particular focus on community healthcare.

The goal of the RBFMRP is to train residents to be excellent providers of family and community medicine at the completion of their training. Residents are trained to provide high quality, comprehensive, cost-effective primary care services to individuals of all ages in both ambulatory and inpatient settings in general, and in multicultural, rural and underserved settings in particular. The RBFMRP recognizes the large number of underserved patients in the Central San Joaquin Valley. This awareness pervades the focus of the Program and is manifested in activities related to the health care needs of residents of rural and inner city portions of the Valley.

An important goal of the RBFMRP is to facilitate the selection of practice sites in the Kern County by graduates of the program. Furthermore, the RBFMRP strives to provide ongoing support to these individuals in practice through continuing medical education efforts, research activities, and program educational activities. The RBFMRP is also committed to the development and implementation of the health team concept in the health care delivery system for this region.

Residents are instructed in the longitudinal care of their patients with an understanding of the impact of psychosocial factors on their health and well-being. Residents are taught the principles of health maintenance, disease prevention, health education, and community-oriented primary care in addition to caring for a broad range of acute and chronic problems encompassing the fields of pediatrics, adult medicine, OB/GYN, and geriatrics. Residents receive training in medical specialties in accordance with guidelines established in the ACGME Special Requirements for Family Medicine. Practice management training including experience in quality improvement processes, incorporating technology, and understanding reimbursement modalities is a priority.

Rio Bravo is highly committed to sustaining learning environments that foster academic excellence, inspire the highest standards of professionalism, and ensure the delivery of safe, high-quality care to patients. To that end RBFMRP adopts the following as commitments of faculty and residents, adapted from the AAMC compact between resident physicians and their teachers.

B. Core Tenets of Residency Education

- **Excellence in Medical Education** - Institutional sponsors of residency programs and program faculty must be committed to maintaining high standards of educational quality. Resident physicians are first and foremost learners. Accordingly, a resident's educational needs should be the primary determinant of any assigned patient care services. Residents must, however, remain mindful of their oath as physicians and recognize that their responsibilities to their patients always take priority over purely educational considerations.
- **Highest Quality Patient Care and Safety** - Preparing future physicians to meet patients' expectations for optimal care requires that they learn in clinical settings epitomizing the highest standards of medical practice. Indeed, the primary obligation of institutions and individuals providing resident education is the provision of high quality, safe patient care. By allowing resident physicians to participate in the

care of their patients, faculty accepts an obligation to ensure high quality medical care in all learning environments.

- **Respect for Residents' Well-Being** - Fundamental to the ethic of medicine is respect for every individual. In keeping with their status as trainees, resident physicians are especially vulnerable and their well-being must be accorded the highest priority. Given the uncommon stresses inherent in fulfilling the demands of their training program, residents must be allowed sufficient opportunities to meet their personal and family obligations, to pursue recreational activities, and to obtain adequate rest.
- **Commitments of Faculty**
  - **i.** As role models for our residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.
  - **ii.** We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers.
  - **iii.** In fulfilling our responsibility to nurture both the intellectual and the personal development of residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.
  - **iv.** We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation; and we will cultivate a culture of tolerance among the entire staff.
  - **v.** We will do our utmost to ensure that resident physicians have opportunities to participate in patient care activities of sufficient variety and frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.
  - **vi.** We will provide resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare residents to function effectively as members of healthcare teams.
  - **vii.** In fulfilling the essential responsibility we have to our patients, we will ensure that residents receive appropriate supervision for all of the care they provide during their training.
  - **viii.** We will evaluate each resident's performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.
  - **ix.** We will ensure that resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.
  - **x.** We will nurture and support residents in their role as teachers of other residents and of medical students.

- **Commitments of Residents**
  - **i.** We acknowledge our fundamental obligation as physicians—to place our patients' welfare uppermost; quality health care and patient safety will always be our prime objectives.
  - **ii.** We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors required to fulfill all the objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.
  - **iii.** We embrace the professional values of honesty, compassion, integrity, and dependability.
  - **iv.** We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability or sexual orientation.
  - **v.** As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.
  - **vi.** We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.
  - **vii.** We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.
  - **viii.** We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.
  - **ix.** We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.
  - **x.** In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

III. RELATIONSHIPS

Through its community affiliations, Clinica Sierra Vista interfaces with medical safety net institutions throughout Kern County. For RBFMRP, Clinica Sierra Vista has formal relationships with Kern Medical and other training sites. These activities are governed by educational policies established by RBFMRP's Graduate Medical Education Committee (GMEC), this RBFMRP Policy and Procedure Manual, the by-laws of the medical staff of the participating institutions, and the procedure manuals of the other health care institutions with RBFMRP affiliation agreements.

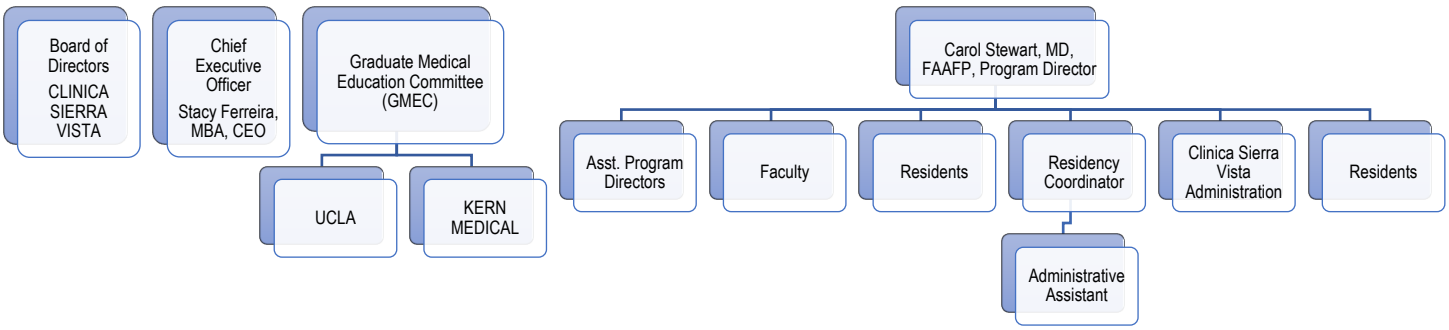
A. Clinica Sierra Vista - Clinica Sierra Vista is a Section 330 Federally Qualified Health Center. It is the Institutional Sponsor of the Rio Bravo Family Medicine Residency Program with primary responsibility for compliance with the ACGME's Institutional Requirements and Program Requirements and, in collaboration with CSV, for the organization, coordination and administration of the Residency Program. The Clinica Sierra Vista Board has created a Graduate Medical Education Committee (GMEC) to perform all functions required by the Accreditation

Council for Graduate Medical Education (ACGME). The GMEC oversees the Rio Bravo Family Medicine Residency Program and ensures its fiscal and educational integrity.

B. Location of Offices - Clinica Sierra Vista offices are located in Bakersfield, California, near the campus of Kern Medical.

C. Affiliation Agreements and Letters of Agreement - In accordance with ACGME guidelines and Clinica Sierra Vista Policy, institutional agreements exist with all major participating institutions which state that the sponsoring institution has responsibility for the quality of the educational experience and retains authority over resident activities. In addition, at the residency training level, Letters of Agreement are developed by the Residency Director for resident training activities outside the major participating institution.

IV. ORGANIZATIONAL STRUCTURE



A. Executive Director - The responsibility and authority for strategic planning, personnel, management, budget, and overall direction for the RBFMRP rests with the Executive Director of Clinica Sierra Vista, the sponsoring institution. The Executive Director in partnership with the Program Director is ultimately responsible for ensuring that RBFMRP training and clinical activities are in compliance applicable guidelines, practices, and accreditation standards.

B. CEO - The CEO of Clinica Sierra Vista, in consultation with the Program Director is ultimately responsible for hiring, reviewing all faculty, and for carrying out corrective actions, if necessary.

C. Program Director - The implementation of strategic planning, personnel, management, and direction for the residency and fellowship programs rests with the Program Director acting after consultation with and in coordination with the GMEC. The Program Director is selected by the GMEC. The Program Director reports to, the CEO of Clinica Sierra Vista and to the GMEC. The Program Director is expected to be the principal liaison to Kern Medical and other key partners.

D. Graduate Medical Education Committee - The Graduate Medical Education Committee (GMEC) is the principal deliberative decision making body of RBFMRP. The GMEC consists of

Voting Members:

CEO Clinica Sierra Vista Designated Institutional Officer (“DIO”)
Program Director
Kern Medical Representative
Program Family Medicine Faculty representative from the Family Medicine Center

A Resident appointed by his/her peers

Appointee from UCLA Department of Family Medicine

Non-Voting Members: TBD

GMEC attempts to resolve issues at its meetings through the consensus process. All GMEC members are offered an opportunity to express opinions and contribute to the discussion. It is the prerogative of the Executive Director and/or Program Directors or designee to decide issues that cannot be resolved through the consensus process.

It is the responsibility of the Executive Director and/or Program Directors or designee to ensure those accurate and complete meeting minutes of GMEC meetings are completed and disseminated. Minutes of each GMEC meeting will be amended and/or approved at the subsequent GMEC meeting.

It is the responsibility of the Executive Director and/or Program Director or designee to bring all pertinent documents to GMEC meetings.

The GMEC meetings will also be used for approval of major changes to the curriculum. It is the responsibility of the Chairperson of the curricular area in conjunction with the Residency Coordinator to prepare these presentations for the Executive Committee. It is the role of the GMEC to accept or reject the recommendations of the Curriculum Committee and make further recommendations of their own, subject to approval by the Program Director or designee.

The progress of all residents is monitored throughout their training. The residency and fellowship programs rely on the Resident Evaluation Committee (REC) and its system of mentors to oversee resident progress. The REC reports to the GMEC on resident progress regularly. All GMEC actions are reviewed at regular CLINICA SIERRA VISTA Board meetings.

E. Assistant Program Directors - RBFMRP maintains the position of Assistant Program Director. The Assistant Program Director positions may be left vacant if agreed to by the Program Director in consultation with the CEO of CSV. The Assistant Program Directors are appointed by the Program Director. The Assistant Program Directors assist the Program Director in carrying out the duties of the Program Director, and assume the role of Program Director when the Program Director is unavailable.

F. Assistant Director of Medical Education - RBFMRP maintains the position of the Assistant Director of Medical Education. This position provides ancillary services to the program as a whole, and runs parallel to the functions of the Assistant Program Directors in a non-clinical capacity.

G. Residency Coordinator & Administrative Assistant - RBFMRP will include a Residency Coordinator to assist in the business and administrative functions of the department. The Coordinator is appointed by the Program Director with input from CSV. The Coordinator will be assisted in carrying out administrative functions by administrative support staff reporting to the Coordinator.

H. Clinic Staff Meeting - The COO or their designee will be chairperson of the Clinic Staff Meeting. The Clinic Staff Meeting consists of representatives from administration, nursing, front office, faculty and residents at the involved

site. Clinic Staff Meetings are held regularly each month. Minutes and follow through on agenda items are the responsibility of the COO.

I. **Faculty Meetings** - Faculty meetings are held on a quarterly basis unless otherwise determined by the Program Director. All faculty members including volunteer faculty and faculty affiliated through the RBFMRP are invited and encouraged to attend faculty meetings. All faculty members who are one quarter time or more with the RBFMRP are expected to attend faculty meetings except during approved educational time away, vacation time, or other outside responsibilities. In addition, the chief resident(s) are expected to attend all faculty meetings unless they are excused for patient care responsibilities, educational time off, vacation, or other approved outside responsibilities.

Faculty meetings are used to review GMEC action and receive input on significant issues facing the RBFMRP and are conducted by the Program Director, or designee. The agenda for the meetings is sent to all faculty and residents. Any faculty member or chief resident may add items to the agenda. Announcements of importance to the faculty as a whole are a regular component of faculty meetings.

V. FACULTY

A. **General Policy** - Staffing levels in CSV and the RBFMRP will be determined by the CEO of CSV in consultation with the Program Director, taking into consideration RRC requirements, the educational needs of the RBFMRP, availability of clinical practice opportunities, and financial support. Decisions on individual RBFMRP faculty hires for RBFMRP positions will be made by the CEO and the Program Director with input from existing faculty.

Family Medicine Faculty will participate in the education of family medicine residents and medical students rotating through the RBFMRP.

B. **University Faculty Appointments** - To be eligible for a university volunteer clinical faculty appointment, teachers will be eligible after at least 50 hours per year towards education and training. CSV utilizes a number of community-based settings for its education. As a result, some individuals contributing to the education and training of Family Medicine residents and medical students provide less than 50 hours of training per year. At other times, residents with specific interests seek out educational opportunities from new sources that may be eligible for a faculty appointment (providing education or training 50 or more hours per year) but do not complete the necessary paper work.

Individuals who are not eligible for faculty appointments (involved in education or training less than 50 hours per year) or who for whatever reason do not follow through on the necessary paper work may still be involved in the education and training of RBFMRP residents if the educational activity is approved by the RBFMRP.

All volunteer clinical faculty have a commitment to teach a minimum of 50-75 hours a year. Teaching can be conducted at any of the hospitals or clinics affiliated with the RBFMRP, or in one's office.

C. **Qualifications** - Faculty Physicians within the RBFMRP must be board certified or board eligible in their area of specialty. They must hold for themselves high moral and ethical standards, have competence in teaching, and hold personal goals which are compatible with the service, education, or research activities of the RBFMRP.

D. Faculty Responsibilities

- ***General***: All RBFMRP faculty have responsibilities in the following areas. The relative amount of time spent in each of these activities will be determined by the CEO and the Program Director.
  - **i.** Supervising residents in continuity clinics.
  - **ii.** Coordinating rotations and development and review of curricula for each recognized RBFMRP rotation.
  - **iii.** Acting as advisor for residents in accordance with RBFMRP policies (see Faculty Advisor Job Description, Chapter X Attachments).
  - **iv.** Involvement in faculty development.
  - **v.** Participating in research and scholarly activities either individually or in conjunction with other faculty and residents.
  - **vi.** Direct patient care services, including supervision of residents in the inpatient and outpatient arena, and participation in faculty practice.
  - **vii.** Attendance and participation in regularly scheduled faculty meetings, and equitable participation in ad hoc committees established by CSV or the RBFMRP.
  - **viii.** Recruitment of faculty and residents.
  - **ix.** Administrative duties associated with CSV.
  - **x.** Educational presentations to residents and medical students.
  - **xi.** Supervising educational presentations of residents and medical students.
- ***Areas of Responsibility***: In addition to the generic responsibilities noted above, specific faculty may be assigned to the following areas of responsibility as may be deemed necessary by the Program Director:
  - **i. Remediation Coordinator Responsibilities**:
    - **a.** Review and approve appropriate education materials for use by residents on remediation.
    - **b.** Develop standardized educational program including expectations for monthly assignments to include learning assignments and completion of sample board questions for residents on remediation.
    - **c.** Be available as contact person for questions regarding academic remediation from both residents and faculty.
    - **d.** Develop and oversee monitoring system utilizing advisors as the first contact person for their advisees on remediation, to ensure that all residents on remediation are complying with their remediation program.
    - **e.** Responsible to the Program Director.
  - **ii. Lecture Coordinator Responsibilities:**
    - **a.** Design series of presentations for family medicine residents during the noon hour (Monday-Friday), and educational half-day sessions.
    - **b.** Ensure a balanced series of presentations incorporating Family Medicine topics including practice management, procedural skills, and topics important to family medicine are presented to the residents on a rotating two year basis.
    - **c.** Balance curricular areas including Medicine, Pediatrics, Surgery, Obstetrics, Emergency Medicine, Orthopedics, Behavioral Science, Public Health, and Case Based Learning conferences. Assess proposals for modifications in noon lecture and

educational half-day series and make recommendations to the faculty as a whole regarding proposed modifications.

d. Ensure a monthly calendar of planned presentations is available at least two weeks prior to the upcoming month including the title of the presentation, and the presenter.

e. Work with curricular chairpersons to ensure selected topics in each curricular area cover key topics in the curricular areas.

f. Ensure a faculty member is assigned to each presentation. The assigned faculty person shall be present at the assigned presentation or arrange for another faculty member to be present. The assigned faculty member will be responsible for conducting the presentation or introducing the presenter, and arranging for sign-up at the session, and to make alternative arrangements if the scheduled presenter is not available.

g. Responsible to the Program Director.

iii. Geriatrics Coordinator Responsibilities:

a. Coordinate the geriatrics curriculum.

b. Oversee nursing home visit activity by residents consistent with Residency Review Committee for Family Medicine guidelines.

c. Responsible to Program Director.

iv. Research Director Responsibilities:

a. Improve research capacity within RBFMRP for both residents and faculty.

b. Develop and maintain collaborative linkages with at least one primary care research network.

c. Develop research resources through Kern Medical.

d. Be available to residents and faculty as the first point of contact regarding research questions.

e. Coordinate primary care research seminars for residents and faculty.

f. Role model primary care research techniques for residents and faculty.

g. Assist residents and faculty on primary care research arising from community projects.

h. Responsible to Program Director.

v. Performance Improvement/Utilization Review Coordinator Responsibilities:

a. Work with hospital and ambulatory care facilities to ensure mechanisms are in place to assess the quality of resident and faculty care.

b. Develop a mechanism for review of cases with identified quality of care or utilization issues.

c. Ensure required physician reviews are conducted in a timely fashion.

d. Ensure feedback is received by involved residents or faculty in cases with identified quality of care or utilization concerns.

e. Coordinate morbidity and mortality conference for the purpose of reviewing unusual or unexpected clinical events and improving quality of care by all members of the RBFMRP.

f. Responsible to Program Director.

vi. Continuing Medical Education Coordinator Responsibilities:

a. Work with UCLA and Kern Medical to maintain accredited status for family medicine lectures including Journal Club, faculty development, and morbidity and mortality.

b. Ensure necessary paperwork identifying the objectives of each presentation, and ensuring that an annual report is completed in proper fashion.

c. Ensure that the RBFMRP is represented on hospital continuing medical education committees.

d. Provide input to Kern Medical on Kern Medical sponsored conferences with a family medicine or primary care focus.

e. Responsible to Program Director.

vii. Faculty Development Coordinator Responsibilities:

a. Identify areas that need faculty development based upon input from faculty members.

b. Arrange monthly series of faculty development activities.

c. Work with CME Coordinator to ensure appropriate paperwork to maintain CME accreditation for the faculty development workshop is preserved.

d. Be the RBFMRP liaison to ongoing faculty development activities at UCLA Department of Family and Community Medicine.

e. Responsible to Program Director.

viii. Medical Student Coordinator:

a. Serve as liaison between RBFMRP and UCLA School of Medicine to facilitate working on medical student issues.

b. Represent RBFMRP on UCLA Undergraduate Medical Education Committee (UMEC).

c. Responsible for arranging and delivery of required didactics for Medical Student lecture series.

d. Work with Curriculum Coordinator to ensure coordination of student rotations and clinical experience provided for medical students.

e. Responsible to Program Director.

ix. Clinical Practice Coordinator:

a. Become familiar with practice parameters at faculty clinical sites.

b. Understand regulations and procedures established by insurance companies contracted to provide reimbursement for clinical services by faculty.

c. Explore and investigate potential sources of faculty practice opportunities. Participate in new business analysis and implementation.

d. Direct and oversee the coordination of clinical care and serve as a clinical liaison to off-site providers.

e. Promote clinical integrity and consistency between the clinical team care and on-site and off-site coordinated specialty care.

f. Identify clinical needs, and insure strong communication supporting consistency, continuity, and access to care.

g. Provide input to Clinical and Education Directors for on-site staffing, including hiring, training and development, terminations, performance appraisals, supervision, monitoring of performance, discipline etc. as may be required.

h. Develop/distribute as may be appropriate clinical criteria, protocols and treatment guidelines, and related standards of practice as needed and appropriate to ensure consistent use of specialty services, consistent care and optimal outcomes;

i. Work with Faculty Development Coordinator to develop relevant education during Faculty Development Meetings on clinical aspects of care.

j. Work with CSV to coordinate compliance with regulatory (hospital, state, federal) guidelines for billing practices and documentation requirements for clinical care

k. Insure staff credentialing maintained.

l. Performs other duties as required.

m. Responsible to Program Director.

- ***Faculty Communication and Meetings*** - To ensure smooth operation and discussion of program issues, faculty is expected to attend meetings held as may be assigned. These meetings serve as a forum for regular communication between faculty at different clinical sites and allow for discussion of programmatic changes. Regular meetings scheduled include quarterly Faculty Meetings.

E. Preceptors - RBFMRP faculty preceptors are assigned to the family health center when residents are seeing continuity patients. If there is only one resident seeing continuity patients, the preceptor may see one-half of their usual patient load. If there is more than one resident seeing continuity patients, the preceptor will be immediately available to precept without other responsibilities. In general, preceptors will be scheduled to provide one preceptor for up to four second or third-year family medicine residents, and one preceptor for every two first-year residents.

The RBFMRP emphasizes with residents the importance of timely arrival at continuity clinics. It is essential that faculty role model this behavior. Persistent tardiness of our part-time and hourly faculty may result in the RBFMRP no longer using the involved physician as an attending. Preceptors are expected to establish the proper tone for our residents in Family Health Centers.

It is the responsibility of the faculty attending to equitably distribute the patients to be seen, based on factors such as each resident's patient load, clinic staffing and support staff availability. Clinic staff that encounter patient flow problems should bring them directly to the faculty attending for disposition. Residents who have finished seeing their scheduled patients must clear their departure from clinic with the attending before leaving.

Preceptors are expected to actively attend including engaging residents in discussions of patients seen, and monitoring and assisting with patient flow in the clinic. The faculty preceptor is expected to be present for the entire continuity clinic unless alternative coverage arrangements are made. Preceptors are expected to be involved with 100% of patients seen by non-licensed residents, and all patients whose clinic visit warrants a billing code of level 99214 or higher. Additionally, preceptors should attempt to see all patients seen by PG-1's, about half of patients seen by PG-2's, and one-third of patients seen by PG-3's. This involvement will be documented by co-signing the patient's chart.

The RBFMRP promotes the use of community physicians as preceptors. Preceptors are expected to maximize revenue generation while acting as preceptors. Preceptors are expected to sign resident and allied health professional charts for patients seen while they are attending in accordance with guidelines established at the family medicine clinic. All patients seen by medical students and allied health professionals must be seen by a preceptor and appropriate documentation of supervision and care must be included in the patient's chart.

Community physicians who are reimbursed for their precepting time in their offices is required to have a contract with CSV which permits them to bill for clinical services while precepting. Community physicians employed by CSV will be assigned precepting days to accommodate their schedules and meet the needs of the RBFMRP.

F. Faculty Leave and Punctuality - Arrival times for faculty are monitored at the clinic site. The information collected is forwarded to the Program Director for review of faculty punctuality. Faculty who are consistently on time will have this information noted on their reviews. Conversely, a persistent pattern of tardiness will be grounds for corrective action.

The RBFMRP believes that it is important that each faculty member take time off for rest and relaxation. The RBFMRP will make every effort to arrange for time off as requested. However, it is understood that approval of elective time off is subject to the requirements of the RBFMRP in determination of residency staffing needs. Multiple requests for elective time off for the same day/week will be handled on a first come/first served basis.

Time off requests must be submitted at least eight weeks prior to requested time off. Requests for time off received less than eight weeks in advance must be accompanied by documentation of arrangements for coverage of all assigned responsibilities during the requested time off. Arranging this coverage is the responsibility of the faculty member requesting the time off. If a faculty member is assigned to an activity less than eight weeks in advance, the RBFMRP will make appropriate coverage arrangements. Requests for faculty leaves of absences must be accompanied by the appropriate documentation supporting the request for leave as defined in the CSV Employee Handbook.

If faculty is unable to carry out their assignments due to illness, it is the responsibility of the faculty member to notify the CSV office of their inability to carry out their assignment as well as the sites where they are assigned. This notification shall occur on a daily basis and shall include contacting the responsible party if the faculty member is expected to be on call. Notification shall occur at the beginning of the business day or at the time of illness. Illness lasting longer than two days shall be documented by a note from a physician caring for the faculty member indicating the expected duration of the illness.

G. Paid Time Off (Guidelines)

- **Vacation** - All RBFMRP faculty with a benefit eligible FTE allocation receive the equivalent prorated vacation hours based on their FTE according to CSV policy.
- **Sick/Bereavement** - RBFMRP faculty with a benefit eligible FTE allocation receive the equivalent prorated hours based on their FTE based upon CSV policy.
- **Holidays** - RBFMRP faculty have designated holidays off per CSV policy.
- **Continuing Medical Education** - All RBFMRP faculty with a benefit eligible FTE allocation receive the equivalent prorated CME hours based on their FTE per CSV policy.
- **Leaves of Absence** - All leaves of absence require appropriate certification, including request and approval as indicated above, and may also require medical certification. Unplanned or emergency leaves must be requested as soon as possible after knowledge of the need for request. Leaves of absence are considered unpaid time, however faculty may request to supplement pay with accrued benefits as appropriate. All leaves are administered in accordance with CSV policy, State and Federal regulations.
- **Pregnancy Disability Leave** - Faculty who are disabled due to pregnancy, childbirth, or related conditions may request a pregnancy leave of absence per CSV policy. All available accrued sick must be used and vacation time may be used. Pregnancy disability leave may be approved for up to four months with appropriate medical verification.
- **Family and Medical Leave** - Faculty with one or more years of continuous service, who have completed at least 1250 hours of service during the previous 12 month period, may be granted a family/medical leave per CSV policy. Family/medical leave may be granted for up to 12 weeks in a 12

month period. An eligible employee may request a family and medical leave for one or more of the following reasons:

i. for the birth of the employee's child,
ii. for the placement of a child for adoption or foster care with the employee or the registered domestic partner of the employee;
iii. to care for an immediate family member (spouse, child, and parent), registered domestic partner, or child of a registered domestic partner provided the person being cared for is suffering from a serious health condition;
iv. due to a serious health condition that prevents the employee from performing the functions of employee's position;
v. due to a "qualifying exigency" arising out of the fact that the spouse, son, daughter or parent of the employee is on active duty, or has been notified of an impending call to active duty status in support of a contingency operation, as defined by law (the term "qualifying exigency" will be interpreted in accordance with guidelines promulgated by federal regulation) or
vi. due to a serious illness or injury sustained in the line of duty while on active duty by a covered service member that causes an employee who is the spouse, son, daughter, parent or next of kin of the service member the need to provide care.

Faculty must use all accrued vacation as a part of the family/medical leave except one week of vacation that may be retained.

- **Workers Compensation Leave** - Worker's compensation leave is available to faculty who become unable to work due to an industrial injury or illness per CSV policy.
- **Military Leave** - Faculty who are members of any branch of the Armed Forces Reserve Corps of the United States will be granted an unpaid leave of absence, supported by official orders or instructions, per CSV policy.
- **Jury Duty Leave** - Is subject to excusal during duration of residency training program.
- **Personal Leave** - A personal leave of absence is time off in a non-pay status for personal reasons and is subject to the staffing needs of the Program and Program Director and CEO approval, per CSV policy.
- **Other Leave** – Other leave as designated by state or federal laws will be made available.

H. Evaluation - All faculty members working half time or more in contractual arrangements with the RBFMRP will be evaluated by the CEO and Program Director, or designees, with input collected from residents, faculty, clinical staff, and Performance Improvement sources. These evaluations will be conducted on a yearly basis for the purpose of evaluation and feedback.

The evaluation process will include reviews in the following areas:

- Job description
  - Precepting
  - Rounds
  - Lecture/Presentations
  - Procedures
- Clinical ability
  - Out-patient
  - In-patient

    - Procedures
    - On-call
- Interpersonal skills
- Research and scholarly activities
- Departmental curriculum and hospital committees
- Medical society/community activities
- Resident advisor functions
- Income generation

Residents, faculty, and administrative/clinical staff are asked each year to complete a Feedback Survey rating faculty on a scale of 1 to 5 in four key areas: clinical role; teaching role; administrative role and interpersonal skills. Evaluations may be submitted electronically and are submitted anonymously. To ensure anonymity, evaluations are collected and compiled by the RBFMRP Residency Coordinator.

Other areas including academic appointment, CME activities, personal and career satisfaction, C.V., setting of goals and subsequent progress, and potential for sharing information with UCSF for news/academic purposes will also be reviewed.

Upon completion of the evaluation, the Program Director or designee will construct a memo to the file of the faculty member. Faculty will be asked to sign the evaluation acknowledging receipt of the evaluation. The faculty member will have the opportunity to add any of their own pertinent comments to their file regarding the evaluation and feedback received.

I. **Corrective Action** - Corrective action may be initiated when CSV or RBFMRP believes that a faculty member's performance can be addressed through corrective action. Corrective action may include verbal counseling, written warning, probation, or other forms of corrective action deemed appropriate by the CEO in consultation with the Program Director. CSV, at its sole discretion, may warn, reassign, place on probation, suspend, or discharge any faculty member as a part of this corrective action policy. The faculty member will have the opportunity to place a written response to the corrective action in their personnel file.

The following identifies examples of where corrective action may apply. Corrective action is not limited to the examples listed below:

- **Patient Care and/or Medical Knowledge** - Fund of knowledge, performance on individual assignments, clinical judgment in the ambulatory or inpatient setting, knowledge of limitations, doctor-patient relationships, obtaining adequate subjective and objective information to allow for an appropriate assessment and plan for each patient, and performance of thorough history and physical in accordance with medical record standards established at the institution at which they are practicing. Performance of procedures in accordance with accepted standards of care, adequate supervision, and proper documentation.
- **Professionalism and Interpersonal and Communication Skills** - Working relationship with patients, peers, and staff, acceptance of responsibility, compliance with clinic and hospital policy and procedures including medical records completion, attendance at assigned departmental conferences and educational sessions, punctuality, and reliability. Unacceptable behavior such as lying, lack of availability while on call, or abusive behavior towards patients, peers, or staff will not be tolerated. Such actions may be grounds for corrective action. In addition, faculty members may receive corrective action for

evidence of impaired function due to alcohol or substance abuse. The examples listed above are not inclusive.

It is essential that all disciplinary action be adequately and appropriately supported by written documentation to protect both the department and the individual. The CEO or assigned designee will determine the course of action best suited to the circumstances. The steps in corrective action and performance improvement are as follows, although the CEO or assigned designee may skip one or more of these steps under appropriate circumstances. Examples of courses of action which may be implemented as a part of this corrective action policy include the following:

- ***Verbal Counseling*** - As the first step in correcting unacceptable performance or behavior, the CEO or designee should review pertinent job requirements with the faculty member to ensure his/her understanding of them. The CEO or designee should consider the severity of the problem, previous performance appraisals and all of the circumstances surrounding the particular case. The CEO or designee should define the problem in specific terms and work with the faculty member to identify the requirements for performance improvement or change of conduct required to serve as a solution of the problem. The seriousness of the performance or misconduct should be indicated by stating that a written warning, probation, or possible dismissal could result if the problem is not resolved. The faculty member should be asked to review what has been discussed to ensure his or her understanding of the seriousness of the problem and the corrective action necessary. Immediately following the verbal counseling, discussion should be documented, with copies sent to the faculty member involved and the personnel file. The CEO may direct that the verbal counseling discussion documentation be removed from the personnel file after a period of time, under appropriate circumstances.
- ***Written Warning*** - If the unacceptable performance or behavior continues, the next step should be a written warning. Also, the circumstances such as non-compliance with a widely known policy or safety requirement may justify a written warning without first using verbal counseling. The written warning defines the problem and how it may be corrected. The seriousness of the problem is emphasized, and the written warning shall indicate that probation or termination or both, may result if improvement is not observed. Written counseling also becomes part of the academic file, although the CEO may direct that the written warning be removed after a period of time, under appropriate circumstances.
- ***Probation*** - If the problem has not been resolved through verbal or written counseling, and/or the circumstances warrant it, the individual may be placed on probation. Probation is a serious action in which the faculty member is advised that termination will occur if improvement in performance or conduct is not achieved within the probationary period. The CEO will determine terms and the length of probation. A written probationary notice to the faculty member is prepared by the CEO and should include the following information:
    - The specific unsatisfactory situation;
    - A review of oral and written warnings;
    - The length of probation;
    - The specific behavior modification or minimal acceptable level of performance required to remove probationary status;
    - Suggestion for improvement;
    - Required counseling session or sessions during the probationary period;

- A statement that further action, including termination, may result if defined improvement or behavior modification does not resolve during probation.

The CEO or designee should meet personally with the faculty member to discuss the probationary letter and answer any questions. The faculty member will be asked to sign receipt of the letter. If the faculty member refuses to sign receipt of the letter, the CEO or designee may sign attesting that it was delivered to the faculty member, identifying the date of delivery. The faculty member will have the opportunity to place a written response including any comments or concerns regarding the reasons and/or the terms of probation in their personnel file. The probationary letter becomes part of the faculty member's personnel file subject to a later decision by the CEO to remove it, under appropriate circumstances. Failure to comply with the terms of probation will be grounds for termination.

The faculty member will meet with the CEO or designee, to review their performance and their progress in correcting the concerns which led to the probation. Brief written summaries of these meetings should be prepared with copies provided to the involved faculty member. At the completion of the defined probationary period, the CEO and appropriate designees will meet to determine whether the faculty member has achieved the required level of performance and to consider removing him/her from probation, extending the period of probation, or taking further action. The faculty member is to be advised in writing of the decision. Should probation be completed successfully, the faculty member should be commended, though cautioned that any future recurrence may result in further corrective action. Once the decision to place a faculty member on probation has been made by the CEO, the Program Director, DIO and the GMEC will also be informed of the action and the reason for the probation.

- ***Suspension*** - A suspension may be warranted when there is a need to: 1) take immediate action to protect the life or well-being of a patient(s) or 2) reduce a substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient, prospective patient, or 3) prevent or address activity which would adversely influence the welfare of CSV, the RBFMRP and/or its component parts including the affiliated hospitals or their staff. The above shall not be construed to limit the CEO's use of suspension, with or without pay in other circumstances, as deemed appropriate by the CEO. In implementing a suspension, a written counseling report should set forth the circumstances explaining the parameters of the suspension and how the suspension is to be used in the corrective counseling process. The faculty member will be immediately suspended without pay pending the outcome of grievances which may be filed by the involved faculty member. Once the decision to suspend a faculty member has been made by the CEO, the Program Director, DIO and the GMEC will also be informed of the action and the reason for the suspension.
- ***Dismissal*** - Dismissal from CSV is a grave and consequential act which is resorted to after only the utmost consideration by the CEO in conjunction with the Program Director and GMEC. A faculty member may only be dismissed upon the action of the CEO of CSV. Faculty members may only be dismissed for just cause or in accordance with their Employment Contract with CSV. Just cause may include failure to comply with terms of corrective action, illegal actions, activities which pose a danger to patients, peers, or staff, or extraordinary actions of sufficient gravity to warrant dismissal. Once the decision to dismiss a faculty member has been made by the CEO, the faculty member will be informed within 24 hours of the action and the reasons for

the dismissal. The Program Director, DIO, and the GMEC will also be informed of the action and the reason for the dismissal. A faculty member who is dismissed may appeal the action through the CSV grievance process.

J. Continuing Education - Full-time faculty are responsible for ensuring that their continuing medical education objectives are met annually. Each individual faculty member is responsible for reporting continuing medical education hours to appropriate agencies.

It is CSV policy that all faculty engage in periodic educational activities to increase their skills as teachers of family medicine. CSV will, from time to time, conduct special teaching seminars and workshops.

- ***Advanced CME*** - The RBFMRP will cover reasonable costs, associated with attending NRP, PALS, ATLS, ACLS, or ALSO or similar courses for residents and faculty above and beyond the standard resident and faculty CME allocation. Faculty who do not successfully complete the course requirements will be responsible for half of the costs related to attendance. Faculty members are strongly encouraged to keep their ALSO provider status current, if needed, by attending this course.

K. CME Reimbursement for Faculty - CSV will reimburse benefit eligible faculty (those working 21 hours or more) with CSV for legitimate expenses related to continuing medical education costs if it does not exceed the CME allowance as stipulated in the CSV Employment Handbook. Legitimate costs will include, but is not limited to conference expenses (registration, travel, accommodations, and meals), and CME materials (e.g. books, journals, review packets). For conferences, the continuing medical education activity must be in the continental United States, must be relevant to the activities of CSV or the RBFMRP, and must be approved at least 90 days prior to the activity by the Program Director and the CEO or their designee. Faculty members receiving reimbursement for continuing medical education activities may be asked to present a synopsis of their experiences/highlights of the CME activity at faculty meeting. CME reimbursement may be received for more than one CME activity if the total cost does not exceed the allowance provided. Participation in CME activities is part of the annual comprehensive faculty evaluation. All CME dollars must be spent in the anniversary year it was provided. There is no accrual from year to year. CME is not paid out at the termination of the contract.

L. Support for Research/Grant Scholarly Activity - All RBFMRP faculty working 21 hours or greater are strongly encouraged to participate in scholarly activity. Participation in scholarly activity can be demonstrated through one of the following mechanisms at least every other year.

- Actively participate in the development and submission of a grant proposal;
- Author a manuscript submitted for publication to a peer-reviewed journal;
- Present findings at a state or national meeting.
- Other activities not listed may be considered acceptable demonstration of scholarly activity at the discretion of the Program Director.

M. Faculty Presentations - FMC encourages residents and faculty to present research and/or original contributions at professional meetings. To encourage presentations, the following policy will be in effect. Assuming there is adequate funding in the annual RBFMRP budget, faculty who are first or second authors on papers or presentations, or who participate as an invited speaker, moderator, or presenter on an expert panel at peer reviewed national health related organizational meetings will receive at a minimum the following incentives:

- Up to two additional CME days in addition to the standard CME allotment (see above). Additional time off will come from the faculty member's vacation or CME pool.
- Payment of reasonable costs –RBFMRP will cover the first $1000 in expenses including registration, transportation, lodging, and meals. The remainder will be covered by the faculty members' available CME funds or personal funds.

Please note that these incentives are dependent on the Program budget. It is the faculty member's responsibility to check with the Program Director to ensure that funding exists for these activities before assuming the incentive will be paid out.

N. Participation in Research Projects - Residents and faculty may participate in clinical trials subject to the following requirements:

- The clinical trial has received IRB approval from CSV and from the Human Research Committee at the involved institution.
- All revenues received for involvement in a proprietary clinical trial will be placed in a special fund reserved for research efforts involving the RBFMRP.
- Residents and faculty who participate in the clinical trials will receive a copy of the summary report of the clinical trials.

RBFMRP is committed to encouraging research and grants. Part of conducting research is ensuring that proper procedures are followed. As such, all RBFMRP-affiliated residents, faculty and staff are expected to review all research projects being considered for submission to either a granting agency or an Institutional Review Board with the Research Coordinator prior to submission. Faculty are also expected to review any recommended changes in research protocols or grant requests with the Research Coordinator prior to interviewing patients or accepting grant awards. The intent of this policy is to ensure a coordinated, cohesive approach to research within Family Medicine.

VI. RESIDENTS

The Rio Bravo Family Medicine Residency Program (RBFMRP) offers a three-year (36 month) residency program. The duration of residency training is specified by and subject to change by the Accreditation Council for Graduate Medical Education Residency Review Committee on Family Medicine (ACGME-RRC). The Rio Bravo Family Medicine Residency Program (RBFMRP) has its Family Medicine Center (FMC) continuity clinic at Clinica Sierra Vista (CSV).

A. Faculty Advisors - Each resident is assigned an advisor by the Program Director at the beginning of residency training. Residents may have their advisor changed by the Program Director at the request of either the resident or the advisor after a review of the reason for the requested change in faculty executive session. An outline of the advisor's functions and the form used to summarize meetings between the resident and his/her advisor is found in *Section XII: Attachments*.

B. Lectures, Educational Half Day Sessions, and Advanced Certification Classes

- ***Lectures*** - Lectures and seminars are integral to resident education. Resident attendance and participation is essential to their success.

  Residents are expected to attend at least two family medicine lectures each week. Family medicine lectures are defined as those listed on the FMC monthly Event Schedule, including noontime lectures provided by the department, the Kern Medical Wednesday Special lecture series, the Wednesday morning

cancer conference lectures which regularly include FM residents, Journal Club, and noon-time test-taking sessions. The following are NOT counted as lectures: Balint, Resident meetings, Resident-Faculty meetings, Clinic Staff Meetings and Curriculum Committee meetings. Residents who attend less than two lectures per week may be required to increase lecture attendance as one mechanism for acquiring medical knowledge.

- ***Educational Half-Day*** - Educational half-day consists of 2-3 educational sessions. Attendance at educational or administrative sessions designated as educational half-day is expected unless the resident is post call, on vacation, sick leave, a leave of absence, or has provided written documentation from the attending physician attesting to the residents' involvement in urgent patient care activities.

  Attending 60% of the educational half-day sessions is a requirement. Since the 60% requirement allows for time off due to vacation, illness, post call work restrictions and rotation-related absences, there are NO EXCUSED ABSENCES. Residents who qualify for a clinic free/call free elective will be given credit for having attended lectures throughout their elective.

  Sign-in sheets are provided and will be kept for Family Medicine department lectures, including the behavioral science seminar, and the family medicine core. Attendance at each of these sessions will be weighted equally. Attendance at nursing home rounds will be monitored separately. Residents are required to attend 12 of 24 sessions throughout their PG2 and PG3 years in order to be eligible to sit for the ABFM certification exam.

  Residents must attend at least one-half of each lecture that is a part of educational half-day to receive credit for attending. Each individual lecture or activity during an educational half-day is considered a session for purposes of attendance.

  Residents who prepare and present lectures will receive attendance credit for two educational half-day sessions for each lecture presented.

  It is the resident's responsibility to ensure that their attendance is recorded. If a sign-in sheet is not circulated, it remains the responsibility of the resident to ensure their attendance is noted and this information is provided to the department.

  Residents will receive reports of their lecture attendance on a quarterly basis. If the 60% attendance requirement cumulative throughout their PG2 and PG3 years is not met at the time of completion of their residency rotations, the resident will not be permitted to sit for the American Board of Family Medicine (ABFM) certifying exam. The 60% attendance requirement that must be met is cumulative throughout for all three years of residency training.

  Residents not meeting the 60% attendance requirement will be allowed to make up missed lectures after they have completed their rotations. Residents may opt to complete this requirement by doing web-based Prescribed Category One continuing medical education (CME) through AAFP (aafp.org). Two hours is needed for every individual educational half-day lecture or session missed. That is, if 3 makeup lecture sessions are needed to meet the 60% requirement, you will need to complete 6 hours of AAFP Prescribed Category One CME in order to be approved to sit for the ABFM Certifying examination. In the event a resident chooses to exercise this option, only CME completed after the completion of residency rotations will be accepted. Residents who do not meet the 60% educational half-day attendance requirement will be permitted to participate in graduation ceremonies with their classmates.

- ***Advanced Certifications*** - RBFMRP will cover reasonable costs associated with attending NRP, ACLS, PALS, and ALSO courses for residents. Residents who do not successfully complete course requirements will be responsible for half of the costs related to attendance.

Attending and completing these certification courses is mandatory. All second and third year FM residents who are not currently certified are required to successfully complete and maintain these certification requirements for graduation from the program.

All second and third year residents must be ALSO certified. Residents who do not participate in the Kern Medical sponsored ALSO course must successfully complete the ALSO course by the end of June of their PGY-1 year at their own expense--Educational stipend (CME) funding may be used if available. Inability to successfully complete the ALSO course will delay advancement to the next training level.

C. Attendance at Recruitment Fairs/Conferences/Presentations - Subject to availability of funds, the RBFMRP sends exceptional and interested residents to a number of resident recruiting activities including high visibility recruitment fairs/conferences such as the American Academy of Family Physicians, the Society of Teachers of Family Medicine, and the California Academy of Family Physicians. Guidelines regarding attendance at recruitment fairs/conferences are listed below.

1. Up to two residents per conference are sponsored.
2. Attendee selection will be made by and is at the sole discretion of the Program Director.
3. Residents selected for conference attendance will be reimbursed actual cost in accordance with CSV Travel policies.
4. Selected residents are expected to transport and set up recruitment materials and be present to answer questions during designated hours.
5. Residents attending a conference at the program's request will not be required to use vacation or CME time unless specifically directed by the Program Director. However, they will be required to notify the appropriate people for scheduling accommodations (Chief Resident, Scheduling Coordinator and Residency Coordinator).

Presentations - FMC encourages residents to present research and/or original contributions at professional meetings. To encourage presentations, the following policy will be in effect. Subject to availability of funds, residents who are first, second or third authors on papers or presentations, or who participate as an invited speaker, moderator, or presenter on an expert panel at peer reviewed national health related organizational meetings will receive at a minimum the following incentives:

1. Up to two additional CME days in addition to the standard CME allotment (see above). Additional time off will come from the resident's vacation or CME pool.
2. Payment of reasonable costs –RBFMRP will cover the first $1,000 in expenses including travel, lodging and meals. Educational stipend (CME) funds may be used to pay additional expenses, as available.

D. Absences/Leaves

- ***Sick Leave*** - If residents are unable to carry out their assignments due to illness, it is the responsibility of the resident to notify the family medicine program office as well as all sites where they are assigned to work that day. Notification shall occur at the beginning of the business day or at the time of illness. This notification shall occur on a daily basis and shall include contacting the responsible party if the resident is expected to be on call. During business hours, residents are expected to speak to a person directly to report their absence due to illness. A voice message is generally considered inappropriate to ensure timely same-day adjustments are made to affected schedules. Illness lasting longer than two days shall be documented by a note from the

physician caring for the resident indicating the expected duration of the illness. When residents call in sick for their continuity clinics, their patients will be reassigned to other residents.

Calling in sick for continuity clinic may result in presumptive modification of the call schedule and activation of the backup call system unless otherwise arranged. If the availability of residents to cover the clinic and call responsibilities impairs call coverage on CSV or other services, the resident calling in sick to clinic will be expected to make up extra call as described in the backup call policy.

Failure to notify the program of an absence from a rotation assignment or on-call responsibility at ANY time—weekday, evening, or weekend will be grounds for a written warning which will be submitted to the Program Director. A repeat occurrence will be grounds for probation.

- ***Vacations and Leave Policy*** - All residents receive three weeks (120 hours) of vacation and one week (40 hours) of educational leave. Educational (CME) leave is time away from regular clinical duties set aside for educational purposes as described in the current RBFMRP Resident Handbook. Each year the Chief Residents or Program Director will designate a deadline for submission of vacation and CME requests sometime after release of the block rotation schedule assignments. Failure to turn in all vacation and CME leave time requests may result in pre-assignment of vacation leave time, as time will not roll over into the next year.

  The Excused Absence Request is an official form that is used by the Chief Resident, Program Director and payroll to process requests for scheduled leave. It is the responsibility of the resident to ensure that the form is filled out completely and approved appropriately. All signatures must be obtained by the resident and the form must be returned to the family medicine Chief Residents or Program Director or vacation/leave will not be granted. The following signatures must be obtained: resident signature, Chief Residents and the Chief Resident of the service the resident will be on if applicable, and the Scheduling Coordinator. Residents are responsible for clearing all call schedules that may be assigned during the week. The completed leave request form should be returned to the Chief Residents. The Chief Residents will evaluate the request, implement changes as needed and will notify the appropriate RBFMRP staff so changes can be made to your schedule. Approved vacation requests are posted to New Innovations.com (look under Blocks, and select Vacations in the first drop down box). CSV and RBFMRP will not be held responsible for travel or other arrangements or costs incurred due to unapproved leave requests. Residents that do not report to work when scheduled are subject to the backup call system policy and disciplinary action.
- ***Educational (CME) Leave*** - Senior residents are expected to utilize their educational leave for educational activities of merit and relevance to the practice of family medicine. Residents may take time off for Board preparation or other approved CME course as an appropriate use of continuing education time after receiving approval from the Program Director. When submitting a time off request form for CME, you must indicate the dates and the name of the activity in which you will be participating. Approval of CME activities is at the sole discretion of the Program Director.

- **USMLE III/COMLEX III**
  - **USMLE STEP 3**
    1. All PGY 1 residents must take the USMLE Step 3 examination during their first year of postgraduate training (no later than June 30), unless previously successfully completed, or unless the Program Director and their faculty advisor recommend additional preparation time. Residents are required to notify the program director of the results of the USMLE Step 3 exam upon receiving their results (pass/fail).

2. Residents accepted into the training program at RBFMRP after completing their first year of training at another institution (at the PGY 2 level), must have successfully completed USMLE Step 3 prior to beginning training at RBFMRP. Residents are required to provide their program director with a copy of their USMLE Step 3 scores to document this.
3. Residents who fail Step 3 must re-take the exam at a time mutually agreed upon by the resident, their advisor and the program director.
4. Residents who have not passed Step 3 by January 1 of their second postgraduate year (PGY 2) will receive notification that they will not be reappointed as a PGY 3, until they successfully complete this step. For American graduates, this delay could result in a period of suspension without pay if they do not get their medical licenses in a timely fashion.

- ***Guidelines for Leave*** - The following guidelines pertain to vacation and educational leave. All vacations and CME requests must be submitted to the Chief Residents or Program Director by the established deadline. Residents are responsible for obtaining all signatures as well as assuring timely completion and processing of the Excused Absence Request form. Forms left with other services and received by the Chief Residents after the submission deadline may not be approved.

  It is the responsibility of the resident to verify that vacation time or educational leave time can be taken during any specific rotation.

  a. PGY-1's will have vacations pre-assigned.

  b. In order to receive credit for a rotation, residents cannot take more than 25% of rotation block length rounded up to the nearest full day within eligible rotations as vacation or educational leave, excluding call and weekend responsibilities. For example, a 4-week block (20 weekdays) will have a maximum allowed leave of 5 weekdays. A 6-week block (30 weekdays) will have a maximum allowed leave time of 8 weekdays. The above calculations for leave time do NOT include weekend days where a resident may or may not have required clinical activity. ***While the program will attempt NOT to schedule the resident for weekend call activity around the requested vacation time, there is NO guarantee that residents will be free of weekend call activity before and/or after their scheduled vacation. Not reporting for call or weekend assignments will result in activation of the backup call system and disciplinary action.***

  c. The RBFMRP values and respects the consideration of preceptors and other specialty services that volunteer time to meet the educational needs of residents. Residents are therefore expected to communicate to the preceptor at the beginning of each rotation his or her expected days off due to vacation or post-call requirements that would interfere with the days they are scheduled to work with them.

  Exceptions to the above will be reviewed on a case-by-case basis with the residents' advisor, Chief Residents and Program Director. (For additional information on vacations and leave, please refer to Section regarding Limitations on Absences and the RBFMRP Resident Handbook. The policy written here supersedes the PTO policy in the CSV Employee Handbook).

- ***Extended Leave and Unscheduled Leaves of Absence*** - Extended leave is defined as any absence from residency training for any reason that exceeds one week (7 calendar days). Individual requests for extended leave and/or leaves of absence will be reviewed on a case-by-case basis by the Program Director.

  If a resident is absent from training for more than one week (unscheduled), even if the resident is compensated during the absence using vacation and/or sick leave, the resident must meet with the Program

Director for the purpose of determining whether their training time needs to be extended to ensure compliance with American Board Family Medicine (ABFM) requirements for duration of training.

The RBFMRP recognizes that PGY-3's may, on occasion, need to take a vacation day to participate in job interviews which may not be scheduled when vacation days are assigned. The RBFMRP will attempt to accommodate these requests, which should be made as soon as possible in writing with justification. The request should follow the procedures established for all other vacation and educational leave requests. These requests will be reviewed on a case-by-case basis by the resident's advisor, Chief Residents, and Program Director. Residents who obtain coverage during their absence are more likely to have their requests approved.

- ***Limitations on*** Absences - Residents must have a deep feeling of personal responsibility for the continuous, comprehensive care of their patients. Outside activities which interfere with the proper discharge of this responsibility are not permitted. Absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one (1) month per academic year.

  Resident schedules are typically divided into 4-week block rotations. To receive credit for a rotation, residents must be present for at least 75% of the rotation, except in unusual circumstances, which require the written prior approval of the residents' advisor and Program Director.

  In accordance with ABFM Guidelines, no two vacation periods may be concurrent (e.g., last week of PG-2 year and first week of the PG-3 year in sequence).

  Annual vacations must be taken in the year of the service for which the vacation is granted. Vacation periods do not accumulate from one year to another.

  A resident does not have the option of reducing the total time required for the residency (36 calendar months) by foregoing vacation time.

  Time off from the residency in excess of one month within the academic year (PG-1, PG-2 or PG-3 year), must be made up before the resident advances to the next training level, and the time must be added to the projected date of completion of the required 36 months of training.

  In cases where a resident leaves the program for any reason and such absence exceeds one month, the Program Director must inform the American Board of Family Medicine (ABFM) in writing of the resident's departure and return. Absences which exceed two months violate the continuity of care requirement. The Program Director may utilize various criteria to determine whether the resident will be readmitted to the program and, if admitted, the training level at which the resident is to be readmitted. Approval from ABFM must be obtained prior to reentry.

E. Holidays - Residents do not have holidays. If a resident is scheduled to work on a holiday, they do not receive extra duty pay or get another day to take later. If the resident is not scheduled to work at their assigned clinical site, they do not have to report for duty. Each academic year, Chief Residents or Program Director will send a written memorandum to all residents at the start of the year regarding call service coverage issues on holidays. Since residents do not get holiday leave, they must use vacation leave if they will be gone (not available to take call or be on service). That is, if the resident has requested a week of vacation and there is a holiday within that week they need to count the holiday as a vacation day. Residents must request in advance specific holidays in accordance with the vacation and leave policy. This policy supersedes the Holiday policy in the CSV Employee Handbook.

F. Educational Stipends-License Fee Reimbursement - Educational Stipends are budgeted annually through CSV and are used for educational materials that benefit all residents. Educational Stipend funds may be used by RBFMRP to pay USMLE/COMLEX Step 3 fees for PG1 residents. Any remaining educational funds may be used to reimburse residents for educational expenses throughout their training up to and until May 1 of their PG3 year. Reimbursement of resident educational expenses is subject to approval by the Program Director and the availability of funds. Examples of allowable expenses include books, supplies, electronic devices with prior approval, tutors, CME registration fees, and, in some instances, tuition and transportation, licensure and credentialing fees. Receipts should be submitted in a timely manner, within 30 days of receipt date.

- ***Licensure Reimbursement*** - Residents will be reimbursed for California Medical Board licensure fees in accordance with the guidelines described in the RBFMRP Resident Handbook. Residents who apply for licensure within the first three (3) months of eligibility for licensure will receive a check for the initial application fee (amount applicable at the time of application) which may be made payable to the appropriate medical licensing authority. US medical school graduates are eligible to apply after completion of 12 months of residency training. International medical school graduates are eligible to apply after 24 months of residency training. Residents who transfer in to the RBFMRP may be eligible for fee reimbursement if their 6-month eligibility period occurs while at RBFMRP.

G. Requirements for State Licensure - Residents who are unable to obtain their license in a timely fashion cause significant disruption to the schedules and supervisory needs of their peers and the services where they are scheduled to work. Delays in obtaining licensure may lead to the involved resident not being able to sit for their Family Medicine Certification Exam with their classmates. To minimize the incidence of delayed licensure, the following measures are to be followed:

Residents who have not passed Step 3 by January 1 of their second postgraduate year (PGY 2) will receive notification that they will not be reappointed as a PGY 3, until they successfully complete this step. For American graduates, this delay could result in a period of suspension without pay if they do not get their medical licenses in a timely fashion.

1. RBFMRP will ensure that timely and comprehensive information is given to all unlicensed residents regarding the licensure application process.
2. Residents should complete and submit their licensure application packet, and all related materials to the Residency Coordinator by the last day in May of each academic year. The Residency Coordinator will assist in tracking and timely submission of licensure materials.
3. If all necessary materials including all necessary fees to complete an application have NOT been turned in to the RBFMRP Residency Coordinator within 30 days of becoming eligible, a written warning for this program deficiency will be sent by the RBFMRP to the involved resident.
4. RBFMRP may reimburse the initial application fee for California Medical Board licensing IF the resident applies for a license within the first three months that he/she becomes eligible to apply. For further information, please contact the Residency Coordinator.
5. Residents that fail to submit a complete application within 3 months of becoming eligible will be subject to probation.
6. If licensure is not received by the date required for licensure, the resident will be suspended and/or terminated.

H. Committee Meetings - Residents assigned to serve on a committee established by CSV or Kern Medical may be excused from their rotational responsibilities after completing their assigned patient care activities. Residents will be scheduled out of their assigned continuity clinics to participate in these committee meetings. Other excused absences for participation in local, state or national committees on which residents are members are approved at the discretion of the Program Director.

I. Continuity of Care - The requirements for continuity of care are defined in the following excerpts from the ACGME "Program Requirements for Residency Education in Family Practice", July 1, 2007.

"The learning of continuity of care requires stable, protected physician-patient relationships that are structured to enhance both resident learning and patient care. Therefore, assignment of patients to a personal physician in the FMC is required. Whenever possible, residents should see their own patients to develop the doctor-patient relationship. In addition, there should be a team structure to ensure appropriate back-up for the patients to experience continuity of care." (IV.A.5..a).(2).(c).(iv)

"A resident must be assigned to one FMC, preferably for all 3 years, but at least throughout the last 2 years of training. Residents must be scheduled to see patients in the FMC for a minimum of 40 weeks during each year of training. Their other assignments must not interrupt continuity for more than 8 weeks at any given time or in any one year. The periods between interruptions in continuity must be at least 4 weeks in length." (IV.A.5..a).(2).(c).(iv)

"Since continuity requires following patients to other settings, the continuity visit numbers may also include patients from the residents' panels who are seen at home, at long-term care sites, and patients seen in an OB continuity care setting." (IV.A.5.a).(2).(c)

"In order to coordinate and integrate each patient's care and to optimize each resident's continuity training, the program must require that each resident maintain continuity of responsibility for some of his or her patients in all settings when such patients require urgent or emergent care, home care, long-term care, hospitalization or consultation with other providers. Continuity of responsibility should include active involvement in management and treatment decisions, and interactive communications about management and treatment decisions." (IV.A.5.a)

- ***Continuity Clinic FMC (Family Medicine Center)*** - To meet continuity of care guidelines, RBFMRP requires residents to attend a sufficient number of continuity clinics. As described above, a minimum of 40 weeks per year is required.

  Residents assigned to a FMC are required to see a minimum of 2000 visits in the continuity care setting throughout three years of training. A resident must have 200 visits during the PG-1 year, 800 visits during the PG-2 year and 1000 visits in PG-3 year.

  Residents are expected to see a minimum number of patients per half-day session commensurate with their level of training (PG-1: 3 patients, PG-2: six patients, PG-3: eight patients). Actual numbers of scheduled patients and average number of patients seen are expected to be higher based upon the attendance patterns of patients in the FMC where the residency is based.

  Residents are expected to see patients in continuity clinic during all rotations in the course of residency training except for one approved clinic-free rotation for residents in good standing. An

exception to the continuity of care requirement may only be granted if explicit written approval is received from the Program Director or designee.

- ***Nursing Home and Home Visits*** - Resident panels must also include continuity patients requiring home care and care in long-term care facilities to provide each resident with continuity experience in those settings. Nursing home experience must consist of at least 2 patients as a continuity experience over a minimum of 24 consecutive months, in addition to that which residents might experience as part of a rotation. PG2/3 residents will be assigned a minimum of two nursing home patients and time will be scheduled monthly to allow residents to maintain continuity of care. Residents must document these nursing home visits using New Innovations software.

  Additionally, each resident must perform at least 2 home visits with at least one being for an older adult continuity patient. Home visits are required and encouraged on otherwise home-bound patients. Faculty must supervise all home and nursing home care either on site or by prompt chart review as is appropriate based on a resident's level of expertise and competence. Residents must document these home visits using New Innovations software.

- ***Inpatient Care*** - Residents must also maintain continuity in the inpatient setting. Identifying and contacting the primary physician is the joint responsibility of the admitting resident and the senior resident on the Family Medicine Service. The resident on the service must document that the primary care physician was notified and the patient discussed. If no primary care provider can be identified, this should be indicated. If the patient has seen multiple residents in the clinic, the last resident to see the patient will be considered the primary care provider. The name of the primary care resident or faculty must be noted on the patient list. It is the expectation of the RBFMRP that, while hospitalized, patients are seen by their primary care resident daily, Monday through Friday. The primary care resident should indicate in the patient's chart that they have seen the patient and reviewed the management. Any recommendations regarding changes in management should be reviewed with the family medicine team.

  When an obstetric patient is admitted to labor and delivery, the resident physician providing continuity of care is notified by the senior or admitting resident on the family medicine services at Kern Medical, or the resident on call. Residents are expected to assist in managing their patients at labor and delivery when in active labor (3-4 centimeters dilated with regular contractions). If the resident providing continuity of care is on an inpatient service or is in their continuity clinic, then they are expected to come to labor and delivery when their patients are six centimeters dilated. ACGME resident duty hour guidelines will also be taken into consideration when considering continuity of care.

J. Clinical and Educational Work Hours and Working Environment - RBFMRP endorses the Comprehensive Resident Duty Hours Policy developed by GMEC and complies with ACGME Clinical and Educational Work Hour requirements effective July 1, 2017. Resident assignments must be made in such a way as to prevent unreasonable patient loads, disproportionate new admission work-ups, extreme intensity of service or case mix, and inappropriate length and frequency of call, contributing to excessive fatigue and sleep deprivation.

RBFMRP has established policies for residents, which ensure:

1. Residents must not be scheduled for more than 80 hours of clinical and educational work per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting;

2. At least one day out of seven, averaged over 28 days, away from the residency program. At-home call cannot be assigned on these free days. The 24-hour period after a resident is post call cannot be counted as a day off;
3. In-house on-call duty: No more frequently than every third night, averaged over a four- week period;
4. In-house night float maximum: Residents must not be scheduled for more than 6 consecutive nights of night float. Night float experiences must not exceed 50 percent of a resident's inpatient experiences.
5. 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 the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty when average over four weeks. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".
6. All residents may be scheduled to a maximum of 24 hours of continuous work in the hospital. Strategic napping, especially after 16 hours of continuous clinical and educational work and between the hours of 10:00 pm and 8:00 am is strongly suggested. Residents may be allowed to remain on-site no longer than an additional 4 hours in order to accomplish safe and effective patient care transitions. Residents must NOT be assigned additional clinical responsibilities after 24 hours of continuous in-house work.
7. All residents should have 10 hours free of clinical and educational work and MUST have 8 hours free of work between scheduled work periods. They must have at least 14 hours free of clinical and educational work after 24 hours of in-house work.
8. While it is desirable that residents have 8 hours free of clinical and educational work between scheduled work periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than 8 hours free of work. Such circumstances are defined by the ACGME Review Committee 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.
9. Adequate back up is provided if sudden and unexpected patient needs create resident fatigue sufficient to jeopardize patient care during or following on-call periods.
10. All residents are required to document hours worked (including days off, sick time, vacation etc.) for every rotation by Friday of each week. If work hours are not reported by Friday of each week, additional call may be assigned to that individual. Residents shall document hours using New Innovations software. This information is collected and reported to the program director on a monthly basis and the GMEC on a quarterly basis, in order to address compliance with ACGME Clinical and Educational Work Hour requirements.

K. On-Call/After Hours Coverage - An on-call/after hour coverage system for residents is developed each year by the department to cover patients. The assignment of call schedules is managed by the Chief Residents and subject to approval by the Program Director. Coverage will include responding to patient calls, authorizing patient care, and admitting and following patients admitted to Kern Medical where RBFMRP has an active Family Medicine Inpatient Service. After hours coverage for the Kern Medical FM service may be provided by the resident(s) on the night float rotation.

Residents are expected to complete a thorough history and physical. This can be documented using a history and physical form approved by the institution where the resident is working or by completing a thorough

admission note and dictating a comprehensive history and physical. If an admission note is written it should indicate that the history and physical was dictated.

The faculty member rounding the following morning is expected to review the history and physical done by the resident on call the prior day and evening. The rounding physician is expected to provide feedback to the resident on call if there are significant concerns regarding their history and physical or the associated orders. Significant concerns may be forwarded by the rounding physician to the Program Director or Resident Evaluation Committee for evaluation.

All faculty will be asked to comment on resident performance while on call as part of our regularly scheduled semi-annual review of each resident.

The Chief Residents or Program Director are responsible for enforcing/maintaining a back-up call schedule for senior residents to be activated if the resident assigned to call is unavailable for whatever reason. If the back-up call person is required to cover for a resident assigned to be on call, the resident assigned will owe the resident providing the back-up call coverage two evenings, weekend days, or holidays for each one evening, weekend day or holiday provided by the back-up call resident. If residents involved are unable to amicably arrange for this coverage, the issue will be brought first to the Chief Residents, and, if necessary, to the Program Director for further action.

For first-year residents' call, the Program Director should be contacted by the senior resident, Chief Resident, or the attending on the service when a PG-1 resident is unavailable for call. The Chief Resident or Program Coordinator will contact and designate another PG-1 intern, if available, for call on the involved service. If a back-up call person is assigned to cover for a resident assigned to be on call, the resident originally scheduled will owe the resident providing the back-up call coverage two evenings, weekend days, or holidays for each one evening, weekend day or holiday provided by the back-up call resident. If a replacement is not available, then the two replacement calls will be added to the scheduled resident's second year call tally for the general FMC call pool.

If residents involved are unable to amicably arrange for this coverage, the issue will be brought first to the Chief Residents, and, if necessary, to the Program Director for further action.

It is considered unprofessional behavior to activate the back-up call system for circumstances that are not beyond the control of the resident on-call. Abuses of the back-up call system are grounds for corrective action as described in the Policy & Procedure Manual.

Residents on call for the Kern Medical Family Medicine and Medicine Department inpatient service are required to be in the hospital when they are on call.

Family Medicine residents are occasionally scheduled to be on call in-house the last day of their rotation. If this occurs, they cannot take call the following day nor can they attend in-patient or clinics on their new rotation (on a different service) due to duty hour restrictions. Please note: this does not include the resident completing the night float rotation as this is not considered in-house call. Residents completing the night float rotation are expected to report for a regular day of work on the Monday of the new rotation.

Residents providing in house call are excused from all clinical and educational activities the following day aside from related post-call educational debriefing and on-site patient care the morning after being on call. Residents are expected to inform the involved service of any planned absence when they are post-call.

Call schedules will ensure equity in call assignments among residents. Equity in resident call means the Chief Residents or Program Director, if necessary, can mandate assigned call, and/or calls on holidays and weekends to more equitably distribute resident calls.

Knowing which residents and faculty are on call is critical. To ensure this occurs, the following procedures are followed:

1. Call schedules are posted online at www.newinnovations.com. They will send a copy to the department scheduler who will notify the necessary departments.
2. Any changes in call must be communicated to the Scheduler, the hospitals involved and the exchange service after being approved by the Chief Residents. The resident initiating the switch is responsible for making these calls. Residents are also expected to notify the service or attending to which they are assigned.
3. The Program Director will be notified by the Chief Residents on a regular basis of changes in the call schedule and whenever the disaster call system is activated.
4. If more than three second or third year residents are unable to contribute to the call pool either because of departure from the training program or for prolonged periods of disability, faculty may cover any additional short-falls in call coverage. (See Attachment 1)

L. Transferring Responsibility for Patient Care (HAND-OFFS) - The resident and faculty responsible for the inpatient service are responsible for transferring responsibility of care for their service to the resident/faculty member assuming responsibility for that service. Patient care information and relevant clinical issues can be communicated in person or in writing. Urgent clinical issues should be discussed directly with the physician assuming care. Resident concerns regarding inadequacy of information, unavailability of the resident either signing out or assuming responsibility for the service, or disagreements regarding management should be addressed to a Chief Resident. Similarly, faculty concerns regarding adequacy of information being received or the availability of the faculty member either signing off the service or assuming responsibility for the service, or concerns regarding clinical management by faculty or residents should be addressed to the program director.

The RBFMRP will work with the Medical Staff at institutions where RBFMRP Faculty and Residents provide clinical care to develop procedures for hand-offs where consultants or other non-faculty physicians assume patient care responsibilities. At minimum, the above guidelines should be followed and may be amended as per specific needs agreed upon by a particular institution's medical staff, RBFMRP, and Kern Medical Department.

M. Clinics - Residents are expected to comply with the policies and procedures established at the clinic site. Residents are required to have a balanced panel of patients including patients with a mix of medical conditions, ages, and genders, i.e., pediatrics, obstetrics, and geriatrics. Non-licensed residents will present 100% of patients to an attending. All patients whose clinic visit warrants a billing code of level 99214 or higher will also be presented to an attending. Additionally, preceptors should attempt to see all patients seen by PG-1's, about half of patients seen by PG-2's, and one-third of patients seen by PG-3's. Second and third year residents in particular should focus on concise presentations, prefacing their presentations with any specific questions for the attending.

Family medicine clinics are a top priority. Inpatient activity on rotations is not an excuse for tardiness at primary care clinics (PCC). Arrival times for residents are monitored at each of the PCC sites. The information collected is forwarded to the Residency Evaluation Committee as well as to the PCC director for review of resident punctuality, and is included as part of the comprehensive semi-annual evaluation. Residents who are consistently on time will have this information noted in their reviews. Conversely, a persistent pattern of tardiness will be grounds for corrective action.

The RBFMRP expects first year residents to see four to six patients per half-day. Second year residents are expected to see eight to ten patients per half-day clinic. Third year residents are expected to see ten to twelve patients per session. The importance of developing skills in efficient and comprehensive outpatient management serves as the basis for these expectations.

Occasionally, residents question whether they need to see patients who are on their schedules who are not part of their continuity practice. There should be no confusion regarding this matter. Residents as well as faculty are expected to see all patients on their schedule in a prompt, courteous, and professional manner. Residents are encouraged and expected to see more patients as their schedules permit. To compensate for low patient attendance rates (no-shows), residents are expected to see walk-in patients and patients of other providers who are not available as necessary. To ensure our Family Medicine Centers run as smoothly as possible, residents are expected to check with the attending prior to leaving the Family Medicine Center to see if other patients need to be seen.

Resident responsibilities are not limited to those patients on their schedule. Inevitably there are occasions where lack of provider availability results in the need to see patients who cannot be rescheduled. In addition, there are times when residents get backed up with patients. When this occurs, it is the responsibility of all residents to help by seeing patients who may not be on their schedule. In short, residents are expected to function as members of a health care team. Residents and faculty working in clinical sites will practice in accordance with established procedures for each of these sites. In particular, residents and faculty must conduct themselves in an exemplary fashion in all patient care settings.

Residents and faculty will:

1. Support the mission of our clinical sites at all times, without compromise to patient care and/or service delivery.
2. Recognize the privilege of serving patients and participating as a member of a health care team.
3. Abide by the policies and procedures of our clinical sites at all times, as outlined in the clinical sites' personnel manual.
4. Demonstrate courtesy and respect for patients and clinical staff at all times.
5. Demonstrate flexibility when assigned to clinics, to ensure patients are served in a timely, compassionate and competent manner. No patients shall be dismissed without due process as established by the clinical site.
6. Demonstrate professional and ethical conduct towards all patients and staff.
7. Honor the integrity of our clinical sites at all times. Statements that are detrimental or of a defaming nature to our clinical sites will not be tolerated. Residents are expected to bring forward issues/concerns within appropriate channels. Issues involving FMC clinical sites are to be addressed with the Program Director as the initial point of contact.
8. Report to clinic on time and complete all patient care responsibilities before leaving clinic, including documentation and chart reviews.
9. Demonstrate stewardship regarding patient care, and notify risk management of all identified problems or operational issues.

N. Off-Service Notes - Family medicine differs from other specialties in its emphasis on continuity of care. An off-service note is an important tool in maintaining continuity. This note allows the physician leaving the practice to insure uninterrupted high quality of care for their patients by communicating very important understandings and insights as to the patient and the patient's family that can only come by caring for patients over time. This

information can often be invaluable in enhancing the new physician's efficiency and effectiveness. Last, but not least, thinking about and writing an off-service note helps the physician that is leaving the practice to consider very important issues involved in caring for their patients and families.

The following is an incomplete list, but gives an idea of some of the issues that have, in the past, been helpful for physicians leaving their practice to comment on in their off-service notes:

1. Revise problem list, medication list, and data summary sheet.
2. Review pertinent problems in a SOAP format, including medical, psychological, and social issues.
    i. Are these problems active or inactive?
    ii. How have these problems been managed successfully or unsuccessfully in the past?
3. Review patient's strengths and resources – family and community resources as well as individual behavioral issues.
4. What is the patient's psychosomatic profile? Stoic or always with multiple complaints?
5. Comment on the family's social situation and make-up.
6. What are the short and long-term goals for this patient? How do they compare with the patient's past status, e.g. a year ago?

It will be the responsibility of residents to write off-service notes on those patients who are exceptionally complicated or who need special attention or services. Residents will be reminded three months prior to the end of their training to begin incorporating off-service notes into their patient visits. In addition, residents will be scheduled one clinic half-day per week during their last month of training to complete off-service notes. Residents are expected to complete at least ten off-service notes each clinic session. Residents must inform the front office staff two months prior to this scheduled day and provide a list of names of those patients who require off-service notes. It will then be the responsibility of the front office staff to have those charts ready for review and off-service notes at the time residents are scheduled. If the residents do not provide a list of patients requiring off-service notes two weeks prior to their scheduled clinic, they will be scheduled patients as usual. Residents who have an unusual number of off-service notes to write can discuss this situation with their advisor. Residents may be allocated up to one extra clinic half-day per month by the Scheduler for writing off-service notes if this is agreed to in writing by their advisor.

O. Transfer of Patients from Graduating Residents - Whenever possible, patients of graduating residents will be distributed based upon birth dates to the remaining residents and to incoming PG-1's to provide an equitable distribution of patients. To minimize separating families among providers, children will be assigned to providers based upon their biological mother or stepmother's birth date rather than on the birth date of the child. Other family members will be given the opportunity to be assigned to the same resident who is following the biological mother or stepmother to keep the family unit intact. If the mother or wife is not being seen in the clinic, the patient will be assigned based on birth date to remaining residents.

Graduating residents may assign the care of any patient to another resident if the receiving resident agrees, regardless of what month of the year the patient was born. This will need to be written in a conspicuous place in the family health center clinic chart or the graduating resident should schedule that patient with the desired resident at the time of their last clinic appointment to facilitate this process.

P. Resident Outside Employment Policy-Moonlighting - RBFMRP believes that the first priority of each resident is to achieve the goals and objectives of the training program. This is to produce in the broadest sense the fully

competent physician capable of providing high quality care to his/her patients. Without compromising this goal, it may be feasible for some residents to seek outside professional activities - "moonlight" - if the resident adheres to the guidelines within this policy.

Residents should recognize the primacy of their duty to the residency program. Each resident in training is expected to learn as much as possible about the art and science of medicine in general and of his or her specialty in particular. Outside employment must not, through fatigue and/or other distractions, create diversions that interfere with or compromise the assimilation of knowledge, the process of learning the skills and professional behaviors of the educational program or the physician's dedication to the care of his/her patients. Additionally, recognizing that the physician with a well-balanced life style may well provide more for his/her patients, the finite limits of the work schedule must be observed to provide for appropriate rest and recreation for good mental and physical health.

Any outside employment of RBFMRP resident must clearly delineate the responsibilities in the moonlighting experience, be approved in writing by the Program Director and be governed by the following principles:

1. The CEO delegates to the Program Director have the exclusive right to approve a request for moonlighting activity. The request may be approved or denied for any reason. PGY-1 residents are not permitted to moonlight.
2. Permission must be obtained PRIOR to engaging in moonlighting activity in writing. See reference to obtaining permission below.
3. The moonlighting workload is such that it should not interfere with the ability of the resident to achieve the goals and objectives of the residency program. As such, only residents in good standing may moonlight. Factors considered for a resident in good standing beyond academic performance include demonstrable progress in completing all program requirements, including scholarly activity, shadowing & videotaping requirements, clinical productivity and lecture attendance. Additional factors may be considered at the discretion of the Program Director.
4. There will be no outside employment during normal duty hours. A violation of this point may result in immediate suspension of moonlighting privileges and further corrective action.
5. Each resident must agree that if fatigue secondary to outside employment interferes with his/her performance, s/he will voluntarily reduce or eliminate that outside employment until the situation is remedied.
6. Total hours in the combined educational program and the moonlighting commitment cannot exceed the limits set by the residency program or the ACGME Residency Review Committee. Therefore, each resident who participates in outside employment must accept the responsibility to keep his/her hours within the limits allowed by the applicable residency program RRC guidelines. Residents who moonlight shall enter their hours into e-value. Please refer to Moonlighting Request form in Attachments.
7. The moonlighting opportunity does not replace any part of the clinical experience that is integral to the resident's training program.
8. In accordance to ACGME regulations, residents must be licensed for unsupervised medical practice in the state where moonlighting will occur.
9. Residents on probation or remediation as defined in Academic Improvement Policies may not moonlight.

10. Malpractice coverage is NOT provided by CSV for any moonlighting activities. It is the responsibility of the resident to make sure malpractice coverage is provided by their outside employer or purchased by the resident.
11. The Program Director reserves the right to approve/deny/restrict any moonlighting activity for any reason and at any time as described in RBFMRP GMEC policies.

Noncompliance with the RBFMRP Resident Outside Employment Policy may lead to corrective actions including verbal counseling, written warning, probation, suspension, or termination. It is the resident's responsibility to report all outside or moonlighting activity to the Program Director. The Program Director will closely monitor that resident, working with the resident with respect to his/her performance. Prior to engaging in any outside employment, the resident must submit and the RBFMRP Program Director must sign, a completed resident Moonlighting Request form which:

1. Identifies the employer;
2. Informs RBFMRP of the maximum number of hours to be scheduled at outside employment;
3. Indicates an understanding and agreement that the CSV's professional liability insurance does not cover residents involved in outside employment;
4. If requested by the Program Director, has signature approval of designated faculty and staff certifying resident is making adequate progress/in good standing with the requirements of the RBFMRP.

Residents must submit all proposed changes resulting in working more hours than the maximum number of hours approved and report them to the resident's advisor and the RBFMRP office in writing. Changes must be approved by the Program Director prior to such changes becoming effective.

Violation of this policy, failure to obtain permission to moonlight, or continuation of moonlighting activities in the absence of explicit approval is grounds for placing the involved resident on probation.

Residents participating in episodic volunteer activities of less than eight hours duration such as school physicals, health fairs, or acting as the physician at sporting events are expected to follow the above guidelines but are not required to complete the Resident Moonlighting Request Form. (See Attachment 2)

Q. Chief Residents - Chief Residents are selected by April 30th for the following academic year. All residents will vote for two Chief Residents. The Chief Residents-elect are expected to help advise, approve and/or develop educational plans, schedules and/ or curriculum as requested by program leadership and participate in ad hoc and regular faculty committees representing resident interests for the coming year and benefit from the three to four months of contact that remain with the current Chief Residents (See Chief Resident Job Description – Attachment 3). The newly elected Chief Residents will be excused from clinic and rotation assignments (immediately after their selection) to attend the necessary meetings (curriculum, Chief Resident mtg. etc.) The Chief Residents receive a stipend from CSV in recognition of leadership roles in the program.

All second year residents except those currently on probation will be included in the election unless the department office receives a request from the resident that her/his name be withdrawn. Ballots are distributed and counted by RBFMRP staff. Final approval of chief-residents election results is subject to review by the Program Director. If irregularities in election procedures occur, or if a faculty member raises significant concerns about the candidate(s), approval of election results will be based upon secret ballot.

R. Counseling and Support Services - It is recognized by the department that residency is a time of intellectual and physical stress. All of the departmental staff maintain an awareness of the stressful nature of residency, and

are prepared to offer help in problem solving for residents who may manifest psychiatric, economic, marital or social difficulties. The RBFMRP will deal with the educational needs of residents with prolonged medical illness on an individual basis. Recommendations regarding appropriate and available counseling and support services will be provided to residents in a confidential manner by their advisor or designee. The Anthem Blue Cross - Employee Assistance Program (800 999-7222) offered by CSV provides 24 hour, toll-free access, up to four free visits with a licensed professional and available to all household and dependent family members. All services are confidential.

S. Clinical Evaluation of Residents

1. ***Evaluation of Resident Performance on Rotation*** - At the end of each rotation, RBFMRP solicits feedback on resident performance during that rotation from the supervising physician. This feedback is taken seriously by the RBFMRP. Residents, who receive an overall evaluation of less than two, i.e. failing, will be required to successfully complete another rotation within the same curricular area. Residents who receive an overall evaluation of two, i.e. poor, will be reviewed by RBFMRP for possible corrective action.

   Failing more than two rotations in an academic year, or failing at least two rotations in any of two academic years is grounds for termination from the program. After failing one rotation residents will receive a written warning. If a second rotation is failed the resident will be placed on probation for 3 months or the remainder of that academic year at the discretion of the Program Director. When a Department submits an evaluation for a RBFMRP resident not using the standard FM form the RBFMRP Resident Evaluation Committee will determine whether the evaluation is considered failing or not after consultation with the involved Department.

   Rotations often involve several preceptors who are asked to evaluate resident performance. The RBFMRP acknowledges the significance of a preceptor's evaluation of performance and pays special attention to those evaluations describing significant concerns. Therefore, ANY grade of fail received from any preceptor will be construed as a failing evaluation for the entire rotation.

   All residents should seek timely feedback to be advised of deficits in performance by each attending with who he/she works to allow an opportunity for remediation and improvement. It is recommended that the attending physician apprise the resident(s) whom he/she is supervising of his/her performance at the midpoint of the rotation. Residents are encouraged to use mid-way evaluation forms to solicit feedback from faculty, and faculty are encouraged to keep the midway evaluation forms on hand so that they can provide timely feedback. The midway evaluation forms do not replace our end of rotation evaluation forms and will not be incorporated into the resident's permanent file.

2. ***Clinical Competency Committee (CCC)*** - The Clinical Competency Committee (CCC) is charged with overseeing the evaluation of all residents. CCC responsibilities include the following:
   - **i.** Prepare a core competency based summary evaluation for each resident on a semi-annual basis using information from the residents' file, advisor feedback, and faculty feedback (see Attachments for Sample Resident Evaluation Summary).
   - **ii.** Evaluate all new residents within the first three months of beginning their residency training to identify deficiencies that require remediation before allowing them to continue.

iii. Review and evaluate all residents for whom unsolicited evaluation correspondence is received. Examples of such correspondence include written letters from faculty, and early warning/commendation notices received.
iv. Evaluate residents on probation at least quarterly.
v. Provide competency based evaluations which comply with the competency standards established by the Accreditation Council for Graduate Medical Education.
vi. Collect feedback from faculty on at least a semi-annual basis for each resident as part of the resident evaluation process (see Attachments for sample Evaluation of Resident Performance).
vii. Prepare recommendations for the GMEC regarding resident performance, the need for any formal remediation, commendation, or disciplinary actions, and determination of satisfactory completion of requirements for advancement.
viii. Monitor resident compliance with remediation and/or corrective actions and provide summary reports with recommendation for further action if any to the GMEC.
ix. Monitor resident stress and emotional status and report as necessary to faculty advisor.

To accomplish these tasks, the CCC employs the following procedures:

i. Requests for evaluation of resident performance are sent to faculty and residents for comments. The following procedures will be followed when evaluations have not been received.
    a. Two attempts will be made to obtain an evaluation from the rotation contact person.
    b. If there is no response within four weeks of sending out the second evaluation request the resident will be contacted to ask which individual they have most contact with on the rotation and the evaluation will be sent to that person.
    c. If there is no response within one month of sending the evaluation, the Curricular Chairperson will be contacted.
ii. A draft Resident Evaluation Summary is compiled with information from faculty & Chief Residents and rotation evaluations (see Attachments for sample Evaluation of Resident Performance), In-service test scores, information from clinic staff and the Clinical Care Coordinator, noon conference and Educational Half-day attendance information.
iii. The CCC meets and reviews the draft Resident Evaluation Summary, and makes a recommendation to the GMEC. All evaluation comments are available between residents and faculty. 360-degree access to evaluations is available for any individual resident's review. While resident evaluations are reviewed by the committee, these comments will not be included on the final Evaluation of Resident summary.
iv. The draft Resident Evaluation Summary is sent to each resident's faculty advisor requesting comments and/or attendance at the GMEC meeting when the CCC recommendations for that resident's progress will be discussed.
v. The GMEC reviews the draft Resident Evaluation Summary and finalizes the report.
vi. The final Resident Evaluation Summary is sent to faculty advisor with a note asking them to meet with resident to review progress and sign off on the Resident Evaluation Summary.
vii. The original copy of final Resident Evaluation Summary is signed by both resident and faculty advisor and returned to the Program Director for signature and placement in resident's file.

The CCC also assists in faculty evaluations by monitoring advisor functions including evidence of regular and thorough meetings with their advisee, and follow-up on recommendations from the REC. The CCC reports to the Program Director regarding the performance of faculty members as advisors.

Feedback from direct observation of the resident can be shared with the Clinical Competency Committee (CCC), at Executive session reviews of resident performance, with the residents' advisor, or with the resident. Written evaluations of resident performance will be maintained in the resident's file.

3. ***Resident Files*** - Residents may view their evaluation file only in the presence of their advisor or designated staff member by appointment. Residents may have copies of documents in their file which they have signed and dated.

   Written evaluations of resident performance placed in their file will be limited to the following:

   i. Electronically generated (New Innovations) evaluation submissions.

   ii. Written rotation evaluation forms by the attending on the service who directly supervised the resident;

   iii. Dictations of meetings between the advisor and advisee;

   iv. Clinical Competency Committee and Behavioral Science summary forms.

   No RBFMRP staff member or other department staff members will be allowed to place in a resident's file an individual evaluation that isn't in the form of one of the approved methods mentioned above. If, however, a staff member feels that an incident is of such significance that he/she wants a letter of either commendation, reprimand, or just an incident report placed in the resident's evaluation file, then the matter shall be brought before the CCC for approval by the faculty in Executive session with concurrence from the Program Director.

   v. Resident files will be kept in a secure location.

T. Requirements for Advancement and Graduation - The decision to promote a resident from the PG-1 to PG-2 year, the PG-2 to PG-3 year, and from PG-3 to graduation shall be determined by the Program Director with recommendation from the Clinical Competency Committee (CCC) and the advice of the faculty using competency based criteria.

The method of evaluation shall consist of direct observation of the resident as well as by indirect observation through videotapes, rotation evaluations, correspondence between departments and written examinations (USMLE, In-Training Exam, and Challenger). Residents will pass all rotations or complete programs of study as determined by faculty. It is expected that residents will participate in all aspects of the curriculum including attendance at conferences, behavioral science sessions, and didactic sessions. Residents will participate in the periodic evaluation of educational experiences and teachers. It is further expected that residents will complete their administrative responsibilities, including medical records completion, licensure, credentialing, etc. in a timely fashion.

1. **Standards for All Residents** - Advancement shall be based upon demonstrated competency in the six ACGME core competencies. These core competencies are:

   i. ***Patient Care*** – Residents must be able to participate in patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

   - Residents are evaluated on each rotation/clinic setting. Major performance deficits are subject to a program of remediation and/or corrective action.
   - Specific Competency Requirements include demonstration of resident competency in:

a. Efficient assessment of patients in inpatient and outpatient settings
b. Appropriate differential diagnoses for the full spectrum of patient presentations
c. Appropriate delegation of patient care activities
d. Efficient and appropriate utilization of health care resources

ii. ***Medical Knowledge*** - Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

- Residents must perform on the In-Training ABFM Examination at or above the z-score of a negative point five (-.5). If lower, active participation in a program of academic improvement/remediation is required.
- Attendance at academic didactic sessions will be monitored and is designed to fulfill needs addressing competency in this area.
- Contributions to the academic and scholarly mission of the department are required. Teaching, conference presentations and participation, as well as overall faculty assessment of performance serve as key components of evaluation in this area. Major performance deficits are subject to a program of remediation and/or corrective action.
- Specific Competency Requirements include demonstration of resident competency in:
  a. An understanding of health and disease across the life cycle
  b. Patient care options for patients presenting in both the inpatient and outpatient setting
  c. Understanding of relevant pathophysiology and evidence based care for neonates, pediatrics, adolescents, adults, and the elderly.
  d. Understanding of relevant pathophysiology and evidence base care for patients with medical, obstetrical, gynecological, surgical and psychiatric problems.

iii. ***Practice-Based Learning and Improvement*** - Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

- Active participation in chart audits and providing recommendations for improving patient care is expected.
- Specific Competency Requirements include demonstration of resident competency in:
  a. A commitment to self-assessment
  b. Constant evaluation of their own performance
  c. Ability to evaluate the health care provided by themselves and other members of the health care team
  d. Incorporate feedback into improvement activities
  e. Efficient use of technology to access and manage information

iv. ***Interpersonal 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 professional associates.

- Residents are evaluated through active participation in videotape reviews of patient encounters with faculty.
- Specific Competency Requirements include demonstration of resident competency in:
  a. Caring, accurate, and appropriate counseling of patients and families

b. Compassionate and empathetic care for patients from multicultural, diverse backgrounds

c. Supervision and teaching for junior residents and students

d. Effective communication of clinical care with faculty and supervisors

e. Appropriate and professional interactions with staff

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

- Personal integrity must be of the highest caliber. This demands strict avoidance of substance abuse, theft, lying, cheating, and unexplained absences. Unauthorized use of hospital and/or clinic equipment and personnel for other than education, professional, and patient care use is prohibited. Failure to follow this standard will be grounds for corrective action.
- Specific Competency Requirements include demonstration of resident competency in:
  - **a.** Respect, compassion, integrity and honesty
  - **b.** Practice ethical decision making including end-of-life care
  - **c.** Willingness to acknowledge errors
  - **d.** Teach and role model responsible behavior
  - **e.** Placing the needs of others above self-interest
  - **f.** Provide compassionate and culturally appropriate care to diverse populations

vi. ***Systems-based Practice*** - Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

- Compliance with all hospital and departmental record keeping and documentation requirements is required. A pattern of lateness and noncompliance will be grounds for corrective action.
- Specific Competency Requirements include demonstration of resident competency in:
  - **a.** Maintain high quality medical records in a timely fashion
  - **b.** Ability to access medical information efficiently and effectively
  - **c.** Efficient use of clinical pathways
  - **d.** Work professionally with other health care providers
  - **e.** Ability to practice effectively as a member of a multidisciplinary health care team
  - **f.** Ability to independently access and mobilize health care resources.
  - **g.** Assist patients in dealing with health care system complexities
  - **h.** Develop and implement health care systems improvement

2. Additional Promotion Requirements from PG-1 to PG-2 - Criteria for advancement may include ability to demonstrate the following:

i. ***Patient Care***

- Identify the purpose(s) for a patient visit.
- Develop appropriate bio/psychosocial hypotheses that apply to the presenting problem.
- Conduct a focused evaluation of the presenting problem (Including H&P, Physical Exam, and Lab/Radiology procedures)
- Appropriately prioritize the probable and potential diagnoses to ensure that attention is given to the most likely, most serious, and most readily treatable options.

- Present a provisional and working diagnosis to the patient.
- Arrange for follow-up of the current problem that fits the guidelines of current standard of care and/or attends to the special needs of the patient.
- Document patient care encounters in the medical record in a concise and legible manner following a problem-oriented format.
- Update the bio/psychosocial problem list and medication list at each visit.

ii. ***Medical Knowledge***

- Satisfactory performance as PG-1.
- Passage of USMLE Steps I, II, & III. Residents who have not passed USMLE III or osteopathic residents who have not passed COMLEX III may be suspended or terminated from the RBFMRP.
- Successful completion of the Advanced Life Support in Obstetrics (ALSO) Course
- Recommendation by faculty to advance.

iii. ***Practice-Based Learning and Improvement***

- Competent to supervise PG-1's and medical students as judged by faculty.
- Documentation of the PGY specific procedures and encounters required for program advancement as listed on the program website. Specific required procedures may change from year to year.

iv. ***Interpersonal Communication Skills***

- Conduct an interview that fosters an adequate and helpful doctor-patient relationship.

v. ***Professionalism***

- Develop a plan of action that attends to salient medical, psychosocial, family, cultural and socioeconomic issues.

vi. ***Systems-based Practice***

- Exercise fair and appropriate billing practices for services rendered, referring those who need financial assistance to the appropriate resources.

3. Additional Promotion Requirements from PG-2 to PG-3 - Criteria for advancement may include ability to demonstrate the following:

i. ***Patient Care***

- Implement the negotiated plan
- Inquire into and discuss sensitive issues that may impact on the execution of the negotiated management plan.
- Incorporate the principles and practice of health maintenance into each patient care encounter, where appropriate.
- Review the biopsychosocial problem list at each visit and attend to appropriate longitudinal issues.

ii. ***Medical Knowledge***

- Satisfactory performance as PG-2.
- California licensure unless international medical school graduate.
- Recommendation by faculty to advance.

iii. ***Practice-Based Learning and Improvement***

- Demonstration of skills in teaching, supervision, and team leadership.

- Documentation of the PGY specific procedures and encounters required for program advancement as listed on the program website. Specific required procedures may change from year to year.

iv. ***Interpersonal Communication Skills***

- Conduct an encounter that recognizes the primacy of patient needs and treats the patient as an appropriately equal health care partner

v. ***Professionalism***

- Conduct an interview in a manner consistent with the values of family medicine using appropriate verbal and non-verbal skills.

vi. ***Systems-based Practice***

- Conduct the visit in a time-efficient and professional manner.
- If indicated, assist the patient in arranging for appropriate medical and ancillary referrals that seek to resolve specific issues in the diagnostic or management arenas.

4. Additional Promotion Requirements for Graduation

i. ***Patient Care***

- Complete the tasks of the patient care session so that all necessary duties (including telephone messages, charting, administrative tasks, patient care) are accomplished in a timely, organized, and professional manner.

ii. ***Medical Knowledge***

- Satisfactory performance as PG-3.
- Complete three years of Family medicine training that meets the Residency Review Committee for Family Medicine guidelines unless prior authorization for advanced credit was received from the American Board of Family Practice.
- Meet standards for attendance at noon lecture and Educational half-day activities.
- Demonstrated engagement in activities that will foster personal and professional growth as a physician.
- Recommendation of faculty to graduate.

iii. ***Practice-Based Learning and Improvement***

- Has engaged in continuing or delivering medical education activities that are influenced by interest, deficiency, and need.
- Documentation of the PGY specific procedures and encounters required for program advancement as listed on the program website. Specific required procedures may change from year to year.
- Anticipate and recognize new curriculum necessary for future practice and advocate for needed reform in medical education.
- Satisfactory completion of a scholarly activity project incorporating community oriented research, as determined by the RBFMRP faculty.

iv. ***Interpersonal Communication Skills*** - Completed exercises in videotaping and shadowing to assess future needs in this area

v. ***Professionalism*** - Demonstrate sufficient professional ability to practice effectively and responsibly.

vi. ***Systems-based Practice***

- Work together with clerical staff and nursing staff in a manner that fosters mutual respect and facilitates an effectively run practice.
- Work together with partners, fellow family physicians, and specialists in a manner that fosters mutual respect and facilitates the effective handling of patient care issues.
- Work together with other professionals on the health care team in a manner that fosters mutual respect and facilitates the effective handling of patient care issues.
- At each patient care encounter, present yourself and the practice in a manner that will encourage the patient to select you, the practice, and family medicine in the future.

5. **Final Evaluation** - A written final evaluation will be provided by the Program Director or his/her designee for each resident who satisfactorily completes the program. This evaluation will be based on performance during the final period of training and must verify that the resident has demonstrated sufficient professional ability to practice effectively and responsibly.

   The information on which advancement and promotion is based shall be contained in the resident's academic file. Residents are permitted and encouraged to review all aspects of their academic file when their advisor or designee is present. Residents are not permitted to review their files without their advisor or a representative of the RBFMRP approved by their advisor in attendance.

6. **Intent not to Renew** - RBFMRP will provide residents with a written notice of intent not to renew a resident's contract no later than four months prior to the end of the resident's contract. However, if the primary reason(s) for the non-renewal occur(s) or is under evaluation less than four months prior to the end of the contract, RBFMRP will provide residents with as much written notice of the intent not to renew as the circumstances will reasonably allow.

7. **Procedural Competency** - In addition to determining whether residents have met requirements for advancement/graduation, RBFMRP is often asked to comment on the competency of residents to perform various procedures. RBFMRP has established minimum expectations in regards to the number of supervised procedures performed during residency to obtain competency. Required procedures are logged into New Innovations.

   RBFMRP must declare the resident competent to perform the required procedures. Those residents who have met these quantitative and qualitative standards for proficiency are considered competent to perform the procedure. If residents do not meet the numeric guidelines established above, or are not considered competent and proficient by the RBFMRP, requests for statements regarding procedure competency will be handled by referring the requesting organization to the residents' documented procedure list.

U. Academic Improvement Policy and Remediation Program - Residents requiring remedial educational assistance ("remediation") will be identified by performance on the American Board of Family Medicine In-Training Exam. Performance on the In-Training Exam correlates well with performance on the American Board of Family Medicine Certification exam.

The faculty recognizes that some excellent clinicians do not score highly on their In-Training exams; however, it is our goal to train physicians who become board certified in family medicine. The program has adopted the following remediation procedure to identify and provide early educational assistance to residents with low In-service scores:

Participation in all In-Training Exams is mandatory. Any requests for special arrangements in accordance with the Americans with Disabilities Act will require appropriate medical documentation denoting the specific needs of the resident. For more information, refer to Special Policies.

A composite score on the In-Training Exams of a z-score at or below negative point five (-.5) will lead to a program of academic improvement.

Academic Improvement Plan Summary

1. While on remediation, residents are expected to participate in a structured educational experience designed to improve In-Training Exam scores. Residents on remediation will be expected to attend Family Medicine Board Review sessions.
2. Residents on the Academic Improvement Plan will participate in a multi-staged program of remedial study. The Plan includes active monthly assignments and emphasizes study by providing question material covering an expansive medical knowledge base as well as recognizing the need for improved test-taking skills.
3. The Plan stresses resident accountability for participation and self-improvement. Periodically, residents will be required to take examinations reflective of the difficulty of ABFM In-Training and Certification examinations. A minimum pass score is required to successfully withdraw from the Plan. Residents who continually do not successfully achieve minimum pass standards will be subject to increased requirements and may be dismissed from the RBFMRP due to academic deficiency.

Remediation Resources - Following is a list of suggested resourced.

- Test Taking--Commercial course such as Kaplan's

Knowledge Base:

- Core Content Review for Family Medicine
- Connecticut and Ohio Academies of Family Physicians: Journals and Monographs
- American Family Physician (includes quizzes)
- American Family Physician monographs (includes quizzes)
- Family Medicine Recertification (includes quizzes)
- American Academy of Family Physicians Home Study Self-Assessment Series
- Challenger

FMC provides the AFP Monographs and distributes new issues to all residents on a regular basis. All residents are free to participate in this board review program paid for by RBFMRP. Completion of the AFP Monographs is voluntary for residents and serves as an adjunct to ABFM Certification preparation.

V. Corrective Action - Corrective action may be initiated by RBFMRP to address a resident's performance. Corrective action may include verbal counseling, counseling letter, notice of concern, academic probation, suspension or other forms of corrective action deemed appropriate by the Program Director. The RBFMRP, at its sole discretion, may issue verbal or written warnings, reassign, place on probation, suspend, or discharge any resident as a part of this corrective action policy.

The resident will have the opportunity to submit a written response to the corrective action for review.

Residents will be advised of the decision to implement corrective action and given a minimum of ten (10) working days to submit a written response to a corrective action that consists of probation, suspension, or

termination. The resident's written response will be considered by the Program's Clinical Competence Committee.

In addition to a written response, the resident may request to address the GMEC directly regarding an imposed corrective action that includes probation, suspension, or termination. The resident's address may be added to the GMEC meeting agenda via the program manager and the resident allowed to present their case within **twenty (20)** working days of notification, or at the next regularly scheduled GMEC meeting, whichever occurs first. If the resident chooses to exercise this option, following the resident's presentation, the resident will be excused and the GMEC will discuss the resident's case in closed session. The GMEC may decide, upon further review of available information and the resident's written and/or verbal response, to recommend that the corrective action stand as is, or may rescind, advance, or modify the corrective action previously assigned. Final decision on the implementation of corrective action rests with the Program Director.

If residents are placed on probation, and choose to submit a written response or address the GMEC, they are expected to adhere to all the terms of probation while awaiting an audience with or review by the GMEC. Except in unusual circumstances where the health and safety of patients or staff are jeopardized, residents with an imposed corrective action of termination may be allowed to continue working pending consideration of the resident's written and/or verbal response at GMEC.

The following are examples of areas in which unsatisfactory performance may lead to corrective action. Corrective action may result from unsatisfactory performance in areas not described below:

- ***Patient Care and Medical Knowledge*** – Fund of knowledge, performance on individual rotations, clinical judgment in the ambulatory or inpatient setting, knowledge of limitations, doctor-patient relationships, obtaining adequate subjective and objective information to allow for an appropriate assessment and plan for each patient, and performance of thorough history and physical in accordance with medical record standards established at the institution at which they are training. Performance of procedures in accordance with accepted standards of care, adequate supervision, and proper documentation.
- **Professionalism and Interpersonal Communication Skills** – Working relationship with patients, peers, and faculty, acceptance of responsibility, compliance with clinic and hospital policy and procedures including medical records completion, attendance at departmental conferences and education sessions, punctuality, and reliability. Residents are expected to dress professionally and appropriately at all times. Unacceptable behavior such as lying, insubordination (defined as failing to carry out a directive issued by a supervisor), unprofessional behavior unbecoming of a physician, cheating on examinations, lack of availability while on call, abusive behavior towards patients, peers, or staff will not be tolerated. In addition, residents may receive corrective action for evidence of impaired function due to alcohol or substance abuse. CSV has resource for impaired physicians through our EAP and inpatient substance abuse resource (level of care) policy 410:1. Kern Medical also has this resource available for residents through their Wellness Committee.

The above behaviors are examples and are not inclusive of all unprofessional behavior. It is essential that all disciplinary actions be adequately and appropriately supported by written documentation to protect both the department and the individual.

The Program Director or assigned designee will determine the course of action best suited to the circumstances. The steps in corrective action and performance improvement are described below, although the Program Director or assigned designees may skip one or more of these steps under appropriate circumstances.

Examples of courses of action which may be implemented as a part of this corrective action policy include the following:

1. **Verbal Counseling** - As the first step in correcting unacceptable performance or behavior, the Program Director or designee should review pertinent job requirements with the resident to ensure his/her understanding of them. The Program Director or designee should consider the severity of the problem, previous performance appraisals and all of the circumstances surrounding the particular case. The Program Director or designee should define the problem in specific terms and work with the resident to identify the requirements for performance improvement or change of conduct required to serve as a solution of the problem. The seriousness of the performance or misconduct should be indicated by stating that a written warning, probation, or possible dismissal could result if the problem is not resolved. The resident should be asked to review what has been discussed to ensure his or her understanding of the seriousness of the problem and the corrective action necessary. Immediately following the verbal counseling, discussion should be documented, with copies sent to the resident involved and the academic file. The Program Director may direct that the verbal counseling/discussion documentation be removed from the academic file after a period of time, under appropriate circumstances.
2. **Written Warning** - If the unacceptable performance or behavior continues, the next step should be a written warning. Also, circumstances such as non-compliance with a widely known policy or safety requirement may justify a written warning without first using verbal counseling. The written warning defines the problem and how it may be corrected. The seriousness of the problem is again emphasized, and the written warning shall indicate that probation or termination or both may result if improvement is not observed. Written counseling also becomes part of the academic file, although the Program Director may direct that the written warning be removed after a period of time, under appropriate circumstances.
    - ***Counseling Letter*** - A counseling letter may be issued by the Program Director to address an academic or professional deficiency that needs to be remedied or improved. The purpose of a counseling letter is to describe a single instance of problematic behavior and to recommend actions to rectify the behavior. The Program Director will review the counseling letter with the resident. Failure to achieve immediate and/or sustained improvement or a repetition of the conduct may lead to other disciplinary actions. These actions are determined by the professional and academic judgment of the Program Director and/or designee and need not be sequential. For purposes of this policy and for responses to any inquiries, a counseling letter does not constitute a disciplinary action.
    - ***Notice of Concern*** - A notice of concern may be issued by the Program Director to a resident who is not performing satisfactorily. Notices of concern should be in writing and should describe the nature of the deficiency and any necessary remedial actions required on the part of the resident. A notice of concern is typically used when a pattern of problems emerges. The Program Director will review the notice of concern with the resident. Failure to achieve immediate and/or sustained improvement or a repetition of the conduct may lead to additional actions. This action need not follow counseling letter nor precede other academic actions described later in this document, and does not constitute a disciplinary action.
3. **Probation** - If the problem has not been resolved through verbal or written counseling, and/or the circumstances warrant it, the individual may be placed on probation. Probation is a serious action in

which the resident is advised that termination will occur if improvement in performance or conduct is not achieved within the probationary period. The Program Director or GMEC will determine terms and the length of probation. A written probationary notice to the resident is prepared by the Program Director and should include the following information:

- A description of the reasons for the probation;
- A review of oral and written warnings;
- The specific time frame for the probation;
- The specific behavior modification or minimal acceptable level of performance required to remove probationary status;
- Suggestion for improvement;
- Required counseling session or sessions during the probationary period;
- A statement that further action, including termination, may result if defined improvement or behavior modification does not resolve during probation.

The Program Director or designee should meet personally with the resident to discuss the probationary letter and answer any questions. The resident will be asked to sign receipt of the letter. If the resident refuses to sign receipt of the letter, the Program Director or designee may sign attesting that it was delivered to the resident, identifying the date of delivery. As described, the resident will have the opportunity to place a written response including any comments or concerns regarding the reasons and/or the terms of probation in their academic file. The probationary letter becomes part of the resident's academic file subject to a later decision by the Program Director to remove it, under appropriate circumstances.

All residents on probation will be reviewed by the Executive Committee or Clinical Competence Committee and the Program Director at least every three months. It will be the responsibility of the resident to meet with their advisor as defined in their probationary letter to review their progress in meeting the terms of probation. Failure to comply with the terms of probation will be grounds for dismissal from the residency program.

If a resident has been offered a contract for the following year and is then placed on probation, the resident contract will be considered invalid until the resident has fulfilled the probationary requirements and has been released from probation. At that point, the program has the option to: 1) Offer the resident a contract for the next year, or 2) Not offer a contract for the coming year. The program has the option to allow the resident to complete the remainder of the training year.

At or near the completion of the defined probationary period, the Program Director and appropriate designees will meet to determine whether the resident has achieved the required level of performance and to consider removing him/her from probation, extending the period of probation, or taking further action. The resident is advised in writing of the decision. Should probation be completed successfully, the resident should be commended, though cautioned that any future recurrence may result in further corrective action.

4. **Suspension** - The Program Director, in consultation with the GMEC, may suspend the resident from part or all of the resident's usual and regular assignments in the training program. An immediate suspension (with prompt communication to the GMEC) may be warranted when there is a need to:
    - **i.** Take immediate action to protect the life or well-being of a patient(s) or
    - **ii.** Reduce a substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient, prospective patient, or

iii. Prevent or address activity which would adversely influence the welfare of the RBFMRP, CSV, and Kern Medical, Clinica Sierra Vista and/or its component parts including the affiliated hospitals or their staff.

The above shall not be construed to limit the Program Director's use of suspension, with or without pay in other circumstances, as deemed appropriate by the Program Director. In implementing a suspension, a written Notice of Corrective Action should set forth the circumstances explaining the parameters of the suspension, its duration, and how the suspension is to be used in the corrective counseling process. The resident will be immediately suspended without pay pending the outcome of grievance which may be filed by the involved resident.

5. **Dismissal** - Dismissal from the residency program is a grave and consequential act resorted to after only the utmost consideration by the GMEC, the CSV CEO, and the Program Director. A resident may only be dismissed upon the advice of the GMEC and the action of the CSV Program Director. Residents may only be dismissed for cause. Just cause may include failure to comply with terms of corrective action, illegal actions, activities which pose a danger to patients, peers, or staff or extraordinary actions of sufficient gravity to warrant dismissal.

   Once the decision to dismiss a resident has been made by the Program Director, the resident will be informed of the action and the reasons for the dismissal. The Clinica Sierra Vista CEO will also be informed of the action and the reason for the dismissal.

   A resident who is dismissed may appeal the action through the RBFMRP grievance process detailed in the Institutional Policy for Academic Due Process and Leave in the RBFMRP Handbook, Appendix A. If the resident is dismissed for patient care issues rather than academic performance, the CSV grievance procedure may be utilized.

W. Grievances - Residents may appeal the actions or inactions of RBFMRP or its representatives (refer to the Institutional Policy for Academic Due Process and Leave. Academic issues shall be addressed per RBFMRP Resident Handbook. Employment issues are to be addressed through the CSV Employee Handbook Grievance Policy. Other grievances are to be addressed to the involved health care organization and a copy should be provided to the RBFMRP program director.

VII. SUPERVISION OF RESIDENTS - RBFMRP residents have both inpatient and ambulatory care responsibilities. They rotate on many of the services at Kern Medical the supervision of family medicine residents in each setting is guided by the policy described in this Chapter.

We endorse the concept that the RBFMRP will provide appropriate supervision for all residents that is consistent with proper patient care, the educational needs of residents, and the applicable program requirements of our RRC.

The RBFMRP will provide faculty to supervise residents in such a way that they may assume progressively increased responsibility for patient care according to their level of education, ability, and experience, as determined by their faculty supervisors. The mechanisms for achieving this lie within the supervisor-supervisee relationship and are described as follows:

A. Clinical Responsibilities - There will be increasing levels of a resident's clinical responsibilities as he/she moves through their years of postgraduate training. Residents should strive to develop a team-based approach to medical care, with members of the team performing the appropriate roles of patient care and allowing for

supervision of junior team members. Individual roles are generally assigned by the senior resident and/or team attending. Guidelines may be available for the specific service in the rotation curriculum.

Family Medicine residents in all three years of training are competent to participate in patient care activities including newborn, pediatrics, obstetrics, psychiatry, surgery, adult medicine, and ICU/CCU under supervision consistent with the rules and regulations at the facility where they are working. In particular, residents in all three years of training may perform initial histories and physicals and daily visits on patients from any of the clinical care categories noted above, document their care in the medical record, and write physician orders under supervision as spelled out in the rules and regulations of the facility where they are working. At a minimum, residents should document in each of their notes that care was reviewed with the attending physician. (See Attachment 3).

B. Resident Evaluation/Promotion - There will be resident evaluation/promotion criteria to assist faculty in determining advancement between these levels of responsibility. The decision to promote a resident from the PG-1 to PG-2 year, the PG-2 to PG-3 year, and from PG-3 to graduation shall be determined by the Program Director with recommendation from the REC and the advice of the faculty. The method of evaluation is described in VI Residents, Requirements for Advancement.

C. Shadowing and Videotaping - This program provides the supervising faculty with a mechanism to assess a resident's clinical judgment and skills, and to identify one who is not achieving the required progression in necessary skills. Failure to cooperate with the faculty member scheduled to shadow, or the clinic staff directed to videotape will result in a letter detailing the resident's failure to cooperate and refusal to meet this RBFMRP requirement. The letter will be submitted to the REC and placed in the resident's file. Residents are required to be evaluated via the use of shadowing. A videotape evaluation is also required.

D. Clinical Competency Committee (CCC) - The CCC is charged with overseeing the evaluation of all residents. CCC responsibilities are described in VI Residents – Clinical Evaluation of Residents.

E. Rotation Evaluation - The RBFMRP solicits feedback on resident performance on rotations from the supervising physician responsible for the rotation as described in VI Residents – Clinical Evaluation of Residents. This feedback is taken seriously by the RBFMRP.

Feedback from direct observation of the resident can be shared with the Resident Evaluation Committee, with the resident's mentor, and with the resident. Written evaluations of resident performance will be maintained in the resident's file.

F. Procedure Supervision - The RBFMRP will provide quality patient care services through their residents in conjunction with faculty supervision that is at or above the community standard of care. The mechanisms for achieving this are described below.

The levels of clinical responsibilities accorded to each resident will be defined by resident year/class (e.g. PG-1, PG-2, etc.) in terms of specific procedural resident competencies that may be performed without supervision.

In accordance with guidelines established by the Family Medicine Residency Review Committee, residents who have demonstrated competency to assume graduated responsibility may be authorized to perform procedures by the RBFMRP after meeting the following conditions: 1) Meet the documentation and supervision

requirements listed below; 2) Written approval from a faculty member with privileges to perform the procedure based upon direct observation of the resident performing the procedure in question. Residents authorized to perform the procedures listed below without direct supervision must still first review the procedure with a responsible member of the medical staff who has privileges to perform the planned procedure.

All other procedures requiring informed consent, including all vaginal deliveries, must be supervised by a physician with privileges to perform the procedure at the hospital where the procedure is performed, or by a licensed resident who has been approved by the RBFMRP to perform the procedure in question without supervision. Residents may be supervised by physicians with privileges to perform the procedure who are "immediately available", which is defined as being physically present on the hospital campus.

All procedures performed by a non-licensed resident or a licensed resident not approved to perform the procedure without direct supervision must be supervised by a physician with privileges to perform the procedure in question at the facility where the procedure is performed.

1. ***Medical Procedures Performed By Residents*** - Family Medicine residents are authorized to perform the following procedures during and after the year of training noted.

OBSTETRIC PROCEDURES

PROCEDURES	PGY			
	1	2	3	4
Administration of local anesthetics	X			
Administration of drugs for pain management	X			
Administration of drugs for conscious sedation		X		
Vulvar, vaginal or cervical condylomata, removal		X		
Management of incomplete abortion		X		
Delivery, uncomplicated vaginal (when attending not present secondary to precipitous delivery)		X		
Culdocentesis		X		
Non-stress test		X		
Ultrasound for fluid, placenta local, dating		X		
Management of induction of term labor		X		
Artificial rupture of membranes	X			
Fetal scalp electrode placement	X			
Intrauterine pressure catheter insertion and monitoring	X			
Evaluate obstetric patients in labor & delivery	X			

MEDICAL PROCEDURES

"A"=Adult Independent; "P"=Peds Independent; "A/P"=Adult/Peds Independent

PROCEDURES	PGY			
	1	2	3	4
Anesthesia, local	**A/P**			
Anesthesia, peripheral nerve block	**A/P**			
Ankle-brachial index	**A/P**			
Arthrocentesis, lower extremity		**A/P**		
Arthrocentesis, upper extremity		**A/P**		
Bladder irrigation		**A/P**		
Blood gasses (arterial)	**A/P**			
Cardiopulmonary resuscitation, closed	**A/P**			
Cardioversion (emergent only)		**A/P**		
Cast/splint (A/R) for fracture	**A/P**			
Cast/splint (A/R) for immobilization/protection	**A/P**			
Central line (femoral/jugular/subclavian), insert		**A**		
Central line (femoral/jugular/subclavian), remove	**A/P**			
Chest tube, remove	**A/P**			
Compartment pressure measurement	**A/P**			
Conscious sedation		**A/P**		
Cricothyroidotomy, emergency		**A/P**		
Cultures (urine/sputum/wound)	**A/P**			
Cutdown, venous, remove		**A/P**		
Cutdown, arterial, remove		**A/P**		
Defibrillation	**A/P**			
Doppler study, venous	**A/P**			
Doppler study, arterial	**A/P**			
Doppler study, graft/fistula	**A/P**			
Drainage tube, insert (fluid/blood/pus - not chest or mediastinal)		**A/P**		
Drainage tube, remove (fluid/blood/pus - not chest or mediastinal)	**A/P**			
Drug administration	**A/P**			
Drug administration (intravenous)	**A/P**			
Drug administration (intra-arterial)	**A/P**			
Endotracheal suctioning	**A/P**			
Endotracheal/nasotracheal intubation (emergent only)	**A/P**			
Foley catheter (I/R)	**A/P**			
Gastric lavage	**A/P**			
Incision & drainage, abscess/fluid collection/cyst		**A/P**		
Laceration repair		**A/P**		
Laryngoscopy		**A/P**		
Nasal packing, anterior	**A/P**			
Nasal packing, posterior		**A/P**		
NG tube (I/R)	**A/P**			
Other resuscitation	**A/P**			
Other wound care - not debridement	**A/P**			
Percutaneous needle aspiration/drainage/biopsy for fluid collection/cyst/abscess/mass	**A/P**			
Perform/interpret lab tests (spin Hct/do UA/EKG/gram stain/peripheral smear/etc.	**A/P**			
Phlebotomy (including blood cultures)	**A/P**			
Rectal tube (I/R)	**A/P**			
Remove foreign body	**A/P**			
Sutures/staples (I/R)	**A/P**			
Umbilical artery catheter, remove	**P**			
Venous line (I/R)	**A/P**			
Wound debridement	**A/P**			

Residents are authorized to perform the following procedures without direct supervision if they have met the numeric requirements noted below, have successfully completed their PG-1 year, and have been signed off as competent to perform the procedure by a .5 FTE or greater Family Medicine faculty member who has medical staff privileges at Kern Medical or CSV to perform the procedure.

INDIVIDUALLY CREDENTIALED PROCEDURES

PROCEDURE	Mininum Number of Documented Procedures	PROCEDURE	Minimum Number of Documented Procedures
Arterial Line	**5**	**Intubation**	**5**
Bone Marrow Biopsy	**5**	**Lumbar Puncture**	**5**
Central Lines	**5**	**Paracentesis**	**5**
Chest Tube Insertion	**5**	**Thoracentesis**	**5**
Circumcision	**5**	**Umbilical Artery Catheterization**	**5**
Colposcopy	**10**	**Vacuum Extraction**	**6**
Dilatation & Curettage	**10**	**Vaginal Delivery**	**40**
Flexible Sigmoidoscopy	**15**	**Vasectomy**	**10**

A list of residents authorized to perform these procedures will be available to inpatient/outpatient clinical staff electronically or in hard copy so the community standard of care can be assured in either setting.

2. ***Documentation of Procedures*** - Residents are required to document their procedures using E*Value software. E*Value software may also be used by an attending physician or supervising resident to evaluate resident performance whenever a procedure is directly observed.

G. Faculty Supervision Policies

1. ***Faculty-Resident Communication*** - To ensure there will be sufficient and appropriate faculty-resident communication to provide the very highest quality of patient care, residents and faculty will adhere to the following guidelines.

   There will be a mutual resident-attending responsibility to recognize the need for increased communication and supervision under the following circumstances:

   a. A significant deterioration in clinical status.
   b. Any patient with a high risk condition (medically unstable or critically ill).
   c. A significant uncertainty re diagnosis or management of the patient.
   d. Decreased experience of the trainee.
   e. Patient requiring procedures or interventions, which entail significant risk.

2. ***Faculty Supervision of Residents – General Policy***

   - There will be decreasing levels of a faculty member's direct supervision of a resident that allows a logical progression in skill base with progressive independence.
   - A supervising attending faculty or a licensed resident physician must oversee all patients under the care of an unlicensed resident physician. Guidelines for documentation of supervision are listed below.

- A supervising attending faculty must be available to supervise the resident for the entire duration of any session at an ambulatory, urgent care, or emergency service site in the following way:
    - **i.** A supervising attending faculty will be present for each ambulatory care or urgent care session to which Family Medicine residents are assigned. In the unusual circumstance where a supervising attending faculty is not available, the Program Director or designee can designate a senior Family Medicine resident to supervise the ambulatory or urgent care session with telephone back-up from a supervising attending faculty member.
    - **ii.** Supervising physicians may only supervise residents in areas/procedures in which they themselves have privileges.
    - **iii.** Family Medicine residents on the Kern Medical Family Medicine Inpatient Service are required to be in the hospital when they are on call.

3. ***Faculty Supervision of Residents – Inpatient Care*** - Family Medicine residents on the Kern Medical Family Medicine Inpatient Service are required to be in the hospital when they are on call.
    - **Inpatient Admissions** - All admissions to the Family Medicine Service at Kern Medical must be reviewed with the Family Medicine attending according to the following guidelines:
        - **i.** PG-1 residents are to review all admissions and orders with senior residents or faculty PG-2's or PG-3's supervise admissions of PG-1's and communicate with attending faculty regarding admissions and appropriate orders at the time of the admission. PG-2's or PG-3's supervising or performing admissions at Kern Medical must review patients with the attending within 4 hours as noted above.
        - **ii.** All Kern Medical admissions must be reviewed with the attending physician within 4 hours and seen by the attending within 24 hours. Any patient who the resident feels is stable for discharge from the emergency room but the emergency room physician feels admission is required must be reviewed with the attending physician, as must any patient requiring urgent care or with an unstable medical condition.

H. Guidelines for Documentation of Supervision

1. ***Ambulatory Care***
    - **a.** All resident cases will be reviewed with faculty.
    - **b.** All patient visits that warrant a billing code of level 99214 or higher will be evaluated by the faculty.
    - **c.** All unlicensed physicians to have prescriptions co-signed by a supervising faculty or senior resident.
    - **d.** Additionally, preceptors shall see all patients seen by PG-1's at least for the first six months until the Clinical Competency Committee deems them proficient to proceed without direct supervision to complex patients (99214 or higher) any resident can request direct faculty supervision whenever needed. This includes office procedures.
2. ***Inpatient Care*** - A licensed resident or supervising faculty member to co-sign all discharges completed by unlicensed family medicine residents on Inpatient Family Medicine services.
3. ***Supervision on non-Family Medicine services*** - RBFMRP residents will assume responsibility in compliance with guidelines established by the respective services on which they rotate.
4. ***Other Supervising Physician Responsibilities*** - Physically evaluate each admission to the Family Medicine service at Kern Medical within 24 hours in accordance with medical staff by-laws for Kern Medical. Review all Family Medicine patients evaluated in the emergency room and seen by Family Medicine residents for possible admission deemed by the residents appropriate for discharge prior to discharge. Document supervision in accordance with guidelines established in the medical staff by-laws for Kern Medical.

5. ***Evaluation of Supervisor-Supervisee Communication*** - The RBFMRP will document and actively monitor the supervisor-supervisee communication and supervision in a way that demonstrates the high quality of patient care given and also satisfies the needs of all accrediting bodies. This will be accomplished in the following manner:
   - **a.** Admitting orders must state the admitting service and admitting physician by name.
   - **b.** The daily communication from the attending to the resident should be documented in the patient's medical record and reference the communication.
   - **c.** Consultation requests should be approved by the attending faculty on the requesting service.
   - **d.** Completed consultations should include evidence of faculty participation and supervision. Exception: A consultation can be done by a resident if approved by the ordering attending and reviewed by the attending on the consulted service within 24 hours.

   The RBFMRP specific monitoring - feedback process will include:
   - **a.** Feedback from patient satisfaction surveys.
   - **b.** Comparison of care with Best Practices Guidelines.
   - **c.** Analysis of cost effectiveness/utilization management.
   - **d.** Compliance with continuity of care guidelines for Family Medicine.
   - **e.** Compliance with chart maintenance standards.
   - **f.** Compliance with obstetric supervision guidelines.

I. Outpatient Care Consultation Documentation - Communication with patients at the Family Medicine Center must be documented in the patient's chart. To ensure that this occurs, the following procedures should be observed:

- During office hours and after hours, all messages and responses should be documented in the patient's electronic health record.

J. Faculty On-Call - The Program Director or designee will ensure that a system of Family Medicine faculty coverage is available 24 hours a day, seven days a week during work hours and off-work hours. This schedule will be posted prominently at FMC and participating hospitals. RBFMRP residents are expected to contact their faculty as per established supervision guidelines for hospital admissions and medical interventions. In cases of emergency, where a delay in care may be detrimental to patient health, the faculty should be contacted as soon as is feasible. Admissions should be reviewed by either the senior resident or attending physician as described above in Supervision Guidelines. The name of the Family Medicine faculty contacted will be noted by the RBFMRP resident in the medical record.

In the unlikely event that the Family Medicine faculty physician on call is not able to be contacted, the second or third year RBFMRP resident will first attempt to consult the alternate physician on-call for Kern Medical, then the program director or program chief.

For obstetric patients, in the unlikely event that the Family Medicine faculty physician on call is not able to be contacted at Kern Medical, the OB/GYN Residency program service may be contacted for management and supervision.

Supervision on Non-Family Medicine Services - RBFMRP residents rotating on non-Family Medicine services will be expected to comply with the guidelines for supervision established for those rotations. Supervision on non-Family Medicine rotations will be provided by the individuals responsible for the service rather than Family Medicine.

RBFMRP residents do not supervise allied health professionals although they can direct allied health professional students under supervision provided by a faculty member. Allied health professionals operate under

written practice agreements which incorporate standard procedures signed off by the involved allied health professional and a faculty member.

K. Use of Student Notes for Documentation Purposes - In order to be in compliance with Kern Medical's expectations of supervision of patient care by attending physicians, and Medicare's documentation requirements for billing, resident and faculty are expected to adhere to the following guidelines when medical students and nurse practitioner students are involved:

Notes written by medical students may not be used to supplant required documentation in a resident note.

Residents must separately and completely document that they performed the significant portion of the HPI and physical examination. Residents and faculty may refer to the review of systems, the past medical, family and social history performed by medical students or others.

Faculty must document the performance of the key elements of the examination including a face-to-face encounter with the patient, and document their oversight of the management of the health care team that is rendering treatment. Faculty may not reference documentation other than as noted above from medical student notes to satisfy documentation requirements.

VIII. EDUCATION POLICY

Education is the focus of RBFMRP activities. Education and healthy role modeling for learners of all ages and members of the community is also inherent in the educational mission of RBFMRP.

A. Curriculum

1. ***Curriculum Documents*** - Written curricula for each of the major professional and/or specialty areas required by the ACGME/RRC will be developed and maintained by RBFMRP. All documents used as reference materials in RBFMRP curriculum will be included in a bibliography.

   Specific rotation assignments and composition may change in accordance with the educational and financial needs of the RBFMRP. A current list of the ACGME-Competency-Based curriculum for all residency rotations and longitudinal training is referenced with up-to-date changes on the RBFMRP website.
2. ***Curricular Areas and Sub-areas*** - The curriculum is organized generally into the following areas:
   - **a. Rotational Curriculum**
     - **i.** Pediatrics
       1. Inpatient Pediatrics
       2. Outpatient Subspecialty Pediatrics
       3. Outpatient General Pediatrics
       4. Inpatient Newborn Care
       5. Sub Rotation Experiences: Developmental Pediatrics
     - **ii.** Internal Medicine
       1. Cardiology
       2. Dermatology
       3. Intensive Care
       4. Inpatient Medicine
       5. Outpatient Medical Subspecialties
       6. Neurology
     - **iii.** Family Medicine
       1. Continuity Clinic
       2. Kern Medical Family Medicine

3. Preventive Health
4. Community Medicine/Occupational Medicine/Community Health
5. Emergency Medicine
    - Emergency Medicine (Adult)
    - Emergency Medicine (Pediatric)
6. Electives
    - Established and Original Educational Rotations
7. Human Behavior & Psychiatry
8. Practice Management/Office Management
9. Ambulatory Procedures
10. Surgery/Sports Medicine
    - Inpatient General Surgery
    - Inpatient Orthopedic Surgery
    - Outpatient Surgical Subspecialties: Ophthalmology, ENT, Urology
    - Outpatient Orthopedics
11. OB/GYN
    - Inpatient Obstetrics
12. Geriatrics

b. Longitudinal Curriculum

- Nursing Home Care, End-Of-Life Care/Hospice
- Scholarly Activity & Scholarly Project
- Evidence Based Medicine

c. Self-Study

- Core Competency Training
- Physician Fatigue and Wellness

3. ***Curriculum Committee*** - A Curriculum Committee for RBFMRP will be maintained. This committee will be appointed by the Program Director and will consist of at least a chairperson, a faculty member, and a chief resident.

    The Curriculum Committee will address issues regarding curriculum scheduling, and conflicting responsibilities involving the separate rotations. The committee will also be responsible for reviewing the recommendations of the subcommittees for particular curricular areas on an annual basis. The Committee will coordinate curricular presentations and a review of evaluations from residents for each of the curricular areas at faculty meetings on an annual basis. The curricular chairperson will meet with the curriculum committee to review their assigned curricular area at these meetings.

    The Curriculum Committee is responsible for reporting to the Program Director if there are persistent inadequacies or incomplete follow through from faculty members assigned curriculum tasks, and to complete the curricular section of the annual faculty evaluations.

    The Curriculum Committee does not have the authority to make major decisions or changes regarding curricula independently. The committee is empowered to recommend major modifications in curriculum to the Program Director. Curriculum issues that must be addressed in a timely fashion prior to scheduled curriculum committee meetings can be addressed by the curricular chairperson in conjunction with the Program Director. Any actions taken for the above reasons shall be reported at the subsequent Curriculum Committee meeting.

4. ***Curricular Chairpersons*** - Each curricular area will have a Sub-Curricular chairperson. It is expected that each Sub-Curricular chairperson will meet at least annually with the Curriculum Committee to review his or

her assigned curricular area. The Sub-Curricular chairperson will be expected to communicate regularly with other entities who contribute to resident education in that discipline (e.g. pediatric chairperson to meet with Pediatric Department) to review educational activity and to provide feedback on resident evaluations of rotations and other educational experiences.

The Sub-Curricular chairperson will be responsible for maintaining a core competency-based written curriculum which is current, up-to-date, reflects the needs of RBFMRP, and meets the requirements of the Residency Review Committee for Family Medicine. Any recommendations for changes in the curriculum will be forwarded to the Curriculum Committee for review and ultimately to the program director and faculty.

The Program Director will also be the initial contact point for any conflicts or issues that surface during the year. Sub-Curricular chairperson faculty may handle pressing issues that occur during the year after consultation with the Program Director or designee. Issues of a more serious nature shall be referred to the Curriculum Committee for further discussion.

5. ***Resident Rotations*** - RBFMRP will establish a rotation schedule for all residents to comply with all Residency Review Committee for Family Medicine requirements. All residents are expected to complete each rotation as scheduled.

   RBFMRP will consider requests for modifications in a resident's schedule only in exceptional circumstances and on the express approval of the Program Director or designee. Rotation schedule change requests must be received at least two months, and or within two weeks of the receipt of the block rotation schedule for the upcoming academic year. Written approval from affected parties including the faculty responsible for the rotation, a chief resident, the Program Coordinator, the residents' advisor, and the Program Director must be obtained. If conflicts arise in the processing of a resident's request for a rotation change, the conflict will be brought to the Curriculum Committee for resolution. Changes to the rotation schedule are subject to the evaluation and approval of the program director.
6. ***Resident Evaluation of Educational Experiences*** - The Program seeks to maintain the quality of all educational experiences. Resident feedback is critical to this process. To collect resident feedback, the Program solicits evaluations of the resident’s educational experience annually as well as after each completed rotation. Residents also evaluate faculty on an annual basis.

   Residents submit their evaluations anonymously. Evaluations of all rotations in the current curriculum are collected by the Program Coordinator and reported to the Program Director, Sub-Curricular chairperson and the Curriculum Committee. Evaluations for longitudinal experiences including the Family Health Center, Behavioral Medicine, Community health, Evidence Based Medicine & scholarly activity are reviewed at least once annually.
7. ***Special Curricular Requirements*** - Certain minimum patient contact requirements exist for RBFMRP residents. These include mandated minimum experiences in obstetrics and intensive care as well as requirements for outpatient continuity care.
   - **a.** Obstetrics
     - **i.** RRC requirements for obstetrics training in Family Medicine require a total of at least 40 deliveries per resident regardless of future practice setting. At least 10 of those patients should be continuity deliveries. In addition, up to 10 of those deliveries may be satisfied as primary surgeon or primary assist at cesarean section.
     - **ii.** First year (PG-1) residents will be required to have completed, documented, and turned into the department evidence of 12 deliveries by the end of the PG-1 year. PG-2 residents will be required to have completed, documented, and turned into the department evidence of a total of 35 deliveries by the end of the PG-2 year.

iii. In the event a PG-1 resident does not complete the required number of deliveries, they will receive a written warning letter describing the consequences of not meeting the PG-2 requirement by the end of the PG-2 year. This warning letter will be placed in the resident's file.

iv. In the event a PG-2 resident does not complete the required number of deliveries, they will be required to complete an elective in obstetrics to include deliveries or be assigned to obstetrics inpatient q4 call coverage for the first available elective in the third year. This elective or call coverage will take place regardless of the number of deliveries obtained in the interim between the end of the PG-2 year and the elective. If, at the end of the elective, the total of 35 deliveries has not been met, a second elective will be used for obstetrics or OB call, and so on, as needed, until graduation.

b. Intensive Care

i. RRC requirements for intensive care training in Family Medicine require a total of experience in ICU management of at least 15 patients per resident regardless of future practice setting. This is defined as patient care where the resident is primarily involved in the management of the critically ill patient.

ii. All residents will be required to have completed, documented, and turned into the department evidence of 15 patients managed in an intensive care setting. This may include ICU-level care in an emergency room or in an inpatient setting where a formal intensive care unit is not available in some cases.

iii. In the event a PG-2 resident does not record an adequate amount of experience in intensive care management, he/she may be required to take an elective in ICU care. The need for additional formal experience in ICU care for residents beyond the PG-1 year that may be required will be decided by the program director in consultation with the resident's advisor and executive committee.

c. Continuity of Care

i. RRC requirements for continuity care training in Family Medicine require a total of 1,500 patients seen per resident in the second and third years of training.

ii. All residents' productivity reports will be reviewed twice yearly by the Resident Evaluation Committee. Those residents not on target to meet the required number of Family Health Center visits may be assigned additional half-days during any remaining rotations. These additional half-day assignments may require forfeiture of elective experiences in order to meet RRC Requirements for continuity of care.

iii. All residents are expected to be proactive in the clinical setting to ensure an adequate experience in outpatient continuity training. Please refer to Section V: Residents – Clinics for an overview of Clinic Policy and resident responsibilities in the Family Health Center.

8. ***Medical Student Curriculum*** - All requests for rotations from medical students will be managed by SVFRMP personnel, to coordinate the rotation, malpractice coverage, and appropriate credit.

B. Electives

1. ***Goals*** - Elective curricula allow the resident to:
   a. Pursue educational experiences which are relevant to the resident's future practice of family medicine but are not included in core rotational areas.
   b. Supplement material from prior rotations.
   c. Provide remediation.

2. ***Objectives***
    a. Residents will be able to list three reasons for taking the elective.
    b. Residents will delineate how electives will provide experiences for competency in the six ACGME core competencies
3. ***Assignments***
    a. All residents will have a minimum of 12 weeks and a maximum of 24 weeks of electives as required by RRC Guidelines.
4. ***Responsibilities***
    a. Choose a topic: The resident is responsible for proposing elective areas to his/her mentor in a timely fashion; a minimum of three months prior to the start of the rotation.
    b. Develop a written curriculum: The resident is responsible for drafting a written curriculum and designating a rotation supervisor who will be required to complete an evaluation of your elective rotation performance. The curriculum must be approved by his/her advisor and shared with the supervisor of the rotation. Credit for elective rotations will not be granted until a completed evaluation is received from the rotation supervisor.
        i. Residents who do not develop their own elective at least three months prior to the first day of the scheduled elective rotation may select from a menu of structured electives. An updated list of these electives is available for review through the residency coordinator. Residents who do not choose a structured elective will be assigned a structured clinic elective by the department.
        ii. Residents must have four half-day clinics during their elective experience. Second and third year residents may request a lesser number of clinics for electives subject to department approval and at the discretion of the program director. Typically approval will include an assessment of adequate clinical productivity.
        iii. Special circumstances, including unexpected changes in resident rotation schedules due to illness or unscheduled leave may require, on rare occasion, residents to forego participation in elective rotations to meet service coverage needs. Residents that are made to forego electives in this manner will, if possible, be given priority to future electives.
5. ***Evaluation***
    a. Residents are expected to complete an evaluation of their elective rotation.
    b. Residents will be evaluated by their rotational supervisor on standard departmental forms. If RBFMRP staff do not receive a response after sending two requests for evaluation to the rotation supervisors, the resident will be responsible for obtaining this evaluation. If an evaluation is not received, credit for elective rotations will NOT be granted which may result in extension of training.
6. ***Off-Campus Electives***
    - **Purpose**: To provide third year residents an opportunity for special "one-time" off-campus residency rotations within California, out of state, or in other countries.
    - **Policy**: These specialized rotations are subject to the following policy guidelines.
    - **Policy Guidelines for Off-Campus Electives**:
        - Off-campus electives are a privilege given to residents in good standing. Third year residents may participate at the sole discretion of the program director.
        - Off-campus rotations that offer educational experiences already available locally may be approved only at the discretion of the program director.

- Rotations must be arranged so as not to create significant service or clinic coverage problems. Off-campus electives will be scheduled during a call-free elective block.
- Preference is given to rotations that support the mission of RBFMRP.
- Rotations must be:
    1. Within fully ACGME accredited programs, and/or
    2. Arranged in conjunction with and under the direct supervision of a RBFMRP or KERN MEDICAL faculty member who is also present at the off-campus site, and/or
    3. Found through the IHMEC web site [www.ihmec.org] and approved by the Program Director, and/or
    4. Other site/experience arranged by individual residents and approved by the resident's Program Director.
- The Program Director will support a request for one four-week/one block, off-campus rotation during the resident's training if the RBFMRP resident is in good standing and has completed their PG-1 and PG-2 year.
- Residents in good standing who receive approval for their off-site rotation from RBFMRP may be provided with CSV malpractice coverage and continuation of salary and benefits if the procedural guidelines described here are followed.
- Residents are responsible for arranging and paying for their own travel, room, board, and incidental expenses during their off-campus rotation.
- Residents must submit in writing or present in a forum approved by the Program Director a summary of the off-campus educational experience and its relevance to health care.
- Off-campus rotations will not be allowed for residents on Step 2 of remediation or academic probation.
- Off-campus rotations will not be allowed if program requirements mandate other additional experiences to be assigned during the resident's elective (See Special Requirements, above). This may also require call coverage to be assigned in order to meet specific requirements.

- **Procedural Guidelines for Off-Campus Electives***:*
    - Complete the "Application for Off-Campus Elective Rotation Outside the RBFMRP." This application includes:
        1. Justification and rationale for the elective rotation.
        2. Description of the educational experience anticipated.
        3. Location and duration of the rotation.
        4. Details about supervision of the resident at the rotation site.
        5. Signed authorization and approval by a representative from the off-campus rotation site.
        6. Approval by the Program Director.
        7. Clearance from the Program Director.
        8. Sign the Off-Campus Residency Training Rotation Waiver of Liability Form.
    - Residents may participate in credit-bearing activities outside of the United States through organized courses and independently arranged experiences. In some cases, the countries where these activities take place present a variety of challenges and risks to residents for which they may not be prepared. These include unfamiliar cultures and languages,

political instability, and infectious diseases and other health hazards that are uncommon in the United States.

- To assist residents in preparing for these eventualities, the RBFMRP strongly recommends that all residents planning to enroll in a credit-bearing course or independent activity with an international component perform the following prior to departure from the United States:
    1. Participate in a course, seminar series, or supervised self-study for cultural orientation and preparation for the trip.
    2. Gather information concerning any political problems or health hazards which may place them at risk by consulting current State Department and Centers for Disease Control information - State Department – www.travel.state.gov, Centers for Disease Control - www.cdc.gov/travel.
    3. Obtain medical travel advice and immunizations appropriate for the country to which travel is planned.
    4. Obtain medical and accident insurance that includes provisions for emergency evacuation to a United States medical facility.
    5. Designate persons both in the foreign country and in the United States who may be contacted in the event of an emergency.
    6. In addition, competency or training in the local language is strongly encouraged.
    7. Completion of these steps is the sole responsibility of the individual student and NOT RBFMRP.
- A completed application must be submitted to the RBFMRP at least 90 days prior to the anticipated start date of the rotation. Within 15 days of receipt of the completed application, the Program Director will determine the final disposition.

RBFMRP residents may seek off-campus educational experiences to augment the roster of electives available at Kern Medical, the VA, and Children's Hospital of Central California. The American Board of Family Medicine requires that residents not interrupt their continuity of care for their panel of families more than two months per year, for any reason. Accordingly, the sum of vacation, sick leave, and elective time away from continuity clinics must not exceed sixty days in any year of the residency (see Section VI: Residents – Limitations on Absences).

- In addition to one month of an approved off-campus elective rotation (see above) residents may also be eligible to participate in rotations outside of RBFMRP's sponsoring institutions as long as the following criteria are met:
    1. The elective experience meets the criteria for off-campus elective rotations as noted above.
    2. The rotation is approved by the Program Director and the CSV Credentialing department.
    3. They continue to see their continuity of care patients.
    4. They participate in the night coverage call system for RBFMRP patients at KERN MEDICAL.

  If the approved elective rotation is supervised by a RBFMRP clinical faculty member, then both the resident and the faculty member can be covered by CSV's malpractice coverage. If the approved rotation is at a site which is commonly used by residents for elective rotations, then an affiliation agreement between RBFMRP and the institution must be in

place. If there is not a RBFMRP clinical faculty member to supervise the approved rotation, nor an affiliation agreement in place, then RBFMRP can only cover the actions of the resident and not the supervising physician in the event of a malpractice action.

7. **Extra Mural Resident Electives** - The RBFMRP may accept residents from other accredited residency training programs to participate in structured rotations through RBFMRP. In order for a resident from outside the RBFMRP to arrange a rotation with the RBFMRP, the resident must be in good standing with their residency program and must have a letter from their residency program stating they are covered for malpractice through their sponsoring institution. The resident requesting a rotation must also receive a letter from the Program Director of the RBFMRP or designee authorizing the rotation and describing the specific educational experiences which will be included and evaluated in the rotation experience. The letter from the RBFMRP authorizing the rotation will also specify the length of time of the rotation and the dates for the rotation. Residents from other training programs must comply with medical licensing requirements of the State of California.

C. Policy on Resident/Faculty Interactions with Pharmaceutical/Health Industry Representatives

1. **Clinica Sierra Vista** - Continuing Medical Education presentations (CME) sponsored by CSV must conform to the standards established by the Accreditation Council for Continuing Medical Education. Specifically, RBFMRP must be responsible for the planning, content, and execution of all educational presentations presented under the auspices of RBFMRP. All educational presentations sponsored by the RBFMRP must be free of commercial bias.

   Pharmaceutical companies and other health related industries may contribute financial support to educational presentations sponsored by RBFMRP. This financial support must be in the form of an educational grant provided to RBFMRP or to Clinica Sierra Vista. In this event, the financial support may not be dependent upon control of the educational content or execution of the continuing education presentation. All educational/CME presentations must be free of commercial bias. Any continuing education presentation receiving financial support must identify the source of this support as part of the continuing education presentation.
2. **Kern Medical** - Residents will follow Kern Medical Drug Representative Policy and Procedure and the Sample Drug Policy and Procedure for Kern Medical.

D. Lectures/Meetings

1. ***Didactic Educational Series***
   a. **The Noon Lecture Series** will be coordinated by the Chief Residents or Program Director. Wednesdays are reserved for a rotating series of grand rounds presentations by visiting lecturers. It will be the responsibility of the faculty members assigned to these lecture presentations to deliver the presentation or arrange for lecturers on core curriculum topics. Each core curriculum lecture series is generally presented on a two year rotating schedule.

      Faculty sub-curriculum chairpersons for each curricular area are expected to update annually the core curriculum for their curricular area. The faculty sub-curriculum chairpersons for each of the lecture series curricular areas are encouraged to assist in including common family medicine topics where applicable.
   b. **Morning Report** - When morning report is available for participation, residents will participate at the scheduled times.
   c. **Lecture Series** - The Lecture Series will be coordinated by a faculty member, Chief Residents, and/or Program Director. Senior residents may be asked to present on a topic of interest.

d. **Morbidity and Mortality** - PG-2/3 residents will be assigned to present for a one-hour block during the course of the academic year. Assignments will be announced in advance, and generally will coincide with the residents' service on an inpatient rotation.

Procedures: Each resident on an inpatient rotation is to keep a current log of all deaths, transfers, and unexpected patient outcomes. When appropriate, the assigned resident will review all cases with the M&M Faculty facilitator to select an appropriate case for presentation and discussion during the M&M Conference. Residents will subsequently familiarize themselves with the aspects of the case pertaining to its selection for presentation.

On occasion, certain patient care issues may come to the attention of individual faculty or the department that may warrant discussion and review during the M&M session. Selection of these cases may supplant scheduled presentations. In this event, every effort will be made to notify the involved resident(s) and faculty so that they may be able to familiarize themselves with and prepare adequately for presentation of the selected case.

- ***Evidence-Based Medicine Educational Series***
  - **a.** Journal Club Meetings will be held regularly, generally during or prior to didactic educational series presentations.
  - **b.** One faculty person will be designated per resident and attend and monitor the meeting preparation and event.
  - **c.** Residents will be responsible for presenting at each meeting, and each will present summaries of articles.
- ***Online / Self-Study Educational Series***
  - **a.** **Physician Wellness and Fatigue** - In an effort to provide residents and faculty with an increased awareness of personal barriers to effective care, this program is provided in addition to standard rotation curriculum and didactic education. Series presentations address these topics to residents and faculty for study and completion on an individual basis. Residents will be required to complete this training activity. The program will be made available to faculty and other learners.
  - **b.** **Core Competency Objectives** - Physicians require ongoing education and training throughout their professional lives. The ACGME core competency objectives provide a modality of outcomes-based evaluation that physicians and educators can use in order to identify and develop additional skills and improve training in areas of concern. An understanding of the widespread adaptation of core competency objectives in residency training provides a framework for residents to evaluate learning opportunities for the rest of their professional lives. This educational tool is a series of online modules designed to instruct residents in the core competencies. Residents will be required to complete this training activity. The program will be made available to faculty and other learners.

E. **Program Evaluation** - Aside from evaluations received on specific curricular components, RBFMRP will be evaluated on an overall basis. This evaluation will be sent to all active residents, staff and faculty for anonymous feedback on program performance. Data will be compiled and reviewed in detail for possible programmatic enhancement.

F. **Graduate Survey** - In an effort to identify attributes of the RBFMRP that impact future practice, graduate follow-up surveys will be distributed. These will be sent to graduates at one year and every five years thereafter. Survey results will be reviewed during Program Evaluation Sessions and acted upon if needed.

IX. MEDICAL RECORDS

A. General Policy - It is the responsibility of each individual physician to ensure that the records for patients for whom he/she has provided care are completed appropriately. Records become delinquent if they are not completed two weeks post-discharge. Failure to complete medical records in a prompt and timely fashion will jeopardize resident, attending, and full-time staff affiliated with the hospital as set forth in medical staff by-laws.

Medical record delinquencies for RBFMRP residents at Kern Medical may be posted at the discretion of the Program Director or designee. Second and third year residents who have more than one outstanding (greater than 14 days old) discharge summary, H&P, or operation report, and/or more than five total medical record deficiencies, and first year residents with more than three outstanding (greater than 14 days old) discharge summaries, H&P's, or operation reports, and/or more than ten total medical record deficiencies will receive a copy of the medical record deficiency report and a copy will be placed their file. The Resident Evaluation Committee will evaluate and report on incomplete medical records as part of the resident's semi-annual evaluation. If the delinquency, type, or total number of incomplete medical records is deemed excessive, corrective actions may be taken.

The Program Director also has the discretion to institute the following policy:

1. RBFMRP residents will be expected to maintain a back-up Family Medicine call schedule.
2. Members of RBFMRP (including residents and faculty) with medical record non-compliance, defined as more than five signatures or more than one summary dictation or history and physical delinquent more than 14 days post discharge, will not be permitted to participate in RBFMRP on-call activities until the following weeks' report indicates there are five or less signatures and one or less summary dictation or history and physical more than 14 days delinquent post discharge.
3. If a resident is unable to participate in call activities due to medical record non-compliance as defined in #2 above, the back-up resident on-call will be expected to take call for the involved resident.
4. Residents who are unable to take call because of medical record non-compliance will be expected to take two calls within the next 60 day period for the back-up resident who had to take over their call responsibilities, as per on-call/after hours coverage policies (See VI. Residents – On-Call Coverage)
5. Three or more episodes of medical record non-compliance as defined in #2 above is grounds for corrective action in the RBFMRP.
6. Prior to triggering the sanctions described above, the RBFMRP must contact the Medical Records Department and document that the involved resident has not completed all available medical records in the week prior to the proposed sanctions.

Hospital records will be reviewed by attending faculty and the Performance Improvement system established by the hospitals to document that records reflect high quality care, logical progression from diagnosis to initiation of treatment, and attention to smooth progression from inpatient to outpatient status. RBFMRP residents should write an admission note that covers pertinent historical points, physical findings, and the assessment and the management plan. A completely filled out and legible medical history and physical form is acceptable in lieu of an electronic or dictated history and physical, if the hospital permits.

B. Do Not Resuscitate Orders - RBFMRP residents will follow hospital procedures when writing orders concerning advanced directives and withholding of life saving interventions. To ensure the smooth completion of medical records, unlicensed first and second year residents will have their do not resuscitate orders and death certificates signed by their supervising senior resident on the Family Medicine Service.

C. **Kern Medical Family Medicine Service Patients -** The Family Medicine inpatient service is a service for all continuity patients of RBFMRP residents. This includes patients from Clinica Sierra Vista, and _____Convalescent Hospital.

Clinica Sierra Vista (CSV) has several sites and several physicians. All patients from the FMC will be admitted to the Family Medicine Service. Other clinical sites the RBFMRP is affiliated with and whose patients are to be admitted to the Family Medicine Service are listed on an ID badge tag which is updated at least annually by the program. The concept of the Family Medicine inpatient service is for our residents to have "continuity of care". Patients need to have been seen at the FHC at least twice within the last three years. If the patient has been seen once at the FHC and needs admission prior to his next scheduled appointment at the FHC, he will be admitted to the Family Medicine Service. If the patient is seen once at the FHC and either missed his appointment (and didn't reschedule) or never made a follow-up appointment, then the continuity has not been established and the patient gets admitted to the medicine team on-call.

There are some exceptions to the above. If, while in the Emergency Department, the resident is unable to find out why the patient was at the FHC (either he/she can't remember or it is after hours and the chart cannot be retrieved), then the patient will be admitted to the Family Medicine Service as long as there have been two visits in the last three years. Another exception is regarding Specialty Clinic patients. Many FMC faculty members see patients in Specialty Clinics offered at the Family Health Center. This does not make those patients Family Medicine patients. If the patient is seen at either the FHC (or any of the other Family Medicine sites listed above) for their continuity care and at a Specialty Clinic, then the patient is a Family Medicine patient and will be admitted to the Family Medicine Service.

The chief residents of both Internal Medicine and Family Medicine have established the medicine team on-call is responsible for administrative admissions of non-Family Medicine patients. Administrative admissions for Family Medicine patients as defined above will be admitted to the Family Medicine Service.

For patients discharged from the ED with need for 24-hour follow-up the following guidelines should prevail... If the patient is an established Family Medicine patient and needs early follow-up, they should be scheduled in/directed to their corresponding medical home. If the patient is not a Family Medicine continuity patient then the patient should go to one of the Kern Medical medicine sites, not the FHC.

Family Medicine patients admitted to the ICU from the ED or who were on the Family Medicine Service and transferred to the ICU will be placed back on the Family Medicine Service when discharged from the ICU regardless of what day the transfer out of the ICU is done. The Family Medicine Service resident should be notified as soon as possible of the transfer to receive appropriate patient hand-off by the ICU Resident.

If there is uncertainty as to who a patient's primary care provider is, the patient should be asked who they identify as their primary care provider or where they receive their usual care. If they identify themselves with any of the Family Medicine sites/providers referred to above, they should be admitted to the Family Medicine service. Otherwise, the patient defaults to the Internal Medicine service. If there are circumstances requiring resolution that arise beyond what is written above, please contact one of the chief residents or the Family Medicine or IM faculty on call.

D. **Performance Improvement** - Residents will participate in the Clinic Staff Meeting and in Performance Improvement and Utilization Review activities at the CSV Clinic. Clinic Staff Meeting meetings will be held regularly at the FMC. RBFMRP residents in all three years of training will be included in practice-based learning systems-based practice, and peer review activities. Each second and third year resident will be expected to review charts of their own or of their peers on a regular basis for Performance Improvement and utilization review indicators. Residents on the Family Medicine Service at Kern Medical are expected to attend the case-based learning/morbidity & mortality conference while they are on these services to be available to comment on and answer questions regarding care of patients.

X. RECRUITMENT

Maintaining the highest possible quality in the RBFMRP begins with the process of recruiting and selecting excellent Family Medicine residents. The outcome of this process is critical to all other aspects of our program.

The RBFMRP morale, reputation, potential to provide excellent services, and ability to reach desired educational goals are all improved with successful recruitment of high quality residents. It is appropriate that all members of the Residency Program should take this process very seriously, and should share in the responsibility of assisting in recruiting, interviewing and selecting candidates for the residency.

There is very intense competition for residents among Family Medicine training programs around the country. In order to be successful, recruitment activities need to be a year-round concern. Such activities include the following.

A. Updating the RBFMRP brochure/Intranet and Internet web sites - The brochure and web sites should be reviewed by faculty and chief residents annually to ensure accuracy of information. Any staff, resident, or faculty who notice a need for change should report this to the RBFMRP Residency Coordinator.

B. Participation in meetings of medical students interested in Family Medicine - Residents and faculty are encouraged to discuss our program at appropriate occasions at national and state-wide conferences and at Family Medicine interest groups for students at California medical schools. Some information and educational aids are available to support such visits. Coordination of participation in and funding for these recruitment efforts is done through the RBFMRP.

C. Communicating with family medicine interest groups for medical students - Residents and faculty are encouraged to correspond with the medical school from which they graduated regarding the Family Medicine interest group at that medical school. They may inquire as to what information we might send them that would be useful to medical students interested in knowing more about our program. RBFMRP should ensure that all Family Medicine interest groups associated with medical schools in California receive copies of our brochure.

D. Paying attention to medical students rotating through our program - Medical students who do a clerkship with us can have an important influence on other students from their medical school who are interested in Family Medicine. The RBFMRP should work to ensure that medical students are welcomed into our professional community, and that all such students are supported in their adjustment to Bakersfield and to their work here.

E. Distribution of application materials - RBFMRP participates in ERAS (Electronic Residency Application Service) and does not accept paper applications for residency positions. U.S. applicants may apply through their dean's office; foreign medical graduate (FMGs) may apply through ECFMG.

F. Interviewing

1. ***Selection of candidates for interviews*** - General Policy - All applications received during the selection period will be reviewed by at least one member of the RBFMRP faculty and/or staff. The RBFMRP will interview the best qualified applicants. Preference will be given to candidates who have a demonstrated commitment to working in the Kern County and/or with underserved populations, and with evidence of satisfactory completion of all clinical rotations undertaken in an ACGME accredited U.S. medical school or international medical graduates who have satisfactorily completed one year of training in an ACGME accredited U.S. medical school. Consideration will also be given to candidates who have participated in an ACGME approved post-graduate program within the last two years or in a country with reciprocity

agreements recognized by the ABFM (Canada, Britain, New Zealand and Australia). Other international medical graduates (IMGs) will also be considered. All IMGs must have applied to receive a valid letter from the Medical Board of California permitting entry into a residency training program to be granted an interview.

2. ***Criteria for Selecting Applicants for Interview -*** All applications are processed through ERAS (Electronic Residency Application Service). U.S. graduates apply through their medical school dean's office. International graduates apply through ECFMG. Paper applications are not accepted.

   Passage of Part 1 of the USMLE, COMLEX, or the equivalent examination from a country with reciprocity agreements recognized by the ABFM is required. Scores on each part of the USMLE, American Osteopathic Association Board or its equivalent which have been taken must be reported.

   Applicants that have completed undergraduate medical education training must provide Part 2 scores prior to consideration.

   If an applicant has post-graduate experience, a letter from the medical school dean's office and the program director from the resident's training program with a copy of medical school transcript are required. A list of completed rotations from the post-graduate experience is also required. A personal statement written by the applicant that includes their reasons for choosing family medicine in general is required.

   Two letters of recommendation from professionals who have worked with the applicant on clinical rotations in the last two years, or who currently work with the applicant in a medical setting, must be submitted. However, three letters are preferred.

   Various, specific applicant attributes will be considered beneficial and granted 'extra points' in the selection process because there is health workforce evidence to support the claim that individuals with these attributes have a higher likelihood of being retained as practicing physicians in the Central San Joaquin Valley, or similar, region, alongside with:

   a. Previous experience, especially origins, in the San Joaquin Valley.
   b. Representatives of underrepresented minority communities who indicate an interest in working in the San Joaquin Valley.
   c. Previous experience, especially origins, in rural communities.
   d. Demonstrated commitment to underserved populations.

   Communication/language skills help in caring for a large number of non-English speaking patients in our region; therefore multi-lingual applicants, particularly those whose language(s) coincide with populations served (Spanish, indigenous Latin American languages, Southeast Asian languages, Armenian, and Punjabi), will be viewed positively. Other professional skills acquired beyond those learned in medical school often help in practice (e.g. advanced professional training in a field related to medicine such as public health, anthropology, computer science, etc.), and will also be viewed favorably Granting preference to applicants with the aforementioned characteristics will help to meet our mission of providing well-trained, culturally-competent physicians to the population we serve.

3. ***Equal Employment Opportunity*** - It is the intent and resolve of RBFMRP to comply with the requirements and spirit of the law in the implementation of all facets of equal opportunity and non-discrimination. In recruitment, selection, or any other personnel action, there will be no discrimination on the basis of race, creed, color, religious belief, sex, age, national origin, ancestry, physical or mental disability, or veteran status.

4. ***Proof of Eligibility to Work*** - In compliance with the Immigration and Reform Act of 1986, all applicants must show proof of eligibility to work in the United States. Should an applicant be offered a position within the Family Medicine Residency Program, upon being hired, the applicant must complete an I-9 form,

which requires verification and certification of current eligibility to work in the United States. Applicants must show proof of eligibility to work in the United States if offered a position within the RBFMRP. Failure of a resident to begin residency training on time causes significant disruption to the program. If proof of eligibility is unavailable at the time of the match, the prospective resident must demonstrate an active pursuit of the process and cooperate with the RBFMRP to secure recommended eligibility. Failure to do so may cause RBFMRP to notify the NRMP of intent to release the employment contract based upon an anticipated breach for the forthcoming academic year and the uncooperative nature of the prospective resident.

5. ***California Letter*** - International graduates are required to submit a current evaluation status /post-graduate training authorization letter from the State of California with their application. The letter must be dated within one year of the start of residency training. Applications received without a current letter will be considered incomplete and will not be considered until a current letter is submitted by the applicant.

6. ***Community Recommendations*** - RBFMRP values the input and participation of physicians in our community and in residency training. In the event a physician in the community or former alumnus of the RBFMRP recommends an applicant to the RBFMRP directly by contacting the program, they will likely be offered an interview as a courtesy, if space permits. The same applies for personal contacts of current residents.

7. ***Interviews*** - RBFMRP will go over the scheduling process for interviews at least once a year. Interviews with faculty are required for all candidates. RBFMRP personnel coordinate the interview schedule, and help candidates in numerous ways to feel comfortable and informed in dealing with the interviewing process, finding directions, etc. - Applicants are accompanied by RBFMRP and/or CSV staff during their tour of RBFMRP sites. Residents may participate as tour guides and are excused from their clinical responsibilities on the half-day they provide tours. Where possible, first year residents should participate in the interview process. Two goals stand out in these interviews: to get to know each candidate better, and to introduce the residency program as a whole to each candidate. Each resident guide completes a copy of the applicant evaluation form. Residents on probation are ineligible to be tour guides.

8. ***Selection of Candidates*** - The RBFMRP evaluation process is designed to ensure fairness and consistency, involvement by interested faculty, and relevance to RBFMRP and community needs. Candidates will be judged based on criteria established by the RBFMRP. The following factors are taken into consideration:

    - Faculty Interview scores. Resident evaluation scores (Resident input is considered an important part of the selection process and residents are encouraged to complete interview forms to receive a better assessment by residents).
    - Board scores
    - Dean's letters
    - Letters of recommendation
    - Personal statements
    - Other desirable applicant attributes as delineated above under “Criteria for Selecting Applicants for Interview.”

A preliminary rank list is compiled from scores in each of the domains described above. The formula used for the analysis will be modified based on feedback from faculty, administrators, and residents each year.

Fine-tuning occurs after tentative rank ordering of all candidates is available.

G. Advance Credit and the Match - No advance credit will be offered for first year positions filled through the Match. Applicants accepted into the residency program outside the Match may receive advance credit consistent with their training and the American Board of Family Medicine guidelines.

H. The Match - Every effort will be made to fill all of the first year positions through the National Resident Matching Program (NRMP) Match.

RBFMRP will select senior students of US allopathic medical schools only through the NRMP's Main Residency Match.

First year positions will be filled through the Match with the following possible exceptions: Outstanding D.O. students, international medical school graduates, or graduates of U.S. medical schools as determined by the faculty and Program Director. Other exceptions may apply at the discretion of the Program Director.

Candidates accepted outside of the Match are expected to apply through ERAS and complete the standard application as well as meet all criteria for acceptance into the program through the Match.

For residents recruited by means other than ERAS (i.e. post-match and use of NRMP Universal Application), a standard letter of inquiry should be used to verify medical school graduation, and, where applicable, previous medical licensure and/or previous residency training.

Medical licensure can be verified via letter or the Federation of State Medical Board's web site: [www.fsmb.org/crvhome.htm]. For international medical school graduates, possession of a valid ECFMG certificate meets the intent of this policy for verification of medical school graduation.

XI. SPECIAL POLICIES

A. General Policy - RBFMRP is committed to working with residents and faculty needing time away for family or pregnancy-related issues. The RBFMRP may assist family medicine residents who become pregnant during their residency in a number of ways. Residents may be allowed to switch rotations with other residents including taking rotations from later years in the residency if coverage issues can be accommodated.

The American Board of Family Medicine states that a resident will not be allowed more than 30 days per year away from the residency without make-up of that time to be eligible to take the board exam. These 30 days include vacation and sick leave.

The Residency Review Committee for Family Medicine rule regarding time away from continuity of patients care in the Family Medicine Clinic states that there can be no interruptions for longer than two months in each of second and third years, with at least two months between "away" months.

The duration of maternity leave for resident physicians should be based on the written recommendation of the physician(s) caring for the resident and infant. Any maternity plan schedule must:

1. Safeguard the health of the mother and infant.
2. Assure that the resident fulfills all educational requirements.
3. Assure that patient care is uninterrupted by the resident's absence.

The pregnant resident should notify the Program Director and those responsible for the scheduling of rotations and call as soon as the pregnancy is confirmed. Efforts should be made to schedule the most demanding

rotations earlier in pregnancy, allowing for the least strenuous rotations to be performed around the time of the resident's estimated delivery date (EDD).

Residents may be allowed to schedule approved home study/reading electives, compliant with RRC-FM requirements, at or around the (EDD), in order to minimize time needed away from the residency. Such home study electives would in most cases include some FMC time weekly in order meet continuity of care requirements for the RRC. The rotation performed around the time of the estimated delivery date should be one in which the resident is not essential to the service.

B. Family Leave - Residents who become pregnant during residency training are allowed three to seven months of absence without pay as defined by state and federal law. During this time, CSV maintain benefits as required by law under the same conditions as for active employees according to the Family Medical Leave Act, the California Family Rights Act, and Pregnancy Disability Leave. If a resident who is pregnant elects to continue working, the RBFMRP may allow them to receive credit for rotations one month before their due date until three months after their due date without call responsibilities if they fulfill their normal daytime hour duties. The resident is expected to make up call before or after the leave so other residents are not overburdened.

Please note that call is an integral part of some rotations and it may not be possible to receive full credit for these rotations without taking their call. If such a rotation is scheduled around the time of the resident's expected delivery date, and the resident does not want to take call, every effort will be made to adjust the rotation (block) schedule so that the rotation can be taken at a different time. In the event such an adjustment is not possible, call responsibilities will be assessed during a different rotation block.

C. Privacy - The RBFMRP is committed to offering residents appropriate personal hygiene facilities while working and on call. The RBFMRP will work with Kern Medical to ensure that both female and male residents have adequate facilities while on call and working.

D. Primary Care Patients - The RBFMRP is committed to allowing all patients the freedom of choice in the selection of providers. Residents have the option of limiting the patients they see only after reviewing this with their advisor.

E. Faculty - The RBFMRP is committed to having a faculty which is representative of the population as a whole with equitable numbers of women and minority faculty. Women faculty members who become pregnant will be allowed three to seven months leave of absence without pay related to pregnancy. Vacation time may be combined to cover pregnancy-related absences and all accumulated sick leave must be used. Female faculty who become pregnant will be exempt from call responsibilities one month before their expected due date up until three months after their delivery. All leave time for faculty will be taken in accordance with CSV policy.

F. Sexual Harassment / Non-discrimination Polices - The RBFMRP and CSV are committed to assisting any resident or member of the RBFMRP who feels they have been a victim of sexual harassment or other form of discrimination. The RBFMRP Residency Coordinator and the CSV Chief of Human Resources will provide confidential support and assist in accessing CSV resources and/or legal procedures for addressing sexual harassment which are available through CSV. If a resident or member of the RBFMRP feels they have been a victim of sexual harassment, or other harassment, and prefers to confide in another member of the RBFMRP, the member of the RBFMRP can receive information from the RBFMRP Residency Coordinator on addressing sexual harassment complaints without divulging the name of the victim. If a resident or faculty member wishes confidential assistance, names of accused perpetrator or details should not be divulged. Such details may incur a legal requirement for CSV to act even if the complainant is not ready to make a formal complaint.

For more information, please refer to the CSV Employee Handbook.

State of California - The Department of Fair Employment and Housing

Department of Fair Employment and Housing
2218 Kasen Drive, Suite 100
Elk Grove, CA 95758
(916) 478-7251

CSV is committed to making the RBFMRP a pleasant and satisfying place to work without regard to sex or sexual orientation, race, religion, national origin, age, veteran status, or physical or mental disability.

CSV supports frank and regularly scheduled discussions on non-discrimination issues including sexual harassment, sexual discrimination, and gender issues in the work place. CSV will utilize educational time for discussion of these issues. In addition, gender and other non-discrimination issues will be included on a regular basis.

G. Disability - CSV supports the intent of the Americans with Disabilities Act. CSV and RBFMRP will make all reasonable efforts to accommodate qualified residents with verified disabilities by providing them with the necessary auxiliary aids and services that do not fundamentally alter the measurement of the skills or knowledge that is integral to residency training or result in an undue burden.

CSV and RBFMRP, in the absence of applicable CSV policies, will refer to the ABFM ADA Policies and Procedures if applicable with regard to special accommodations for residents with disabilities and act in accordance with all local, state, and federal regulations pertaining to the Americans with Disabilities Act.

If a resident or student wishes to receive special aids or assistance during an ABFM in-service examination or other tests and evaluation procedures due to a disability, the candidate must promptly submit to CSV, at the candidate's expense, documentation substantiating the candidate's disability. Appropriate documentation must meet the general requirements listed below. The following are adapted from the ABFM ADA Policies and Procedures:

Generally, proper documentation must:

1. Be typed or printed on official letterhead, and be signed by the qualified evaluator making the diagnosis. Information should be included regarding education/training, licensing, certification and areas of specialization of the evaluator;
2. Clearly state the diagnosed disability;
3. Provide a description of the functional limitations resulting from the diagnosed disability, including the identification of the major life activity that is limited by the disability, and how that major life activity is impacted;
4. Be current:
    a. Within the last six (6) months for psychiatric disabilities
    b. Within five (5) years for learning disabilities and for all other disabilities, determined with respect to the first day of the calendar year during which the examination is administered. (This requirement will not apply to most physical or sensory disabilities of a permanent and unchanging nature);
5. Include copies of records relating to and documenting the candidate's disability including a complete educational, developmental and medical history relevant to the disability for which testing accommodations are being requested;
6. Include a list of all test instruments used in the evaluation report and relevant subtest scores used to document the stated disability (This requirement will not apply to most physical or sensory disabilities of a permanent and unchanging nature);

7. Provide names and dates of previous tests taken with accommodations and the accommodations provided. Provide copies of notification allowing these accommodations;
8. Provide a description of the specific accommodation(s) requested;
9. Provide a statement of why the disability qualifies the candidate for the testing accommodations requested

The foregoing are general documentation guidelines applicable to all disabilities. In the case of certain disabilities, such as learning disabilities, ADHD, and psychiatric disabilities, ABFM has more detailed guidelines for documentation to supplement the foregoing requirements. If the candidate is requesting accommodations for one of these disabilities, please refer to the specific documentation guidelines for that particular disability.

After receiving this information, CSV will need to verify the candidate's documentation. CSV reserves the right to have the candidate's disability documentation evaluated by an independent expert, and to request that a candidate undergo an evaluation by an independent expert.

CSV will evaluate all requests for accommodations and will attempt to reasonably accommodate all applicants with properly documented and substantiated disabilities within the meaning of the ADA.

XII. ATTACHMENTS

A. Duty Hours and Working Environment

POLICY: ***Clinical and Educational Work Hours and Working Environment***

PURPOSE: RBFMRP endorses the Comprehensive Resident Duty Hours Policy developed by GMEC and complies with ACGME Clinical and Educational Work Hour requirements effective July 1, 2017. Resident assignments must be made in such a way as to prevent unreasonable patient loads, disproportionate new admission work-ups, extreme intensity of service or case mix, and inappropriate length and frequency of call, contributing to excessive fatigue and sleep deprivation.

RBFMRP has established policies for residents, which ensure:

- Residents must not be scheduled for more than 80 hours of clinical and educational work per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting;
- At least one day out of seven, averaged over 28 days, away from the residency program. At-home call cannot be assigned on these free days. The 24-hour period after a resident is post call cannot be counted as a day off;
- In-house on-call duty: No more frequently than every third night, averaged over a four- week period;
- In-house night float maximum: Residents must not be scheduled for more than 6 consecutive nights of night float. Night float experiences must not exceed 50 percent of a resident's inpatient experiences.
- 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 the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty when average over four weeks. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".
- All residents may be scheduled to a maximum of 24 hours of continuous work in the hospital. Strategic napping, especially after 16 hours of continuous clinical and educational work and between the hours of 10:00 pm and 8:00 am is strongly suggested. Residents may be allowed to remain on-site no longer than an additional 4 hours in order to accomplish safe and effective patient care transitions. Residents must NOT be assigned additional clinical responsibilities after 24 hours of continuous in-house work.

- All residents should have 10 hours free of clinical and educational work and MUST have 8 hours free of work between scheduled work periods. They must have at least 14 hours free of clinical and educational work after 24 hours of in-house work.
- While it is desirable that residents have 8 hours free of clinical and educational work between scheduled work periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than 8 hours free of work.

Such circumstances are defined by the ACGME Review Committee 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.

- Adequate back up is provided if sudden and unexpected patient needs create resident fatigue sufficient to jeopardize patient care during or following on-call periods.

All residents are required to document hours worked (including days off, sick time, vacation etc.) for every rotation by Friday of each week. If work hours are not reported by Friday of each week, additional call may be assigned to that individual. Residents shall document hours using New Innovations software. This information is collected and reported to the program director on a monthly basis and the GMEC on a quarterly basis, in order to address compliance with ACGME Clinical and Educational Work Hour requirements.

Under no circumstances should a resident feel compelled or coerced into reporting inaccurate work hours to portray compliance with work hour requirements. Any concern that this is occurring should immediately prompt a report to an advisor or a meeting with the program director.

On-Call/After hours Coverage - An on-call/after hour coverage system for residents is developed each year by the department to cover RBFMRP patients. The assignment of the call schedule is to be managed by the Chief Residents once the program matures and subject to approval by the Program Director. Coverage will include responding to patient calls, authorizing patient care, and admitting and following patients admitted to the RBFMRP \Inpatient Service. After hours coverage for the RBFMRP service may be provided by the resident(s) on the inpatient night float rotation. Residents are expected to complete a thorough history and physical. This can be documented using a history and physical form approved by the institution where the resident is working or by completing a thorough admission note and dictating a comprehensive history and physical. If an admission note is written it should indicate that the history and physical was dictated.

The faculty member rounding the following morning is expected to review the history and physical done by the resident on call the prior day and evening. The rounding physician is expected to provide feedback to the resident on call if there are significant concerns regarding their history and physical or the associated orders. Significant concerns may be forwarded by the rounding physician to the Resident Evaluation Committee for evaluation.

All faculty will be asked to comment on resident performance while on call as part of our regularly scheduled semi-annual review of each resident.

The Chief Residents will be responsible for enforcing/maintaining a back-up call schedule for senior residents to be activated if the resident assigned to call is unavailable for whatever reason. If the back-up call person is required to cover for a resident assigned to be on call, the resident assigned will owe the resident providing the back-up call coverage two evenings, weekend days, or holidays for each one evening, weekend day or holiday provided by the back-up call resident. If residents involved are unable to amicably arrange for this coverage, the issue will be brought first to the Chief Residents, and, if necessary, to the Duty Hours Committee for further action.

For first-year residents' call on a non-family medicine service, the RBFMRP Chief Resident should be contacted by the senior resident, Chief Residents, or the attending on the service when a RBFMRP PG-1 resident is unavailable for call. The Chief Residents will contact and designate another RBFMRP PG-1, if available, for call on

the involved service. If a back-up call person is assigned by RBFMRP to cover for a resident assigned to be on call, the resident originally scheduled will owe the resident providing the back-up call coverage two evenings, weekend days, or holidays for each one evening, weekend day or holiday provided by the back-up call resident. If a replacement is not available, then the two replacement calls will be added to the scheduled resident's second year call tally for the general RBFMRP call pool.

If residents involved are unable to amicably arrange for this coverage, the issue will be brought first to the Chief Residents, and, if necessary, to the Duty Hours Committee for further action.

It is considered unprofessional behavior to activate the back-up call system for circumstances that are not beyond the control of the resident on-call. Abuses of the back-up call system are grounds for corrective action as described in the Policy & Procedure Manual.

Residents on call are required to be in the hospital when they are on call.

Family Medicine residents are occasionally scheduled to be on call in-house the last day of their rotation. If this occurs, they cannot take call the following day nor can they attend in-patient or clinics on their new rotation (on a different service) due to duty hour restrictions. Please note: this does not include the resident completing the night float rotation as this is not considered in-house call. Residents completing the night float rotation are expected to report for a regular day of work on the Monday of the new rotation.

Residents providing in house call are excused from all clinical and educational activities the following day aside from related post-call educational debriefing and on-site transitioning of patient care the morning after being on call. Residents are expected to inform the involved service of any planned absence when they are post-call. The program coordinator is available for confirmation when questions arise.

Call schedules will ensure equity in call assignments among residents. Equity in resident call means the Chief Residents, if necessary, can mandate assigned call, and/or calls on holidays and weekends to more equitably distribute resident calls.

Knowing which residents and faculty are on call is critical. To ensure this occurs, the following procedures are followed:

1. Call schedules are posted online at www.new innovations.com. When at full capacity this will be done by the Chief Residents. They will send a copy to the department scheduler who will notify the necessary departments.
2. Any changes in call must be communicated to the program office, Scheduling Coordinator, and the clinical sites involved after being approved by the Chief Residents. The resident initiating the switch is responsible for making these calls. Residents are also expected to notify the service or attending to which they are assigned.
3. The Duty Hours Committee will be notified by the Chief Residents on a regular basis of changes in the call schedule and whenever the disaster call system is activated.
4. If more than three second or third year residents are unable to contribute to the call pool either because of departure from the training program or for prolonged periods of disability, faculty may cover any additional short-falls in call coverage.

B. Resident Outside Employment Policy – Moonlighting

POLICY: ***Resident Outside Employment Policy - Moonlighting***

PURPOSE: Rio Bravo Family Medicine Residency Program believes that the first priority of each resident is to achieve the goals and objectives of the training program. This is to produce in the broadest sense the fully competent physician capable of providing high quality care to his/her patients. Without compromising this goal, it may be feasible for some residents to seek outside professional activities - "moonlight" - if the resident adheres to the guidelines within this policy.

POLICY: Residents should recognize the primacy of their duty to the residency program. Each resident in training is expected to learn as much as possible about the art and science of medicine in general and of his or her specialty in particular. Outside employment must not, through fatigue and/or other distractions, create diversions that interfere with or compromise the assimilation of knowledge, the process of learning the skills and professional behaviors of the educational program or the physician's dedication to the care of his/her patients. Additionally, recognizing that the physician with a well-balanced life style may well provide more for his/her patients, the finite limits of the work schedule must be observed to provide for appropriate rest and recreation for good mental and physical health.

For any employment outside of the RBFMRP residents must clearly delineate in writing the responsibilities in the moonlighting experience, be approved in writing by the Program Director and be governed by the following principles:

1. The Program Director has the exclusive right to approve a request for moonlighting activity. The request may be approved or denied for any reason. PGY-1 residents are not permitted to moonlight.
2. Permission must be obtained PRIOR to engaging in moonlighting activity in writing. See reference to obtaining permission below.
3. The moonlighting workload is such that it does not interfere with the ability of the resident to achieve the goals and objectives of the residency program. As such, only residents in good standing may moonlight. Factors considered for a resident in good standing beyond academic performance include demonstrable progress in completing all program requirements, including scholarly activity, shadowing & videotaping requirements, clinical productivity and lecture attendance. Additional factors may be considered at the discretion of the Program Director.
4. There will be no outside employment during normal duty hours. A violation of this point may result in immediate suspension of moonlighting privileges and further corrective action.
5. Each resident must agree that if fatigue interferes with his/her performance, s/he will voluntarily reduce or eliminate outside employment until the situation is remedied.
6. Total hours in the combined educational program and the moonlighting commitment cannot exceed the limits set by the residency program or the ACGME Residency Review Committee. Therefore, each resident who participates in outside employment must accept the responsibility to keep his/her hours within the limits allowed by the applicable residency program RRC guidelines. Residents who moonlight shall enter their hours into e-value. Please refer to Moonlighting Request form.
7. The moonlighting opportunity does not replace any part of the clinical experience that is integral to the resident's training program.
8. In accordance to ACGME regulations, residents must be licensed for unsupervised medical practice in the state where moonlighting will occur.
9. Residents on probation or remediation as defined in Academic Improvement Policies may not moonlight.
10. Malpractice coverage is NOT provided by RBFMRP for any moonlighting activities. It is the responsibility of the resident to make sure malpractice coverage is provided by their outside employer or purchased by the resident.
11. The Program Director reserves the right to approve/deny/restrict any moonlighting activity for any reason and at any time as described in RBFMRP policies.

Noncompliance with the RBFMRP Resident Outside Employment Policy may lead to corrective actions including verbal counseling, written warning, probation, suspension, or termination. It is the resident's responsibility to report all outside or moonlighting activity to the Program Director. The Program Director will closely monitor that resident, working with the resident with respect to his/her performance. Prior to engaging in any outside employment,

the resident must submit and the RBFMRP Program Director must sign, a completed resident Moonlighting Request Form which:

1. Identifies the employer
2. Informs RBFMRP of the maximum number of hours to be scheduled at outside employment;
3. Indicates an understanding and agreement that the RBFMRP's professional liability insurance does not cover residents involved in outside employment;
4. If requested by the Program Director, has signature approval of designated faculty and staff certifying resident is making adequate progress/in good standing with the requirements of the RBFMRP.

Residents must submit all proposed changes resulting in working more hours than the maximum number of hours approved and report them to the resident's advisor and the RBFMRP office in writing. Changes must be approved by the Program Director prior to such changes becoming effective;

Violation of this policy, failure to obtain permission to moonlight, or continuation of moonlighting activities in the absence of explicit approval is grounds for placing the involved resident on probation.

Residents participating in episodic volunteer activities of less than eight hours duration such as school physicals, health fairs, or acting as the physician at sporting events are expected to follow the above guidelines but are not required to complete the Resident Moonlighting Request Form.

C. Chief Resident Job Description

1. ***Call Schedule***
   - **a.** Develop the call schedule for the current academic year, as well as keeping New Innovations.com software updated with the call schedule. While the goal is to develop the call schedule for the entire year, New Innovations must be updated at least 3 months in advance so that the Scheduling Coordinator can proceed with developing the clinic schedule appropriately. This will be done with the assistance of the Assistant Program Director.
   - **b.** Vacation requests must be completed by residents and submitted to the Chief Residents for review and approval by the established deadline date. Vacations will be ASSIGNED if the requests are not received by the due date. All requests turned in after the due date will be DENIED. All approved vacation requests will need to be given to the Scheduling Coordinator.
   - **c.** Schedule, enforce and report Back-Up coverage to the Executive Committee when activated.
   - **d.** Assist residents with implementation of time-off requests or call switches. While it is at the discretion of the Chief Residents, any requests or switches need to be reported to the Scheduling Coordinator to ensure clinic coverage. In addition, it is the responsibility of the Chief Residents to update New Innovations as needed.
   - **e.** Update the "Department Holidays and Coverage" memo.
   - **f.** Attend the "Intern Master Rotation" meeting held with all the Chief Residents from the other departments to discuss departmental needs and vacations.
2. ***Lectures***
   - **a.** Develop and maintain the lecture schedule for the current academic year, with the intent of focusing on resident interests and needs regarding educational talks, as well as by soliciting and facilitating speakers. In addition, the lecture series will be developed with the assistance of the Assistant Program Director.
   - **b.** Assign lecture dates and times for the PGY-3 Resident Lectures and M&Ms. Coordinate with the Geriatric lecture schedule, and with the Journal Club schedule.
   - **c.** Provide a moderator for all lectures provided by the Department.
   - **d.** Participate in the development of the Cancer Conference Resident Moderator Schedule.

e. Develop an agenda (based on the Resident-Resident meetings, etc.) for the Resident Support Group Meetings.

f. Prepare an agenda and coordinate resident meetings and assist in planning resident-faculty meetings.

g. Prepare an agenda for the ½ day they are scheduled to meet with the interns during intern orientation.

h. Assign resident lectures and M&M presentations.

i. Work with research faculty to ensure resident presenters are available for Journal Club presentations.

3. ***Meetings***

a. Attend and participate at the monthly Resident Evaluation Committee (REC) by providing input as needed during resident reviews.

b. Attend and participate at the Curriculum Oversight Committee meetings.

c. Attend the Chief Resident meetings with the Program Director every other month as scheduled.

d. Serve on University and Hospital committees as appointed by the Program Director.

e. Attend GMEC Meetings.

f. Attend the Chief Resident Seminar provided by the AAFP if time, rotation schedules, and budget permit. Encourage resident participation in local, state, and national AAFP functions.

g. Assist in assigning residents to participate on committees/councils that affect patient care or resident education as described in the Institutional Requirements.

4. ***Liaison Functions***

a. Serve as a resource for junior residents and interns regarding rotation activities and department policies.

b. Assign a senior to an incoming intern to serve as a "Senior Buddy."

c. Serve as a liaison between faculty and residents in the RBFMRP.

d. Serve as a liaison between RBFMRP and other departments' Chief Residents and leadership.

e. Represent RBFMRP on hospital committees as needed.

f. Meet with the Program Director on a regular basis.

g. Work with the core faculty and staff as needed to improve/modify educational and service coverage policies based on overall program needs and requirements.

h. Miscellaneous functions as determined by Program Director and residents.

5. ***Other***

a. All written correspondence to residents prepared by the Chief Residents must be reviewed and approved by the Program Director or designee prior to sending out.

b. Update the Resident Guidebook and distribute to all the residents at the start of the academic year. Make subsequent updates as may be needed to contained information throughout the academic year.

c. Assist with departmental plans for resident recruitment and take a lead role in soliciting residents to assist with recruiting.

d. Arrange for resident participation in planning for departmental functions including social functions such as the Holiday Party, Welcoming Party, Graduation Party, and Resident Retreat.

D. Supervision of Residents Policy

POLICY: ***Supervision of Residents/Fellows at Rio Bravo Family Medicine Residency Program***

PURPOSE: To comply with ACGME common program requirements for resident supervision and provide appropriate supervision for all residents and fellows at every level of training.

In accordance with ACGME Common Program Requirements, residents of the RBFMRP will abide by established guidelines for supervision. In particular, there will be a gradual progression of authority and responsibility, based on resident abilities, as determined by the program director, with input from the faculty and CCC.

Levels of Supervision will include:

1. **Direct Supervision**: the supervising physician is physically present with the resident and patient.
2. **Indirect Supervision**:
   - **a.** with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
   - **b.** with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
3. **Oversight** – the supervising physician is available to provide review of procedures/encounters with feedback provided aftercare is delivered.

This privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and its faculty members.

The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

Senior residents should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident.

The program has specific guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members. These include the need to transfer a patient to a higher level of care, such as the transfer of a patient to an intensive care unit or another medical facility, unstable patients, and end-of-life care decisions. Additionally, any patient who the resident feels is stable for discharge from the emergency room, but the emergency room physician feels admission is required, must be discussed with the faculty attending physician at the time of the consultation.

Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

Rio Bravo Family Medicine Residency Program adopts the above Common Program Requirements as stated above and taken from the ACGME Common Program Requirements.

E. Resident Evaluation Summary

Rio Bravo Family Medicine Residency Program
Residency Completion Verification
Final Training Summary Evaluation

[RESIDENT NAME, DEGREE] was a resident in good standing in the Rio Bravo Family Medicine Residency Program from ***[START DATE]*** to ***[STOP DATE]***.

Comments from preceptors about **his/her** strengths and performance this last year include the following:

- ***Strengths***

Procedural experience will be presented in a separate report.

Performance on standardized testing was as follows:

TEST SCORES

EXAMINATION	***DATE***	***SCORE***	***PERCENTILE***

In-Training Examination	MM/DD/YR	###	##%
In-Training Examination	MM/DD/YR	###	##%
In-Training Examination	MM/DD/YY.	###	##%

Additional comments regarding personal attributes, interests, leadership, and community participation and volunteering include;

- ***Added comments from Program Director, Coordinator***

He/She plans to practice in **Practice Site/Location**

[RESIDENT] has completed the required components of our Core Competency-based curriculum in an exemplary fashion. Specific requirements as stipulated by the Residency Review Committee-Family Medicine for clinical patient care volumes, completion of required rotations activities, delivery of continuity maternity care, domiciliary care, practice management, etc… have been met.

His/Her composite scores on our evaluation system are listed below. We use a progressive rating system from 1 = Novice to 5 = Competent (6 = Exceptional)

COMPETENCIES

CATEGORY	***PGY3 AVERAGE***	***AVERAGE***
COMMUNICATION SKILLS	##.#	##.#
MEDICAL KNOWLEDGE	##.#	##.#
PATIENT CARE	##.#	##.#
PRACTICE-BASED LEARNING AND IMPROVEMENT	##.#	##.#
PROFESSIONALISM	##.#	##.#
SYSTMES-BASED PRACITCE	##.#	##.#

[RESIDENT] demonstrated outstanding interpersonal skills and professional behaviors. **He/She** has developed a strong foundation of medical knowledge and clinical skills from which he/she has demonstrated acceptable clinical competency.

We, as members of the faculty of Rio Bravo Family Medicine Residency Program, verify the accuracy of the above information and believe that this resident has demonstrated sufficient professional ability to practice competently and independently as a family physician at the time of **his/her** graduation.

We recommend **him/her**

☐ **Highly without reservation**

- *Met all expectations during training*
- *No deficiencies*
- *May have demonstrated some degree of difficulty during training but remediated or corrected satisfactorily*

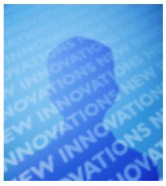
☐ **As qualified and competent**

- *Did not meet all expectations during training*
- *Continues to demonstrate a degree of difficulty with appropriate behaviors but these are not considered significant in regards to the quality of patient care*
- *Had demonstrated significant difficulty during training but remediated or corrected satisfactorily*

☐ **With some reservations**

- *Continues to demonstrate significant difficulties by objectively observed behaviors or by the consensus opinion of the faculty. It is felt that these may impact the quality of patient care. S*
- *Specifically:*

F. Evaluation of Resident Performance



Subject Name
Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by: **Evaluator Name**
Status
Employer
Program

General Resident Evaluation

Patient Care

1 Gathers essential information about the patient (history, exam, diagnostic testing, psychosocial context) PC1, L 1/ PC 2, L2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

2 Generates appropriate differential diagnoses for any presenting complaint PC 1, L 1, PC 4, L2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

3 Consistently recognizes common situations that require urgent or emergent medical care and utilizes appropriate protocols to stabilize patients PC 1, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

4 Develops appropriate diagnostic and therapeutic management plans for acute conditions PC 1, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

Medical Knowledge

5 Demonstrates the capacity to improve medical knowledge through targeted study MK 1, L 1

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

Systems-Based Practice

6 Demonstrates the capacity to correctly interpret basic clinical tests and images MK 2, L 1

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
◯	◯	◯	◯	◯

7 Synthesizes information from multiple resources to make clinical decisions MK 2, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
◯	◯	◯	◯	◯

8 Anticipates expected and unexpected outcomes of the patients’ clinical condition and data MK 2, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
◯	◯	◯	◯	◯

Professionalism

9 Demonstrates honesty, integrity, and respect to patients and team members PROF 1, L 1

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
◯	◯	◯	◯	◯

10 Completes all clinical and administrative tasks promptly PROF 2, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
◯	◯	◯	◯	◯

11 Consistently recognizes limits of knowledge and asks for assistance PROF 2, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
◯	◯	◯	◯	◯

12 Accepts constructive feedback PROF 4, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
◯	◯	◯	◯	◯

13 Knows and considers costs and risks/benefits of different treatment options in common situations SBP 1, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

14 Understands and follows protocols to promote patient safety and prevent medical errors SBP 2, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

PRACTICE-BASED LEARNING AND IMPROVEMENT

15 Uses point-of-care, evidence-based information and guidelines to answer clinical questions PBLI 2, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

16 Incorporates feedback and evaluations to assess performance and develop a learning plan PBLI 2, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

17 Compares care provided by self and practice to external standards and identifies areas for improvement PBLI 3, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

Communication/Interpersonal Skills

18 Recognizes that effective relationships are important to quality care and actively engages patients and their families C 1, L 1

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

19 Organizes information to be shared with patients and families C 2, L 2

Below Expectations	Working to Meet Expectations	Meets Expectations	Exceeds Expectations	Not Observed or Not Applicable
○	○	○	○	○

XIII. OTHER

A. CLOSURE OF RESIDENCY DUE TO ADVERSE ACGME ACCREDITATION ACTION

- The Clinica Sierra Vista / Rio Bravo Family Medicine Residency Program shall notify each resident affected:
- As soon as reasonably possible of a decision to discontinue any training Program for any reason.
- As soon as reasonably possible upon receipt from ACGME, or any other relevant accrediting body of any notification regarding non-accreditation or probation of similar change in the professional status of any training Program.
- As soon as reasonably possible of a decision regarding merger or closure, that has substantial impact on any training involved.

For residents continuing in a Program for which accreditation is lost, Clinica Sierra Vista / Rio Bravo Family Medicine Residency Program shall maintain levels of training to continue to provide rotations required for certification and add ancillary and professional staff to cover losses in resident coverage. Clinica Sierra Vista / Rio Bravo Family Medicine Residency Program shall take reasonable steps to try to regain full accreditation for the Program, to encourage residents to remain in the Program, and to balance the service needs of the Clinica Sierra Vista / Rio Bravo Family Medicine Residency Program with the professional goals of the residents involved.

Upon receipt from the ACGME of any confirmation of an adverse accreditation action, Clinica Sierra Vista / Rio Bravo Family Medicine Residency Program will notify and provide a plan of response for the change in accreditation status within 30 days. Program Director will notify each affected resident / fellow about the intended plan of action.

If a decision is made to reduce the size or close a program, the Program Director will inform the affected residents/fellows already in the program to complete their education or assist them in enrolling in another ACGME accredited program at other institutions.

B. ADMINISTRATIVE SUPPORT IN EVENT OF A NATURAL DIASTER - Clinica Sierra Vista / Rio Bravo Family Medicine Residency Program is committed to its GME programs and residents. In order to protect and assist residents in the event of a natural disaster, Clinica Sierra Vista / Rio Bravo Family Medicine Residency Program will continue patient care and post-graduate training activities during a disaster if at all possible. If a break in training does occur, Clinica Sierra Vista / Rio Bravo Family Medicine Residency Program will review the situation to decide the best course of action.

The Program Director will immediately notify residents in the event an interruption in training is imminent. If determined that post-graduate training is discontinued for a period of time, Clinica Sierra Vista / Rio Bravo Family Medicine Residency Program will support resident transfer to another ACGME accredited program. While it will be the residents' responsibility to locate interested programs, Clinica Sierra Vista / Rio Bravo Family Medicine Residency Program will provide letters of support for residents who require transfer to another institution. If available, evaluations and other employment documentation will be supplied upon request of the resident and/or receiving institution.

C. NON-COMPETITION - The Rio Bravo Family Medicine Residency Program, along with their sponsoring institution, Clinica Sierra Vista maintains a policy that residents/fellows are not required to sign a non-competition guarantee or restrictive covenant upon graduation.

D. MOONLIGHTING - RBFMRP believes that the first priority of each resident is to achieve the goals and objectives of the training program. This is to produce in the broadest sense, the fully competent physician capable of providing high quality care to his/her patients. Without compromising this goal, it may be feasible for some residents to seek outside professional activities-"moonlight"- if the resident adheres to the following guidelines:

- Moonlighting can begin in Post-Graduate Year (PGY) 3 with Program Director and Faculty approval. The resident must be in good academic standing. Residents can moonlight within or outside of Clinica Sierra Vista.
- Per the Accreditation Council for Graduate Medical Education (ACGME), moonlighting hours must not put a resident over the 80-hour work week. Residents can work the weekend, as long as they are rested and can participate in required residency activities.
- Moonlighting must not interfere with the resident's primary responsibility which is the completion of his/ her residency duties. A resident is expected to spend a minimum of forty (40) hours per week at their residency responsibilities. An exception would be if a resident chooses to take paid time off (PTO) hours to moonlight. The Program Director will determine the number of hours of PTO that may be used in this fashion, including care to avoid burnout. Therefore, if a resident would like to moonlight on a weekday, it must be ensured that the 40-hour work week has been met. The moonlighting request is to be approved by the resident's faculty advisor/ faculty preceptor of the rotation. Additionally, the following guidelines must be followed:
    - **i.** Moonlighting is a privilege reserved for residents in good standing. Before a resident can start moonlighting, it must be approved by the program director.
    - **ii.** Moonlighting cannot be scheduled during required residency activities (didactics, continuity clinic, rotations).
    - **iii.** When scheduling moonlighting, the resident must send their residency schedule to the moonlighting coordinator (Anaisa Arambula), and inform the residency coordinators (Arianna Herrera and Elena De La Torre), to confirm that there are no conflicts with required residency activities.
    - **iv.** If a resident is moonlighting and a continuity delivery is scheduled to happen soon, the resident must make arrangements to get coverage for the delivery. He/she will not abandon his/her moonlighting commitment to go to a delivery.
    - **v.** If a resident commits to a moonlighting shift, and he/she is unable to keep that commitment, it is his/her responsibility to find coverage for that shift.
    - **vi.** Moonlighting is a privilege that can be rescinded at any time, as determined by the program director.
    - **vii.** Failure to comply with the moonlighting policy will result in losing the privilege to moonlight.
    - **viii.** Delineation of specific privileges (procedures) is determined during the credentialing process by Clinica Sierra Vista (CSV), the program director and/or faculty.
    - **ix.** The resident's patient schedule will be determined by Clinica Sierra Vista (CSV) based on his/her moonlighting site (ie. Walk-in clinic/ primary care clinic).
    - **x.** Moonlighting residents will be included in Quality Assurance Measure activities such as peer and chart reviews.
    - **xi.** The resident will be given a copy of this policy and sign an acknowledgement form before approval of moonlighting privileges.