

Resident Handbook

**Mercy Redding Family Practice
Residency Program**

2026-2027

Resident Handbook

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2026-2027

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Resident Handbook

Mercy Redding Family Practice Residency Program

I. Welcome

At its inception in 1975, the Family Practice Residency Program was based at the Shasta General Hospital in Redding, California. The program began with the mission to produce well-trained family physicians to enter practice in the surrounding region. Our graduates have met many of those needs, especially as the population has grown, but there remains substantial, under-served populations in the north state in need of basic primary care services. A fundamental goal of this residency is to meet these needs, while advancing the practice of health promotion and disease prevention in the community.

In February of 1988, Shasta General Hospital closed. Through the efforts of many, but perhaps most notably the resident staff, sponsorship of the residency program was transferred to Mercy Medical Center, Redding. With our new hospital partner, the underlying residency mission to address the unmet health needs of the north state, through training qualified family physicians was reaffirmed. The Sisters of Mercy, and parent organization Dignity Health, sponsor this residency program as a tangible effort to meet the needs of the poor and under-served in our community. We welcome you to share this mission.

In your role as a family physician in training, you will be called upon, in widely varied and often challenging circumstances, to provide competent and compassionate care to others. With the support of your fellow residents, the residency faculty, the hospital and community, you will further your confidence and skills as a physician. We challenge you to take a broad perspective of your developing role as a family physician. You have entered training as a generalist, but beyond that, the community in which you practice will need you as a community physician. Use your time with us to enhance your understanding of, and effectiveness in, working with the community you serve. In doing so, you will truly reach your potential to positively impact the lives of your patients.

While becoming a family physician, we do not expect you to sacrifice your life outside of residency. Family Practice training can be a demanding task, yet truly effective family doctors have learned to balance their personal needs for fulfillment with the demands of their job. While short-term compromises must be made, our goal is to support a healthy personal, family and emotional lifestyle during residency that you will carry into practice. You will only be effective and satisfied as a family physician to the degree that you can find balance and fulfillment in the many roles you play.

Your time in residency training will be divided between the Family Practice Center, Mercy Medical Center, and community based opportunities. The majority of PGY1 clinical rotations are spent at Mercy Medical Center where you'll learn to function effectively in the in-patient environment. As you progress through your residency training, an increasing proportion of your

time will be focused on the Family Practice Center and ambulatory rotations. Each week in the center you will build relationships with a growing panel of your own patients. Your patients will look to you for ongoing care and advice. Through these relationships you will learn to be a personal physician. Try to stop by the center every day, if possible, to keep up with patient messages, prescription refill requests, etc. You'll know your patients better, be more helpful to the clinic staff, and everyone will get more satisfaction out of the relationship. Following your patients when they are hospitalized or when they deliver an infant is part of your education as well. While this can be a challenge at times, continuity of care is a foundation of family practice.

From time to time, the family practice center is also involved in the training of primary care associates such as Family Nurse Practitioners and Physician's Assistants. This association of resident physicians and primary care associates gives you the opportunity to learn to function as a team member in an interdisciplinary approach to health care. Take advantage of it as the skills to function effectively as a team member/leader will be essential to your success as a modern physician.

The faculty is here to support you in your clinical care and professional growth. Family Physicians from the community (many of whom are program graduates) share their time as family practice preceptors as well. Many other physicians are actively involved in the Family Practice Residency Program as preceptors, guest lecturers and consultants. We welcome you to our community, look forward to working with you, and hope your experience offers both challenge and achievement.

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

Mercy Medical Center GME Integration of Mission, Vision, Core Values, and Statement of Commitment

CommonSpirit Mission, Vision, and Values

Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Vision

A healthier future for all-inspired by faith, driven by innovation, and powered by our humanity.

Values

Compassion

- Care with listening, empathy, and love.
- Accompany and comfort those in need of healing.

Inclusion

- Celebrate each person's gifts and voice.
- Respect the dignity of all.

Integrity

- Inspire trust through honesty.
- Demonstrate courage in the face of inequity.

Excellence

- Serve with fullest passion, creativity, and stewardship.
- Exceed expectations of others and ourselves.

Collaboration

- Commit to the power of working together.
- Build and nurture meaningful relationships.

GME Mission and AIMS

Mercy Medical Center Redding's Graduate Medical Education mission is to train family medicine physicians to provide the highest quality of safe and competent care for the community they serve in both the inpatient and outpatient settings. We share the mission of CommonSpirit

Health to make the health presence of God known in our world by improving the health of people we serve, especially those who are vulnerable, while we advance social justice for all.

Goals and Objectives

- Develop and maintain resident education curricula incorporating the ACGME Milestone Competencies.
- Recruit and train physicians to practice medicine in any setting while caring for patients of all ages and backgrounds with an emphasis on meeting the primary care needs of Northern California.
- Promote Scholarly Activity to build medical knowledge and educate residents, faculty, students, and the general medical community.
- Maintain a highly competent faculty to educate medicine residents and students while providing high quality care to the underserved.

Statement of Commitment for Graduate Medical Education

Mercy Medical Center Redding is committed to applying its mission, visions, and core values towards patient care and graduate medical education. We are committed to providing appropriate clinic experience and effective supervision and teaching to achieve the highest level of competency. Mercy Medical Center will provide the necessary educational, financial and human resources to support graduate medical education. We are committed to ensuring that clinical and administrative resources are made available to ensure the compliance with ACGME requirements for its graduate medical education training.

In the event of a disaster or even resulting in the interruption in patient care and resident education, Mercy Medical Center decides to reduce or close the resident program, the following will be notified as soon as possible: the graduate medical education committee, the DIO, the Program Director, and the residents. In such circumstances, residents already in the program will be allowed to complete their education or assistance will be provided in enrolling in an ACGME-accredited program in which they can continue their education.



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Mercy Medical Center
Redding

I have reviewed and approve the Mission Statement, Vision, Core Values, and
Statement of Commitment for Graduate Medical Education at Mercy Medical Center
Redding.

G. Todd Smith, President
Mercy Medical Center Redding

Robert Folden, Chief Operating Officer
Mercy Medical Center Redding

Jerome B. Myers, M.D., PhD, Chief Medical Officer
Mercy Medical Center Redding & Dignity Health North State

Nikita Gill, M.D., Board Chair
North State Service Area Hospital Community Board

Duane Bland, M.D., Program Director, DIO
Mercy Redding Family Practice Residency Program
June 2024

**RESOLUTION OF THE
DIGNITY HEALTH NORTH STATE SERVICE AREA COMMUNITY
BOARD OF DIRECTORS
Residency Program Mission Statement and
Statement of Commitment**

WHEREAS, Mercy Medical Center Redding ("MMCR") operates a family medicine program (the "Mercy Redding Family Practice Residency Program" or "Residency Program") under an affiliation agreement with University of California Davis School of Medicine and is accredited by the American College of Graduate Medical Education ("ACGME"); and

WHEREAS, the Residency Program has developed a Mission Statement and Statement of Commitment that articulates the mission, vision and core values for Residency Program's graduate medical education that is consistent with ACGME requirements and which is attached herein as Attachment A ("Mission Statement, Vision, Core Values and Statement of Commitment" or "Mission Statement"); and

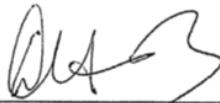
WHEREAS, the North State Service Area Community Board of Directors has determined that the attached Mission Statement as promulgated by the Residency Program and approved by MMCR, is appropriate and consistent with the North State Service Area hospitals' mission;

NOW, THEREFORE, BE IT RESOLVED, that, the Mission Statement is hereby approved effective immediately.

CERTIFICATE OF SECRETARY

I, the undersigned, certify that I am the presently appointed and acting Secretary of the North State Community Board of Directors, and that the foregoing Resolution was adopted at a meeting of the foregoing Board on September 11, 2014, at which a quorum was present, and is now in full force and effect.

IN WITNESS WHEREOF, I have subscribed my name on September 11, 2014.



Douglas Hatter, M.D.
Board Secretary

CURRICULUM 2026 - 2027

PGY 1	Weeks	PGY 2	Weeks	PGY 3	Weeks
ABFM/RAD/Lab	1	ABFM/RAD/Lab	1	Clinic Doctor 1 - Specialty Clinics	2
Behavioral Science	2	Clinic Doctor 1 - Specialty Clinics	6	Elective (Includes 4 wks away)	14
Community Medicine	2	Clinic Doctor 2 - Emphasis on GYN	4	Emergency Department	2
Emergency Department	4	Elective (Includes 2 wks away)	10	Specialty Clinics (VA)	4
Intensive Care Unit	2	Medicine	5	Family Practice Service	5
Medicine	10	Night Float Med/FPS/Ped	2	Flexible*	3
Night Float Med/FPS/PED	3	Night Float OB/NB	2	Geriatrics/SNF	4
Night Float OB/NB	3	Obstetrics	4	Night Float Super Senior	3
Obstetrics	6	Orthopedics	2	Obstetrics	1
Orthopedics	4	Pediatrics Outpt.	4	Pediatrics Outpt.	4
Pediatrics Inpt.	6	Pediatrics Inpt.	4	Pediatrics Inpt.	1
Surgery	4	Rural Location	4	Pediatric ED	2
Vacation	4	Vacation	4	Psych	2
Family Practice Services Orientation	1			Urgent Care	1
				Vacation	4

*Includes additional weeks in MED, Night Float Med, Night Float PEDs/OB, Obstetrics, Pediatrics, Clinic Doctor 1, Family Practice Service, or Elective

**

ABFM & Rad = American Board of Family
Medicine Modules and Radiology
AwE = Away Elective
BSC = Behavioral Science
C1 = Outpatient Specialty Clinics 1
C2 = Outpatient Specialty Clinics 2
CM = Community Medicine
Elect = Elective
ER = Emergency Medicine
Flex = Flexible (C1,FPS,Med,NFM,NFOBP,OB,
Elect)
FPS = Family Practice Service
ICU = Intensive Care Unit
Med = Internal Medicine Service Inpatient
NFM = Night Float Medicine

NFOBP = Night Float Obstetrics and Pediatrics
NFS = Night Float Senior (Supervise PGY1 on Med,
Ob & Peds)
OB = Obstetrical Service Inpatient
Ortho = Orthopedics and Musculoskeletal Medicine
Peds = Pediatric Service Inpatient
Psych = Psychiatric
Out Peds = Outpatient Pediatric Clinic
Rural = Rural Rotation
Surg = Surgery
UrgC = Urgent Care
Vac = Vacation

**Note: Residents have 2 weeks of orientation prior to
PGY1 Block 1*

CURRICULUM RESOURCES

The residency program has a variety of educational resources including the hospital online library (journals and textbooks), Mercy Family Health Center library (outpatient-oriented textbooks), Up-to-date on-line, and Clinical Key on-line (textbooks, journals, and multimedia). The residency program also subscribes to Family Medicine Residency Curriculum Resource which can be accessed at www.fammedrcr.com using the residency password. On our Google website, the residency program has created an Independent Study resource page; this includes an extensive list of on-line educational resources and modules organized by topic and our block curriculum.

II. Clinical Rotations and Experiences

ADVANCED LIFE SUPPORT TRAINING (PGY1, PGY2, PGY3)

A. Core Competencies

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

- Demonstrate an ability to rapidly assess and gather information pertinent to the care of patients in an urgent and emergent situation and develop treatment plans appropriate to the stabilization and disposition of these patients. (Patient Care, Medical Knowledge)
- Be able to identify the indication and perform procedures appropriately for the stabilization of the patient in an urgent and emergent care setting. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement)
- Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care). (Systems-based Practice)
- Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns. (Practice-based Learning and Improvement)
- Appropriately inform, educate, and elicit patient and family participation in medical decision making in a professional and caring manner with sensitivity to cultural and ethnic diversity. (Professionalism, Interpersonal and Communication Skills)

Residents are required to maintain certification in NRP and PALS, Cardiopulmonary Resuscitation (Basic Life Support) and Advanced Cardiac Life Support (ACLS) all of which are completed during orientation. Re-certifications are completed quarterly (one small set of 3 modules at a time) through Resuscitation Quality Improvement (RQI) computer modules done on the hospital network. The modules will be accessed through Pathways at Employee Central. Occasionally, one of the modules will require some hands-on training, which can be done in education or specific computers up on the floors at the hospital. Upon graduation, you can obtain a copy of your certifications from Education. These certifications will be valid for 2 years. Advanced Trauma Life Support (ATLS) is an excellent intensive course, which is required for any resident who is licensed and who wishes to moonlight at a rural/remote ED in California. ATLS courses are available but often hard to schedule, so planning ahead is very important. The residency program will pay for the course registration, but all other costs are the resident's. Finally, ALSO courses are provided through the Shasta Community Health Center, and all first year residents are required to attend.

BEHAVIORAL SCIENCE & PSYCHIATRY (PGY1, PGY3)

A. Core Competencies

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

- Understand normal and abnormal psychosocial growth and development across the life cycle and be able to apply this knowledge to the care of the individual patient. (Medical Knowledge, Patient Care)
- Be able to recognize, initiate treatment for, and utilize appropriate referrals for mental health disorders to optimize patient care. (Systems-based Practice, Practice based Learning and Improvement)
- Demonstrate the ability to effectively interview and evaluate patients for mental health disorders using appropriate techniques and skills to enhance the doctor patient relationship. (Interpersonal and Communication Skills, Patient Care)
- Have sensitivity to and knowledge of the emotional aspects of organic illness. (Patient Care, Professionalism)
- Be able to intervene effectively and professionally in emergent psychiatric, domestic violence, child abuse, and disaster situations. (Professionalism, Systems-based Practice)
- Understand the impact of mental health disorders on the family unit.

B. Service Goals

The primary objective of the Behavioral Science Curriculum is to help Family Practice Residents more fully develop the skills and the knowledge base needed to intervene meaningfully and efficiently in the mental health issues of patients. A large percentage of patients seeking ambulatory care have a psychosocial or cultural issue of significance that if unrecognized or mismanaged seriously impairs the effectiveness of the physician's care. Residents are expected to achieve the full set of Behavioral Science and Psychiatry Competencies through this curriculum. Curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description

- A two-week rotation occurs in the first year, and includes a variety of elements of behavioral medicine, psychiatry and psychopharmacology. Periodic site visits may be conducted to vital community agencies and mental health programs. This will provide residents with practice in networking within a mental health community and will provide them with referral and consultation resources. Some aspects of behavioral health training can be best implemented in an experiential manner including Counseling Skills Training, Interviewing Skills Training, Relaxation and Stress Management (for both residents and significant others), psychological testing and behavioral science precepting.

- A two-week rotation occurs in the third year focused on clinical experiences working alongside psychiatric specialists at Shasta-Community Health Center and Hill Country Community Clinic.
- Two half-days per month are allocated for an ongoing “specialty clinic” devoted to psychiatry which occurs throughout the year and residents will rotate individually through this clinic at the Mercy Family Health Center (viz., FPC).
- In addition to the specific rotations and specialty clinics, behavioral science is integrated into the entire three-year experience at the FPC, in lectures, hospital rounds, clinic “shadowing”, “curbside” consulting, and when requested, through elective experiences.
- As well as the Behavioral Science Rotation, Residents will be assisted in the process of developing a more comprehensive knowledge of behavioral strategies and resources necessary to address the patient’s needs in the practice of Family Medicine. To this end, the following ABFM and STFM training modules will be utilized as indicated:
 - Depression
 - Health Behavior
 - Mental Health in the Community

D. Duties

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

Integration of Behavioral Science with general clinic-based outpatient medicine will occur during the rotation (and also during the second and third years of training) through precepting in which Behavioral Science faculty will see patients along with Residents during typical clinic visits. During the course of the first year rotation, the Resident will have regular contact with the Behavioral Science Coordinator who will provide supervision and will help the Resident process and integrate his/her experiences in therapy, intakes and with other professionals and agencies. Each Resident will be evaluated by the Behavioral Science Coordinator with respect to his/her competencies in this domain. Each mental health professional with whom the Resident came into contact during the rotation will also have an opportunity to provide feedback about the Resident. The Resident will also be given feedback and an oral review during a closure session with the Behavioral Science Coordinator.

Priority for the psychiatry “specialty clinic” at the FPC will be given to second and third year residents whenever the clinic schedule permits. This is because, for the most part, it will be a more advanced experience designed to assist residents in learning to provide independent,

primary care level psychiatric services. However, when a first-year resident is assigned to this training experience, teaching will be focused and guided toward the residents' level of training and experience. The special psychiatry clinic is an important training opportunity for all residents inasmuch as Family physicians are frequently called upon to provide initial psychiatric screening and treatment in both inpatient and outpatient settings. They are also frequently required to provide longitudinal psychotropic medication management for patients whose primary clinical issues are psychiatric and yet are not severe enough that a referral to a psychiatrist is mandated. Accordingly, it is essential for residents to gain experience in handling this level of primary care independently. Services will mostly involve psychotropic medication management, but there will be elements of psychotherapy and counseling, crisis intervention, and coordination of special referrals. The focus of teaching with these cases will be appropriate for primary care physicians, resulting in a better integration of general medicine and psychiatry.

CARDIOLOGY (PGY3)

A. Competencies

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

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

B. Service Goals

The goal of this experience is to prepare a resident to enter practice with the knowledge, attitudes, and skills to effectively evaluate, manage, and treat patients with cardiac conditions. Residents will also learn when to seek consultation appropriately. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description

Cardiology is incorporated into the four week SpC rotation. This experience is designed to expose residents to the evaluation and management of common cardiac conditions that present in the ambulatory and inpatient settings. The experience is based in a cardiologist's office practice and hospital with case based one on one teaching. Where appropriate to accomplish educational goals, residents may accompany cardiology preceptors into the hospital setting to consult on hospitalized patients. This rotation represents one component of a resident's training in cardiology. Substantial training in the primary care of patients with cardiac conditions is received in the Family Practice Center and during time spent on the inpatient medicine service. Responsibility for the medical management of inpatients with cardiac conditions occurs throughout residency training.

D. Duties

Attendance at the cardiologist's office and hospital is scheduled. During this time you will work one on one with the cardiologist. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/weeks.

CLINIC I and CLINIC II ROTATIONS (PGY2, PGY3)

A. Service Goals

The Clinic I and Clinic II Rotations are unique and valuable sets of ambulatory family practice and specialty experiences scheduled at MFHC and SCHC. The general goal is to provide the resident with a hands-on, longitudinal experience in various specialty areas (Colposcopy, Dermatology, ENT, Family & Community Medicine, GYN, HIV, Orthopedics and PEDS Cardiology) as defined below under the supervision of the relevant attending. The resident also develops a higher level of involvement and responsibility for the daily operations of the FHC, seeing acute add-on patients, participating in office management, ancillary services, review of patient care studies, and process improvement. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

B. Service Description

The Clinic I (C1) rotations total 8 weeks during the PGY II and PGY III years. The Clinic II (C2) rotation is 4 weeks during PGY II year. See the Specialty Clinic descriptions under section D, which indicate the rotation (C1 and/or C2), site -- at the MFHC, SCHC or other site). Each month, the C1 & C2 clinic schedule may vary slightly, so the resident must consult the published schedule.

C. Duties

During this rotation the resident will be in clinic from 8:00 a.m. to 5:00 p.m. daily, Monday - Friday. The resident will be responsible for all specialty clinics as scheduled. They are also responsible for follow-up on all patients seen in specialty clinics during their clinic rotation.

When not scheduled for a specialty clinic, the resident will see his/her continuity patients and/or work-ins. Following call, the resident will have the day off (but call must be scheduled so that required specialty clinics are covered). Other health center responsibilities vary according to the Track. The C1 resident is responsible for covering the Cerner inbox for residents on vacation, away elective, and rural rotations.

D. Specialty Clinics

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

Clinic I Specialty Clinic Monthly Frequency

Dermatology:	1x
HIV:	1x
Practice Management	2x
Minor Surgery/Plastics:	3x
Vasectomy:	3x
Ortho Sports Medicine	1x
PEDS Cardiology	4x

Clinic II Specialty Clinic Monthly Frequency

Behavioral Science:	2x
Colposcopy:	5x
Dermatology:	1x
GYN:	2x

Psychiatry Clinic (C2 – MFHC)

A. Core Competencies:

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

- Understand normal and abnormal psychosocial growth and development across the life cycle and be able to apply this knowledge to the care of the individual patient. (Medical Knowledge, Patient Care)
- Be able to recognize, initiate treatment for, and utilize appropriate referrals for mental health disorders to optimize patient care. (Systems-based Practice, Practice based Learning and Improvement)

- Demonstrate the ability to effectively interview and evaluate patients for mental health disorders using appropriate techniques and skills to enhance the doctor patient relationship. (Interpersonal and Communication Skills, Patient Care)
- Have sensitivity to and knowledge of the emotional aspects of organic illness. (Patient Care, Professionalism)
- Be able to intervene effectively and professionally in emergent psychiatric, domestic violence, child abuse, and disaster situations. (Professionalism, Systems-based Practice)
- Understand the impact of mental health disorders on the family unit.

This involves seeing patients referred to the MFHC psychiatry clinic with a board-certified Psychiatrist.

Colposcopy Clinics (C2 – and SCHC):

A. Core Competencies:

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

- Be able to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to sensitive issues, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform a comprehensive pelvic examination with appropriate screening tests and wellness counseling, based on the patient's age and risk factors. (Patient Care, Medical Knowledge)
- Be able to perform routine gynecological procedures (Patient Care, Medical Knowledge)
- Develop treatment plans for common conditions affecting female patients, including reproductive issues, utilizing community resources when indicated. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women. (Patient Care, Interpersonal and Communication Skills)
- Consult with obstetrician-gynecologists, other physician specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice)

Training is provided in the management of abnormal cervical pathology under the supervision of family practice faculty. Procedures include Colposcopy, cryotherapy and LEEP. Colposcopy clinic is held four times per month at Shasta Community Health

Center. Residents may also be scheduled at SCHC Maternity Clinic as the schedule allows.

Dermatology Clinic (C1 and C2 – MFHC):

A. Core Competencies:

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

- Provide compassionate and culturally appropriate patient care that recognizes the effect of skin problems on the patient and emphasizes the importance of comprehensive preventative care. (Patient Care)
- Be proficient in the diagnosis and treatment of common dermatologic diseases and be adept at performing common dermatologic procedures. (Medical Knowledge)
- Utilize diagnostic and evidence-based treatment guidelines as well as maintain up-to-date knowledge of appropriate usage of evolving dermatologic treatment technology. (Practice-based Learning, Improvement)
- Demonstrate the ability to communicate effectively with the patient so that dermatologic diagnosis and treatment is provided in a non-judgmental, caring manner. (Interpersonal Communications, Professionalism)
- Incorporate knowledge of the dermatology specialty in order to determine which problems can be managed by a family physician and to understand how to coordinate needed referrals to specialty providers. (Systems-based Practice)

During this outpatient rotation the resident will gain experience in recognition and proper management of common dermatological problems and minor dermatological surgical procedures. This rotation is a “hands-on” experience that depends on the residents to provide direct care, so residents must be present in the dermatology clinic at all times during this rotation. The residents see patients and present them to the dermatologist, discuss management and strategy. All extensive surgical procedures are referred to the Procedure Clinic. The resident on Dermatology does biopsies while excisions are referred to the Procedure Clinic or Plastics Clinic.

Policy for Follow-up of Pathology Results from Procedure Clinic or Derm Clinic

Residents who perform excisions or biopsies during Procedure or Derm Clinic will be sent the pathology report. If the patient is not scheduled for a post-op clinic visit, the resident will contact the patient to inform them of the path results and if needed will refer the patient to the appropriate Procedure or Plastics Clinic for definitive treatment. A copy of the path report will also be sent to the PCP and to Dr. Namihas who will be available to discuss with the resident appropriate follow-up. If the resident who performed the procedure is on vacation or otherwise not available, the resident assigned to C1 Clinic doc rotation will be responsible for contacting the patient regarding the path report and making the appropriate referral. The resident will also document in Cerner indicating that

the patient was contacted and referral made as indicated. A copy of this documentation and the Procedure Note will be sent to the PCP.

Pathology Reports will be sent to the following providers depending on the source of the referral:

MFHC continuity patients that are referred to Derm or Procedure Clinic:

MFHC staff will send the pathology report to the physician that performed the biopsy, Dr. Namihas and the patient's assigned MFHC PCP.

Referrals from outside MFHC referred to MFHC Derm or Procedure Clinic:

MFHC staff will send the pathology report to the resident that performed the biopsy and Dr. Namihas. The resident will ask the front office staff to send copies of the Procedure Note and follow up documentation to the referring physician.

GYN Clinic (C2 – SCHC):

A. Core Competencies:

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

- Be able to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to sensitive issues, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform a comprehensive pelvic examination with appropriate screening tests and wellness counseling, based on the patient's age and risk factors. (Patient Care, Medical Knowledge)
- Be able to perform routine gynecological procedures (Patient Care, Medical Knowledge)
- Develop treatment plans for common conditions affecting female patients, including reproductive issues, utilizing community resources when indicated. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women. (Patient Care, Interpersonal and Communication Skills)
- Consult with obstetrician-gynecologists, other physician specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice)

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

HIV Consultation Clinic (C1 – SCHC):

A. Core Competencies:

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

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

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

Ortho Sports Medicine (C1-MFHC)

A. Core Competencies

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

- Perform an appropriate musculoskeletal history and physical examination, and formulate an appropriate differential diagnosis and recommend treatment, including requisite subspecialty referrals (Patient Care, Medical Knowledge, Systems-based Practice)
- Perform an evidence-based, age-appropriate, and activity-specific pre-participation physical examination (Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism)
- Communicate effectively with a wide range of individuals regarding musculoskeletal health care, including patients, their families, coaches, school administrators, and employers (Interpersonal and Communication Skills)
- Understand that sports medicine involves caring for the medical conditions of athletes in addition to the musculoskeletal conditions (Patient Care)

Residents will work with a sports medicine physician during the Ortho Sports Medicine at MFHC with referrals to the clinic coming from providers at MFHC.

PEDS Cardiology (C1-MFHC)

The general goal is to provide the resident with a hands-on, longitudinal experience in PEDs Cardiology under the supervision of the relevant attending. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

A. Core Competencies

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

- Perform an appropriate pediatric cardiac history and physical examination, and formulate an appropriate differential diagnosis and recommend treatment, including requisite subspecialty referrals (Patient Care, Medical Knowledge, Systems-based Practice)
- Perform an evidence-based, age-appropriate, and activity-specific pre-participation physical examination (Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism)
- Communicate effectively with a wide range of individuals regarding cardiology health care, including patients and their families, (Interpersonal and Communication Skills)

Practice Management (C1 – Private office)

A. Core Competencies:

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

- a. Demonstrate physician leadership as an uncompromising advocate for patient-centered care of the highest value within the constraints of a viable and sustainable business model for the Patient-Centered Medical Home (PCMH), Patient-Centered Medical Neighborhood (PCMN), and the Health Home (Healthy Community) for the patient's welfare while balancing the business realities of practice management and financial success. (Patient Care and Professionalism)
- b. Actively conduct a practice search, interviews, contract negotiations, and successfully enter practice. (Interpersonal and Communication Skills)
- c. Demonstrate knowledge of the legalities and ethics of hiring, promoting, and firing of employees in a practice setting. (Professionalism)
- d. Identify the structure and operations of health organizations and systems, and the role of the family physician in this structure. (Systems-based Practice)
- e. Identify the measures of health, including determinants of health, health indicators, and health disparities. Advocate for the development of value metrics which will optimize Meaningful Use reporting and payment for value in the healthcare system. (Practice Based Learning and Improvement)
- f. Identify and foster partnerships that maximize achievement of public health goals. (Systems-based Practice)

This rotation will be incorporated into one half day during the PGY2 year. It will take place at SCHC. The experience will primarily focus on Practice Management, with opportunities to meet with the various office staff and physicians to learn how to provide patient care efficiently and effectively in a private practice setting. Residents will learn the following skills:

- Effective billing
- Designing a budget and managing overhead costs
- Collections for various insurance carriers
- Assessing practice staffing needs
- Understanding of office manager function
- Personnel management and labor issues
- Employment law and procedures
- Integrating new technologies into one's practice
- Determining value of patient care in one's community
- Assessing customer satisfaction
- Measuring clinical quality

- Tort liability and risk management
- Office scheduling systems
- Use of computers in practice
- Alternative practice models

Vasectomy Clinic (C1 – SCHC)

A. Core Competencies:

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

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

Residents also participate in Vasectomy Clinic, which is located at SCHC and precepted by family physicians. The goal is to have residents become proficient at performing vasectomies, and all aspects relating to the procedure, including counseling, pre-op exam, and post-op care.

COMMUNITY MEDICINE (PGY1)

A. Core Competencies

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

- Demonstrate an ability to work effectively with multicultural and impoverished patients/populations. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Systems-based Practice)
- Define the needs of special populations in the suburban and rural setting. (Medical Knowledge, Systems-based Practice)
- Be knowledgeable in adapting the health delivery organization to the culture and the needs of the patients and community being served. (Practice-based Learning and Improvement, Systems-based Practice)
- Describe the epidemiological / demographic characteristics of the population being served. (Medical Knowledge)
- Be knowledgeable in improving and transforming patient services based on patient outcome data and self-assessment. (Practice-based Learning and Improvement)
- Explain how the social determinants of health contribute to health outcomes. (Medical Knowledge)

- Be knowledgeable in affecting health behavior change. (Medical Knowledge, Interpersonal and Communication Skills)
- Be knowledgeable in self-care practices that prevent burn out. (Professionalism)

B. Service Goals

Family physicians work predominantly in the ambulatory care environment and must have a strong understanding of the community and its resources for assisting in a patient and family's care. The family physician's role in providing health care to a community includes the application of medical knowledge to the care of various populations, school medicine, occupational medicine, epidemiology, health education, Home Care and Hospice, and public health. This rotation will also emphasize health care delivery issues unique to rural and remote locations in Far Northern California. Residents are expected to achieve the full set of defined Community Medicine Competencies during this rotation. Finally, additional and important longitudinal experiences are structured in the Family & Community Medicine rotation in the PGY II and PGY III years (see Clinic I and Clinic II). Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description

During this rotation, residents will be exposed to a variety of community partners. Completion of the "Community Needs Assessment & Planning" E-learning module is also expected.

Finally, the resident also has an "immersion" experience at the FPC for orientation and to appreciate their belonging to the model practice team.

D. Duties

Residents will attend various activities scheduled during community medicine rotation and complete the Community needs Assessment & Planning module. Other modules may be scheduled as indicated. Call scheduling should be avoided if possible, during this rotation.

CONTINUITY HOME CARE VISITS (PGY2, PGY3)

A. Clinical Competencies:

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

- Be able to perform standardized comprehensive assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high quality care. (Interpersonal and Communication Skills, Professionalism)
- Recognize self-limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)
- Be able to communicate effectively with patients of all ages, demonstrating active listening skills, a respectful approach to issues that may be sensitive for women, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive issues in women as well as comprehensive wellness counseling based on the patient's age and risk factors. (Patient Care and Interpersonal and Communication Skills)
- Consult and communicate appropriately with obstetrician-gynecologists, maternal fetal medicine specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice, Professionalism)
- Demonstrate the ability to take an age-appropriate history and perform a physical exam. (Patient Care, Medical Knowledge)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure that the diagnosis and the treatment plan are clearly understood. (Interpersonal and Communications Skills)
- Recognize his or her practice limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care. (Professionalism, Systems-based Practice)

B. Service Goals:

The goals of performing continuity home care visits are to allow residents to see patients in their home environments and to identify social and/or environmental concerns which impact patients' ability to maximize their health/health care system. These visits will

assist the resident in better understanding the obstacles to, as well as resources for, improving their patients' overall health and well-being.

C. Service Description:

Each resident must perform at least one home visit during his/her residency training.

D. Duties:

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

A faculty member must supervise all home care either on site (preferable) or by prompt chart review, as is appropriate based on a resident's level of expertise and competence. If a faculty member is unable to accompany the resident to the patient's home, it is recommended that he/she take another resident. Home Visit Packets with the appropriate forms documenting pertinent social/clinical information and education can be found in the MFHC Preceptor Room file. It is preferable that these visits be recorded on the forms provided, opposed to dictating, as this will ensure prompt chart reviews and verification/tracking of these educational experiences. Completed home visit forms will be filed into the patients MFHC clinic record. Each home visit should also be entered by the resident into the New Innovations on-line tracking program.

Home Visit Instructions

- 1) Identify an appropriate patient for home visit and contact the patient to discuss the home visit, schedule a time, and get directions. Coordinate with a faculty member's schedule if he/she is to attend the home visit with you.
- 2) Obtain the Home Visit Packet from MFHC Preceptor Room file prior to your scheduled visit.
 - a. Continuity Home Care Visit policy statement
 - b. Home Visit Instruction Sheet
 - c. Home Visit Record (Infant, Maternal, Geriatric)
 - d. CPSP Billing Sheet or Purple Nursing Facilities Billing Sheet
- 3) Enter the home visit in New Innovations

DISCHARGE SUMMARIES

The Discharge Summary needs to be countersigned by the faculty attending involved the day of discharge. The resident will note on the progress note in EMR or in dictation itself, who that

attending is. The resident will also note to whom the patient is being sent for further care. This can be an individual physician or a facility. This information should also be placed in the discharge orders as many individuals and agencies need this information shortly before or after discharge. Discharge summaries should be completed on the day of discharge, if this is not possible they must be completed within 48 hours of discharge. A full discharge summary is not required for uncomplicated admissions of less than 48 hours or for normal OB deliveries, but the final progress note on the day of discharge must include the final diagnosis, outcome of hospitalization, care disposition and plan for follow up care.

Otolaryngology - ENT (PGY3)

A. Core Competencies:

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

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

B. Service Goals

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

C. Service Description

The ENT rotation is integrated into a four week Specialty Clinic (SpC) block in the third year of residency along with Urology, Cardiology, and Ophthalmology and is designed to expose residents to the evaluation and management of common ENT conditions that present in the ambulatory setting. The experience is based in an ENT office practice with case based, one on one teaching. Where appropriate to accomplish educational goals, residents may accompany ENT preceptors into the hospital setting to assist or observe

surgical procedures. This rotation represents one component of a residents training in ENT. Substantial training in the primary care of patients with ENT conditions is received in the Family Practice Center. Responsibility for the medical management of inpatients with ENT complaints occurs throughout residency training.

D. Duties

Attendance at the ENTs office is scheduled. During this time you will work one –on-one with an ENT. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/week.

ELECTIVES (PGY2, PGY3)

A. Service Goals

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

B. Service Description

There are 24 weeks of elective time (6 of these weeks are away elective). While on Elective, residents participate fully in their continuity health center duties, call, and conference attendance. If an Away Elective is approved by the Program Director, even if that time is taken locally, the resident has no health center, call or conference responsibilities, which nearly doubles the actual amount of time for the elective experience(s) during this Away Elective block. While we will make every attempt to accommodate resident requests for time away, that is not a guarantee, because of Medicare funding, and provision of continuity services to the residents' patients at the FPC.

International electives must meet the criteria below before they will be considered. Out of state electives will also require exceptional justification.

Research Electives can be structured as a research or academic project, focused on a research or evidence based literature clinical project resulting in a formal presentation at Grand Rounds.

C. Duties

The residency must comply with the regulations of both the Accreditation Council for Graduate Medical Education (ACGME) and Medicare for the appropriate approval and documentation of elective time. Without this documentation, credit cannot be given to the resident for the elective rotation. Further, the hospital will be in violation of its financial obligations to Medicare and cannot be paid the monies that support the residency program. **For these reasons, the Elective Form, which contains the required steps to obtain approval for the elective and document approval from the supervising physician, must be completed in its entirety. If the resident has not submitted the proper and completed Form to the Program Director (who approves each Elective) one month in advance for local or 3 ½ months in advance for away electives, the resident will be assigned by the program to an in-patient rotation or outpatient /clinic rotation with the usual FPC duties.**

General Elective Procedure: (see 'Request for Elective form')

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

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

Section 3: If the supervising physician is an employee (not owner), section 3 must be completed and signed by owner or authorized employee, which is an employee who is permitted to obligate the facility to accept the resident

Section 4: The resident must submit the Request for Elective form to the Residency Program Director for approval:

- No later than one block in advance of a local Elective
- No later than 3 ½ blocks in advance of international or away electives and electives requiring special scheduling requests involving the health center or call are desired. If not, one block advance is sufficient.

Section 5: The final evaluation must be completed by the supervisor for the resident to receive credit for the rotation. It is the resident's responsibility to have the supervisor complete Section 4 Final Evaluation and return this to the residency office (Except SonoSim, see specific instruction with elective).

Additional Criteria for SonoSim Electives

See SonoSim Elective category

Additional Criteria for Away Electives

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

Additional Criteria for International Electives

- Residents must be performing well in competency areas of patient care, medical knowledge, and practice-based learning and improvement, interpersonal

communication, professionalism, systems-based practice, procedural skills, and are functioning at a level appropriate to training. (Based on resident's rotation evaluations, ITE scores, and academic counseling reports)

- Faculty quality preceptor available on-site
- Medical repatriation insurance is obtained and the resident understands/accepts the limitations of CommonSpirit insurance policies (**Note: The AAFP has information on their website under International Travel and Health which includes links on travel information, insurance, etc.**)
- Specific Rotation goals and objectives established ahead of time
- Fluency in native language or access to bona fide translator
- Grand rounds caliber presentation on relevant clinical topic after return
- Resident bears all costs of travel, housing, food, pre-health screenings and immunizations
- Resident may be responsible for acquiring and paying their own separate malpractice insurance during the international rotation

Additional Requirements for Parental Newborn Electives:

- See Parental Newborn Elective category

Additional Requirements for Research Electives:

- Define the scope of the project and how it directly relates to the care of your patient(s) at Mercy Family Health Center
- Limit to 2 weeks per the span of residency training unless exceptional circumstances
- Schedule as Elective (addressing when resident will be in clinic). Research Electives will not be scheduled as "Away" electives unless the nature of the project requires the resident to be away from Redding. Requests for exceptions to this policy will be made on a case by case basis and reviewed by the residency office.
- Define how the resident plans to organize and present the material covered during the elective. Choices include:
 - Giving a noon conference or grand rounds (If a resident elects to give didactics lecture he must talk to the faculty lead for noon conferences to schedule a day to present.) The presentation of the material covered in the research elective must be ready at the completion of the designated elective time.
 - Summarizing the material in a written report and presenting it to the faculty advisor. The summary of the material must be ready for presentation at the completion of the designated elective time.

Additional Requirement for Site Visits (see also Management of Health Systems):

- Senior residents are allowed to take 3 days from their usual resident duties providing that any time off is arranged around their clinic schedule, as per the clinic scheduling policy.

- A Paid Time Off / Master Change form must be completed and approved prior to approval of time away for interview(s).
- Time spent for evaluating a site beyond three days will be counted as PTO time. Of note, additional days away from the program may result in an extension of residency training and a delayed graduation. Travel days may require online study time, which is to be recorded in the resident 'Study Log'.
 - If the resident thinks he/she will need additional interview days, it is recommended that elective rotation days be scheduled during a portion of the regularly scheduled vacation weeks. This will allow upcoming vacation days to be used for interviews.
 - The resident must fill out an elective rotation application form prior to this activity and have it signed by the program director.
- This is considered an educational opportunity in the area of practice management; the resident must complete a practice site evaluation form (available in residency office). The supervisor at the practice site who provides the information about the site must sign and date the form.

EMERGENCY MEDICINE (PGY1, PGY3)

A. Core Competencies

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

- A. Demonstrate an ability to rapidly assess and gather information pertinent to the care of patients in an urgent and emergent situation and develop treatment plans appropriate to the stabilization and disposition of these patients. (Patient Care, Medical Knowledge)
- B. Be able to identify the indication and perform procedures appropriately for the stabilization of the patient in an urgent and emergent care setting. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement)
- C. Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care). (Systems-based Practice)
- D. Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns. (Practice-based Learning and Improvement)
- E. Appropriately inform, educate, and elicit patient and family participation in medical decision making in a professional and caring manner with sensitivity to cultural and ethnic diversity. (Professionalism, Interpersonal and Communication Skills)

B. Service Goals

The goal of this rotation is to develop the skill in the assessment and management of acute medical and surgical disease entities in the emergency department setting. This rotation will

allow the resident to better see things from the perspective of an ED physician, which is different from continuity of care outpatient medicine. In the ED, all patients are seen as having the worst possible diagnosis until that diagnosis is “ruled out”. In many cases, patients who do not have a clear diagnosis must be admitted for further evaluation. By the end of the rotation, residents will be able to triage many patients within a few minutes regarding the need for admission.

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

- Demonstrate an ability to rapidly assess and gather information pertinent to the care of patients in an urgent and emergent situation and develop treatment plans appropriate to the stabilization and disposition of these patients. (Patient Care, Medical Knowledge)
- Be able to identify the indication and perform procedures appropriately for the stabilization of the patient in an urgent and emergent care setting. (Patient Care, Medical Knowledge, Practice based Learning and Improvement)
- Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care). (Systems-based Practice)
- Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns.(Practice-based Learning and Improvement)
- Appropriately inform, educate, and elicit patient and family participation in medical decision making in a professional and caring manner with sensitivity to cultural and ethnic diversity. (Professionalism, Interpersonal and Communication Skills)
- To achieve competence in diagnosing and managing emergency conditions as appropriate for the primary care physician (Knowledge, Patient Care)
- To achieve competence in recognizing, stabilizing, and referring complex emergencies (Knowledge, Patient Care)

Knowledge Objectives:

The Family Practice Resident should have knowledge of:

1. Principles of history taking appropriate to the emergency situation.
2. Principles of problem solving in Internal Medicine.

3. Technique of basic and advanced cardiopulmonary resuscitation, including Assessment, resuscitation & stabilization of critically ill patients (including codes).
4. Indications for and method of procedures including venipuncture, arterial puncture, lumbar puncture, thoracentesis, paracentesis, airway insertion and chest tube placement.
5. Indications for referral and consultation.
6. Pathophysiology, diagnosis, and management of emergencies including:
 - a. Cardiovascular emergencies (e.g. hypertensive crisis, acute myocardial infarction, cardiopulmonary arrest, acute coronary syndrome, cardiac arrhythmias, ruptured aortic aneurysm)
 - b. Pulmonary emergencies (asthma, COPD, foreign body, pneumonia, CHF, PE)
 - c. Endocrinological emergencies (e.g. diabetic ketoacidosis, hypoglycemia, hyperosmolar coma)
 - d. Pulmonary emergencies (e.g. status asthmaticus, acute pulmonary edema, pneumothorax, smoke inhalation, airway obstruction, pulmonary embolus, near drowning)
 - e. Hematological emergencies (e.g. shock, acute blood loss, bleeding disorders, sickle cell crisis, thromboembolism)
 - f. ALOC (toxic, metabolic, infectious, trauma)
 - g. Gastroenterological emergencies (e.g. GI bleeding, thrombosed hemorrhoid, abdominal pain, peritonitis, AAA, renal calculi, gallbladder disease, appendicitis, mesenteric ischemia, Hernia) Infectious disease emergencies (e.g. meningitis, septic shock)
 - h. Genitourinary emergencies (e.g. hematuria, renal colic, electrolyte disorders, obstructive uropathy, testicular torsion)
 - i. Allergic emergencies (e.g. anaphylaxis)
 - j. Neurological emergencies (e.g. stupor and coma, head injuries, status epilepticus, heat injury, CNS bleeding, meningitis, CVA, TIA, peripheral deficits, e.g. Bell's palsy or w/LBP)
 - k. Surgical emergencies (e.g. trauma, burns, foreign bodies, abrasions including corneal abrasions, sprains, bites)
 - l. Gynecological emergencies (e.g. PID, rape, pelvic pain, ectopic pregnancy, first trimester bleed, DUB, ovarian cyst/torsion)
 - m. Pediatric Fever (how kids are different, ED w/u, 1st 1-3 months)
 - n. Psychiatric emergencies (e.g. acute psychosis, suicide attempt, or high risk for suicide attempt)
 - o. Chemical emergencies (e.g. poisoning, drug intoxication)
 - p. Orthopedic trauma (e.g. splinting, casting, interpreting x-rays, general assessment, orthopedic and soft tissue injuries)
 - q. Ophthalmologic emergencies (e.g. corneal abrasions, eye pain, foreign bodies)

- r. Minor surgery (e.g. suturing, I&D).

Skill Objectives: The Family Practice Resident should be able to:

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

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

Other educational activities related to this field are provided by:

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

C. Service Description

Emergency Medicine Rotation 6 weeks): As required by the ACGME, residents receive over 100 hours and at least 125 encounters of emergency medicine training. It is scheduled in each of the first, second, and third years. The ED physicians are all partners with Vuity Physician Group and work at both Mercy Medical Center Redding (MMCR) and St. Elizabeth Community Hospital (SECH) in Red Bluff. The hospitals are considerably different and provide varied opportunities for learning. SECH is a small community hospital that has a significant migrant worker population and limited subspecialty resources, while MMCR is a Level II trauma center for the whole north state.

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

Residents will have all post-call days off. Usual shifts at MMCR for doctors are 6a-2p, 10a-6p, 2p-10p, 6p-1a, and 10p-6a (the schedule has been in flux and there may be changes). At St. Elizabeth shift times are 7a-3p, 3p-11p, and 11p-7a. There will be flexibility for scheduling shifts but for the most part, they should coincide with an oncoming doctor's shift with a minimum of 8 consecutive hours (except 6p-1a which is 7) to maximize patient care continuity and workflow. We will also try to schedule longer shifts of 10-12 hours when possible. When two residents are scheduled for ED rotation during the same block, they cannot be scheduled in the same ED during the same shift but may overlap. While on shift a resident may see a patient with any of the attending physicians there if they are part of the volunteer faculty pool, but understand near shift change, it makes sense to staff the case with the doctor that will be staying or newly arrived. Look and ask to get involved with higher acuity cases, traumas, procedures, and other interesting cases. Please introduce yourself to the physicians as you meet them and let them know you're working the day's schedule. R2s may spend up to eight hours in the pre-hospital arena to develop an understanding of the challenges in the field. (Air Ambulance exposure is excluded due to liability). Attending ED physicians can provide supervision, but not mid-level providers.

Nick Schulack, MD will coordinate the ED rotation and manage the schedule. He is available at Mercy ED, his cell is 720- 233-5884, email: nick.schulack@vuity.com. Scheduling issues should be worked out at least 2 weeks before the beginning of the ED rotation. Please contact him directly to initiate this. There will be a brief orientation before the rotation starts.

Although residents may be excused to attend noon conference, that hour does not count toward the total time expected for the ED. Residents must inform the ED attending when

leaving and returning to the ED. Before leaving, residents must also inform the ED attending of their action plan for each patient, including test results pending, written instructions, and prescriptions if needed.

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

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

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

Pediatric Emergency Medicine Rotation (2 weeks):

Third year residents will be scheduled for two weeks of a Pediatric Specific ED rotation. This experience should include a minimum of 50 emergency department encounters with children. This will occur during winter months as pediatric patient volumes tend to be higher during this time. We do not have a separate pediatric ED or zone. You will be expected to identify all pediatric patients (17 years of age or less) and become involved in their care. During this rotation, residents will not be expected or allowed to see adult patients, this is an ACGME requirement and is strictly adhered to. During this time residents will be expected to see all pediatric patients in the main emergency department, and should actively watch for pediatric patients in the lobby or in the triage area that they can be involved with. You will receive an email from Dr. Schulack reminding you of this before the rotation.

D. Duties / Faculty Expectations:

To maximize learning opportunities, residents should be allowed to select ED cases of highest educational value while potentially taking these cases out of order given the steady high volume of patients in our ED. Residents should ask the ED attending for advice on case selection as needed. Residents should be alert for codes or patients arriving by ambulance, helicopter, or being brought straight back from triage since most critical patients offer good learning opportunities. These cases must be discussed with the ED attending prior to ordering therapeutic and diagnostic interventions. Although residents will be granted greater autonomy with additional experience, part of the educational benefit comes from learning how an experienced ED physician approaches clinical problems. Unstable patients may require resuscitation prior to obtaining the entire H&P and diagnostic studies. Residents may observe codes, but are encouraged to

participate, as they feel comfortable, particularly intubations or other procedures. If residents are aware of specific experience for which they need additional training, they are encouraged to inform the attending at the beginning of the shift so the attending can direct the resident to those patients or discuss with Dr. Schulack.

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

Residents will be evaluated on the following:

1. Patient care--which includes gathering essential and accurate history and physical exam data, ordering appropriate tests, integrating medical facts with clinical data, formulating logical plans, and documenting appropriately. Residents must present cases in a concise, logical, structured, appropriate manner. Residents must see a minimum number of patients per shift according to year of training: 0.5 patients per hour for R1s, 0.8 patients per hour for R2s, 1 patient per hour for R3s. (e.g., In a 10 hour shift, R1s will see a minimum of 5 patients, R2s 8 patients, and R3s 10 patients). These are minimum numbers with the expectation that residents will see more.
 - i. To keep track of total numbers of patients seen, residents should keep a paper with the stickers of the patients they see and the diagnoses they encountered. If more than one diagnosis was addressed, please document and include any procedures performed. Place a copy of this list at the end of each shift in Dr. Schulack's hanging file (located in the bottom drawer of the file cabinet under the far left ED physician's desk). Dr. Schulack has created a form for this purpose which is included in the rotation folder. Residents will also track their encounters in either Google Docs or New Innovations.
2. Medical knowledge--which includes formulating extensive differential diagnoses for all patient problems, integrating biopsychosocial factors, and applying evidence-based medicine. Residents will be encouraged to see patients throughout their rotation to get exposure to the broad curriculum of emergency medicine. A curriculum list will be included in your rotation folder for your reference. Reading topics have been included in the rotation folder also. While they all are not required, they are strongly suggested and Dr. Schulack will meet periodically to assign readings and discuss. Please feel free to use the books and resources in the ED and online to further your learning about cases you have encountered or other topics or skills. The textbook where most of the readings are derived is Harwood-Nuss's —Clinical Practice of Emergency Medicine" Fifth Edition, 2010. Others are from, Roberts and Hedges —Clinical Procedures in Emergency Medicine" Fifth Edition 2010 and Tintinalli's —Emergency Medicine: A comprehensive Study Guide" Seventh Edition 2010. A variety of other sources are included.
3. Procedural skills- with attention to proficiency, patient comfort and safety. Noon conferences for EM occur once a month (on the third Monday from 12:45 to 1:30 in conference room AB. Periodic (goal will be twice monthly) sessions with Dr. Schulack

as mentioned earlier. Topics will include procedure training. Residents will be expected to visit PHI Aeromedical Transport headquarters for training in Airway management. This will be arranged by Dr. Schulack.

4. Self-directed learning--including self-initiative, asking for assistance and consults appropriately, accepting criticism, and applying new information.
5. Interpersonal and communication skills--including effective and appropriate communication with nurses, ED attendings, peers, consultants, patients, and families.
6. Professionalism--relating with staff and patients in a responsible, ethical, empathic, compassionate, and trustworthy manner.
7. Systems based practice--uses all care resources and ancillary care providers appropriately.

ED Organization:

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

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

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

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

residents must decline taking the call.

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

Emergency Medicine Rotation Requirements	
_____	Contact Dr. <u>Schulack</u> at least 1 week before the start of your first intern year rotation to set up an orientation (usually 30-45 minutes) before starting your first shift. This is very important as we usually have technological issues to work through.
_____	Keep a log of your patients, diagnosis/problems, and procedures. Your residency department may need these in the future to evaluate your patient numbers.
_____	Be accountable, timely, and humble.
Comments: _____ _____	
Signed: _____	Date: _____
Nick. <u>Schulack</u> , MD	
Cc: Duane Bland, MD, Residency Director	

Documentation: Residents must document patient care notes within Cerner. If a resident performs a procedure entirely, he should check with the supervising attending to clarify who will document the procedure note.

F. Emergency Medicine Knowledge and Skill Competencies:

1. Cases you will see and be involved include, but are not limited to:
 - Assessment, resuscitation & stabilization of critically ill patients (including both medical and traumatic)

- Chest Pain (AMI, ACS, PE, aneurysm, arrhythmias)
- Respiratory Distress (asthma, COPD, foreign body, pneumonia, CHF)
- Abdominal Pain (peritonitis, AAA, renal calculi, gallbladder disease, appendicitis, mesenteric ischemia, hernia)
- ALOC (toxic, metabolic, infectious, trauma)
- Neurological Deficit (CVA, TIA, peripheral deficits)
- Female pelvic pain (STI's, ectopic, first trimester bleed, ovarian cyst/torsion)
- Pediatric Fever
- Headache/Back pain (CNS bleed, meningitis, pain management)
- Trauma (general assessment, orthopedic and soft tissue injuries)
- A host of other things.

2. Skills:

- Efficient patient evaluation & disposition (directed H&P, testing, communication with physicians, f/u, while managing multiple patients simultaneously).
- Airway/ Breathing (intubations, non-invasive adjuvant, ventilator, meds)
- Circulation (access lines, cardioversion, vasopressors, monitoring)
- Conscious Sedation/ Pain Management (indications, meds, monitoring)
- Orthopedic interventions (immobilization, reductions)
- Wound care (infiltration, blocks, irrigation, laceration repairs, bites, I&D)
- Eye procedures (slit lamp exam, FB removal, tonometry)
- ENT procedures (nasal cautery/packing, peritonsillar abscess, dental blocks, FB removal)
- Miscellaneous (use & interpretation of x-ray, LPs, urinary caths, NG/Ewald, lavage, anoscopy)

THE FAMILY PRACTICE CENTER

See Section IV: ADDENDUM: MERCY FAMILY HEALTH CENTER CLINIC MANUAL

HOME VISITS

Each resident is to make at least one home visit over the course of training. The appropriate form is available in the preceptor room and is to be completed by the resident during the visit. Please see Academic Advisor for further information.

FAMILY CENTER CONTINUITY OBSTETRICS EXPERIENCE

FAMILY PRACTICE SERVICE (Inpatient/Outpatient Rotation) (PGY2, PGY3)

A. Core Competencies:

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

- Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)
- Coordinate admissions, inpatient care, and throughput within the hospital system. (Systems-based Practice)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high quality care. (Interpersonal and Communication Skills, Professionalism)
- Recognize self-limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)
- Demonstrate the ability to take an age-appropriate history and perform a physical exam. (Patient Care, Medical Knowledge)
- Synthesize an appropriate diagnosis and treatment plan for common pediatric conditions in both the outpatient and inpatient settings. (Patient Care, Medical Knowledge)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure that the diagnosis and the treatment plan are clearly understood. (Interpersonal and Communications Skills)
- Recognize his or her own practice limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care. (Professionalism, Systems-based Practice)

B. Service Goals:

The family practitioner must be competent to manage the care of his/her patients in the hospital, either in its entirety or as the coordinator and manager of the more complex patients involving multiple specialists. In addition, the practitioner cares for the patient pre- and post-hospitalization and interacts with family members as appropriate. The skills and experience therefore go well beyond a disease/illness orientation. The RRC in Family Practice considers this experience so important that it requires the family practice resident to follow any of their continuity patients when admitted to the hospital unless their current rotation makes this impossible (e.g. Away Elective). Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description:

All resident adult and pediatric continuity patients and Mercy Family Health Center (MFHC) faculty patients are admitted to the Family Practice Service (FPS).

D. Duties

All Residents are encouraged to follow their continuity patients in-house along with the FPS team, writing a "primary care doctor" note daily. While this can be a challenge at times, continuity of care is a foundation of family practice and one of the Essential Requirements of the ACGME. One PGY II or III resident is assigned to the service each rotation and provides primary in-house coverage for patients and meets daily with Family Practice preceptors who rotate onto the service each week. This resident "runs" the service and has oversight of continuity residents as well. On weekends, holidays, and after 5:00 p.m., the residents on call (PGY1, PGY2, PGY3) will be responsible for covering the FPS patients in addition to other service patients on medicine, pediatrics and obstetrics. Occasionally, an additional resident may be assigned to the service for remedial training, and will work with the senior resident and attending.

Residents are expected to round on all patients between 7:00 am and 9:00 am. Rounds with the attending have been occurring from 8:00 am to 9:00 am. This is arranged on an attending-by-attending basis. Outpatient clinic is an important part of this rotation. Residents will be in the FPC twice weekly, seeing work-ins, hospital follow-ups, acute patients, and their own continuity patients.

When a resident (or faculty member) sees and admits his/her continuity patient from MFHC, it is the responsibility of that PCP (Primary Care Physician) in the clinic to enter admit orders and the admission H&P. If another provider is seeing the patient and the FP service resident is available, the FP service resident should do admit orders and the H&P. If the FP service resident is not available, then admit orders and the H&P are to be done by the provider seeing the patient at clinic. It is the duty of the physician writing the admission orders to contact the FPS preceptor at the time of admission.

The PCP of admitted patients, whether resident or faculty, should be alerted that their patient is in house no later than the morning following admission on weekdays, and on Monday morning for weekend admissions. PCPs are encouraged round daily on weekdays, and to be actively involved in their patient's care and disposition on discharge.

MFHC continuity OB patients are to be taken care of by their PCP or their OB resident partners under the supervisions of OB faculty or on call FP Faculty who supervise on labor and delivery. Newborns go to the FP Service.

Once eight patients are on the FP service, a redistribution policy can go into effect at the discretion of the FP service team (resident and attending). Once the policy is enacted, the FP service will communicate with the other residency inpatient services; FP service eligible admissions will be admitted to the residency internal medicine or pediatric services. If the internal medicine and pediatric services are full, the faculty and/or 3rd year resident patients that have been on the service the longest will be taken over by their PCP until six – eight or fewer patients are on the FP service (the family practice attending physician will continue to provide preceptor services to the PGY3 in such circumstances). If the service still has an excess number of patients, PGY2s will assume care of their continuity patients with attending backup. All patients being taken care of by their PCPs will remain on the FPS computer list. Well newborns will not count towards the total number of patients on the service and should be followed by the resident providing care for the newly delivered mom. The faculty members or senior residents following their own patients are responsible to sign out those patients before 5:30 pm Mon. - Fri to the FPS resident so the resident can provide night sign-on for the call team. During evening and weekend hours the on-call residents will provide care for both FPS patients and those patients whose hospital care has been assumed by their PCP.

Faculty Notification Guidelines: The FPS preceptor MUST be notified at the time of admission for all emergency room and direct admits after the patient has been evaluated by the admitting resident (or faculty member). Admissions or transfers to any of the critical care units MUST involve the immediate notification of the preceptor. The preceptor should be notified of any significant deterioration in the status of any service patient. The preceptor should also be notified of all sick or unstable newborns at the time of birth or deterioration. For normal, stable, uncomplicated healthy newborns, the preceptor can be notified in the morning following birth. Note: it is the responsibility of the resident or faculty member arranging the direct admission of a patient from the FPC to directly contact the on-call FPS preceptor to relay the appropriate information regarding the admission. Timely contact allows the attending to make appropriate arrangements to see the patient and assist with care without delay. The FPS resident will be admitting ER admissions by phone when scheduled in the FPC, and must inform the preceptor at the time of admission.

Expectations and Duties: The FPS intends to have the senior resident function as a “real world” family physician, combining inpatient duties with ongoing office responsibilities. We encourage, and expect, the senior resident will function with greater autonomy than when on categorical services. The preceptor, who remains ultimately the attending physician of

record, should serve more as a consultant and role model to the senior resident while at the same time exercising his/her supervisory responsibilities.

The preceptor should be available at 8:00 am on weekdays for rounds; earlier rounding times, or afternoon rounding times may be negotiated under unusual circumstances only. Sit-down-rounds, followed by bedside rounds of new and critical patients, will have to be accomplished efficiently. The attending will still be responsible to supervise care of patients handed over to their PCP by the Cap.

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

CRITERIA FOR ADMISSION TO FPS FOR MERCY FAMILY HEALTH CENTER PATIENTS

- 1. Patient is an established patient at MFHC followed for continuity care by resident or core faculty.** Please review Cerner notes prior to admitting a patient to FPS. Evidence that the patient is a continuity patient include:
 - a. Visit note(s) present in Cerner. *Note: patients that have been seen during a specialty clinic (i.e. Dermatology or Procedure Clinic) may not be considered a continuity patient.*
 - b. The resident or faculty name is included in the banner bar. *On occasion the admitting desk will remove the physician's name or insert the wrong name - please evaluate clinic notes to determine if they are a continuity patient.*
- 2. Please review Cerner notes prior to admitting a patient to FPS to determine if patient was removed from the MFHC patient panel.** Evidence that the patient has been removed from the MFHC patient panel include:
 - a. A letter or note in Cerner indicating the patient transferred care
 - b. A letter in Cerner stating the patient was officially discharged from the clinic
 - c. A note in Cerner stating the patient was not accepted after initial consultation: *A formal letter is sent to the patient if not accepted after a consultation visit.*

Note: Patients that have not been seen recently may still be part of the patient panel unless their care has been assumed by another physician. *The “three year rule” is specific to billing and does not necessarily apply to the doctor-patient relationship.*

GYNECOLOGY (PGY2, PGY3)

A. Core Competencies

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

- Be able to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to sensitive issues, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform a comprehensive pelvic examination with appropriate screening tests and wellness counseling, based on the patient's age and risk factors. (Patient Care, Medical Knowledge)
- Be able to perform routine gynecological procedures (Patient Care, Medical Knowledge)
- Develop treatment plans for common conditions affecting female patients, including reproductive issues, utilizing community resources when indicated. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women. (Patient Care, Interpersonal and Communication Skills)
- Consult with obstetrician-gynecologists, other physician specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice)

B. Service Goals

As a second and third year rotation, the gynecology experience is intended to strengthen the resident's knowledge base and skills in the wide range of primary care gynecology complaints seen by a family doctor. Residents are expected to achieve the full set of defined Gynecology Competencies during this rotation. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description

The various experiences in gynecology occur at SCHC, and private offices and are described in the Clinic II Rotation. See above.

INTENSIVE CARE UNIT (PGY1, PGY2, PGY3)

A. Core Competencies

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

- Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally

recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)

- Coordinate admissions, inpatient care, and throughput within the hospital system. (Systems-based Practice)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high quality care. (Interpersonal and Communication Skills, Professionalism)
- Recognize self-limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)

B. Service Goals

The Intensive Care Rotation in the first year is intended to immerse the resident in the critical care setting to understand guidelines for appropriate admission, manage critically ill patients, and obtain procedural experience under supervision. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description:

Each first year resident spends two weeks in the ICU and will work with one preceptor for one week at a time. Residents will round on all assigned patients, write appropriate notes, and participate in procedures. Residents also gain ICU experience while rotating on the internal medicine service.

D. Duties

Work up all assigned patients, review with the intensivists, and write daily notes in the chart. Conduct daily rounds and see patients as needed. Report all significant changes in condition to the attending.

Attend ICU Rounds at 10 a.m. Shift is normally from 6a-12:30p. Noon didactics is mandatory while on an ICU rotation.

Complete all required readings and be prepared to present/discuss with the intensivist during the tutorials.

Work with respiratory care practitioners and nurses in providing daily patient care.

Residents should keep a log in New Innovations of ICU patients cared for and their diagnoses as well as procedures performed.

INTERNAL MEDICINE SERVICE (PGY1, PGY2, PGY3)

From Dr. Huxley June 30, 2025 to Attendings -

Dear Team:

Attached is the overall goals for the 2025-2026 Academic Year for MMCR hospitalist rotations.

Preceptor Services: Patient Care, Education, and Supervision of Residents

Residents participate in the admission, medical care including daily follow-up and emergency response (code gray, rapid response and code blue) and discharge of patients assigned to the resident at the Mercy Medical Center Hospital. Patient assignments will be made by the contracted hospitalist service under the supervision of Vituity employed physicians.

The expectations for team integration and patient care depend upon the day and time (day/ night during the weekdays). Resident teaching can be done during, between or after patient presentations. The Attending may decide on the topic, the type of learning and the requirements for successfully completing the rotation. While on service, residents are expected to be done with morning rounding by 1100 to finish patient follow up, and attend residency didactic conferences Monday - Friday 1230-130 pm, and morning report on Wednesday 7:15 – 8:00 am. To fulfill ACGME requirements for family medicine, all residents are assigned Family Practice continuity clinic during their weeks on the internal medicine service. In general, these clinics occur in the afternoon between 1:30-5:00 with the residents having one to three clinics weekly depending on the post-graduate year.

Resident's blocked time:

7:15-8:00 - Morning report wednesday

11:00-12:30 Dedicated note time and patient follow up

12:30-1:30 - Didactic Conference monday through friday

1:30 - 2:00 – Case management rounds

1:30 - 5:00 - Clinic one day a week per resident

5:30 – Transition to night service

5:30 pm – 7:00 am Resident may take 2 patients from the hospitalist service

Day Service (Monday-Friday):

Up to three residents composed of two PGY1 residents and one senior resident (PGY2 or PGY3) are assigned to work with Vituity Hospitalists' teams. The integration of these residents into the hospitalists' team is done in a fashion that is mutually agreed upon by hospitalists and residency program. During the initial months of the academic year, the senior resident functions primarily as a resident supervisor to junior residents. The ACGME recommends that each junior resident routinely follow a minimum of three/ five/ seven patients for optimal education. After several months, when the PGY1 residents have increased knowledge and efficiency, the senior residents begin accepting and following their own panel of patients. Patients followed by residents during the day are cross-covered at nights by Vituity hospitalist physicians. Patients are transferred to Vituity hospitalist service on weekends and holidays.

Night Service (Monday-Friday):

During the initial half of the academic year, a senior resident will be assigned to the night float medicine service with the following duties:

1) Admit and care for patients on the family medicine service composed of patients followed at Mercy Family Health Center and patients followed by residents in their continuity clinics at both Mercy Family Health Center and Shasta Community Health Center (Supervision for the care of these patients is provided by the on-call Family Medicine Attending); and 2) As available, assist the Vituity night coverage hospitalist with admissions capped at 2/ 3 admissions per night.

During the second half of the academic year, PGY1s are assigned to the night float medicine service with the same duties. A senior resident is in-house to assist the PGY1 as necessary; of note, they also provide back-up and supervision to a PGY1 assigned to Obstetrics/pediatrics.

Expectations for residents:

Show up at 7:00 am and receive patients by phone or in person prior to morning report and check out critical patients to the attending by 5:30 pm. Please notify attending as soon as possible if the patient is critical.

Carry a load of 3/ 5/ 7 patients in any manner (admissions, consults, follow-ups, discharges) in a day. These numbers will increase over the course of the year.

Ensure Attending is in agreement with notes prior to finalizing by 7:00 pm.

Ask for verbal feedback at the end of the day Wednesday and Friday.

Residents will see patients with a variety of ailments that are typical for a hospitalist to see and keep track of case number in a log that will be copied and given to Attending. Evaluations/ grades will be based on performance, timeliness, interest in learning, demonstrating an understanding of the diagnosis and treatment, potential outcomes depending on the different treatment plans, medication uses and side effects, advanced care planning and discussions with family.

If there are concerns or disagreements, please notify Dr Angie Huxley, the Residency Liaison immediately, and if not available, Dr Joshua Travis, Medical Director for Vuity Hospitalist Group.

A. Core Competencies

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

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

B. Service Goals

The service provides resident physicians with experiences in general medicine, primarily managing common medical problems. Additionally, residents will learn to recognize uncommon problems, obtain consultations as needed and/or make referrals to facilities for treatment not locally available. Residents are expected to develop the full set of defined Medicine Competencies over the course of their three years' experiences. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description

Residents participate in the admission, medical care including daily follow-up and emergency response (code gray, rapid response and code blue) and discharge of patients assigned to the

resident at the Mercy Medical Center hospital. Patient assignments will be made by the contracted hospitalist service under the supervision of Vituity employed physicians. At times medical students and FNP/PA students also participate on the service.

The expectations for team integration and patient care depend upon the day and time (day/night during the weekdays). Resident teaching can be done during, between or after patient presentations. The Attending may decide on the topic, the type of learning and the requirements for successfully completing the rotation. While on service, residents are expected to attend residency didactic conferences Monday - Friday 1230-130 pm. To fulfill ACGME requirements for family medicine, all residents are assigned to a Family Practice continuity clinic during their weeks on the internal medicine service. In general, these clinics occur in the afternoon between 1:30-5:00 with the residents having one to two clinics weekly depending on the post-graduate year.

Resident's blocked time:

12:30-1:30 - Didactic Conference Monday through Friday

1:30-5:00 - Clinic one day a week

5:30 - Night Float check cut

Day Service (Monday-Friday):

Up to three residents composed of two PGY1 residents and one senior resident (PGY2 or PGY3) are assigned to work with Vituity Hospitalists' teams. The integration of these residents into the hospitalists' team is done in a fashion that is mutually agreed upon by hospitalists and residency program. During the initial months of the academic year, the senior resident functions primarily as a resident supervisor to junior residents. The ACGME recommends that each junior resident routinely follow a minimum of five patients for optimal education. After several months, when the PGY1 residents have increased knowledge and efficiency, the senior residents may begin accepting and following their own panel of patients. Patients followed by residents during the day are cross-covered at nights by Vituity hospitalist physicians. Patients are transferred to Vituity hospitalist service on weekends and holidays.

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

Night Service (Monday-Friday):

During the initial half of the academic year, a senior resident will be assigned to the night float medicine service with the following duties:

1) Admit and care for patients on the family medicine service composed of patients followed at Mercy Family Health Center and patients followed by residents in their continuity clinics at both Mercy Family Health Center and Shasta Community Health Center (supervision for the care of these patients is provided by the on-call Family Medicine Attending); 2) As available, assist the Vituity night coverage hospitalist with admissions capped at 1 admission per night, and 3) Admit and care for pediatric patients, (supervision for the care of these patients is provided by on-call Pediatric attending)

During the second half of the academic year, a PGY1 is assigned to the night float medicine/FPS/pediatric service with the same duties. A senior resident is in-house to assist the PGY1 as necessary; of note, they also provide back up and supervision to a PGY1 assigned to Obstetrics/Newborn.

Expectations for residents:

Show up at 0700 am and receive patients via TigerConnect from attending.

Carry a load of at minimum of 5 patients in any manner (admissions, consults, follow-ups, discharges) in a day. Patient load will gradually increase throughout the year as deemed appropriate by chief residents and Program Directors.

Ensure Attending is in agreement with notes prior to finalizing by 7:00 pm. Ask for verbal feedback at the end of the day Wednesday and Friday.

Residents will see patients with a variety of ailments that are typical for a hospitalist to see and keep track of case number in a log that will be copied and given to Attending. Evaluations/grades will be based on performance, timeliness, interest in learning, demonstrating an understanding of the diagnosis and treatment, potential outcomes depending on the different treatment plans, medication uses and side effects, advanced care planning and discussions with family.

If there are concerns or disagreements, please notify Dr. Angie Huxley, the Residency Liaison immediately, and if not available, Dr. Josh Travis, Medical Director for Vituity Hospitalist Group.

D. Duties

Senior resident duties:

- See new admits each morning before rounds

- Seniors will be supervising every patient that the interns are carrying. This means reviewing the chart, seeing the patient, being aware of the assessment and plan, and in particular ensuring that action items are completed correctly.
- Perform all consults at the attending's direction.
- Pre-round each day with the PGY1s if appropriate
- Review progress notes each day
- Write addendum admit notes on all admits and review all orders when on duty in the hospital
- Spend what time is available and appropriate to support the teaching functions of the service. Seniors should be engaging with the interns and the patients throughout the day to supervise the interns to make sure things aren't missed, help the interns learn and to keep up learning for themselves.
- Encourage team efforts and support
- Give feedback and evaluations to junior residents
- Provide appropriate sign-out of the Medicine Service to covering resident when going to afternoon continuity clinic. To facilitate this, the senior resident will have his/her afternoon continuity clinic blocked off for the first time slot and the resident will not be expected at clinic until 2:00 pm. (Note: Only the senior resident on IMS will have clinic schedule blocked for this purpose).
- Seniors have no requirement to carry patients themselves, although they are not prevented from doing so if they work it out with their attending.

Junior resident duties:

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

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

Peds/FP Service Call

- Pediatrics and FPS services are managed by separate teams of residents during the week and by a single resident team on weekends and holidays.
- The Peds service includes any pediatric patients not covered by private pediatricians or residents.

- FPS service includes MFHC clinic patients (residents & attendings) and SCHC resident patients. Also, residency pediatric patients and continuity newborns will be covered on the FP service as identified above.
- The sign-out location is the LLCR.
- It is the PGY2/PGY3's responsibility to coordinate rounding times for both the pediatric service and FPS service each attending.

OB Service Call

- The OB service is managed by the OB team during the week as well as weekends and holidays and by the OB/NBF resident at night. OB/GYN attendings are on call for 24 hr shifts as well.
- The OB service includes any OB/GYN patients not covered by private OB/GYN physicians. You are responsible for these patients in triage, admissions, and discharges. The ER or hospitalist service may also request a consult or admission from the OB/GYN attending, and the attending will communicate with residents if appropriate.
- The sign-out location is the LLCR.
- Computer round on all OB patients/GYN and see patients. Prep discharges. Round with OB attending on call when available after pre-rounding.
- The goal for splitting patients should be roughly 60/40 (60% for interns and 40% for seniors). Later in the year splitting should be based off of the size of lists and the intern's comfort level and if mutually agreeable.

Call after April

Interns are on call with a "super senior" – a PGY2/3 working with two PGY1s

- Super Senior Duties:
 - Assures PGY1s are keeping up with workflow and are not getting overwhelmed.
 - Follow all patients and round on all unstable patients and/or any patients the PGY1 is concerned about. Seniors do not have to completely round with attendings with PGY1 (Super Senior rounding is modified based on patient severity and census).
 - Be present for deliveries with attending as available/needed.
 - Discuss/review all FPS/peds admissions with intern.
 - Be available to answer questions and assist PGY1 when needed.
 - Discuss patient plans of unstable patients with intern after rounds.
 - Seniors should attend all rapid responses that are called on patients along with intern (intern should also attend all rapids even if it is on a patient the senior is covering).
 - Due to the need to oversee multiple services, the Super Senior will always be available for assistance throughout the 24 hour call, but will not be the primary physician for managing patient care. PGY1s are responsible for taking calls, doing admits, and managing the patients on their respective services. Seniors are expected to closely monitor critically ill/sick patients.

Noon Lecture Time 12:45 – 1:30pm

- This is protected time.

- Residents should feel the time is allotted to attend learning sessions.
- If an admission is called, residents will accept it, residents will use holding orders to satisfy the ER throughput and then put the rest of the admission orders in after lecture.
 - A bed, diet, code status, DVT orders, pressure ulcers
 - Rounds should be completed by 12:30 to allow for lecture. If additional rounding to be done, it can be done after lecture

Attending Duties:

- Be the attending physician of record and supervise care according to the Graduate Medical Education Committee policy.
- Round daily with residents, review service notes, see the patients on service and make personal chart documentation as appropriate.
- Be available to residents for specific questions related to the management of patients on the service.
- Supervise residents as appropriate for any procedures.
- Complete an evaluation on each resident's performance and review the evaluation in person with the resident. (Please see EVALUATION, SECTION)

Physician Guidelines for Admit Status

The decision for admission status to the hospital is a complex medical decision based on the provider's judgment and the patient's need for medically necessary care. The patient placement order must be completed or co-signed by a provider with admitting privileges at MMCR.

Inpatient: A term used to describe a person admitted to a hospital for at least 24 hours. The necessity for admission must meet both severity of illness and intensity of service by Interqual criteria.

The following documentation is required for the admission of a patient to Inpatient status:

1. The order and location for patient placement
2. Reason for hospitalization
3. The need for care requiring greater than 24 hours (2+ midnight for Medicare)
4. Evidence of services planned or provided
5. The discharge plan for the patient

Observation: Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged within 24 to 48 hours. Observation is the status to use for the patient who will require $\leq$ 24 hours of care before being able to be discharged.

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

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

** These are basic guidelines. If you need assistance with patient placement issues please feel free to call the ED case manager at ext. 6413.

Consultation Etiquette

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

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

MANAGEMENT OF HEALTH SYSTEMS (PGY1, PGY2, PGY3)

A. Core Competencies

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

- A. Demonstrate physician leadership as an uncompromising advocate for patient-centered care of the highest value within the constraints of a viable and sustainable business model for the Patient-Centered Medical Home (PCMH), Patient-Centered Medical Neighborhood (PCMN), and the Health Home (Healthy Community) for the patient's welfare while balancing the business realities of practice management and financial success. (Patient Care and Professionalism)
- B. Actively conduct a practice search, interviews, contract negotiations, and successfully enter practice. (Interpersonal and Communication Skills)
- C. Demonstrate knowledge of the legalities and ethics of hiring, promoting, and termination of employees in a practice setting. (Professionalism)
- D. Identify the structure and operations of health organizations and systems, and the role of the family physician in this structure. (Systems-based Practice)
- E. Identify the measures of health, including determinants of health, health indicators, and health disparities. Advocate for the development of value metrics which will optimize

Meaningful Use reporting and payment for value in the healthcare system. (Practice Based Learning and Improvement)

- F. Identify and foster partnerships that maximize achievement of public health goals. (Systems-based Practice)

B. Service Goals

This instruction is integrated throughout the three years of training to develop management and leadership skills in the resident including both the didactic and the practical settings. The curriculum prepares residents to assume leadership roles in their practices, their communities, and the profession of medicine. Mercy Family Health Center (MFHC) is considered the primary site for teaching management and leadership skills, and serves as an example on which residents may model their future practices. Residents also work with community and rural physicians to further develop their practice management skills. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description

The curriculum for Management of Health Systems involves a variety of formats to achieve over 100 hours of instruction in both the didactic and the practical settings. A summary of hours can be found below under item 11.

Intern Orientation Activities

1. All interns receive at least 15 hours of health systems management training during a two week orientation period.
 - a Department Director Meetings
Interns meet with inpatient and outpatient department directors, learning the policies and procedures of each department. They learn how to work with and lead the ancillary staff of the hospital and clinic.
 - b Pathways through Dignity Health Training modules
 - c During orientation time, interns also participate in a Dignity Health online training which is a compliance/education program. This training will occur during orientation and intermittently throughout residency training, covering the areas of:
 - i. Compliance
 - ii. Billing
 - iii. Ethics, including review of fraud and abuse laws
2. Medical Staff Quality Improvement Meetings and Presentations
Residents participate in several medical staff meetings and presentations, including the monthly Perinatal Morbidity and Mortality Conference, Friday Grand Rounds, and Journal Club, and monthly Noon Report. During these presentations, residents discuss and receive feedback from the residency faculty

and medical staff on case presentations and quality care improvement. Residents participate by developing and providing presentations which are evaluated by faculty physicians and medical staff physicians. Residents also evaluate presentations provided by community and faculty physicians.

3. Inpatient Resident Physician Assessment and Evaluation: Senior residents evaluate junior residents for all inpatient rotations, including OB, Peds, and Internal Medicine. Residents also evaluate their attending physicians regarding the quality of instruction provided.
4. Health Systems Management Training at MFHC
This training has several components through all three years of residency training as outlined below.
 - a. Clinic Staff Team Training and Billing Education
Interns spend two hours observing and learning the role of each member of the front office and nursing staff. This experience allows them to better know each member of the healthcare team and how they function in the clinic. They also receive instruction regarding outpatient billing.
 - b. Clinic Care Coordination Training (C1 rotation)
Significant training continues during second and third years of residency when residents spend two blocks, four weeks each on the C1 Clinic Doc Rotation. On this rotation, the resident is responsible for all specialty clinics in addition to seeing their continuity patients. Residents must also review and triage daily lab results and prescription requests for all of the other residents, determining the appropriate follow-up, and making sure prescriptions are appropriately refilled for patients seen by residents on away electives or vacation.
 - c. An orientation to this rotation is provided by the Clinic Medical Director, Steve Namihas, MD. This includes a review of Clinic Doc responsibilities and ways to coordinate care with the clinic staff and specialty physicians.
5. Community Health Systems Management Training and Practice Site Evaluation
 - a. Each resident will perform a thorough investigation and evaluation of at least one practice site typically during their practice management rotation (C1) using the Practice Site Evaluation instrument. While doing this, residents will learn to identify the key components of a practice and community health system. They are also encouraged to use this tool when evaluating a practice that they are considering for a future job or during their rural rotation. (More information on the Practice Management Rotation is found below. Information on job interviews can be found under the Job Interview section under the heading Elective Rotations.)
 - b. The following items are included in the Practice Site Evaluation instrument which is available in the residency office:
 - Type of practice
 - Patient mix
 - Payer groups
 - Scope of practice
 - Management
 - Working conditions for physicians

- Financial
 - Insurance
 - Patient flow
 - Personnel
 - Geographic concerns
 - Medical Records
 - Past History of Practice Changes
 - Future Plans for the Practice
 - Strengths of the Practice
 - Challenges
 - Special Services
6. Practice Management Rotation (C1 Rotation)
- a. This rotation will include two half day training sessions for a total time of 8 hours.
 - b. This will take place at SCHC or a private physician office(s) in Redding.
 - c. As much as possible, this training will be scheduled towards the end of the PGY2 year and the beginning of the PGY3 year to have the greatest impact on future practice planning.
 - d. If requested 12 weeks in advance, residents may schedule this rotation at other sites outside of Redding.
 - e. Residents meet with the various office staff and physicians in the practice, learning how to provide patient care efficiently and effectively in a community clinic, private practice, or rural health clinic setting.
 - f. Residents will learn the following skills:
 - Effective billing
 - Designing a budget and managing overhead costs
 - Collections for various insurance carriers
 - Assessing practice staffing needs
 - Understanding of office manager function
 - Personnel management and labor issues
 - Employment law and procedures
 - Integrating new technologies into one's practice
 - Determining value of patient care in one's community
 - Assessing customer satisfaction
 - Measuring clinical quality
 - Tort liability and risk management
 - Office scheduling systems
 - Use of computers in practice
 - Alternative practice models
 - Principles of public relations and media training.
7. Leadership training
- This will occur through a variety of means in the family health center, hospital, and community.
- a. Hospital Leadership Training

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

- i. Resident Leadership (i.e. Chief Resident, UCD Conference Planning Committee)
 - ii. Hospital or Medical Staff Committees, Quality Assurance Committee, Ethics Committee, Emergency Services Section Committee, Family Practice Residency Committee, Health Equity, Infection Control, Length of Stay Committee, Utilization Management Committee, CME committee, Cerner, etc.
 - b. Community Leadership Training
During their community medicine rotation, residents may work with the county Public Health Officer learning various aspects of health in the community. They also have the opportunity to participate in a variety of public health community projects such as tobacco cessation or STD education. Residents are encouraged to speak to community groups on health education topics.
2. Academic Advisor Meeting and Analysis of Clinic Productivity Reports
Residents will demonstrate progress in completion of duties and mastery of skills in the management of health systems during their bi-annual faculty advisor meetings. An academic advisor assigned for each resident will summarize the meeting using the academic counseling form. This will include the following:
 - a Review of rotation specific evaluations to assess clinical competencies
 - b Assessment of diligence in maintaining medical records
 - c Review of opportunities for future practice
 - d Completion of required documents for medical licensure
 - e Review of procedure training
 - f Analysis of FMC reports regarding individual and practice productivity and financial performance
 - g Review of patient continuity for individual resident, including number of OB patients delivered
 - h Review of Leadership Training experience
9. Management of Health Systems Didactic Training
 - a Management of Health Systems Lectures
Residents receive at least 4 hours of lectures each year on a variety of practice management topics, including professionalism, malpractice, evaluation of contracts, preparing for a job interview, billing and coding, and providing feedback to co-workers.
 - b Pathways Modules through Dignity Health
This online educational program for residents and faculty covers a number of issues including the following:
 - Leadership / Performance Improvement
 - Environment of Care
 - Infection Control
 - Patient Rights / Ethics / Responsibilities
 - Safety and Security in the Healthcare Organization

- Management of Medications
 - Incident Reporting
 - Redding Population Specific Care
10. Directed Reading and Study in Practice Management Residents will spend at least four hours in directed reading of practice management materials during the C1 and 2 rotations, including:
- i. AAFP training book: Quality and Patient Safety in the Physician's Office at Quality & Safety -- FPM Topic Collection
 - ii. AAFP Practice Essentials at Practice Essentials
 - iii. STFM Family Medicine Residency Curriculum Resource at Practice Management Curriculum
11. Summary of Hours for Management of Health Systems
- | | |
|--|----------|
| 1. Intern Orientation Activities | 15 hours |
| 2. Medical Staff Q/I Meetings and Presentations | 36 hours |
| 3. Inpatient Resident Physician Assessment and Eval Training | 6 hours |
| 4. Health Systems Management Training at MFHC | 24 hours |
| 5. Community Health Systems Mgm and Practice Site Eval. | 3 hours |
| 6. Practice Management Rotation (C1 Rotation) | 8 hours |
| 7. Leadership Training | 12 hours |
| 8. Academic Advisor Meeting and Analysis of Clinic Reports | 6 hours |
| 9. Management of Health Systems Didactic Training | 17 hours |
| 10. Directed Reading and Study in Practice Management | 4 hours |
| Total = 131 hours | |
12. Additional Meetings
- In addition to this, residents spend another 90 hours participating in a variety of additional meetings which occur regularly during residency training.
- a Bi-monthly Meetings:
 - MFHC Staff/Resident Meetings
 - b Resident/Faculty Monthly Meetings:
 - Director /Resident Meetings, aka "Dialogue with Duane"
 - Resident Meetings lead by the chief resident
 - c Meeting Topics include the follow:
 - Health systems training
 - Practice-related policies and procedures
 - Business and service goals
 - Budget issues
 - Practice efficiency
 - Patient satisfaction surveys
 - Billing practices
 - Staffing issues
 - Ways to improve communication with patients and co-workers
 - Quality improvement

D. Duties

Residents will accomplish the tasks outlined above, attend the rotations and meetings, perform the required reading analysis, and will maintain appropriate documentation of their training, which will be reviewed bi-annually with their academic advisor.

NIGHT FLOAT SENIOR (PGY2, PGY3)

A. Service Goals

Family Physicians actual practices vary considerably in the extent to which they provide inpatient care for patients. This portion of the curriculum is designed to provide residents with the skills and expertise expected of family physicians with active practices involving this area. Additionally, this rotation emphasizes the care of adult, pediatric and obstetrical patients with a variety of medical disorders. The learning goals and competencies are the same as for OB/Peds/Medicine/FPS.

B. Service Description:

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

C. Service Duties:

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

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

MFHC Clinic: Residents scheduled in the clinic must arrive on time. Patients are scheduled starting at 1:30 PM. The last patient will be scheduled to ensure enough time to arrive to sign-out by 5:00 PM.

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

OB/NB NIGHT FLOAT (PGY1, PGY2, PGY3)

Core Competencies, Service Goals, Service Description, Duties are the same as the Pediatrics/OB (PGY1, PGY2, PGY3) section. See Page 75.

OPHTHALMOLOGY (PGY3)

A. Core Competencies

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

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

B. Service Goals

The goal of this rotation is to prepare a resident to enter practice with the knowledge, attitudes and skills to effectively perform an ophthalmologic evaluation, initiate management and seek consultation on patients with more complex ophthalmologic conditions. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description

The ophthalmology rotation is integrated into a 4 week block in the third year of residency along with Urology, Cardiology, and ENT and is designed to expose residents to the evaluation and management of common ophthalmologic conditions that present in the ambulatory setting. The experience is based in an ophthalmologist's office practice with case based, one on one teaching. Where appropriate to accomplish educational goals, residents may accompany ophthalmology preceptors into the hospital setting to consult on hospitalized patients with ophthalmologic conditions. This rotation represents one component of a resident's training in ophthalmology. Substantial training in the primary care of patients with ophthalmologic conditions is received in the Family Practice Center. Responsibility for the medical management of inpatients with ophthalmologic complaints occurs throughout residency training.

D. Duties

Attendance at the ophthalmologist's office is scheduled. During this time you will work one on one with an ophthalmologist. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/week.

ORIENTATION

The goal of orientation is to prepare incoming residents for the administrative and patient care requirements for being a family resident at Mercy Medical Center. The following topics, didactics, and courses are covered during orientation. See the following example:

New Intern Orientation 2026						
		LEGEND:		Mercy Medical Center Family Practice SCHC Family Medicine MMCR Pharmacy Program		UPDATED: Inpatient Shadowing Rounds
				Lunch/Noon Conference/Didactics		
				PENDING		
	Date	Time	Who Attends by Program	Topic	Speaker / Presenter	Location
Tuesday	6/9/2026	8:30 - 10:30 am	MMCR Prog SCHC Prog Pharm Prog	Resident Welcome	Duane Bland, MD Amanda Mooneyham, MD Pam Cruzan	MMCR Auditoriums A & B
		10:30 - 11:00 am	MMCR Prog SCHC Prog Pharm Prog	Orientation Schedule Overview "what to expect"	Lynda, Amy, Susie, Eugenio	MMCR Auditoriums A & B
		11:00 - 11:30 am	MMCR Prog SCHC Prog Pharm Prog	Intern Photos	Lynda, Amy, Susie, Eugenio	MMCR Auditoriums A & B, Garden
		11:30 - 12:30 pm	MMCR Prog SCHC Prog Pharm Prog	Hospital Tour/Pharmacy Walk-through	Chief Residents: Torres, Sidhu, Singh, Oliva	Hospital Meet in AUD AB
		12:30 - 1:30 pm	MMCR Prog SCHC Prog Pharm Prog	Lunch	Meet interns for Lunch	MMCR Auditoriums A & B,
		1:30 - 2:30pm	MMCR Prog SCHC Prog Pharm Prog	Access Review: Corner, Dragon, Pharmacy Products, Pathways Modules, Personal Phone, X-Matters, AirStrip, PECOS, Tiger Connect (Setup to verify access works and settings set up)	Clinical Informatics (CI) (Carrie Cox) and Information Technology (IT),	MMCR E-Learning 1 Clairmont Bldg (Mercy Parking Lot Bldg)
		2:30 - 3:45 pm	MMCR Prog SCHC Prog	IT Set up for SCHC/MMC interns	Alex Froehlich	SCHC - Training Rooms 1-3 TBC
		3:45-5:00 pm	MMCR Prog SCHC Prog	NexGen System Set up for SCHC/MMC interns	Lillian Nguyen	SCHC - Training Rooms 1-3 TBC
Wednesday	6/10/2026	8:00 am - 12:00 pm	MMCR Prog SCHC Prog Pharm Prog	ACLS	CEEMED	MFHC Classroom
		12:00 - 1:00 pm	MMCR Prog SCHC Prog Pharm Prog	Lunch	Lynda to Cater Lunch	MFHC Classroom
		1:00 pm- 6:00 pm	MMCR Prog SCHC Prog Pharm Prog	ACLS	CEEMED	MFHC Classroom
Thursday	6/11/2026	8:00 am-12:00 pm	MMCR Prog SCHC Prog Pharm Prog	PALS	CEEMED	MFHC Classroom
		12:00 - 1:00 pm	MMCR Prog SCHC Prog Pharm Prog	Lunch	Lynda to Cater Lunch	MFHC Classroom

New Intern Orientation 2026						
		1:00 - 6:00 pm	MMCR Prog SOHC Prog Pharm Prog	PALS	CEEMED	MFHC Classroom
Friday	6/12/2026	7:00 am - 12:00 pm	MMCR Prog SOHC Prog Pharm Prog	NRP/BLS	CEEMED	Auditoriums A and B
		12:15 - 1:30 pm	MMCR Prog SOHC Prog Faculty, Admin	Graduation/Welcome Intern Lunch	Amy/Susie	SCHC - Upper Level Conference Rooms
		1:30 - 5:30 pm	MMCR Prog SOHC Prog	SCHC Nextgen Clinic Computer Training	Lillian Nguyen	SCHC - Training Rooms 1-3
Saturday	6/13/2026			Day off		
Sunday	6/14/2026			Day off		
Monday	6/15/2026	8:00 am - 4:30 pm	MMCR Prog SOHC Prog Pharm Prog	Mercy New Employee Orientation	Mercy Leadership	MMCR Auditoriums A & B by Inge Lusher (Education)
Tuesday	6/16/2025	8:30 am - 10 am	MMCR Prog SOHC Prog Pharm Prog	Workplace Violence (wear comfy clothes)	Mercy Education	MMCR Auditoriums A & B
		10:00 am - 12:15 pm (Room busy at 12:30pm)	MMCR Prog SOHC Prog	New Innovations, Procedure and Encounter logging, Google Drive, Cerner Inbox	Chief Residents: Torres, Sidhu, Singh, Oliva	LLCR
		12:30 - 1:30 pm	MMCR Prog SOHC Prog	Lunch	Mercy cafeteria	LLCR
		1:30 - 3:30 pm		Medi Lab Modules	Will Morris to Register Interns Residents to start with their Modules	Computer Lab - Lower Level MMCR
		1:30 - 3:30 pm	SOHC Prog	Academic Advising/ILP	Nicora, Ruiz, McMullin, Davainis	D3 at SOHC
		3:30 - 5:30 pm	MMCR Prog SOHC Prog	POCUS Training	Dr. Davainis & Dr. Evans	D1 & D2 at SCHC
Wednesday	6/17/2026	8:00 - 10:30 am	MMCR Prog SOHC Prog Pharm Prog	Get to Know Redding Scavenger Hunt	Group	SCHC Sundial Board Room
		10:30 am - 11:30 am	MMCR Prog SOHC Prog Pharm Prog	Infectious Disease and Infection Control	Kelli Sweig & Matthew Miles, MD	Auditoriums A & B
		11:30 am - 12:30 pm	MMCR Prog SOHC Prog	Wound Care	Lory Hartland	Auditoriums A & B
		12:30 - 1:30 pm	MMCR Prog SOHC Prog	Lunch	Mercy cafeteria	Auditoriums A & B
		1:30 - 5:00 pm	MMCR Prog SOHC Prog	Pediatric and Newborn Nursery Tour	Sharon Joo, MD	Auditoriums A & B

ORTHOPEDICS / SPORTS MEDICINE (PGY1, PGY2, PGY3)

A. Core Competencies

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

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

B. Service Goals:

Musculoskeletal injuries comprise a common part of family medicine, and family physicians provide a significant amount of school and sports medicine in the communities we serve. Degenerative arthritis is becoming increasingly prevalent as our population ages and as the youth obesity epidemic grows. This rotation is intended to prepare the resident to appropriately manage such problems. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description:

Residents are assigned to various orthopedic physicians, sports medicine fellowship trained physicians (both family medicine and orthopedic), physical therapists, physiatrists, and athletic trainers in this rotation. Residents will attend at least one major athletic event and will assist in sports pre-participation evaluations which, given the nature of the sports seasons, may not happen during this actual rotation. Residents spend a total of 6 weeks on musculoskeletal medicine rotations. In addition orthopedics specialty clinics occur while on the Clinic 1 rotation up to two times per month. The sports medicine component of this rotation involves the following: 1) Working with the sports medicine fellowship trained family physicians, in the office, at athletic events and post-game clinics and 2) Participating in sports pre-participation physical exams at local

schools and in the Family Medicine continuity clinic setting. In addition, residents may work with a sports medicine fellowship trained orthopedic surgeon who combines sports medicine and general orthopedics in his practice.

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

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

D. Duties:

During the orthopedic/sports medicine rotation, residents are assigned to work with a variety health care providers covering a broad spectrum of musculoskeletal medicine – orthopedic surgery, casting, sports medicine, physiatrist, athletic training, and physical therapy. A schedule of sporting events is produced by the residency office for the block rotations. In addition, residents must participate in a sports pre-participation evaluation event at least two times over three years (total = 2) and attend at least one athletic event with a physician. Some sporting events and sports pre-participation physicals take place in the evenings and Saturdays, and will count toward rotational requirements/hours.

OUTSIDE TELEPHONE CALLS

1. All outside telephone calls should be directed to the backup/senior resident.
2. Accept outside calls only from these patients:
 - a. MFHC resident or faculty patients
 - b. SCHC Resident Patients
3. Advice given over the telephone should be limited and treated with considerable caution, given at times limited access to medical records, no prior knowledge of the patient, and inability to perform a physical exam.

4. All conversations with patients should be documented immediately and sent to the physician/clinic providing the patient's care for review. Documentation should also include the following:
 - a. Your name, the doctor creating the note (who took the patient's call)
 - b. Patient's name (use for acct #99999999)
 - c. Patient's DOB
 - d. Date of the telephone report
 - e. Presenting problem or question
 - f. Any discussion
 - g. Impression
 - h. Instructions given to patient
5. Consider concluding all conversations and documenting in your report that you *advised the patient that the ability to provide medical care over the phone is limited. Therefore, the patient must go to the Emergency Department for further evaluation of urgent conditions.* If the decision is made for the patient to see their own doctor for follow-up, have them set up the earliest possible appointment and to seek care at the Emergency Department if the problem persists, or worsens.
6. If the patient needs a refill for pain medications or other controlled substances, have them follow-up with their private physician or go to the ED. In very rare circumstances, using your judgment, you may send to their pharmacy a refill prescription with a limited amount of medication to last until their clinic re-opens.

PARENTAL NEWBORN ELECTIVE (PNE) – PGY1, PGY2, PGY3

A. Core Competencies:

- Through the experience gained as part of this rotation, residents will be able to:
 - Improve counseling of new parents on normal postpartum experience and difficulties
 - Improve counseling of new parents on care of the infant in the neonatal period (Patient Care)
- Resident will have increased ability to:
 - Understand the experience of the role of patient and of families of patients
 - Understand the management of pregnancy and delivery through experience and and relevant literature review
 - Understand the psychosocial literature on childbirth, parenting and parental roles (Medical Knowledge)
- At the completion of this rotation residents will be able to:
 - Conduct a critical review of the evidence underlying the management of a condition of importance to patients, regarding pregnancy, postpartum, or newborn care (Practice-Based Learning and Improvement)

- At the completion of the rotation residents will be able to:
 - Present a synthesis of experience
(Interpersonal Communication Skills)
- During this rotation, residents will exhibit characteristics of a professional health care provider by:
 - Using reflective discussion and/or writing to deepen understanding of the role of physician and patient in expressing and responding to change and to physical and emotional stressors.
(Professionalism)
- At the completion of this rotation, residents will be able to:
 - Describe the differences between the patient's view and the medical professional's view of childbirth and family development in early childhood.
(System-Based Practice)

B. Service Goals:

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

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

C. Service Description:

This rotation is 2-week Away Elective structured academic experience to augment

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

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

D. Service Resources:

- Perinatal psychiatry consult available for providers via Postpartum Support International: (877) 499-4773 <https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/>
- Downloadable toolkit that addresses a wide range of perinatal mental health issues (in OB binder at MFHC). See:
 - <https://www.mcpapformoms.org/Docs/AdultProviderToolkit12.09.2019.pdf>
 - [2023 American Psychiatric Association | Perinatal Mental and Substance Use Disorders](#)
 - [First 5 California](#)
 - [Google Drive/Independent Study: Learning Resources/Obstetrics](#)

E. Service Evaluation:

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

F. Addendum:

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

PEDIATRICS/OB (PGY1, PGY2, PGY3)

A. Core Competencies

Pediatrics:

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

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

Obstetrics:

- Be able to communicate effectively with birthing patients of all ages, demonstrating active listening skills, a respectful approach to issues that may be sensitive for patients, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform comprehensive physical examinations of female anatomy with appropriate screening tests for pregnant and non-pregnant patients, and be able to perform routine gynecological and obstetrical procedures (detailed below). (Patient Care, Medical Knowledge)
- Develop treatment plans for common gynecologic conditions and pregnancy complications, utilizing community resources when indicated, and demonstrate appropriate post-operative care following cesarean section or gynecologic surgery, both inpatient and for office follow-up. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive issues in women as well as comprehensive wellness counseling based on the patient's age and risk factors. (Patient Care and Interpersonal and Communication Skills)
- Consult and communicate appropriately with obstetrician-gynecologists, maternal fetal medicine specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice, Professionalism)

B. Service Goals:

The success of this service will require the senior resident to carefully manage the demands of the various services against his/her resources, assign duties, adjust for volume and acuity, have

the full support of the attendings and the understanding of the nurses. Open communication will be critical. On-time Rounds must be maintained to get through the teaching and supervision tasks of the morning. Finally, there will be times when the residents will not be able to cover all patients and attendings on OB may be required to deliver patients; this option should be uncommon.

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

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

Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources*.

C. Service Description:

Obstetrics

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

Residents should meet in the OB nurses station as arranged with the OB attending and be prepared to present all OB/GYN patients to the OB attending. Coordination with the attending is especially important prior to the weekend so that rounds occur smoothly and the resident familiar with the service patients can be available to round with the attending. As time and hospital

duties allow, residents may spend a limited amount of time providing prenatal and postpartum care for the SCHC **Maternity Clinic** patients at the outpatient clinic

Pediatrics:

In the **Nursery**, the residents are responsible for doing admission History & Physicals on all of the babies admitted to their service, regardless of the time of day in which they were delivered. On the weekends, it will be the responsibility of the covering resident to perform this duty. (For more information about newborn care for MFHC patients, see heading IV. MERCY FAMILY HEALTH CENTER: section II. CLINICAL AREAS: NEWBORN CARE.) Residents are responsible for patients ≥ 35 weeks in the normal newborn nursery. With all newborns, including "normal cases" it is expected that the resident will write appropriate daily notes. A brief delivery note must accompany the newborn to the nursery. This should include:

- History of mother's prenatal care and all events surrounding labor
- Type of delivery, with or without complications,
- Condition of amniotic fluid,
- Apgars, resuscitation,
- Evidence of fetal distress,
- Visualization of cords,
- Complications, etc.

On the **Pediatric Ward**, the resident will follow all service patients.

The residents care for service patients in the pediatric ward, newborn nursery and those admitted to the Pediatric service but housed in the Emergency Department. Residents should meet as arranged with the pediatric attending and be prepared to present patients to the pediatric attending according to their preferred schedules. Coordination with the attendings is especially important so that rounds occur smoothly and the resident familiar with the service patients can be available to round with the attending.

Night Float Ob/NB

The service is staffed by a single resident working closely with the obstetrical service and pediatric service attendings. PGY1s will always have an upper level resident available on the Night float service to provide supervision. The night shift resident will work from 5:30 p.m. to the 7 a.m. check out. The night shift resident will work five shifts Monday-Friday. Admission policies are described in the Ob and Peds rotation section above. The night shift should review all admissions with the attending physician during the night or prior to end of shift – this assures both quality of care for the patient and education for the resident.

D. Service Duties:

Overview: The resident team (excluding the night float resident) will generally consist of one PGY1 and one senior resident. Each senior resident/ PGY1 team generally spends two 2-week blocks alternating between the pediatric and obstetrical service. The senior resident is the team leader and assigns duties as appropriate. Each attending for OB, Pediatric, and NICU will arrange with the senior resident the time for rounding. See also Night Float Ob/NB above.

MFHC Clinic:

- Residents scheduled in the FPC must arrive at the FPC on time (These patients count on you being there).
- The PGY2 or PGY3 resident in house will manage the POB service, assign PGY1s to admissions, L&D, etc.

Admits:

- Newborns from attendings who do not do Nursery care will be managed on the newborn service with the senior assigning those newborns to first year residents as appropriate.
- Pediatric ward admissions will be followed by the team member who performed the admission, or assigned if the admission occurred during the on-call period.

Obstetrics Service:

Residents are responsible for:

- Managing prenatal care at the Mercy Maternity based on the schedule defined above.
- Managing labor and delivery and postpartum care of patients from the Mercy Maternity Clinic or unassigned patients.
- Notifying the attending preceptor of patients being admitted in labor and all discharges. Residents shall also contact the attending preceptor about management plans including when to call the attending with updates on labor and for the delivery. Residents must present cases in a standard format and interns should discuss with upper level residents before calling the attending after hours and on weekends:
 - Gravida _ Para _ AB _
 - Age
 - EDC
 - Presenting condition
 - Onset of labor
 - Contraction pattern and intensity
 - Membranes
 - Dilatation
 - Station
 - Vitals
 - Strips or other tests
 - Complications if any
 - Prenatal course

- Plan
- The expectation is that the OB attending should be present for all deliveries; the only exception should be precipitous delivery or an issue that prevents the attending from getting there as expected (i.e. multiple deliveries). The OB Senior should be present if the OB attending cannot be present. It is the resident's responsibility to communicate appropriately with attendings on the progress of labor and the expected time (as much as this is possible!) of delivery.
- The delivery note on the mother's chart should comply with Mercy Medical Center operative note guidelines.
- The OB residents are expected to pre-round and be prepared for daily inpatient obstetrics rounds with the attending of the day by having seen each patient and formulated a management plan prior to the attending's arrival at 8 am.
- All L&D patients cared for by the residency program service must be evaluated in person and discussed with the attending. This includes patients who are sent home without being admitted (rule out labor, etc.) A note should then be placed in the chart documenting this care.
- In the Maternity Clinic, residents will provide patient care under the supervision of the OB attending.
- When the need to perform an emergency C-Section arises, the following procedure should be pursued:
 - Call the OB attending regarding the case.
 - If the OB attending agrees C-section is needed, notify the OB nursing staff and make sure they contact the anesthesiologist.
 - Dictate an H&P for the patient before the C-section unless it is a "crash" C-section.
 - Contact the on-call neonatologist as discussed with the obstetrician.
- Residents are expected to attend Noon Conferences.
- Compliance with these guidelines is essential to a determination of "successful completion" of this rotation.

a. Service Guidelines

Pediatrics In-Patient Service

1. Inpatient Service

- a. Complete history and physical examination, appropriate orders and procedures
- b. Learn appropriate diagnosis, treatment and management of common pediatric hospital problems.
- c. Write appropriate progress notes, communicate with parents, referring doctors and involved agencies
- d. Dictate discharge summaries within 48 hours from discharge
- e. Arrange appropriate follow up plan for outpatient appointments
- f. Maintain appropriate partnership relationships with fellow residents

2. Newborn Nursery

- a. Follow sick or high-risk neonates ≥ 35 weeks with attending neonatologist
- b. Attend high risk deliveries and C-sections on requests
- c. Make appropriate follow-up referral to pediatric clinic
- d. Collaborate on Family Practice newborns with resident if needed.
- e. Gain experience at neonatal circumcision if done as in-patient.

Monthly Perinatal Case Presentation:

Guidelines:

- Case Presentations will be scheduled each year on the second Wednesday of the month (see below).
- Cases will be scheduled by the residency office. The obstetrical and neonatal attendings may assist in identifying appropriate cases for review.
- The PGY1 who was on OB service the month prior will be assigned to present the case. Most residents will present twice during their residency training. They may need to present during their second or third year of training.
- PowerPoint presentations and overheads should be used that clarify the patient's course, including key events, rhythm strips, x-rays, etc. These will substantially improve the effectiveness and professionalism of the presentation and are expected.
- There may be "last minute" cases worth presenting where thorough preparation is not possible but where the value of the discussion makes it worth the exception. This could also include an OB case at a Neonatology M&M, or vice versa.
- Patient confidentiality should be maintained.

Outline for Perinatal Case presentations:

- Residents will choose an OB case of interest for the purpose of discussing proper management.
- Although most cases will involve the resident they can also include cases in which the resident was not involved.
- Typically, the case chosen will involve a discussion of ways to achieve best possible outcomes and available guidelines.
- The presentation will involve a case overview which will include the basic facts of the case.
- Residents are asked to pay particular attention to researching the details to avoid unnecessary time spent debating details with the audience.
- The case overview will involve the initial presentation, hospital course, and outcome.
- If possible the presentation will include copies of the fetal heart tracing, toco monitor, and imaging. If not available, similar strips and imaging may be available on the Internet to demonstrate examples of the condition being presented.
- This will be followed by a discussion which will include a definition of the condition, current recommended screening and management.

Residents may email a copy of their presentation to their academic advisor for review and to receive advice prior to their presentation

PEDIATRIC OUTPATIENT ROTATION (PGY2 & PGY3)

A. Core Competencies

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

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

B. Service Goals

The goal of this rotation is to expose first year residents to common ambulatory pediatric problems. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

- Perform a thorough but efficient H and P on patients including family and social history
- Perform a thorough well child check on pediatric patients of various ages
- Be comfortable with and make them comfortable with your examination.
 - Speak to the patient and make it “fun” and they won’t fight you as much
- Growth Chart Evaluation and Interpretation.
 - Check at every visit.
- Correct Assessment of Developmental Milestones
- Fundamental knowledge of medications used for common diagnoses in pediatrics
 - Basic antibiotics and their coverage. Weight based dosing.
- Fundamental knowledge of vaccines and their schedule.
 - Common misconceptions, why the schedule is set up as it is, ingredients and side effects.
- Diagnosis and basic management of behavioral issues
 - ADHD
 - Autism
 - depression/anxiety
 - normal childhood behaviors, i.e. picky eater, tantrums, sleep resistance, etc.
- Recognition of a critically sick child vs one that can be managed safely at home.
- Comfortable with basic evaluation of a teen including HEEADSSS exam

- Learn evidence-based management and evaluation of and differential Dx at various ages for:
 - Common Cold and other pediatric URI
- Croup
- Bronchiolitis
- Sinusitis
- Throat
- RSV/Bronchiolitis
- Strep Failure to thrive
 - Short stature
 - Recurrent/chronic headaches/migraines
 - Asthma
 - Allergies
 - Otitis media/Ear pain
 - Jaundice
 - Febrile neonate
 - Common injuries
- Fractures
- Nursemaid elbow
- Sprain/strain
 - Acute gastroenteritis
 - Dehydration
 - Intussusception
 - Constipation
 - Eczema
 - Acne
 - Common childhood rashes
- Roseola
- Molluscum
- Parvo/Fifth's disease
- Scarlet fever
- Coxsackie/HFM
- Varicella
- Scabies
- Urticaria
- Impetigo
- Tinea
 - Febrile seizures
 - Concussion
 - Chronic abdominal pain
 - Amenorrhea
 - Anemia
 - Diaper rash
 - Diarrhea
 - DUB

- o Colic
- o Reflux
- o Hematuria
- o UTI
- o Genetic conditions
- Downs
- Turner
- Klinefelter
- Fragile X
- Prader Willi
- Angelman

C. Service Description

PGY2 and PGY3's residents will spend 4 weeks each year on this service working with an attending pediatrician at Shasta Community Health Center.

D. Duties

Residents will work at the pediatric clinic Monday through Friday. Residents will continue to have continuity clinic at MFHC during this rotation.

RADIOLOGY, LAB, ABFM ROTATION (PGY2)

The Radiology, Lab, ABFM rotation occurs 1 week during the first and second year. This rotation includes continuity clinic three half-days per week. One half-day will be spent in the Clinical Laboratory, and a minimum of four half-days will be spent doing ABFM modules. Time may be spent with one on one learning with a radiologist if available. . The exact number of radiology days may vary depending upon the availability of radiologists.

The following is a description of each component of this rotation.

Radiology

1. Service Goals and Competencies

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

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

- Be able to interpret basic radiological tests - Chest x-ray, Abdominal X-ray, Cervical/Thoracic/Lumbar spine X-rays. (Patient Care)

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

2. Service Description

Residents will have scheduled time during the two week rotation to work on radiology learning modules.

3. Service Duties

The resident will be scheduled time to complete radiology learning modules. As of 2025, significant changes within the organization developed limiting 1:1 learning time with a radiologist. If time becomes available for direct learning with a radiologist or interventional radiologist, the resident will need to provide the Residency Office with the names of radiology attendings they were able to spend learning time with so as New Innovation evaluations may be sent to the involved attendings..

Laboratory Medicine

A. Service Goals and Competencies

The primary objective of the Lab portion of this rotation is to help the family practice resident more fully develop the knowledge base needed to effectively and efficiently manage the laboratory portion of patient care. Laboratory testing, both inpatient and outpatient, constitutes a significant portion of patients' medical care. Residents will gain an appreciation of the ordering, costs, utility and limitations of laboratory tests. Every year all residents are required to participate in CLIA lab training as well as "Provider Performed Microscopy Procedure" (PPMP) direct observation.

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

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

- Be knowledgeable in the cost considerations of laboratory testing. (Medical Knowledge, Systems-based Practice)

B. Service Description

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

C. Service Duties

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

ABFM Maintenance of Certification (MOC)

A. Service Goals and Competencies

Through this rotation, the resident will gain experience in the ABFM Maintenance of Certification process (MC-FP) which is required for achieving and maintaining family medicine board certification. (Medical knowledge)

B. Service Description

The ABFM requires completion of 50 Family Medicine Certification points in order to be eligible to sit for the ABFM Board Examination. Below are the ABFM Module requirements which must be completed prior to applying for the ABFM Exam in PGY3:

Completion of 50 Family Medicine Certification points which includes:

- Minimum of one (1) Knowledge Self-Assessment (KSA) activity (10 points each)
- Minimum of one (1) Performance Improvement (PI) activity with data from a patient population (20 points each)
- Additional approved KSA Knowledge Self-Assessment, Clinical Self-Assessment (CSA 5 points each), or Performance Improvement activities to reach a minimum of 50 points
- Due to the licensing requirement for the Residency Program to verify Pain Management training, the Pain Management module is required as a part of the 50 points

This rotation will include four - half days to work on these modules. Residents may be scheduled additional time to complete a module during their C2 Rotation. The Performance

Improvement module requires evaluation of data from our continuity patient population over a period of time and may need to be completed after the rotation. Completion of the 50 Family Medicine Certification points may involve work at home either during or outside of this rotation block.

Scores for Self-Assessment Module (Part II) are provided by the ABFM.

Physicians must complete training in pain management, which Dr. Bland will certify for the Medical Boards for licensure process. Completion of the Pain Management ABFM module is required and will be tracked by the residency office for documentation purposes in each resident file.

C. Duties

The resident will access the resident portfolio to utilize the tools/modules after they have been entered into The Resident Training Management System (RTM) by the Program Coordinator. Residents will complete the modules during the scheduled rotation using a computer set up in the conference room at MFHC. You are not expected to complete all of the ABFM module requirements during these 2 weeks, but we do require the following:

Minimum Requirements for ABFM/Rad Rotation

1. Initiate PI Module
2. Complete Minimum of 1 KSA
3. Complete Minimum of 1 CSA
4. Submit evidence of module initiation and completion at the end of the rotation.

If Minimum Expectations are not met, the rotation must be repeated using elective time. This will include a mixture of clinic, modules, and at least one call.

The residency office has access to the ABFM website and routinely performs audits for each half day during this rotation. This includes the number of ABFM modules initiated and completed and which days this work was done. Each day of the rotation must be accounted for. **Time not accounted for during this rotation will be taken from the resident's allotted PTO which may result in decreased vacation time and/or residency training extension beyond 3 years.**

RURAL FAMILY MEDICINE (PGY2)

A. Core Competencies:

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

- Be able to discuss the issues of social determinants of health, health equity, social justice, and US policy impacts in the distribution of health services in low-resource settings. (System-based Practice)
- Assess the health care and public health needs of communities and make evidence-based decisions about resource allocation and the delivery of population health services. (Medical Knowledge, Patient Care)
- Demonstrate knowledge of effective advocacy strategies for health systems improvement within the rural context. (Interpersonal and Communication Skills, System-based Practice)
- Tailor health outreach and clinical interventions by taking into consideration local socioeconomics, politics, health disparities, and cultural influences. (System-based Practice)
- Demonstrate the ability to communicate effectively and collaborate with the patient, the patient's family, and the patient's caregivers with sensitivity to sociocultural and health literacy issues so that the diagnosis and plan of care are clearly understood and pertinent to their specific situation. (Interpersonal and Communication Skills)
- Demonstrate the ability to use interpreters when the physician and patient cannot speak the same language. (Interpersonal and Communication Skills)
- Create treatment plans based on knowledge of rural influences, utilizing resources that include local, state, and federal agencies as applicable. (System-based Practice, Practice-based Learning and Improvement)
- Recognize his or her own practice limitations and seek consultation with other health care providers and systems resources to provide optimal care within a rural construct. (Practice-based Learning and Improvement, System-based Practice)
- Develop the following general competencies in rural medicine including:
 - a. Adaptability – how to shape one's skill set to the needs of the rural community
 - b. Improvisation – how to deliver quality care within the resources and skills you have available in the moment
 - c. Life-long learning – how to continually acquire additional knowledge and skills as needed
 - d. Collaboration – how to get help from others and work together
 - e. Endurance – how to sustain oneself in rural practice

B. Service Goals:

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

C. Service Description:

Second year residents have the opportunity to request the locations for this four week rotation including: 1) Siskiyou Medical Group (Mt. Shasta) 2) Lassen Medical Group (Red Bluff) and 3) other sites including Shasta Community Health Center and Weaverville. To broaden experiences and exposure to various practice sites, two separate locations may be selected during this

rotation. Residents have the option of living in the mountain communities during the rotation or being reimbursed for daily commute miles. Residents will be scheduled in their family health center for continuity patients during the rotation, and will participate in some hospital call at MMCR.

D. Duties:

Residents see patients in the ambulatory practices and in the hospitals serving those practices under the supervision of the attending family physicians.

SCHOLARLY ACTIVITY AND RESIDENT PRESENTATIONS (PGY1, PGY2, PGY3)

A. Core Competencies:

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

- Demonstrate the ability to ask answerable questions applicable to the direct clinical care of their patients. (Medical Knowledge)
- Demonstrate the ability to search, find, and appraise both primary and secondary information sources for answers to these clinical questions. (Practice-based Learning and Improvement)
- Demonstrate the ability to apply this information to the care of patients. (Patient Care)
- Complete a scholarly project. (Medical Knowledge, Interpersonal and Communication Skills).
- Demonstrate knowledge of the principles of ethics as it applies to medical research. (Professionalism)

ACGME Program Requirements stipulate:

“The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. Residents should participate in scholarly activities. Residents should complete two scholarly activities, at least one of which should be a quality improvement project.”

Our program meets this requirement through the following activities:

Critical Evaluation of Medical Literature

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

Quality Improvement Project

Residents are required to complete a Performance in Practice Module (PPM) which also fulfills the ABFM Part IV module requirement. Each physician will assess his or her care of patients using evidence-based quality indicators. After a physician enters patient data into the ABFM Website, feedback is provided for each of the quality indicators. The performance data is used by the physician to choose an indicator for which a quality improvement plan will be designed. Using a menu of interventions available from various online sources, the physician designs a plan of improvement, submits the plan, and implements the plan in practice. After a minimum of 1 week, the physician again assesses the care provided in the chosen health area and enters the data into the ABFM Website. The physician then is able to compare pre- and post-intervention performance, and compare their results to those of their peers.

Resident Presentations

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

Primary Care Case Presentation (PCCP):

During the second or third year, each resident is required to present a primary care case with which they have been clinically involved.

- a. The case may come from the health center or hospital service
- b. After describing how the patient presented to the clinic or hospital, the resident will then ask fellow residents what additional information they would like to know such as history, exam, labs, etc. with an emphasis on keeping the conference interactive. The resident may request a scribe to write this information on the board
- c. The case should be relevant to family medicine and the amount of detail appropriate, neither too detailed nor superficial
- d. In addition, the resident may invite specialists to elaborate on specific aspects of the case
- e. Following the presentation, the resident will discuss the following aspects of the case as applicable:
 - Epidemiology
 - Clinical presentation
 - Diagnosis
 - Treatment
 - Prognosis
 - Prevention
 - Screening summary
- f. The use of Google Slides is encouraged to facilitate learning along with handouts

- g. Key learning points should be summarized at the conclusion of the talk
- h. Presentation should take around 35 minutes with 10 minutes for questions

Senior Grand Rounds:

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

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

Alternative Scholarly Activities:

1. **Research.** As an alternative to presenting Grand Rounds, a senior resident with prior approval from the program director may participate in an active research program which gives the resident an awareness of the basic principles of study design, performance, analysis, and reporting, as well as of the relevance of research to patient care.
2. **Presentation at a national, regional, state, or local meeting.** This must involve a medical audience of larger scope than just the residents and faculty members. Such presentations must be approved ahead of time by the program director and attended by the academic advisor or his/her designee. Presentations must include a thorough and critical review of the medical literature concerning the topic, with at least 10 references cited in the bibliography.

POCUS AND SONOSIM ELECTIVE ROTATION OPTIONS (PGY 2 or 3)

A. Core Competencies

Electives are primarily intended to enrich the residents' training with experiences relevant to their future practice, their special interests, or for rounding out the training experience with competencies not attained through the required rotations. As adult learners responsible for their continuing medical education beyond residency, each resident must be able to identify educational opportunities and then craft experiences that

will address those individual needs. The program supports and encourages this self-directed learning opportunity.

B. Service Goals

Residents may choose a specific elective time of SonoSim only or a more integrated experience including SonoSim with concurrent active POCUS use.

SonoSim:

The Resident will personalize the training by selecting modules from a library according to the resident interests and practice goals. A list containing the approximate length of the modules is supplied with the elective form. For SonoSim only elective, the resident will be accountable for **35 hours of Sonosim learning time per week minus 4 hours for each half day of continuity clinic time**. If doing SonoSim only elective during an Away Elective time without continuity clinic time, 35 hours per week of SonoSim modules is the requirement.

SonoSim plus POCUS:

Integrated POCUS will involve real time use of a POCUS ultrasound unit and learning modules such as SonoSim and/or in person POCUS learning courses. Experiences will include patients and volunteer subjects for POCUS scans. Regular continuity clinic will be scheduled during this rotation.

Educational Plan for POCUS

1. 2-4 week Elective rotation for POCUS – clinical application can begin once an elective is started and/or a hands-on course or longitudinal online course is completed.
2. Independent Study
3. Formal course training – simulator (SonoSim), web based, and/or hands-on
4. Practice imaging – specific point of care patients as well as volunteer subjects
5. Image capture and review with feedback

C. Service Description

SonoSim elective provides an ultrasound training solution that offers engaging didactic courses, hands-on simulated training, and knowledge assessments, allowing the resident to improve their knowledge and foundation ultrasound skills and recognize real-patient pathology.

The SonoSim plus POCUS elective provides a 2-4 week integrated ultrasound training that offers engaging didactic learning, hands-on simulation training, hands on POCUS use, and knowledge assessments. These activities allow the resident to improve their ability to perform POCUS for primary care and recognize real-patient pathology.

Sample Schedule

10 half days per week excluding Holidays. Allowance for 2-3 post call days during 4 week rotation.

Independent study times during the combined SonoSim/POCUS elective - **Average of 1 hour per scheduled weekday of SonoSim module learning is required during the SonoSim plus POCUS elective. 2 week elective without Holiday or post-call days = minimum 10 hours SonoSim module learning required.**

Week 1:

2 half days continuity clinic

½ day introduction to the clinic ultrasound unit with preceptor; POCUS basics videos: Knobology, Basic US Physics, Ultrasound Artifacts I, Ultrasound Artifacts II, CW and PW, Doppler, Color and Power Doppler, Machine Decontamination
½ day SonoSim or observation in radiology department with an ultra-sonographer if available

Week 2:

3-4 half days continuity clinic

½ day independent study

1-2 days floating MFHC clinic POCUS or ER POCUS

½ day clinic POCUS and image review with preceptor

Week 3:

3-4 half days continuity clinic

½ day independent study

1-2 days floating MFHC clinic POCUS or ER POCUS

½ day clinic POCUS and image review with preceptor

Week 4:

3-4 half days continuity clinic

½ half day independent study

1-2 days in ER or urgent care or floating MFHC clinic POCUS

½ day clinic POCUS image review with preceptor

*If a formal hands-on course is completed prior to the rotation, then the designated time for completing a training course otherwise will be filled with SonoSim modules, time for POCUS in ER or clinic setting, and/or volunteer subject exams. Hands-on course fees are currently not able to be covered by the residency program. A stipend to support covering course fees may be available.

Basic POCUS competency

POCUS in this residency is being initiated as purely educational. It does not replace formal imaging studies when clinically indicated. It will include the requirement of a hands-on and simulator or formal virtual training course as above. A current proposed basic competency for Family Medicine POCUS is not defined by medical training guidelines. This program's basic competency will focus on establishing a foundation of understanding the technology, the practical application in the point of care setting to provide specific information aiding in medical decision making, and ultimately integrating POCUS into a common use pattern for the physician with intention they will be confident to continue learning POCUS through their career after residency training. Various organizations have proposed competency based on a number of exams performed. Our program's current exam based targets (but not required for basic learning competency) will be 60 POCUS exams done within a minimum of 2 different organ systems as listed, a minimum of 20 exams in any one system with the exception of a minimum of 10 US guided injections if that is used is as part of the total, and no greater than half of the exams done on any one system should be on normal subjects.

Ex: 25 basic cardiac + 25 biliary + 10 US guided injections = basic competency

Ex: 20 biliary + 20 lung + 20 abdominal aorta = basic competency

Proficiency of POCUS use within a minimum number of systems and not every system is based on reasonable anticipation of resident physicians continuing to learn and use POCUS in practice across multiple other systems over time beyond residency training similar to physicians improving procedural skills throughout their career.

Systems:

Basic cardiac

Biliary

Abdominal aorta

Renal/ureter/bladder – hydronephrosis, pvr

Lung

Deep venous examinations of the extremities

Soft tissue/musculoskeletal

Obstetrical – early dating, fetal lie

US guided injections

Residents successfully completing the competency requirements will be given documentation of POCUS completion to accompany their documentation from the chosen formal course training. While there is no standardization for this type of certification currently, the intention of providing such documentation of completion will be to support residency graduating physicians pursuing privileges at their future institutions of practice.

D. Duties

The residency must comply with the regulations of both the Accreditation Council for Graduate Medical Education (ACGME) and Medicare for the appropriate approval and documentation of elective time. Without this documentation, credit cannot be given to the resident for the elective rotation. Furthermore, the hospital will be in violation of its

financial obligations to Medicare and cannot be paid the monies that support the residency program. **For these reasons, the specific SonoSim Elective Form, which contains the required steps to obtain approval for the elective and document approval from the supervising physician, must be completed in its entirety for both the SonoSim specific Elective and the POCUS elective if SonoSim is done during POCUS elective. If the resident has not submitted the proper and completed Form to the Program Director (who approves each Elective) one month in advance at the latest (earlier for international electives – see below), the resident will be assigned to an in-patient rotation with the usual FPC duties.**

General Elective Procedure: (see ‘Request for Elective form’)

- Section 1: The resident must identify the experience and develop educational objectives that describe what the resident seeks to learn in the experience.
- Section 2: The resident must obtain the signature and other demographic information requested from the supervisor
- Section 3: The resident must submit the Request for Elective form to the Residency Program Director for approval:
 - No later than one block in advance of a local or Away Elective
- Section 4: After completion of your elective, Highlight modules completed from the list of SonoSim modules, which was attached to the original SonoSim Elective Form.
 - (NOTE: While SonoSim Software allows residents to practice ‘Live Lectures by going to Scan/Finding/Live Lectures’, these 5-10 minutes practice sessions are not considered appropriate use of the SonoSim Program other than a short practice session after completion of an appropriate module).
 - The residency office will calculate the time spent on this elective using the modules completed not the Live Learning Practice.
- B. Return the list of completed (highlighted) courses to the Residency Office (List attached to Elective Form)
- C. The Residency Office will run a report that shows the number of hours you were actively working in each module, which should total approximately 35-40 hours minus time in clinic.
 - Note: the program must report all hourly information to MMCR for the hospital Medicare Cost Report, which is why we define the elective specifics.
- The Residency Office will give your academic advisor the report and elective form to complete section 5.

As with all electives, the final evaluation must be completed by the supervisor for the resident to receive credit for the rotation. It is the resident’s responsibility to have the supervisor complete Section 4 Final Evaluation and return this to the residency office.

SURGERY ROTATION (PGY1)

A. Core Competencies

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

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

B. Service Goals

The surgery rotations in the first and third years are intended to provide the family practitioner with appropriate diagnostic and management skills to recognize and appropriately refer to the surgical patient in a timely fashion and to manage the medical and social issues of the surgical patient. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com or *Independent Study: Learning Resources* on the FMResidency Google drive, using your assigned login and password.

C. Service Description

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

D. Duties

- Provide surgical assistance to their respective preceptors.
- Accompany the surgeon in both out- and in-patient rounds
- Attend FHC continuity clinic, noon conferences and post-call time off. Residents will be scheduled in continuity clinic during the rotation.

URGENT CARE (PGY3)

A. Core Competencies

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

- Demonstrate an ability to rapidly assess and gather information pertinent to the care of patients in an urgent and emergent situation and develop treatment plans appropriate to the stabilization and disposition of these patients. (Patient Care, Medical Knowledge)
- Be able to identify the indication and perform procedures appropriately for the stabilization of the patient in an urgent and emergent care setting. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement)
- Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care). (Systems-based Practice)
- Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns. (Practice-based Learning and Improvement)
- Appropriately inform, educate, and elicit patient and family participation in medical-decision making in a professional and caring manner with sensitivity to cultural and ethnic diversity. (Professionalism, Interpersonal and Communication Skills)

B. Service Goals

The goal of this rotation is to prepare residents to effectively manage acute medical conditions, and perform minor surgical procedures in outpatient centers and to seek consultations appropriately.

C. Service Description

The Urgent Care rotation consists of a one week block at Dignity Health Urgent Care, SCHC or other urgent care facility during the 3rd year.

D. Duties

The resident is generally scheduled from 8am – 5pm Monday through Friday with scheduled time out for the FHC continuity clinics, noon lectures, and post-call.

UROLOGY (PGY3)

A. Core Competencies

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

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

B. Service Goals:

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

C. Service Description:

The urology rotation is integrated into the third year of residency SpC rotation along with Ophthalmology, Cardiology, and ENT. The Urology component is designed to expose residents to the evaluation and management of common urologic conditions that present in the ambulatory setting. The experience is based in a urology group practice with case based, one on one teaching. Where appropriate to accomplish educational goals, residents may accompany urology preceptors into the hospital setting to assist or observe surgical procedures. This rotation represents one component of a resident's training in urology. Substantial training in the primary care of patients with urologic conditions is received in the Family Practice Center. Responsibility for the medical management of inpatients with urological complaints occurs throughout residency training.

D. Duties:

Attendance at the Urologist's office is scheduled by the Residency office. During this time you will work one-on-one with an Urologist. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/weeks.

III. Policies and Procedures

- For general personnel policies and procedures please refer to Mercy Medical Center Redding North State Service Area Human Resources Policy Manual. Copies of this manual may be located in the Human Resources Department or by signing into a hospital computer using single sign-on and selecting the Everyday Use MMR Icon.
- Policies relating to residency training may be modified to meet requirements and policies of the American Board of Family Medicine and the American College of Graduate Medical Education

ACADEMIC COUNSELING

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

Goals of academic counseling are:

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

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

- Review of preceptors' evaluation of resident including core competencies
- Conference attendance and Mandatory module completion
- Review scholarly events completed and those needing to be completed
- Discussion goals and plans after residency
- Discuss elective planning and opportunities
- Review of resident's procedure, Encounter logs and ABFM status'
- PGY 1 Educational List (for first years)

- Review family practice clinic data including
 - individual and clinic productivity, financial performance
 - continuity of care data including obstetrical care, SNF visits, and home visits
 - medical records chart audit
- Discuss moonlighting policies and opportunities
- Review on-going leadership experiences
- Review of ABFP In-Training Assessment scores (including plan of study for identified areas of deficiency)
- Discussion of academic problems residents may be encountering
- Summarize areas of needed improvement
- Provide an overall performance evaluation of satisfactory, unsatisfactory, or marginal.

ADMITTING PROCEDURES

Hospital and Medical Staff Policies can be found on all hospital computers under the Policy Manager icon and/or the Medical Staff Service Department.

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

Mercy Family Health Center Admissions: see MFHC Policy and Procedures

Maternity Clinic: see MMC Policy and Procedures

Newborn Nursery:

- When delivered by a resident's continuity OB, patient goes to the Family Practice Service: The FPS resident has the overall responsibility for the newborn, but the primary care physician (PCP) is expected to see his/her patients and write a note daily while they are in-patients, and see the mother. Exceptions will be made for out-of-town rotations, vacations, and weekends when not on call.
- Delivered from the maternity clinic, goes to Pediatrics Service to be managed by the team.

Unassigned admits from the ED:

- When the service is open to admissions, the medicine attending will determine which admissions are to be done by the resident.
- Pediatrics and OB admissions will go to the services as appropriate
- The supervising attending should be notified as soon as possible re the admission, and immediately if patient is in any way critical or will be admitted to ICU or CCU. Resident physicians will be called to the Emergency Room to admit patients whom the ER physician has determined are candidates for admission.
- If the resident determines that in his/her opinion the admission is not necessary, the patient may not be discharged from the Emergency Department until having been personally evaluated by the resident's supervising preceptor. The preceptor is required to communicate that decision directly to the ER physician on duty.

- Transmit orders in a timely fashion.

With the increasing volume of ED patients, and the occasional need to be On Diversion, a timely assessment of the admission in the ED is essential.

ADMISSION STATUS

The decision for admission status to the hospital is a complex medical decision based on the provider's judgment and the patient's need for medically necessary care. The patient placement order must be completed or co-signed by a provider with admitting privileges at Mercy Redding; the attending of service must sign the order to admit.

ADVANCE DIRECTIVES & RESUSCITATION STATUS

These hospital policies are located in the Policy Manager. Policy Manager is located on all hospital computer desktops under the following tab:



Specific policies can be accessed via folders or using the search option at the top of the screen.

APPEARANCE

Your appearance has a significant impact on how others view you personally, gauge your professional competence, and judge the residency and hospital. Residents will present a professional appearance during working hours in compliance with Mercy Medical Center Attire Policy and Dress Code. These hospital policies are located in the Policy Manager. Policy Manager is located on all hospital computer desktops located on the launch pad under the following tab:



Specific policies can be accessed via folders or using the search option at the top of the screen.

ANNUAL PROGRAM EVALUATION (APE) AND PROGRAM EVALUATION COMMITTEE (PEC)

1. The Residency will establish a Program Evaluation Committee (PEC) which will:
 - a. Plan, develop, implement and evaluate the educational activities of the program.
 - b. Review and make recommendations of revision of competency based curricular goals and objectives.
 - c. Address areas of non-compliance with ACGME standards and citations.
 - d. Annually assess the effectiveness of the program's education of residents using evaluations of faculty and residents.
2. The PEC includes all core faculty along with the chief and assistant chief residents.
3. The PEC will meet annually at the Annual Planning Meeting and quarterly to review APE action items.
4. The PEC will document formal, systematic evaluation of the curriculum and is responsible for rendering a written Annual Program Evaluation (APE).
5. The PEC will create an action plan for each academic year.
6. The APE will be developed by the PEC at the Annual Planning Meeting and presented in the form of a summary, meeting minutes, and Action Plans to the GMEC for approval:
 - a. Faculty Development
 - b. Review Action Plans from Prior Year
 - c. ACGME Citations
 - d. Mercy Annual Internal Program Evaluation
 - i. Resident Survey
 - ii. Faculty Survey
 - e. ACGME Surveys
 - i. Resident ACGME Survey
 - ii. Faculty ACGME Survey
 - f. ABFM Exam Take and Pass Rates
 - g. Resident ITE Performance
 - h. Resident Encounter Data
 - i. Graduate Survey
 - j. Resident Attrition
 - k. Curriculum Review
7. The GMEC Committee will review the APE. As a single program institution, the APE will be an essential component for developing the Annual Intuition Review (AIR) Action Plans

AUTOPSIES:

These hospital policies are located in the Policy Manager. Policy Manager is located on all hospital computer desktops in the launch pad under the following tab:



Specific policies can be accessed via folders or using the search option at the top of the screen.

BALINT GROUP/ RESIDENT WELLNESS/ INTERN CONFERENCE/WELLNESS CHIEF ACTIVITIES:

Intern Conference:

All interns meet every 2 weeks during the first 6 months and 1-2 times per month for the last 6 months with Christine Woroniecki and Amanda Mooneyham for a one-hour conference. Conferences will primarily be structured in a support group format to promote group cohesiveness and the learning of specific mind-body medicine self-care skills. Sessions will provide the opportunity to discuss issues that affect all of us as physicians, but especially interns. Examples would include adjusting to a new environment and role, the “difficult” patient, death and dying, frustrations and sources of satisfaction as well. The purpose is to develop a forum for sharing and understanding, not correcting or advising! All discussions are held in strict confidence among the participants.

Some sessions may be devoted to clinical topics as part of the program’s commitment to achieving PGY 1 clinical competencies. These topics may include common outpatient clinical diagnoses and care management issues including health care maintenance, diabetes care, hypertension, asthma/COPD, respiratory infections, hyperlipidemia, pharmacology and prescriptions, cost effective healthcare, etc. These sessions help orientate the first year residents to a comprehensive approach to health care and promote the development of an identity as a family physician.

Balint Group/General Wellness

ACGME requires programs to have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. This is accomplished through various means, including academic advisor meetings, monthly meetings involving the residents, program director, and clinic staff. Residents also receive training on fatigue, well-being, and impairment during their Annual Hospital Staff Education and lectures provided by Behavioral Science Coordinator, Dan Rubanowitz, PhD. Other regular lectures include Communicating with Compassion (Dr. Lupeika), Progressive Muscle Relaxation / Stress Management (Dr. Rubanowitz) and Dialogue with Duane (informal monthly meetings with program director),

The ACGME also requires a structure and facilitated group designed for resident support that meets on a regular schedule. For the first year residents, this is accomplished in the regularly scheduled intern conferences. For second and third year residents, a Senior Conference support group meets on a regular basis. This group is specifically designed for resident support, promotion of physician well-being, and prevention of impairment. Dr. Rubanowitz also coordinates an Annual Wellness Screening and Consultation for all residents. This involves

assessing the individual resident's score on the Professional Quality of Life Scale, filling out a Wellness and Physician Impairment Prevention checklist (see below), and participation in facilitated discussions. This occurs on an individual basis in PGY1 and via group sessions during PGY2-3 (with an option for individual sessions).

Every core faculty member is available to provide individual discussion, consultation and referral for any Resident experiencing wellness related concerns. The Behavioral Science faculty members are available for additional, more individualized wellness-educational consultations as needed for each and every Resident during the course of their training. Residents also have access to the Employee Assistance Program (EAP):

Lyra's Employee Assistance Program (EAP) is a confidential informational, support, and referral service offering tools and resources designed to help maximize productivity and meet the challenges of modern life. As an employer-sponsored program, EAP services are available to employees and their household members at no additional cost to them. Areas frequently addressed by the EAP include:

Child care and parenting

Helping aging parents

Financial issues

Legal concerns

Work and career

Emotional well-being

Addiction and recovery

Wellness and prevention

Concierge and convenience services

Life events

*The **Employee Assistance Program** can be accessed by calling: Lyra 877.312.1884 or on the web at www.commonspirit.lyrahealth.com (enter Dignity Health to log in). Free, confidential help 24 hours a day, 7 days a week.*



Register to access free, confidential coaching and therapy 24/7. Lyra connects you to mental and emotional health care that is effective.

Resident Wellness Post Call

To promote resident wellness for residents who are too tired to drive home post-call, the residency program has set up the following policy:

- During the week, residents can call the residency office at 225-6090 to arrange for a ride home.
- During the weekend, the jeopardy resident can be contacted for a ride home if needed. If the jeopardy resident is unavailable, a resident may call for a taxi and will be reimbursed by the residency office.

Wellness Chief

The Wellness chief resident is a position offered to a senior resident in good standing who accepts additional responsibilities beyond those normally included in the senior resident's academic program. This position is one of distinction, professionalism, and leadership serving as an example for other housestaff.

Assist program director, program coordinator, and faculty wellness champion with advocating for resident and faculty well-being and cultural competency education. They serve as a liaison between residents of both programs and administration to communicate resident needs. The position is just over 1 year, from March of PGY2 through April of PGY3 year, allowing for a transitional period.

Responsibilities include:

1. Plan regular wellness events that include residents, resident/faculty, and all staff specific events.
2. Create a budget proposal for wellness funds.
3. Help plan a yearly Cultural Competency Event and Resident Retreat.
4. Coordinate and plan cultural competency didactics quarterly
5. Institute and reinforce positive encouragement and feedback to staff, residents, and faculty regularly (i.e., written, email, text).
6. Assist in and help plan orientation and graduation events.

Optional:

1. Use of elective time for advocacy at organizational, local, state, or federal levels, particularly if in-line with planned campaigns.
2. Partner with Northern Valley Medical Association and Shasta- Trinity CAFP Chapter for events
3. Attend AAFP Physician Well-Being Conference
4. Create a quality improvement project focused on wellness or cultural competency.

Appointment procedure:

Residents in good standing may nominate themselves, then all residents may vote on a candidate. Faculty and program director will then vote to approve the nominee.

RESIDENT WELLNESS AND PHYSICIAN IMPAIRMENT PREVENTION CHECKLIST

The following items were presented for review and basic education, with an opportunity for discussion, additional information, follow-up, and/or referral resources:

- ☐ Professional Quality of Life Scale: Completed, Scored, Feedback Sheet Given
- ☐ Conceptual Model of Compassion Satisfaction/Compassion Fatigue Discussed
- ☐ Review/Discuss Work-Environment Stressors or Traumatic Experiences
- ☐ Review/Discuss Promotion of Collegial or Professional Peer Support System
- ☐ Review/Discuss Importance of Preventing Family Life Interference
- ☐ Health Behaviors: Sleep Hygiene
- ☐ Health Behaviors: Exercise
- ☐ Health Behaviors: Diet and Caffeine Management
- ☐ Health Behaviors: Substance Use and Abuse
- ☐ Health Behaviors: Rest, Relaxation, Recreation
- ☐ Review Health Care Benefits for Mental Health Services; Referral Options
- ☐ Review/Encourage Ongoing Availability of Informal Consultations (viz., Behavioral Science faculty, Faculty Advisor, Program Director).

Resident Name _____

Resident Signature _____

Date _____

BOARD CERTIFICATION:

For board certification, graduates of the residency program must meet the eligibility criteria specified by the American Board of Family Medicine (ABFM). Per the ABFM, these include:

1. Completion of 50 Family Medicine Certification points
2. Successful completion of the Family Medicine Certification Examination (the residency program cover the cost of the first exam fee if taken during residency)
3. Continuous compliance with ABFM Guidelines for professionalism, license and personal conduct. This includes holding a medical license(s) which meet ABFM licensure requirements.
4. Successful completion of family medicine residency training and verification by the program director

The residency program will reimburse the resident for the cost of the board certification costs one time during their residency. Any retake exams are the residents' responsibility.

Additional information on board certification may be found at www.theabfm.org.

CHIEF RESIDENTS:

The Chief Residents are key members of the residency program whose leadership, advice to the faculty and program director, and hard work makes the program strong. As an elected representative of the residents, the chief resident deserves the respect of both faculty and residents. At times, the chief resident may participate in confidential discussions involving residents or faculty. Examples include participation in the weekly faculty meetings and discussion of an individual resident's performance and progress and how this may affect his/her responsibilities and the residency program schedules.

Electing the Chief(s): There are two overlapping terms of chief resident office: July 1-June 30 and January 1 – December 31. The assistant Chief(s) must be an R-2 in good standing when elected, receiving a majority of resident votes with final approval by the program director. The overlap allows for smooth transitions as well as back-up functions when one of the chiefs is away. A R3 Wellness Chief is elected in July for a full year term. (See Wellness Chief Resident under Balint Group/ Resident Wellness/ Intern Conference)

Chief Resident Duties: The two chiefs share the duties, with responsibility for the schedule assumed by each during the last six months of their terms.

- Administrative representative of residents (provided with appropriate administrative time to accomplish his duties)
- Attends weekly faculty meetings

- Attends quarterly Graduate Medical Education Committee meetings and other Medical Staff meetings as invited by Program Director
- By example, foster the public and professional image of family practice and our program
- Fields resident complaints and concerns
- Oversees jeopardy call system.
- Prepares Master Schedule with input from residents, health centers, and residency coordinator, and Program Director
- Prepares call schedule with input from residents and core faculty
- Provides first contact with acutely ill residents to facilitate coverage

The Chief Resident may be scheduled 4 hours of administrative time per four week rotation, which must be scheduled in advance and cannot accumulate or be carried over to the next month.

CLINIC INBOX MANAGEMENT

You are responsible for managing your inbox on both inpatient and outpatient rotations with the exception of vacation rotations, rural rotations, and away elective rotations. Remember, you are the primary care provider for your clinic patients, and thus they rely on you to manage medications, results, imaging, etc. It is important to remember to address your inbox frequently as this can be easily forgotten given that, interns, are only in clinic one half day a week.

If you have any questions regarding medication management, how to deal with certain lab/imaging results, answer patient questions, etc, you should ask a senior resident or your advisor. Your facility advisor is your touch person for all things inbox related. Feel free to message them on Cerner with your questions. Please try to avoid asking clinic preceptors (ie the person your review clinic visits with) as they should be focusing on actual clinic visit, not peripheral management; this is what faculty advisors are for. Additionally, start to develop the skill of delegating. For example, Have nursing call patients to inform them of normal results, but schedule patients for an appointment to discuss abnormal results that need to be addressed. Time is valuable as residents, so begin to learn how to use it wisely.

Remember, residency is a learning process; you are supposed to ask questions. One of the most important skills you will develop as an intern is knowing your knowledge limits and when to ask for help.

CLINICAL COMPETENCY COMMITTEE

Introduction

The Mercy Redding Family Practice Residency Program regularly collects information on residents for the purpose of performance improvement and to ensure delivery of safe patient care. This information is reviewed by the Clinical Competency Committee (CCC). The creation

of the CCC is mandated by the ACGME as part of the Milestone evaluation process. The members of the CCC make a consensus decision on the Milestone achievements of each resident using multiple sources and types of resident assessments. The CCC determines how well a resident is meeting program standards and progressing along an expected educational trajectory. This process provides an opportunity for ongoing educational feedback and early identification of competency issues and helps to shape resident performance improvement and remediation plans. CCC members will conduct themselves in a professional and respectful manner and provide honest, constructive evaluation and feedback for all residents. Decisions will be made by consensus. If consensus cannot be achieved, the issue will be referred to the Program Director. Proceedings of the CCC are confidential.

Membership

- The CCC will be selected by the program director and have a minimum of four members, including the following individuals (all are voting members except the program director):
 - CCC chair (A core faculty member who is not the Program Director)
 - Two additional core faculty
 - Other core faculty, non-core faculty, and non-physician members of the health care team as assigned by the program director
 - Program director

Role and Responsibilities of Members

- d Review resident evaluations semi-annually to meet ACGME reporting deadlines
- e Review & assess each resident in the six core competency areas on entrance into the program (CCC will meet by the end of September - Intern Pre-Milestone Meeting)
- f Assign a CCC member who will preliminarily review and present the resident at CCC
- g Determine proper weighting of each performance measure (utilization of the Milestones will involve comparisons to peers as well as national benchmarking data when available)
- h Prepare and assure the reporting of required semi-annual Milestones evaluations to the ACGME (The residency administration and support staff will provide the necessary review materials and assist with ACGME reporting)
- i Provide input on resident competence and required procedures across ABFM Core Competencies for program director attestation upon graduation
- j Advise the Program Director regarding resident progress, promotion, remediation, and dismissal. Example recommendation may include:
 - i. Assigning a mentor with expertise in a given area of deficiency
 - ii. Additional required study, readings, question sets, oral cases, etc.
 - iii. Sessions in a skills lab or addition of selected rotations
 - iv. Extension of residency training
 - v. Residency termination

Measures of Performance

The CCC will use explicit assessment data to measure resident performance including the following:

11. ABFM In-Training Exam
12. ABFM Certification Activities
13. Advisor Semi-Annual Summative Evaluation
14. Annual Compliance & On-line Education Training
15. Behavioral Science Direct Observation
16. Board Exams – Part 1, 2, and 3
17. Electronic Health Records In-Box
18. Encounter Logs
19. ILP (Individual Learning Plans)
20. Leadership Committee Participation
21. Life Support Training – ACLS, ALSO, BLS, NRP
22. MFHC Medication Reconciliation
23. Mercy Medical Center PGY1 Check list
24. Patient Chart Audits
25. Procedure Logs
26. Required Presentations
27. PPMP (CLIA) Certification Exam
28. Resident Peer Evaluations
29. Required online modules, written materials and didactic attendance
30. Rotation Evaluations

CLOSURES AND REDUCTIONS POLICY

Policy: It is the policy of Mercy Medical Center to address oversight of reductions in size or closure of the Accreditation Council Graduate Medical Education (ACGME) accredited Family Medicine Residency Program per ACGME Institutional Requirements. MMC (the Sponsoring Institution) shall inform the Graduate Medical Education (GMEC), Designated Institutional Official (DIO), and affected residents as soon as possible if it intends to reduce the size of or close the ACGME-accredited Family Medical Residency Program. MMC will allow residents already in the Program to complete their education at MMC (the Sponsoring Institution), or assist them in enrolling in another ACGME-accredited Family Medicine Residency Program in which to continue their education.

Purpose: To ensure compliance with ACGME Institutional guidelines on closures and reductions of the Family Medical Residency Program.

Scope: This policy applies to all residents participating in ACGME accredited programs at Mercy Medical Center

Definitions:

Accreditation Council for Graduate Medical Education (ACGME) - The ACGME is the body responsible for accrediting all graduate medical training programs for physicians in the United States. It is a non-profit council that evaluates and accredits medical residency and internship programs.

Sponsoring Institution - A Sponsoring Institution is an entity that oversees, supports, and administers a certain set of ACGME-accredited residency programs. A governing body (the DIO-Designated Institutional Official and GMEC-Graduate Medical Education Committee) have ultimate authority over the responsibility for graduate medical education (GME) in a Sponsoring Institution.

Procedure:

- A. General Implementation - In the event of a disaster or event resulting in the interruption in patient care and resident education, MMC shall provide assistance for the continuation of resident assignments and education.
- B. Notification - If MMCR decides to reduce or close the residency program, the following will be notified as soon as possible:
 - 1. The Graduate Medical Education Committee (GMEC);
 - 2. The DIO;
 - 3. The Program Director;
 - 4. The Residents in the Program.
- C. Residents already in the program will be allowed to complete their education or assistance will be provided in enrolling in an ACGME-accredited program in which they can continue their education. MMC as a Sponsoring Institution acknowledges an ongoing commitment to the viability of the Family Practice Residency Program by providing the necessary financial, administrative, educational and clinical resources to carry out its ACGME educational and training requirements and compliance requirements.

References:

ACGME Intuitional Requirements
MMCR GME Integration of Mission, Vision, Core Values, and Statement of Commitment

CONFERENCES:

Noon didactic conferences occur Monday - Friday on non-holidays, from 12:45 - 1:30 pm., in Lower Level Conference Room, except during the first week of the month when Academic Half Day didactics take place on Tuesday afternoon from 1:00-4:45 pm. . The residency office maintains the Conference Schedule using **Google Calendar**. The schedule indicates the topic, speaker, location and whether lunch is provided. If lunch is not provided, residents may obtain their lunches from the cafeteria and bring them to the conference.

The noon conference curriculum features talks covering a variety of medical specialties on a one to three year rotating schedule. Other conferences include the following:

Resident/Faculty MeetingBi-Monthly
Resident Meeting Monthly
FHC Resident/Staff Meeting. Bi-Monthly
Perinatal (OB and Peds) Case Presentation. Monthly with resident case presentation
Senior Resident Grand Rounds. One for each senior resident/year on Fridays
Primary Care Case Presentation. Monthly given by PGY2s and PGY3s
Dialogue with Duane. Bi-Monthly with residents and Dr. Bland

In addition Noon Case Report occurs on the 3rd Friday from 12:45-1:30pm with the following structure:

- *Presenter-presents and prepares teaching points*
- *Moderator-keeps discussion and questions going-writes on board*
- *Present without stopping: Chief complaint, HPI, ROS*
- *Break for questions about CC/HPI/ROS*
- *Present without stopping: Allergies, Meds, PMH, Surg Hx, FH, SH*
- *Break for questions about Allergies/Meds/PMH/Surg Hx/FH/SH*
- *Create a Differential Diagnosis with Moderator*
- *Present without stopping: Physical Exam*
- *Moderator asks Residents for labs and studies they want*
- *Present labs and studies as requested*
- *Revisit and revise Differential Diagnosis*
- *Present final diagnosis, Order set, and What floor to admit to and why*
- *Present Evidence based guidelines and novel treatments*
- *Summarize Take Home Points for disease (i.e.-work up and treatment, key facts, 2am calls and what to do)*
- *If handout is done, this will be put in Library in Morning Report Binder for future reference*

Live vs Zoom Conference Participation

Live Participation:

- Speakers will either present live or via zoom to the residents in Lower Level Conference Room at Mercy Medical Center.
- Live participation is expected for residents unless they are on rural rotation

Zoom Participation:

- Optional for noon conference speakers who prefer to use Zoom and for residents on Away Electives and Rural Rotations.
- Residents on all other outpatient rotations, are expected to participate by either Zoom or Live
- Residents on Night Float or Vacation are excused from attending noon conferences
- If a resident is on an outpatient rotation they should make every attempt to attend live to improve participation.

Conference Start Time

Noon conferences start at 12:45 pm and finish at 1:30 pm.

Residents on Inpatient Rotations must attend noon conferences live and not by Zoom. Residents on OP rotations have the option of attending live or by Zoom.

Video cameras must be on for residents participating by Zoom and residents are expected to participate in noon conference discussions, and will respond to questions unless extenuating circumstances exist. If a resident does not have their camera on, they will be counted as absent.

Conference Attendance

The ACGME requires programs to define core didactic activities for which time is protected and the circumstances in which residents may be excused and monitoring of attendance. Although residents may need to attend to urgent patient care needs, **prompt and regular attendance of conferences is expected for all residents.** Most speakers have put a great deal of effort into preparing their talks and their time should be respected.

Residents who attend less than 50% of conferences over a six month average will be assigned an additional call within the following 6 months. Missing conferences due to vacation (PTO), night float, away elective, or post call does not count towards the 50%.

If a resident is more than 5 minutes late, it will be counted as an absence.

Residents may track their attendance on New Innovations to see if they are meeting the requirements.

Residents and faculty members may offer suggestions for conference topics to the noon conference coordinator, Laura DiPaolo, MD

Academic Half-Day:

Academic half-day didactics will be held on the first Tuesday of each month from 12:45-4:45. Location may vary so please refer to the google calendar.

- There will not be noon conferences during the first week of the month to accommodate the AHD.
- Attendance is mandatory and will count as 4 lectures and time is protected.
- OB senior will need to cover the OB service so will be excused from AHD attendance but may attend lectures if OB is not busy.
- FPS senior will also need to cover FPS.

CONTINUITY POLICY

The Mercy Redding Family Practice Residency Program considers continuity care to be an integral component of family medicine and residency education. As health care team members, we also recognize that coverage for colleagues who are unavailable (due to illness, vacation, etc.) is imperative for timely and appropriate patient care. The following continuity policy has been established taking into consideration PTO, away electives and coverage for colleagues.

1. Clinic Continuity:

- a. Annual patient-sided continuity should be at least 30 percent at the end of the PGY-2 and 40 percent at the end of the PGY-3.
- b. Annual resident-sided continuity should be at least 30 percent at the end of the PGY-2 and 40 percent at the end of the PGY-3
- c. Panels must include a minimum of 10 percent pediatric patients (younger than 18 years of age).
- d. Panels must include a minimum of 10 percent older adult patients (older than 65 years of age).
- c. The resident will be encouraged to take new patients into their clinic from hospital rotation
- d. The Clinic Management Team will assign new patients to residents from the new patient applications that have been approved based on resident panel size and complexity. .

2. Hospital Continuity:

- a. The program has set a hospital continuity goal of at least 80% for each resident who has continuity patients in the hospital receiving care on the Family Practice Service. Residents will be excused if out of town.
- b. If the goal is not met as determined by quarterly audit, the resident will be scheduled to give a noon conference case presentation on one of his or her patients.

COUNTERSIGNATURE REQUIREMENTS FOR RESIDENT CHARTS:

Per Medical Staff Policy Statement on Graduate Medical Education Program Supervision of Residents:

The attending physician is responsible to round with the resident team everyday he/she is on service. The attending physician is responsible to review the clinical records of all patients on his/her service, checking the work-up and progress notes of the residents. This monitoring should include attention to the resident's ability to structure a differential diagnosis and diagnostic plan, review of therapeutic options and approval of all medications and therapies prescribed by the resident. The attending physician is responsible for signing off on the clinical records including discharge summaries of all patients admitted to their service. The attending physician will complete a brief admission note or authenticate the residents' admission note within 24 hours of admission. H&Ps will be authenticated by a preceptor within 24 hours. For all admissions, the attending will review the resident progress notes daily and authenticate or complete a separate note. Individual orders, including orders for initiation or renewal of patient restraints, are monitored by the attending physician. For billing it is the attending physician's responsibility to follow insurance (i.e. Medicare, Medi-Cal, etc.) requirements for supervision and documentation.

CONSENTS AND RELATED MATTERS:

Up to date information of consents may be found in the Informed Consent Policy and/or California Hospital Association (CHA) Consent Manual. The consent manual is located in Risk

Management Services, Health Information Management, Emergency Departments, and Mercy Family Health Center. Hospital policies are located in the in Policy Manager. Policy Manager is located on all hospital computer desktops under the following tab:



Specific policies can be accessed via folders or using the search option at the top of the screen.

CRITERIA FOR ADVANCEMENT/PROMOTION OF RESIDENTS IN FAMILY PRACTICE:

Policy: It is the policy of Mercy Medical Center Redding (MMCR) to maintain a criteria for promotion and renewal of appointment policy consistent with the ACGME Institutional guidelines and specifically ACGME Institutional Requirement. MMCR will provide a resident written notice of intent when a resident agreement will not be renewed, when a resident will not be promoted to the next level of training or when a resident will be dismissed in a sufficient timeframe that meets ACGME requirements. The Residency Handbook contains specific details regarding criteria for promotion and the role of the CCC (Clinical Competency Committee) and Promotions Committee in determining competency of resident performance. All residents are provided with a written agreement of appointment/contract outlining the terms and conditions of their appointment to the program. MMCR monitors the implementation of terms and conditions of appointment

Purpose: To ensure compliance with the ACGME Institutional Guidelines on promotion and appointment of residents.

Scope: The policy applies to all residents participating in ACGME accredited programs at MMCR.

Definitions:

Accreditation Council for Graduate Medical Education (ACGME) - The ACGME is the body responsible for accrediting Graduate all graduate medical education programs for physicians in the United States. It is a non-profit council that evaluates and accredits residency and internship programs.

Sponsoring Institution - A Sponsoring Institution is an entity that oversees, supports, and administers a certain set of ACGME-accredited residency programs. A governing body (the DIO-Designated Institutional Official and GMEC-Graduate Medical Education Committee) have ultimate authority over the responsibility for graduate medical education (GME) in a Sponsoring Institution.

Procedure:

The decision to promote a resident each year shall be determined by the Residency Director with the advice of the Promotions Board, Clinical Competency Committee, and Faculty. The method of evaluation shall consist of direct observation of the resident as well as by indirect observation through videotapes, rotation evaluations, and written examination (National Boards, In-training exams, etc.). It is expected that residents will participate in all aspects of the curriculum, as well as in the periodic evaluation of educational experiences and faculty. It is further expected that residents will complete all administrative responsibilities of a resident, including medical records, licensure, credentialing, etc. in a timely fashion.

Incorporated into the criteria for advancement are the ACGME's six core competencies and the Milestones. These are specifically included in the attending rotation evaluations and include:

- Patient Care
- Medical Knowledge
- Practice-based Learning/improvement
- Interpersonal/Communication Skills
- Professionalism
- Systems-based practice

PGY1 residents must graduate from a medical school recognized by the Medical Board of California or the Osteopathic Medical Board of California, pass USMLE Steps 1 and 2 CK or COMLEX Level 1 and 2 CE, and obtain a California postgraduate training license (PTL) within 180 days of the residency start date. US or Canadian medical schools must be accredited by the Liaison Committee on Medical Education (LCME). Osteopathic Medical Schools must be accredited by the American Osteopathic Association (AOA). Graduates from medical schools outside of the United States or Canada must hold a currently-valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment or hold a full and unrestricted license to practice medicine in California.

To be promoted from the PGY1 to the PGY2 year, the resident must meet the promotions criteria outlined below, perform at a competency level adequate to warrant licensure in California, act with limited independence, and perform at a competency level to supervise junior residents and students

For promotion from the PGY2 to PGY3 year, residents continue to meet the PGY2 competency requirements listed above and meet the promotions criteria outlined below.

To graduate, the resident must continue to meet the PGY 2 and PGY3 competency requirements, meet the promotions criteria outlined below, and be judged to have demonstrated sufficient professional ability to practice competently and independently as a family practice physician.

The Promotions Board is composed of six voting members, three faculty, appointed by the residency director, and three residents. One resident is elected from each class to sit on the Board. The Board meets annually in the winter and as needed thereafter to review each resident and recommend to the residency director for or against promotion to the next level of training. At least four months prior to the end of the academic year, the program director will provide written notification to the resident of a decision to promote to the next level of training, extend training, or dismissal. The following criteria are used by the Board in their deliberations.

Major criteria: These criteria must be met to be promoted to the next year of training.

- Receive at performance rating of average (3) or better on the Family Practice In-patient and Family Practice Clinic rotations and receive a majority of performance evaluations showing sub-competencies are at the expected PG level (1-2 for PGY1, 2-3 for PGY2, and 3-4 for PGY3).
- Meet the following California licensing requirements:
 - USMG: Obtain California medical license within 90 days after completing 12 months of residency training.
 - IMG: Obtain California license within 90 days after completing 24 months of residency training.
- A positive Faculty Advisor's report. Faculty Advisors shall meet with all residents at least every six months. If satisfactory progress is not noted, or if problems are identified, additional meetings

may be scheduled on a more frequent basis with regular reports to be submitted to the Faculty Committee.

- Complete, or provide evidence of progress, the resident's third year grand rounds presentation. Determination of progress will be the decision of the resident's faculty advisor.
- Satisfactory participation in all required activities of the training program; including nursing home visits, FPC resident/staff meetings, noon conferences, continuity care of patients admitted to hospital, etc.
- Attend all rotations as scheduled.
- Be competent to function independently and in a supervisory role with junior residents. The faculty committee will make this determination.
- Abide by standards consistent with expected professional and ethical behavior.
- For graduation, demonstrate sufficient professional ability to practice competently and independently as a family practice physician. The faculty committee and program director will make this determination.

Minor Criteria: These criteria will also be considered by the Promotions Board in determining a resident's readiness for promotion. They are not necessarily required for promotion, but may affect promotion based on individual circumstances and the achievement of other major and minor criteria.

- In-training Assessment Examination composite score corresponding to $\geq 90\%$ predicted pass rate using the ABFMs Bayesian Score Predictor
- Satisfactory evaluations by Family Practice Center nursing, office staff and peers.
- Receiving a performance rating of 3 (average) or better on non-family practice services and community rotations.
- Pass USMLE or NBOME part 3 before the end of PGY1.

References:

ACGME Intuitional Requirements
Medical Board of California
Osteopathic Medical Board of California

DEATH RELATED ISSUES:

Information and hospital policies Deaths can be found under hospital policies. These hospital policies are located in the Launch Pad, Policy Manager. Policy Manager is located on all hospital computer desktops under the following tab:



Specific policies can be accessed via folders or using the search option at the top of the screen.

Residents must be licensed senior residents in order to declare death. Please include the name of the physician who will sign the death certificate in the death note and "discharge" orders.

- Death Certificate Guidelines:

- DO NOT PUT "CARDIO-RESPIRATORY FAILURE" or, "Cardio-respiratory collapse" for the cause of death.
- The first line of the "Cause of Death" section is the disease or trauma that caused the death, e.g. myocardial infarction, **NOT** common final pathways like cardiopulmonary failure, etc.
- The second line is for secondary causes, e.g. Atherosclerotic Cardiovascular Disease, trauma
- The third line is for tertiary causes, if any. The contributing factors can include things like smoking or diabetes. Please be sure there is documentation for the cause(s) mentioned, and touch base with any faculty person if you have any question about what to include in the certificate, your attending or faculty advisor will be happy to help you with any questions.

DISASTER / DISRUPTION POLICY

Policy: To define the responsibilities specific to Graduate Medical Education (GME) following a disaster at Mercy Medical Center Redding (MMCR). Per ACGME Institutional requirement (IV.M., IV.M.1), the Sponsoring Institution must maintain a policy that addresses administrative support for the program and residents in the event of a disaster or interruption of patient care. The policy includes continuation of salary, benefits and resident assignments.

Purpose: Per ACGME Institutional requirement (IV.M., IV.M.1), the Sponsoring Institution must maintain a policy that addresses administrative support for the program and residents in the event of a disaster or interruption of patient care. The policy includes continuation of salary, benefits and resident assignments.

Procedure:

A. Declaration of a Disaster

1. The Designated Institutional Official (DIO) immediately notifies the Accreditation Council of Graduate Medical Education (ACGME) of the occurrence of a disaster at MMCR.
2. Upon notification from the DIO or designee, the ACGME Chief Executive Officer makes a declaration of a disaster.
3. A notice of the MMCR disaster is posted on the ACGME website with information relating to the ACGME response to the disaster.

B. Responsibilities Following the Declaration of a Disaster

1. The DIO:

- i. Immediately convene the Graduate Medical Education Committee (GMEC) and other institutional leadership in order to ascertain the status and operating capabilities of the Family Medicine Residency Program.
- ii. Contact the ACGME within ten days to discuss due dates for Family Medicine Residency Program to:
 1. Submit program configurations to the ACGME
 2. Inform each Resident of a transfer decision

3. Submission dates will be no later than thirty days after the disaster unless otherwise approved by the ACGME.

2. Program Director:

- i. Immediately verify the health and safety of all residents in the training program and relay this information to the DIO.
- ii. Arrange temporary transfers to other institutions until such time as MMCR is able to resume providing an adequate educational experience.
- iii. Assist residents in obtaining transfers to other institutions, as needed, in order to continue and complete training.
 1. If a transfer to another institution is necessary and if more than one institution is available, the Program Director considers the educational needs and preferences of each resident and make best efforts to find an appropriate training site.
 2. Programs must make these transfer decisions expeditiously so as to maximize the likelihood that each Resident will finish training in a timely fashion.
 3. At the outset of a temporary Resident transfer, the program must inform each transferred Resident of the minimum duration and the estimated actual duration of the temporary transfer, and continue to keep each Resident informed.
 4. Residents will be informed if a temporary transfer is extended to and/or through the end of a training year.
 5. Transferred residents will be allowed to return to MMCR as soon as the institution is operative, or they may stay at the transferred institution for a reasonable length of time in order to maintain a continuum of education.
- iv. The Program Director will regularly confer with the residents and Program Director(s) at the site to make sure that educational needs are being met.
- v. The Program Director will call or email the appropriate Review Committee Executive Director with information and/or requests.

3. Residents

- i. Call, text or email the Program Director as soon as reasonably possible to verify current/anticipated location, and any changes to contact information.
- ii. Call or email the appropriate Review Committee Executive Director or the Residency Office with information and/or requests for information.
- iii. All transferred residents must refer to instructions on the ACGME Web Accreditation Data System (ADS) to change Resident email information.

C. Salary and Benefits

1. MMCR is responsible for maintaining continuity of Resident salary and benefits during a declared disaster.
2. All residents must elect to receive paychecks electronically in order to guarantee continuation of salary during a declared disaster.

DOCUMENTATION OF RESIDENCY EXPERIENCE:

A comprehensive documentation of your residency experience is important to your future practice as a family physician. The information you collect will provide a basis of documentation when requesting hospital privileges and malpractice. Educational content of your training, board certification, as well as experience with specific diagnoses and procedures will all be considered when medical staff membership is granted. All residents are required to document procedural experiences using New Innovation on-line procedure logger. In addition, your Google Drive Dashboard Encounter Logs should be used to document patients seen in the ICU, SNF, and home visits.

The ACGME also requires tracking of specific patient encounter types (i.e. Pediatric outpatient, Pediatric ED, etc.). These encounters are tracked using “Encounter Log” spreadsheet located on the Residency Google Drive Data on procedures and encounters may be used as a source of information for future reference letters from the Residency Program, which may be requested by places of employment and hospitals. It will also be used to provide data to regulatory bodies such as the ACGME and ABFP to confirm we are meeting the requirements for residency education in family medicine.

All encounter and procedure logs must be completed prior to ‘sign off’ with the ABFM for certification purposes after graduation.

Minimum Encounter Requirements

Adult Inpatient Medicine = 750

Adult ED = 125

Older Adult = 125

Pediatric Inpatient = 50

Pediatric ED = 50

Newborn = 40

MFHC Continuity Patients = 1650 (tracked my clinic)

- **No one patient should be counted in more than one category for any one day.**
- ***A patient encounter is a meaningful interaction between a physician and a patient that includes a history, assessment, critical thinking, and care plan. An encounter is documented in the patient record for later reference.***
- ***These should be documented in Google drive, except for MFHC continuity patient which are tracked by the clinic***
- ***Procedures are documented separately in New Innovations***

Urgent Care - ED Equivalents

Redding is a medically underserved community with limited medical resources and shortage of primary care physicians. The Emergency rooms in our area are often full with patients waiting to be seen and waiting to be admitted. Many patients present to the urgent care setting who may otherwise have been directed to the ED by a primary care physician or wish to avoid the wait times or expenses associated with the ED. While you are on your urgent care rotation, we ask that you track ED equivalent patients and incorporate this into your logs. The following is a non-exhaustive list of patients who may fill this criteria.

Adult/Peds

- **Severe Uncontrolled Acute Pain** Requiring intervention
- **Respiratory** - Apnea, Tachypnea, Stridor, Hypoxia, Continuous neb, pneumonia, suspected PE
- **CV**-Chest pain, Suspected MI, Suspected Heart Failure Exacerbation, Severe Tachycardia, Severe Bradycardia, Severe Hypertension (i.e. requires immediate tx), Severe Hypotension (i.e. requires IVF), Syncope
- **GI**- Severe abdominal pain (i.e. peritonitis), dehydration due to N/V requiring fluid resuscitation, GI bleeding, suspected bowel obstruction
- **ID**- Suspected sepsis, suspected meningitis, pneumonia, severe cellulitis, necrotizing fasciitis, peritonsillar abscess, suspected appendicitis, pyelonephritis
- **Trauma** - "significant trauma" from MVA, falls, fractures, lacerations
- **Endocrine** - DKA, Hyperosmolar state, symptomatic hypoglycemia, thyroid storm, adrenal crisis
- **Toxicology** - OD with sx, Toxic exposure requiring antidote, severe withdrawal sx
- **Neuro** - Altered Mental Status, Seizure, New onset focal neuro deficit (weak, numb, dysarthria), Severe new onset H/A, Suspected CVA, Head Trauma with LOC or vomiting
- **Psych** - Altered Mental Status, Obtunded, Acutely Suicidal, Severe agitation/psychosis
- **Immune** - severe reaction - food, substance, medication - requiring urgent intervention and observation

General: The following may indicate emergency equivalent care

- Evaluation/W/U leads to transfer to ED for further w/u
- Continuous oxygen or cardiac monitoring required
- New Acute Oxygen Requirement
- IVF hydration required
- POC Nebulizers required
- Procedure performed due to an emergent issue
- Required immediate consult

DUE PROCESS PROCEDURE FOR RESIDENCY PROGRAM

Policy: It is the policy of Mercy Medical Center (MMC) to maintain a due process that is consistent with the Accreditation Council for Graduate Medical Education (ACGME) Institutional guidelines. The MMC Residency department has a policy that provides residents with due process relating to the following actions regardless of when the action is taken during the appointment period against a resident: suspension, non-renewal, non-promotion or dismissal. The Residency Handbook contains specific details regarding due process and the criteria for promotion.

Purpose: To define the policy of Mercy Medical Center Redding Community Health Center on due process in Residency that is consistent with the ACGME Institutional guidelines.

Scope: This policy applies to all residents participating in ACGME accredited programs at MMCR.

Definitions:

Accreditation Council for Graduate Medical Education (ACGME) - The ACGME is the body responsible for accrediting all graduate medical training programs for physicians in the United States. It is a non-profit council that evaluates and accredits medical residency and internship programs.

Sponsoring Institution - A Sponsoring Institution is an entity that oversees, supports, and administers a certain set of ACGME-accredited residency programs. A governing body (the DIO-Designated Institutional Official and GMEC-Graduate Medical Education Committee) have ultimate authority over the responsibility for graduate medical education (GME) in a Sponsoring Institution.

Procedure:

Introduction: A number of administrative actions may affect the continued participation of a resident in the residency program. These include, but are not limited to: periodic evaluations; letters of counseling, warning, admonition, reprimand, and censure; probation; reduction of privileges; suspension from the residency program, which may include suspension of clinical privileges for medical record delinquency, or for other reasons; and dismissal.

Grounds for Disciplinary Action: Grounds for disciplinary action include, but are not limited to, the following:

- Failure to rectify deficiencies of which the resident has been notified in one or more letters of warning, censure, probation, or suspension.
- Incompetence or conduct adversely affecting quality of patient care.
- Unethical or illegal conduct.

- Violation of standards of the residency program, or of the Bylaws or the Rules and Regulations of the Medical Staff of Mercy Medical Center.

Medical Record Delinquency: Suspensions of clinical privileges, which arise from medical record delinquencies under the provisions of the Bylaws of the Medical Staff of Mercy Medical Center, shall automatically result in a like suspension of participation in the residency program, without right of hearing or appeal. Participation shall be reinstated upon reinstatement of clinical privileges pursuant to the Bylaws of the Medical Staff of Mercy Medical Center. Continued medical record delinquency may be cause for other disciplinary action.

Letters: Letters of counseling, warning, admonition, reprimand, and censure shall be issued by the Residency Director when a resident's performance fails to meet the standards set by the training program. Receipt of such a letter requires that the resident physician correct the deficiency as presented within the letter. The letter shall stipulate the specific reasons for any actions noted and the recommended course for correction. If patient care activities are involved, a copy of the letter will be submitted to the Medical Director of Mercy Medical Center. Continued failure to correct the deficiencies may result in suspension or dismissal from the residency training program. Such a letter shall not give rise to a right to a review hearing or to appeal.

Temporary Suspension: A resident physician may, without right to a review hearing, be temporarily suspended, for a period not to exceed ten (10) days, from participation in the residency program, including loss of clinical privileges, at any time upon the written, specific recommendation of a faculty member to the Residency Director if, after review, the Director, in his sole judgment and discretion, determines that patient care has been compromised or that the resident physician is involved in activity not otherwise appropriate to the program. During the period of temporary suspension, the Residency Director may review the resident's performance and determine whether or not additional disciplinary action should be taken against the resident.

The Residency Director may determine that suspension of a resident's privileges should remain in effect for a period in excess of ten (10) days. In that event, the resident shall be entitled to a review hearing and appellate review if requested by him in the manner prescribed.

The Residency Director may also determine that privileges should be suspended pending the review hearing and appeal process. In this event, the resident shall be entitled to a preliminary review of that decision as soon as it can be arranged before the Medical Director and the Chief of Staff of Mercy Medical Center. The decision of the Medical Director and the Chief of Staff as to whether or not suspension should remain in effect pending the review hearing and the appeal process shall be final and conclusive upon the resident.

Other Disciplinary Actions: Disciplinary action other than or in addition to, temporary suspension or letters described in Section 4, may be recommended at any time by the Residency Director. The Residency Director shall notify the resident, in writing, of the proposed action which has been recommended, the reasons for the recommendation, and a summary of the resident's rights under the provisions of this due process procedure. Upon notification of the

recommendation for disciplinary action by the Residency Director, the resident, within a period of ten (10) days, may request a review hearing by written request delivered to the Residency Director. In the event that the resident fails to request a review hearing, the recommendation of the Residency Director shall be submitted to the Family Practice Residency Committee for action, whose decision and judgment on the matter shall be final and conclusive.

Review Hearings: Upon request by the resident for a review hearing, a Review Panel shall be convened within twenty (20) days. The resident shall be notified of the hearing date not less than (10) days prior to the review hearing. The notice of hearing shall include a list of the witnesses to be called in support of the recommendation of the Residency Director. The Review Panel will consist of five individuals, all of whom shall be faculty members of the residency program. The Medical Director of Mercy Medical Center shall select four members of the panel and the affected resident shall select one. At the hearing, the Residency Director on the one hand, and the affected resident on the other, will each have the right to call witnesses and present relevant verbal and written evidence of the sort that responsible persons are accustomed to rely on in the conduct of serious affairs. Evidence need not conform to common law or statutory rules, which might make it inadmissible in a court of law. The resident will be afforded the opportunity to present a personal statement in his or her own defense. The statement may be presented orally or in writing. The review hearing will be closed and the proceedings shall be recorded by a court reporter or by other means approved by the panel. Legal counsel may be consulted to assist in preparation for the hearing, but may not directly participate in its proceedings. The Review Panel shall render a recommendation, in writing, to the Family Practice Residency Committee within ten (10) days of the hearing. The recommendation shall include the reasons supporting the decision. A copy of the recommendation shall be delivered to the affected resident and to the Residency Director.

Appeal: Following receipt of the Review Panel's decision, the resident may appeal that decision, in writing, to the Family Practice Residency Committee. To exercise that right he shall give written notice of his intent to appeal to the Residency Director within ten (10) days following delivery of the decision to him. Failure to give notice in the manner and within the time provided shall constitute a waiver of the right to appeal. Notice of the time and place of the appearance before the Family Practice Residency Committee, which shall be scheduled not less than twenty (20) days following the request for the appeal, shall be given to the resident not less than (10) days before the time scheduled. The proceedings on appeal shall be in- the nature of an appellate review, based upon the record of the hearing before the Review Panel. However, the Family Practice Residency Committee, in its sole judgment and discretion, may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Review Panel Hearing. The resident and the Residency Director shall each have the right to present oral and written statements and authorities at any time prior to submission of the matter, in support of his or her position on appeal. The Family Practice Residency Committee may affirm, modify, or reverse the recommended action of the Review Panel or may, in its sole judgment and discretion, refer the matter for further review and consideration. The decision of the Family Practice Residency Committee shall be final and conclusive.

Medical Staff Proceedings: Nothing in this due process procedure shall be construed to prohibit the Medical Staff of Mercy Medical Center from taking disciplinary action against a resident in accordance with the provisions of the Medical Staff Bylaws. Suspension of the privileges of a resident or termination of his membership on the Medical Staff by reason of proceedings taken by the Medical Staff in accordance with the Medical Staff Bylaws of Mercy Medical Center, shall result in like suspension or termination from the residency program without any right to appeal, or without any right to review or appeal under this due process procedure.

Error in Procedure: The Family Practice Residency Committee, in its sole judgment and discretion, shall determine whether or not any failure to follow the procedure outlined in this document has deprived a resident of due process, and should constitute grounds for a new review hearing and appeal or for other remedial action. Its determination with regard to that matter should be final and conclusive.

References: ACGME Institutional Requirements and Program Requirements

ELIGIBILITY AND SELECTION OF RESIDENTS

Policy: It is the policy of MMC to have a policy for eligibility and selection of resident physicians to the Mercy Redding Family Practice Residency Program. This policy is consistent with the ACGME Institutional and Program Requirements.

Purpose: To ensure compliance with ACGME Institutional guidelines on Resident eligibility and selection to the Family Medicine Residency Program

Scope: This policy applies to all residents participating in ACGME accredited programs at MMC.

Definitions:

Accreditation Council for Graduate Medical Education (ACGME) - The ACGME is the body responsible for accrediting all graduate medical training programs for physicians in the United States. It is a non-profit council that evaluates and accredits medical residency and internship programs.

Sponsoring Institution - A Sponsoring Institution is an entity that oversees, supports, and administers a certain set of ACGME-accredited residency programs. A governing body (the DIO-Designated Institutional Official and GMEC-Graduate Medical Education Committee) have ultimate authority

Procedure:

General Qualifications

Residents must graduate from a medical school recognized by the Medical Board of California or the Osteopathic Medical Board of California, pass USMLE Steps 1 and 2 CK or COMLEX Level 1 and 2 CE, and obtain a California postgraduate training license (PTL) within 180 days of

the residency start date. US or Canadian medical schools must be accredited by the Liaison Committee on Medical Education (LCME). Osteopathic Medical Schools must be accredited by the American Osteopathic Association (AOA). Graduates from medical schools outside of the United States or Canada must hold a currently-valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment or hold a full and unrestricted license to practice medicine in California. We do not sponsor visas. International medical graduates must have clinical care experience in the US along with a recent letter of reference documenting this experience. There are no minimum score requirements, however applicants with more than one USMLE or COMLEX examination failure may be excluded. Applicants must have graduated within the past 3 years.

Resident Selection:

Applicants with interest in the Mercy Redding Family Practice Residency Program are directed to find detailed and updated information at the residency website. Applicants are recruited via student rotations, residency recruitment events and medical school partnerships. MMC participates in the National Resident Matching Program (NRMP) and utilizes the Electronic Residency Applications Service (ERAS) for applications. All applicants are provided information on our interview screening criteria. Applicants are selected for interview and ranking based on objective criteria including Dean's letter, transcripts, recommendation letters, interest in practicing in northern California, and board scores. All residents and core faculty are eligible to interview and participate in the ranking process. Interview criteria include attitude, communication skills, interest in the local area, interest in underserved or rural healthcare, commitment to family medicine, and overall compatibility with the program. All residents and faculty are educated on avoiding inappropriate bias and illegal questions.

Promotion to PGY2/PGY3

To be promoted from the PGY1 to the PGY2 year, the resident must meet the promotions criteria outlined below, perform at a competency level adequate to warrant licensure in California, act with limited independence, and perform at a competency level to supervise junior residents and students

For promotion from the PGY2 to PGY3 year, residents continue to meet the PGY2 competency requirements listed above and meet the promotions criteria outlined below.

To graduate, the resident must continue to meet the PGY 2 and PGY3 competency requirements, meet the promotions criteria outlined below, and be judged to have demonstrated sufficient professional ability to practice competently and independently as a family practice physician.

Promotions Criteria

Major criteria: These criteria must be met to be promoted to the next year of training.

- Receive at performance rating of average (3) or better on the Family Practice In-patient and Family Practice Clinic rotations and receive a majority of performance evaluations

showing sub-competencies are at the expected PG level (1-2 for PGY1, 2-3 for PGY2, and 3-4 for PGY3).

- Meet the following California licensing requirements:
 - USMG: Obtain California medical license within 90 days after completing 12 months of residency training. (See separate **Licensure** section for policies on reimbursement etc.)
 - IMG: Obtain California license within 90 days after completing 24 months of residency training. (See separate **Licensure** section for policies on reimbursement etc.)
- A positive Faculty Advisor's report. Faculty Advisors shall meet with all residents at least every six months. If satisfactory progress is not noted, or if problems are identified, additional meetings may be scheduled on a more frequent basis with regular reports to be submitted to the Faculty Committee.
- Complete, or provide evidence of progress, the resident's third year grand rounds presentation. Determination of progress will be the decision of the resident's faculty advisor.
- Satisfactory participation in all required activities of the training program; including nursing home visits, FPC resident/staff meetings, noon conferences, continuity care of patients admitted to hospital, etc.
- Attend all rotations as scheduled
- Be competent to function independently and in a supervisory role with junior residents. The faculty committee will make this determination.
- Abide by standards consistent with expected professional and ethical behavior.
- For graduation, demonstrate sufficient professional ability to practice competently and independently as a family practice physician. The faculty committee and program director will make this determination.

Minor Criteria: These criteria will also be considered by the Promotions Board in determining a resident's readiness for promotion and may affect promotion based on individual circumstances the achievement of other major and minor criteria.

- In-training Assessment Examination composite score corresponding to $\geq 90\%$ predicted pass rate using the ABFMs Bayesian Score Predictor
- Satisfactory evaluations by Family Practice Center nursing, office staff and peers.
- Receiving a performance rating of 3 (average) or better on non-family practice service and community rotations.
- Pass USMLE or NBOME part 3 before the end of PGY1.

References:

ACGME Institutional Requirements

EVALUATIONS:

Evaluation and feedback are essential to knowing if we are meeting our intended goals. In the residency program, this is true for resident performance, teacher performance, curriculum

composition, rotation performance, conference quality, and significantly, graduate assessment of the effectiveness of their training. Evaluations may be formative, where feedback is given at the time of performance and helps to correct, or confirm, the appropriateness and effectiveness of the performance (e.g. you did that circumcision just right. The block could be improved by using a little more anesthetic). Evaluation may be summative, which occurs following input of all evaluation information and results essentially in a grade.

Resident Evaluations:

Attending Evaluation of the Resident - On each rotation, the appropriate attending(s) will complete the milestone based evaluation. These evaluations are performed using New Innovations.

Procedure Competency - Procedural competency evaluations are provided by the precepting attending using New Innovations (see Procedural Competency section below).

Peer Evaluations - Residents have the opportunity to evaluate each other on the Medicine and Pediatrics/Ob services using the New Innovations on-line evaluation system. Junior residents evaluate seniors in specific milestone competencies. These evaluations are anonymous. Senior residents also evaluate junior residents in specific milestone competencies. The senior residents are encouraged to review their evaluations directly with junior residents in addition to using the New Innovations on-line evaluation system.

Presentation Evaluations – Primary care case presentations provided by residents are evaluated by both peers and attending using new innovations. Third year Grand Round presentations are evaluated by core faculty.

Rotation Evaluations:

Rotation strengths, weaknesses and opportunities for improvement are incorporated into the attending evaluations. With New Innovations, this collated data is available for review during the Annual Program Evaluation in the spring. Based on these evaluations, program modifications are made for the upcoming residents.

Family Health Center Evaluations:

MFHC conducts a health center evaluation annually (and monthly for the Clinic Rotation), or more frequently as needed. Issues such as clinical material, office design and function, procedures and protocols, teaching and reference materials are included in this evaluation. In addition, there are health center management meetings held throughout the year with resident participation, to discuss important issues.

Conference Evaluations:

Conferences which are designated CME will include an evaluation form completed by the participants to track the quality and relevance of the material presented. These evaluations help determine the quality and relevance of lectures and the need for modification.

American Board of Family Practice In-training Assessment Exams:

In-training Assessment Exams are given to all residents in October / November, and residents must take the exam. If vacation or away electives have been scheduled for the same time, the resident must make appropriate arrangements with the Residency Coordinator to take the exam elsewhere, or return to Redding. Exams are similar to Board exams in content and format. . If the overall score is below the 20th percentile, moonlighting privileges may be forfeited pending improved performance on the next In-training Exam and/or a period of restudy and repeat examination. The scores will be another instrument for review and feedback on the resident's progress as well as on the overall performance of the program in order to identify any areas of program weakness.

Graduate Evaluation:

Graduates are surveyed every 5 years on the quality and relevance of their residency training. This information is vital to keeping our program relevant in our changing world of medical practice.

Informal and formal discussions:

Informal discussions with the Program Director, faculty advisors, faculty and peers are valuable ways to improve the partnership of teachers and learners, and to improve the quality of care we deliver to our patients. Residents have the opportunity to provide feedback at regularly scheduled resident/faculty meetings, clinic staff resident meetings, and “Dialogue with Duane” meetings.

Milestone Evaluations:

The Mercy Redding Family Practice Residency Program regularly collects information on residents for the purpose of performance improvement and to ensure delivery of safe patient care. This information is reviewed by the Clinical Competency Committee (CCC). The creation of the CCC is mandated by the ACGME as part of the Milestone evaluation process. The members of the CCC make a consensus decision on the Milestone achievements of each resident using multiple sources and types of resident assessments. The CCC determines how well a resident is meeting program standards and progressing along an expected educational trajectory. This process provides an opportunity for ongoing educational feedback and early identification of competency issues and helps to shape resident performance improvement and remediation plans. The CCC will use explicit assessment data to measure resident performance including the following:

- ABFM In-Training Exam
- ABFM Maintenance of Certification
- Advisor Semi-annual Summative Evaluation
- Annual Compliance & On-line Education Training
- Behavioral Science Direct Observation
- Board Exams – Part 1, 2, and 3
- Leadership Committee Participation
- Life Support Training – ACLS, ALSO, BLS, NALS
- Mercy Family Health Center Preceptor Evaluations
- Mercy Medical Center PGY1 Check list
- Patient Chart Audits
- Presentations - Primary Care, Grand Rounds, Journal Club
- Procedure Performance Evaluations
- PPMP (CLIA) Certification Exam
- Resident Peer Evaluations
- Rotation Evaluations

FAMILY OR FRIENDS VISITING RESIDENTS AT HOSPITAL:

Issues such as professionalism, hospital policies, privacy, and HIPAA must be considered when residents have family members or significant others visiting for meals or during breaks on call. These visitations must be limited to non-clinical areas (i.e. cafeteria, resident lounge). Discussion of patient care issues should be avoided in their presence. While family members may visit, their presence should not interfere with the resident duties. In addition, family members and significant others must not sleep or nap in resident lounge or call areas.

FNP/PA STUDENTS:

Students rotating at Mercy Medical Center shall be under the direct supervision of an attending physician and comply with the affiliation agreement and medical staff guidelines.

GRADUATE MEDICAL EDUCATION COMMITTEE (Family Practice Residency Committee)

The Graduate Medical Education Committee (GMEC) has the responsibility for monitoring and advising on all aspects of residency education. The committee will meet quarterly, covering the GMEC responsibilities as determined by the ACGME. Minutes from the GMEC are provided to the Medical Executive Committee for the Mercy Medical Center Medical Staff for review. A regular agenda with committee members and standing agenda items is included below:

*Graduate Medical Education Committee /
Family Practice Residency Committee*

<Date>

GENERAL SESSION AGENDA

Members include:

Program Director:
Program Coordinator:
Chief Resident:
Assistant Chief Resident:
Mercy Family Health Center Medical Director:
Mercy Family Health Center Manager:
Behavioral Science Coordinator:
Mercy Maternity Clinic Manager:
SCHC Residency Director:
Representatives of In-Patient Services:

- *ED:*
- *FP:*
- *IM:*
- *OB/GYN:*
- *Pediatrics:*
- *Surgery:*

Quality Improvement:
Hospital Administration Representative:

□ □

CALL TO ORDER:

MINUTES OF THE PREVIOUS MEETING

DATES:

UNFINISHED BUSINESS:

NEW BUSINESS

DEPARTMENT REPORTS:

STANDING AGENDA ITEMS - Per the ACGME Institutional Requirements, the GMEC has responsibility for review and approval of the following items. Agenda topics and minutes are tracked by line item. (Not all topics are reviewed at each meeting and are dependent upon relevance and time of year.)

I.B.4. Responsibilities: GMEC responsibilities must include:

- *1.10.a.; 1.13.b.; 3.2.f.; 3.2.g. PEC Review and Updates*
- *1.12.; 1.14.a.1.; 3.2.g Clinical Experience and Education (Duty Hours) Report*
- *1.12.; 1.14.a.1.; 3.2.g Clinical Experience and Education (Duty Hours Policy/Timeliness of Hour Entry) Report*
- *1.13.f Site Reductions and Closures of Program, Sites, & Institutions*
- *1.14. Annual Institutional Review (AIR) and Accomplishments*
- *2.3. (a.-c.); 3.1.; 3.2.d.1.; 3.2.f. Resident Support and Feedback:*
 - PEC Work Plan (See Pec Workplan*
 - Resident Anonymous QRC Reporting: No new items*
- *1.13.j. Reports & Responses by Review Committee(s) -*
- *3.2.f.; 4.1. - 4.15.. Resident Recruitment:*
 - Advancement:*
 - Graduation:*

Disciplinary Update (Professionalism):

(Annual or As Needed Reviews)

- 1.6.a.1; 1.6.a.2. Documentation of Institutional Accreditation for Provision of Patient Care
- 1.12b; 1.13.f.; Rotations / Curriculum
- 1.12. (a-d); 1.13. (a-j) Accreditation Status
 - Institutional
 - Program
- 12.d APE Review and Sign-off

Major Changes:

- 1.12.e. Institutional Policies Vacation & all Leaves
- 1.136.c.; 2.1., 2.2., 2.4.,; 2.5; 2.6. Salary/Benefits/Resources Update
- 1.4.a.b Annual Review Sponsoring Institution 'Statement of Commitment'
- 1.9.b. (1-4) Resident GMEC/ Voting Members
- 1.13.b CCC Updates
- 1.14.b. DIO Annual Report to the Board
- 1.14. (a.1.-a.3). Proposed "Institutional Performance Indicators" for Annual Institutional Review APE/AIR Annual Agenda
- 1.15. Special Review: Effective Oversight of underperforming program(s) through identifying criteria
- 4.2.a.3, 4.2.b. Review Resident Appointment Qualifications
- 1.13.a.; 4.2.; 4.3.; 4.1 - 4.15 Policy Annual Review and Approval
 - Physician Impairment 4.9.b.) {Health & Well Being}
 - Harassment & Discrimination 4.9.c.) {Anti-Discrimination and Harassment}
 - Accommodations for disabilities 4.9.d.) {Reasonable Accommodations Under the ADA}
 - Resident Supervision Policy 2.2.d. & 4.10. {MMCR Supervision of Residents} {GMEC Supervision and Call Expectations}
 - Substantial Disruptions in patient care or education 4.14.) & Disaster Policy 4.14. and 4.14.a.
 - Clinical/Education Work Hours Policy 4.11.
 - Closures and Reduction Policy 4.15.a. and 4.15.b.
 - Criteria for Advancement / Promotion 4.4.
 - Due Process Procedure for Residency Policy 4.4.b.
 - Moonlighting Policy 4.11.a., 4.11.a.1-4,
 - Restricted Covenants Policy 4.13.
 - Interactions with Vendors 4.12.
 - Grievance Policy 4.5
 - Resident Appointment Policy 4.2., 4.2.a., 4.2.a.1-3. & 4.2.a.3., 4.2.b.1-2.
 - Special Review 1.15
 - Program Implementation of Institutional Policies for Vacation and Leaves of Absence & Residency Leave Policy IF.H.1. {Holidays and Vacations}
 - Evaluations 3.1
 - Clinical Competency Committee 4.4., 4.4.a-b., 3.2.e.
 - Clinical/Education Work Hours Policy 4.11.
 - Closures and Reduction Policy 4.15.a. and 4.15.b.

ADJOURNMENT

Event reports and specific patient care related issues are addressed in Executive Session.

GRIEVANCES AND COMPLAINTS

Policy: It is the policy of Mercy Medical Center to maintain a grievance process that is consistent with the Accreditation Council for Graduate Medical Education (ACGME) Institutional guidelines.

Purpose: To provide guidance to MMC residents on a grievance process consistent with the ACGME Institutional guidelines and Mercy Medical Center policies.

Scope: This policy applies to all residents participating in ACGME accredited programs at MMC.

Definitions:

Accreditation Council for Graduate Medical Education (ACGME) – The ACGME is the body responsible for accrediting all graduate medical training programs for physicians in the United States. It is a non-profit council that evaluates and accredits medical residency and internship programs.

Sponsoring Institution – A Sponsoring Institution is an entity that oversees, supports, and administers a certain set of ACGME-accredited residency programs. A governing body (the DIO-Designated Institutional Official and GMEC-Graduate Medical Education Committee) have ultimate authority over the responsibility for graduate medical education (GME) in a Sponsoring Institution.

Procedure:

There may be experiences during the residency when the resident is placed in difficult positions that may, or may not, be related to any action on his/her part. Often such issues can be resolved by talking them through with the involved parties with or without a neutral third person. But sometimes they cannot. The program is committed to being supportive and fair in its response to problems and utilizes its recommendations and the hospitals Human Resources Department and its official Policies as needed to reconcile the problem. We recommend the following options:

- Refer to MMC Non-Represented Employee Grievance Procedure
- Present and Discuss concerns with:
 - Chief Resident
 - Academic Adviser
 - Residency Program Director, Duane Bland, M.D.
 - MMC Human Resources Representative
- Where not to air grievances:
 - Nurses in public areas

- Medical students in public areas
 - Patients, especially in public areas
- If you believe a significant issues exists that impacts the safety and quality of patient care, a incident report should be made using iVOS so an investigation (and improvements) can be initiated by the appropriate clinical leader.

References:

ACGME Institutional Requirements

Mercy Medical Center Non-Represented Employee Grievance Procedure

PGY1 EDUCATIONAL LIST

PGY 1 EDUCATIONAL LIST

Overview – Educational Items

Hospital Tour: badge access, 4 West (Cardia Tele & CCU), L&D, 2 West (IMCU), ICU, OR, PASS, PACU, 2 Central (PCU), 2 East, 2 South, 1 East, 1 South (Oncology), Pediatrics, ED, Radiology, IR, Lab, conference rooms, lounge/sleep rooms, cafeteria, patio, library, shortcuts

Programs Access: Cerner (all accounts), remote Cerner (Citrix), Fetal Monitoring, AirStrip OB, PACS, Dragon, ePCS, iConnect, Mobile MD, WebtopSSO, sign-out lists

Cerner: downtime procedures, powerplans/orders/verbal orders, powernotes /notes/addendums/dictations, labs/imaging, messages, patient lists/personal lists/tracking board, templates/macros/.phrases

Documentation: note requirements (content/timeliness), co-signatures, D/C summary responsibility, working/final Dx

Rounds and Daily Work: pre-rounding, data harvesting/organizing, rounds, admissions, appropriate census numbers, sign-out list details/updates, timely orders/consults, timely note completion, anticipate note addendums, telephone encounters, learn/personalize/demonstrate efficient workflow routine, departs/transfers, things commonly overlooked/forgotten/delayed

Transitions of Care: orientation to rotation/team, set expectations, sign-out readiness/thoroughness, trust your peers

Admissions: ensure EDIP, timely throughout, patient placement order via attending phone/verbal order, inpatient/observation, diet/IVF/pain/prophylaxis considerations, insulin/hypoglycemia protocols, appropriate floor, dispo/discharge planning, med reconciliation, code status (AD/POLST)

Consults: Physician Specialists (daily ED call list), PT, OT, RT, Speech Therapy, Nutrition Therapy, Social Services, Spiritual Care, Palliative Care, Hospice, Care Coordination, Rapid Response Nurse

Communication: staff, phone/text/pager, senior resident/attending, new admits, change in status, closed-loop, and HIPAA Codes: expectations, refer to BLS/ACLS/PALS/NRP/ALSO training, team development

Quality Measures: stroke, ACS, PNA, influenza, sentinel events, against medical advice (AMA), medical staff rules and regulations

References: Resident Survival Manual, Policy Medical, UpToDate, Textbooks (library, peds desk, OB desk), smartphone apps/links (Epocrates, Medscape, UpToDate, OB Wheel, ASCCP, BiliTool, ASCVD, GBS, AHRQ ePSS, ABFM Exam Prep, AirStrip OB, etc...)

Overwhelmed: senior resident, short call, jeopardy, consult, rapid response RN/MD, attending, and ED physician

Learning: read daily, morning report, ITE and licensing/board exams, journals, noon lectures

Residency Curriculum Resource: <https://www.fammedr.com>

Derm lectures: <https://www.aad.org/education/basic-dermatology-curriculum>

INPATIENT

Medicine-Family Practice

Common Cases:

- Acute coronary syndrome
- TIA / CVA
- Pneumonia
- COPD
- CHF
- Pancreatitis
- EtOH Withdrawal Protocol
- AKI/CKD
- Upper GI bleed
- Anemia
- A-fib with RVR
- Sepsis / Metabolic Acidosis
- Delirium
- Syncope
- Hyponatremia / Hypernatremia
- Hypokalemia / Hyperkalemia
- Urinary retention
- Constipation / SBO
- Edema
- Cellulitis

OB-GYN Common Cases:

- Normal labor and

delivery (scrubbing in, sterile technique)

- Preterm labor
- PPROM
- PROM
- Ectopic pregnancy
- IUGR
- Dystocia
- Postpartum hemorrhage
- Pre-eclampsia / Pregnancy induced hypertension
- Gestational Diabetes
- Non-stress Test
- UTI / Pyelonephritis in pregnancy
- Abnormal uterine bleeding
- Ovarian torsion / cyst
- Tubo-ovarian abscess
- Pregnancy dating
- Induction of labor (plus IUPC, ESE, AROM)
- Intrauterine fetal demise
- Perineal repair
- GBS prophylaxis
- IUPC
- Foley Bulb

- Fetal Scalp Electrode
- Artificial Membrane Rupture (AROM)

Pediatrics Common Cases:

- Normal newborn exam
- Newborn discharge spiel
- Hyperbilirubinemia
- Neonatal fever/EOS Calculator (Kaiser)
- Bronchiolitis
- Asthma
- Pneumonia
- Pyelonephritis
- Appendicitis
- Cellulitis / cervical adenitis / peritonsillar abscess
- Non-accidental trauma (SCAN protocol)
- Neonatal abstinence syndrome
- Cardiac murmur
- Neonatal hypoglycemia protocol
- Kawasaki Disease
- Dehydration/Acute gastroenteritis

- Failure to thrive
- BRUE/Febrile seizure
- Diabetic ketoacidosis

OUTPATIENT MFHC

- Hypertension
- Immunization
- Routine infant / child health check
- Diabetes type 2
- Hyperlipidemia
- Back pain / Lumbago
- Joint Pain
- Anxiety
- Hypothyroidism
- Routine general examination
- Obesity
- Depressive disorder
- Abdominal pain
- Dermatitis
- Osteoarthritis
- Malaise, fatigue asthenia
- Chronic Pain
- Gastroesophageal reflux
- Headache
- COPD

Created: 04/18/2022

IN-TRAINING EXAMINATION

The In-Training Exam (ITE) developed by the American Board of Family Medicine and administered by all residency programs in the fall, provides one of many gauges of resident training and progress. Our program uses a passing score above or equal to 90 % predicted pass rate (based on the ABFMs Bayesian Score Predictor).. Given that the ITE simulates the board exam, the program takes specific action for residents who score below 90% predicted pass rate:

- No moonlighting privileges for that resident*
- Resident meets with academic advisor and develops written plan for study and retesting
- Academic Advisor meets with residents on a regular basis to monitor progress
- Resident takes ITE (retest) and academic advisor makes recommendations to program director based on results
- Program director considers reinstating moonlighting privileges

*Exception: In consultation with academic advisor, the program director may consider continuation of moonlighting under the following circumstances:

- Good performance on residency clinical rotations
- Moonlighting occurs at a site that has a residency faculty member (community preceptors or core faculty) who has been informed by the resident of plans for study and retest due to a low score on the ITE

LEAVE POLICY

Policy: It is the policy of Mercy Medical Center to provide for vacation and other leaves of absence consistent with applicable laws and the Accreditation Council for Graduate Medical Education (ACGME) Institutional guidelines residents are provided with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's eligibility to participate in examinations relevant to the American Board of Family Medicine Certification. During orientation, each resident is given detailed information both verbal and in writing regarding the impact of an extended leave on training and Board certification. The Residency Handbook provides specific details regarding vacation, sick time and various leave of absence and how it will affect the resident in their training requirements.

Purpose: To provide information and resources to residents regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's eligibility to participate in examinations relevant to ACGME certification.

Scope: This policy applies to all residents participating in ACGME accredited programs at MMCR.

Definitions:

Accreditation Council for Graduate Medical Education (ACGME) - The ACGME is the body responsible for accrediting all graduate medical training programs for physicians in the

United States. It is a non-profit council that evaluates and accredits medical residency and internship programs.

Sponsoring Institution - A Sponsoring Institution is an entity that oversees, supports, and administers a certain set of ACGME-accredited residency programs. A governing body (the DIO-Designated Institutional Official and GMEC-Graduate Medical Education Committee) have ultimate authority over the responsibility for graduate medical education (GME) in a Sponsoring Institution.

Procedure:

The following policy is established to meet the guidelines and requirements for vacation and leave of absence from the ACGME, ABFM, Medical Board of California, the Osteopathic Medical Board of California, Sponsoring Institutional policies, and applicable laws.

Each resident is allowed six weeks of 100% paid leave of absence during their three-year residency that must meet the qualifying reasons for medical, parental and/or caregiver leave(s) set forth by the institution. Eligibility for this leave begins on the hire start date. Leaves do not have to be continuous - intermittent leave is eligible. A minimum of one week paid time off must be reserved for the resident's use outside the first six weeks of leave of absence; this can be accomplished with use of the additional PTO provided each year (see below).

In addition to the paid leave of absence, Dignity Health allotted 200 hours of Paid Time Off (PTO) per PGY level. 160 of these hours are used for scheduled vacation and are incorporated into the residency program master schedule. 40 of these hours are reserved for sick days. PTO in excess of 30 days per academic year may require program extension. Sick days must be approved and qualify under institutional rules and may require a physician note.

The maximum allotted time away without continuity clinic (i.e. leave of absence, away elective, and vacation) per year without the need for extension is 12 weeks per 12 month PGY period, or 20 weeks per 36 month residency period. If a resident exceeds limits, they will be required to extend residency.

The determination if a resident will need to extend after a leave is taken will be determined by the Promotion Committee with input from the Program Director and Clinical Competency Committee. If approved, equivalent Elective time or Away Elective time may be replaced with leave. The resident must meet all ACGME requirements and program requirements in order to graduate and this may require program extension. Requirements include 40 weeks of continuity clinic time in each academic year. For residents graduating after 2023, residents are required to complete a minimum of 1,000 hours dedicated to caring for continuity patients.

Residents who require a Leave of Absence need to notify the Program Director and Residency Coordinator as soon as possible and meet with them to determine if the Leave will require an extension of the program.

Residents may take the PNE (Parental Newborn Elective) rotation in addition to the six week leave time, but this must be approved by the Program Director. The combination of PNE and leave time must not exceed 8 weeks. The PNE may be taken as home (PNEH) or away (PNEA). If taken as an away elective, the resident must still have 40 weeks with continuity clinic per year to avoid residency extension.

Beginning in 2023, the PNE may be taken for a maximum of two weeks following the rotation requirements including goals and objectives.

Resources:

ACGME Institutional Requirements
ABFM Leave Policy

LEAVING THE HOSPITAL AGAINST MEDICAL ADVICE (AMA)

Should a patient insist upon leaving the hospital without approval of the attending physician, the hospital has absolutely no right to detain him, unless he is a minor or under legal commitment. The hospital must avoid, as far as possible, permitting the patient to jeopardize his safety and must protect itself from possible slander and lawsuits. The following procedure must be carried out, and this is the responsibility of the CHARGE NURSE ON THE FLOOR on which the patient is staying:

- Notify the attending physician of the patient's intention.
- Warn the patient of the possible risk incurred in his leaving against medical advice.
- Request the patient to sign "Release from Responsibility, Leaving the Hospital against Doctor's Advice" form.
- If the patient refuses to sign, be sure to make a notation in the chart, and have at least one witness to the patient's verbal refusal to sign.
- Complete a Notification Form.

LEGAL ISSUES

Legal Procedure for court summons for cases involving residents

1. Resident signs and dates when the summons is received
2. Deliver the summons to the Residency office as soon as possible.
3. Coordinator copies and submits the summons to Risk Management and they will process the paperwork with the Legal Department and advise you of the follow up needed.

LICENSURE

MMCR will pay for the initial California Post Graduate Training License. Resident's reimbursement is included in their employment contract as additional initial compensation in the amount of \$700. Residents are expected to submit an application for licensure prior to or during their orientation weeks.

Residents are expected to apply for transition to full licensure 60 days prior to the expiration of the PTL. The transition process is for a resident who currently holds or has held a Postgraduate Training License (PTL) and is transitioning to a Physician's and Surgeon's (P&S) License. To apply for the P&S License through the transition process, you must have successfully:

1. Received credit for either 12 (United States and Canadian medical school graduates) or 24 (international medical school graduates) months of board-approved postgraduate training; and
2. Taken and passed Step 3 of the United States Medical Licensing Examination (USMLE) within four attempts, Part I of the Medical Council of Canada Qualifying Examination (LMCC) and Step 3 of the USMLE, or both parts of the LMCC.

MMCR will reimburse the resident for expenses related to the transitioning of licensure process. All receipts should be submitted to the residency office at one time, showing resident name, date paid, amount paid, and to whom it was paid.

Each family practice resident is responsible for scheduling and completing the USMLE or COMLEX in a timely fashion in order to send a completed application at the expected time. This means taking the exam mid-year. **Time off for the exam is considered residency time (not PTO), but it MUST be scheduled in advance through the residency office so that the call, service, and FPC schedules can be adjusted.** If possible when scheduling test dates, do not schedule during Inpatient rotations due to coverage constraints with hours. The residency office will provide residents with application packets from the California Board of Medical Examiners, but it is the full responsibility to apply online with the California Board, including for any questions about Board policy and procedures. MMCR does not reimburse for USMLE or COMLEX testing.

After licensure, residents must apply to the US Drug Enforcement Agency for controlled drug prescribing privileges (DEA license). MMCR will reimburse the resident for expenses related to obtaining their DEA license. All receipts should be submitted to the residency office at one time, showing resident name, date paid, amount paid, and to whom it was paid. After obtaining a DEA number, the resident can obtain controlled substance prescription pads in order to write for Class II-IV drugs. Please see the Residency Office for application information.

MAIL AND MESSAGES

Mailboxes at Mercy Medical Center, Mercy Family Health Center, and e-mail should be checked frequently, and action taken expeditiously when needed. Residents are provided with pagers. If a request is given to the residency office, pagers can send pages to a smart phone in addition to the pager. Please attempt to keep your pager from dropping into puddles, toilets, or rivers and please safeguard it from loss or theft.

MALPRACTICE

The program provides ongoing malpractice insurance to all residents. If you encounter any situation that you think might involve legal action, notify the Program Director at once. This includes receiving legal documents asking for patient records; a bad clinical outcome, which could in any way be construed to involve negligence or other malpractice; or threats of suit from an angry patient or family member. The hospital also provides a “Tail” coverage, which means

you are covered for events that occur while you are a resident even after you leave the program. If after graduation you are ever named in a lawsuit involving a patient at Mercy, contact the Residency Program immediately so that we may involve our Risk Management and assist you as appropriate. NEVER “GO IT ALONE.”

MASTER SCHEDULE

The Master Schedule of rotations for all residents and 13 rotations is extremely complex. The Schedule is put together in the spring and must balance the interests of rotations, service coverage, resident requests, health center coverage, and a logical sequence of certain rotations and responsibilities. This schedule has been developed along a variety of pathways in the past, but the bottom line is the appropriateness of the final product. All stakeholders (rotations, health centers, residents) have input in its development and final version. The residency program director has final authority in approving the Master Schedule.

SCHEDULE CHANGES MASTER SCHEDULE:

There are events that occur, unpredictably, that impact the Master Schedule such as illness, pregnancy, and personal problems. For such unavoidable reasons, the Master Schedule will be modified by the Program Director in consultation with the Chief Resident, the health center, and the Residency Coordinator using the appropriate PTO / Schedule Change Form, which must be completed prior to requesting change. No changes will be discussed or completed without the correct form. (No email requests.)

Schedule changes require in depth analysis of many different items including:

- duty hours
- rotation time requirements
- clinic schedule and effect of change on other residents and patients
- minimum weeks of continuity clinic required by the ACGME
- effects on call and jeopardy call
- master schedule

If an emergent situation arises for the current day, contact the following in a single group text:

- Chief resident
- Assistant chief resident
- Residency Coordinators
- Clinic manager

There may be other reasons for changing the Master Schedule. These require a PTO / Schedule Change form. These requests will be reviewed and may be considered. However, many changes have a significant domino effect and will likely not be approved.

If you are trying to find coverage by changing dates with another resident, please list the name of the other resident on your PTO / Schedule Change Form. The above items must be considered and reviewed for both residents.

HOLIDAYS:

The Mercy Family Health Center is closed on hospital holidays. Hospital call is treated as a weekend call. Mercy Medical Center observes these holidays:

- New Year's Day (Not New Year's Eve)
- Martin Luther King Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving
- Day after Thanksgiving
- Christmas Day (Not Christmas Eve)

As relates to call, generally the Mercy Medical Center holiday schedule dictates which days are considered holidays.

JURY DUTY

Jury Duty - please refer to Mercy Medical Center Redding North State Service Area Human Resources Policy Manual. You must coordinate with the Residency Office if summoned so that we can arrange appropriate coverage or provide a written letter to the judge requesting resident be excused from jury duty until after completion of residency due to training time requirements per state and federal regulations to be licensed..

VACATIONS

Residents take vacation according to the Master Schedule, which is done by the Program Director and Chief Resident after obtaining residents' requests and while making up the Master in order to balance everyone's request vs. service and FPC staffing needs. Vacation periods may not accumulate from one year to another. Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of the G-2 year and first month of the G-3 year in sequence) and a resident does not have the option of reducing the total time required for residency (36 calendar months) by relinquishing vacation time.

PGYI and PGYII Vacation time is broken up into two 2-week blocks whenever possible..

PGY III residents may take one to two week vacation blocks. Vacation cannot be taken during the last two weeks of residency.

Changes to scheduled vacation will only be considered for exceptional circumstances and will usually be denied by the program director. This is a reflection of the difficulty of balancing call, service and FPC coverage. If you do have a request, it must come with a solution to these issues and must be approved by the Chief Resident, the service, and the FPC.

Vacation and PTO time must be used each academic year. Neither can be carried over to the next year. At the end of the academic year, any unused time is “paid out” to you as salary. Any excess use of PTO results in the resident has to extend his/her training time.

MEDICAL RECORDS

Hospital and Medical Staff Policies can be found on all hospital computers under the Policy Manager icon and/or the Medical Staff Service Department.



Completion of medical records is important for multiple reasons including communication of patient care between providers, patient safety, billing, and regulatory requirements. The medical staff rules regarding timely completion of charts apply to residents, even though they are not official members of the medical staff and do not have admitting privileges; residents work under the privileges of the attending. Residents placed on “suspension” for incomplete medical records must remedy this within 24 hours. If records are not completed, the resident will be pulled from their rotation. If the suspended resident is on an in-patient service, another resident on an elective or other available rotation will be pulled to cover. This resident will be paid back. If the “suspended” resident is scheduled for call, the Jeopardy resident will replace them. This resident will be paid back. A copy of medical records suspension will be added to the resident file for reference. A residence who has been on 90 days of suspension will be suspended from the residency program for 10 days resulting in delayed graduation and documentation in the resident file.

MEDICAL RECORD QUERIES

The typical process for initiating and escalating queries:

The CDI team reviews the chart concurrently or upon patient admission so we typically send the query while the patient is still in house, but we also send retrospective queries for those who were admitted on the weekends and discharged that same weekend. After the 3rd business day, if it's still pending response, we usually escalate it especially when the pt is about to be discharged. If it remains unanswered post discharge, the chart is pended by the coders for up to 10days prior to billing.

MEDICAL STAFF BYLAWS / RULES / REGULATIONS OF THE MEDICAL STAFF

Hospital and Medical Staff Policies can be found on all hospital computers under the Policy Manager icon and/or the Medical Staff Service Department.



MEDICAL STUDENTS

Policy and Procedures for medical students rotating at Mercy Medical Center Redding are coordinated through the residency office and distributed to the health center and hospital rotations when students are present. We only take senior students, or third year students, from LCME or AOA approved schools who have completed core rotations.

MEDICAL STUDENTS APPLYING TO RESIDENCY–CRITERIA

The following information is provided to medical students applying to our residency program and includes criteria for interviewing. (Changes may be made for the upcoming interview season.)

Thank you for your interest in the Mercy Redding Family Practice Residency Program. Our ACGME accredited residency program is located in Redding, California. We are sponsored by Mercy Medical Center, a member of Dignity Health, and affiliated with the University of California, Davis. It is our goal to train high-quality family physicians to meet the health care needs of California, to practice with medically underserved populations, and to be leaders in our medical communities.

We are a member of the UC Davis Network of Family Medicine Residency Programs. These programs include seven separate programs: Mercy Medical Center, Redding; Mercy Medical Center, Merced; Doctors Medical Center, Modesto; Shasta Community Health Center, Redding; University of California, Davis Medical Center, Sacramento; San Joaquin General Hospital, Stockton; and David Grant USAF Medical Center, Travis AFB. The Mercy Redding Family Practice Residency Program works closely with Redding's Shasta Community Health Center Family Medicine Residency Program sharing resources and working together on inpatient and outpatient clinical rotations. To make it more convenient for our applicants, we coordinate our own interview days and encourage you to apply to both programs.

Intern Positions: *In order to ensure the best interview date, please submit all application materials no later than December 1, 2020. We only accept applications through ERAS. You need to submit an ERAS application to each program you are interested in.*

International Medical Graduates: *Applicants must have a current ECFMG certificate and a Post Graduate Training Authorization Letter (PTAL) from the Medical Board of California by rank day to be considered for the match. Keep in mind that it can take up to 100 days for the California Medical Board to process your documents once they have*

all been submitted. Due to this processing time, we will not consider interviewing international graduates who have graduated more than three (3) years prior to residency start date. Applicants must also provide a receipt of application from the Medical Board of California before we will consider interviews. If you are an international medical graduate with more than 36 months of post graduate training in the USA (24 months for US Medical Graduates), you must have a California Post Graduate Training License before starting residency training in California. For further information, visit the website for the Medical Board of California <http://www.mbc.ca.gov>.

Frequently asked questions

1. What are your minimum score requirements?

There are no minimum score requirements, but scores may be used to prioritize invitations to interview. Applicants with more than one examination failure on the USMLE or COMLEX may be excluded from the applicant pool.

2. Do you accept IMGs in your program?

Yes, we accept IMGs.

3. Are there IMGs working in your program?

Yes.

4. Is US experience mandatory for the program?

Yes, US experience including hands-on patient care, writing notes, developing treatment plans, and writing orders is required in hospital based and outpatient settings. Observation alone does not meet these criteria. Experience in family practice or another primary care field is encouraged. Applicants must have recent letter of reference from a physician supervisor in the U.S. documenting clinical performance and level of care. These references should include documentation of experience in hands-on patient care and responsibility for writing notes, developing treatment plans, and writing orders. Applications without clear documentation of these experiences will not be accepted.

5. Does the program sponsor Visas?

No.

6. Does your program accept DOs?

Yes, our program has a long tradition of accepting and training osteopathic physicians. In addition, we have core and community osteopathic faculty members.

7. Are both the USMLE and COMLEX needed for DO students?

No. One or the other is acceptable.

8. Where can I get a listing of where your residents attended medical school?

Please take a look at our website or brochure for information pertaining to our current residents and graduates.

9. When does your program conduct interviews?

The interview season runs from October through January. Please take a look at our website for the most current information.

10. How many years after graduation from medical school do you still consider applicants for an interview?

We only consider applicants which have graduated within the last three (3) years prior to the start date of the residency program. For example, the 2021 incoming class, applicants must have graduated from medical school during or after 2018. For applicants who have not graduated in the past year, significant

clinical experience since graduation must be documented along with written letters of reference. Applicants must have recent (the past year) US clinical experience to be considered for an interview.

11. Does your program offer observerships?

No, students who participate in rotations at our program must be currently enrolled in LCME or AOA accredited schools.

I suggest taking a look at the following websites to get detailed information on our residency programs:

Mercy Redding FP Residency:

<http://www.ucdmc.ucdavis.edu/fpnetwork/redding/>

Shasta Community Health Center FM Residency:

<http://www.shastahealth.org/schc-family-medicine-residency-center>

UC Davis Family Medicine Residency Network: <http://www.ucdmc.ucdavis.edu/fpnetwork/index.html>

If you have any additional questions, please contact me. Thank you again for your interest in our program.

Residency Coordinator

Mercy Redding Family Practice Residency Program

MERCY MEDICAL CENTER PERSONNEL POLICIES

For general personnel policies and procedures, please refer to Mercy Medical Center Redding North State Service Area Human Resources Policy Manual. Copies of this manual may be located in the Human Resources Department or by signing into a hospital computer using single sign-on and selecting the Everyday Use MMR Icon.

For any injury on the job, employees should be seen at Employee Health (6193) during the day or at the Emergency Room (7200) during off-hours. You must report even minor injuries that are incurred while working for Mercy Medical Center as such injuries (which may incur considerable expense and loss of work) are covered by Workman's Comp, not by your regular health insurance! Failure to report can have significant negative consequences for you personally.

MOONLIGHTING POLICY

Policy: It is the policy of Mercy Medical Center to monitor and maintain Resident Moonlighting that is consistent with the ACGME Institutional guidelines. Residents must have written permission from the Program Director in order to moonlight. Moonlighting is counted in the work hours. Any adverse effects of moonlighting will lead to withdrawal of permission to moonlight. At any time the Sponsoring Institution (MMCR) may prohibit moonlighting by the resident.

Purpose: To define the policy of Mercy Medical Center policy on Moonlighting that is consistent with the ACGME Institutional guidelines.

Scope: This policy applies to all residents participating in ACGME accredited programs at MMCR.

Definitions:

Accreditation Council for Graduate Medical Education (ACGME) – The ACGME is the body responsible for accrediting all graduate medical training programs for physicians in the United States. It is a non-profit council that evaluates and accredits medical residency and internship programs.

Sponsoring Institution – A Sponsoring Institution is an entity that oversees, supports, and administers a certain set of ACGME-accredited residency programs. A governing body (the DIO-Designated Institutional Official and GMEC-Graduate Medical Education Committee) have ultimate authority over the responsibility for graduate medical education (GME) in a Sponsoring Institution.

Internal Moonlighting – Voluntary, compensated, medically-related work performed within the site where the resident or fellow is in training or at any of its related participating sites.

Moonlighting – Voluntary, compensated, medically-related work performed outside the site where the resident or fellow is in training and any of its related participating sites.

Procedure:

Outside employment must be approved by the Residency Program Director and this approval is subject to the conditions outlined below:

1. Moonlighting is a privilege permitted only to the extent that it does not interfere with a resident's performance in the program, complies with the ACGME guidelines on Duty Hours including the 80 hour work limit, and has the Program Director's approval taking into account the resident's performance in the program and readiness to assume the responsibilities of the moonlighting experience.
2. Every resident must complete the intention to moonlight form available from the residency office prior to starting moonlighting. A separate form must be completed for each employer.
3. PGY1 residents are not allowed to moonlight. Licensed PGY2 and PGY3 residents in good standing may be granted moonlighting privileges; these are effective through the remainder of residency unless evidence of inadequate academic progress becomes apparent.
4. Clinical services rendered while moonlighting are NOT covered by the residency liability-malpractice policies. Residents must not undertake any outside physician employment unless professional liability coverage is obtained. Residents may obtain personal malpractice coverage or arrange for this to be covered by the external employer. Moonlighting agreements should clearly document liability coverage provided. Evidence of coverage must be provided to the program director.

5. Residents must document the number of moonlighting hours worked and submit to the residency office through New Innovations. While on rotation, we recommend limiting moonlighting to a maximum of one time per week and one time per weekend. Moonlighting on post-call days is not permitted. No moonlighting is permitted during residency duty hours at any time including daytime rotations or on-call periods. In addition, moonlighting must not affect availability while on jeopardy call.
6. If moonlighting activities detract from the residency experience, then the program director may revoke moonlighting privileges. Issues that may affect moonlighting privilege include excessive fatigue, not being available to family practice obstetrical patients, excessively delinquent medical charting, and poor performance on the In-Training Assessment Exam as defined by <20% for Post-Graduate Year.
7. Potential consequences of not following the moonlighting policies include: 1) No moonlighting permitted 2) Recommendation of remedial rotations, substitution of core for elective rotations, or a delayed graduation date. 3) Failure to be certified as board eligible by successful completion of the entire prescribed curriculum.
8. Approval for moonlighting is subject of revocation at any time. Approval for moonlighting does not constitute an endorsement or recommendations of the outside employer.
9. MMCR does not allow internal moonlighting.

Reference:

ACGME Institutional Requirements

OTHER RESIDENT/EMPLOYEE BENEFITS

- Employee Assistance Program: Confidential professional counseling and referral service for you and your family
- Parking: Residents should obtain pass cards from the Medical Staff Office for entering the Doctor's Parking Lot.
- Meals: Food will be free from the Mercy Medical Center cafeteria for residents on duty.
- Sleep Room: A room with telephone in the hospital will be provided for residents on night and weekend call.
- Immunizations: Residents may receive immunizations for rubella, hepatitis B, and diphtheria-tetanus via Mercy Medical Center Employee Health. The program encourages staff members to be fully protected against these potential occupational hazards.
- Book Allowance: Dependent on funding from UC Davis, a book allowance for up to \$300 per year may be used to purchase medical texts, journals, computer software or other educational items as approved by the program director. Residents should bring request to residency office to notify UC Davis. UC Davis purchases the books and sends them to residency office to disperse to resident.
- Pager: The program will provide use of one pager plus one replacement pager for loss or breakage that occurs during residency training. The resident will be financially responsible for the cost if more than one replacement pager is needed.
- Membership on the AAFP for all three years.

- Cost of California medical license while in our residency. Post Graduate Training License (PTL) is reimbursed through a supplemental employment contract payment. Transition to full licensure is reimbursed through receipts submitted to the residency office. (See Licensure)
- Cost of DEA certificates while in our residency
- Expense Reimbursement: Residents may be reimbursed for certain expense such as mileage for the rural rotations and expenses for attending approved meetings or residency fairs. In order to be reimbursed for expenses, residents must provide the residency office with original receipts and documentation of the expenses within 30 days of when the expense is incurred. If the resident is attending a residency fair, conference or meeting at the request of the program, the resident must complete a “Request for Permission to Attend Workshop, Seminar, Institute, Etc.” form. This form must be approved by the Program Director prior to the event.
- Advance payments for travel expenses: In certain cases the Residency Office can obtain advance payments for expenses incurred on behalf of the residency. In order to obtain an advance, the resident must provide an approved “Request For Permission to Attend Workshop, Seminar, Institute, Etc.” form and other requested documentation to the Residency Coordinator at least 2 weeks before the money is needed. The resident must also specifically request an advance payment of expenses, as one will not automatically be given.

PAID TIME OFF (PTO)

There are several policies to consider when taking PTO. These include the Mercy Medical center Paid Time Off (PTO) policy and the policies for absence from a residency program as defined by the American Board of Family Medicine (ABFM). Policies relating to leave may be modified to meet requirements and policies of the American Board of Family Medicine and the American College of Graduate Medical Education. The Mercy Redding Family Practice Residency Program provides the maximum allowable vacation/leave allowed by the ABFM without extending residency training. Scheduled PTO includes up to 4 weeks’ vacation. Per Mercy Medical Center policies, another 5 days of PTO is available for short term sick leave, but using this time may result in extension of residency training.

Depending upon individual circumstances and PTO hours already used, PTO for illnesses may be taken from the scheduled vacation days to prevent extension of residency training. However, PTO and vacation times cannot be applied to other academic years for this purpose. PTO hours must be used in the post graduate academic year in which it is provided. Residents will be paid for unused PTO at the end of the contracted year.

Mercy Medical Center recognized holidays do not require special accounting and do not detract from PTO hours unless this occurs during scheduled vacation. A bank of long term sick leave begins to accrue at the beginning of employment with Mercy. For additional PTO, short term sick leave, and long term sick leave policies (i.e. pregnancy), the Mercy Medical center human resources department and/or the residency office should be consulted.

PERSONAL DAYS

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

Once a year, however, residents may make one unscheduled clinic change with at least 10 working days' notice so staff can contact patients prior to their appointments. One-time clinic changes may be done for personal time off (PTO), or work reasons: CME, interviewing for a future job, or elective rotation time. Additionally, the change must be approved by the clinic manager (Sharon Babcock) to make sure that it will not affect clinic staffing. The residency office has the appropriate paperwork. We ask that you begin the paperwork as soon as possible to make these days as smooth as possible for all concerned.

PRESCRIPTIONS

California law requires all medication prescriptions be transmitted electronically. Some limited exceptions do exist.

Hospital Discharge: A licensed resident preferably enters discharge orders and prescriptions through the EHR, using his/her name and license number. If an unlicensed resident creates discharge prescriptions, then the attending physician must co-sign the prescription and the attending physician's name and prescribing information is used by means of the EHR in the process. The discharge orders should indicate the correct name of the attending and the date of discharge as this is used both for medications and a variety of other health care agencies. Follow up instructions should be clearly documented on the discharge including the recommended interval of time for followup such as within 3 days, and the anticipated provider or clinic location at which the followup should occur.

If a PGY1 receives an outside call from a MFHC patient needing medication, that PGY1 will need to refer the request to the senior resident who will send the prescription after reviewing all pertinent information.

The following items will apply to prescriptions for controlled substances:

- Schedule II drugs:
 - These controlled substances must be sent electronically by law unless the electronic prescribing is not functioning in which case they may be printed or written on designated controlled substance prescription paper. The prescription must be signed by the physician specific for that prescription, whether it is an attending or licensed resident with an active DEA number.
 - Schedule II drugs may be written and faxed for terminally ill patients using standard prescription pads. The physician must write on the prescription "11159.2 Exemption"
- Schedule III and IV drugs:
 - These controlled substances must also be sent electronically unless electronic means are not functioning. They may be printed by a licensed resident or attending physician using the DEA number of the prescriber and on specified controlled substance prescription paper. Alternatively, some schedule III or IV prescription may be faxed or called into the retail pharmacy using the prescriber's DEA number in select situations.

- Residents must be licensed and have an active DEA number to prescribe controlled substances.

Outpatient: When unlicensed residents prescribe outpatient prescriptions, the prescription must be proposed in the EHR to an attending preceptor and co-signed by the preceptor to send to the pharmacy. If the preceptor of the clinic session is a community preceptor, the resident may have the community preceptor co-sign non-controlled substance medications but the resident should seek a faculty member or their faculty advisor for any controlled substance prescriptions.

Licensed residents do not need co-signatures. Prescriptions for controlled substances can only be signed and sent by a licensed physician possessing an active DEA license that is also active within the EHR.

Reduce medication errors:

In the EHR, be sure you are in the correct patient chart for whom you are wanting to prescribe. Do double check the sig instructions, dosing - especially calculations for weight based dosing, quantity to dispense, and refills if appropriate.

AVOID error prone abbreviations if using free text functions in EHR or hand writing prescriptions such as:

Do not use:

“u” for units, “iu” for international units

“pen” for penicillin,

“QD” for daily, “QID” for 4 times daily, “QOD” for every other day,

“MS” for Morphine Sulfate, “MSO4” for Magnesium Sulfate,

or apothecary symbols for drams, minims, or ounces. These words should be written out instead.

Write “ml” not “cc”

Eliminate the use of “trailing zero’s” – use 2mg instead of 2.0mg (easily mistaken for 20mg).

Always use “leading zero’s” – use 0.125 rather than .125.

Order medications by “mcg,” “mg,” or “g” strength when possible. Example: Tylenol 650 mg instead of Tylenol 2 tabs (Tylenol comes in different strengths).

Be aware of potential look-alike and sound-alike drugs

When providing inpatient care at the hospital, orders entered by the physician in the EHR are preferred.. Avoid giving “phone orders” whenever possible.

PROCEDURE COMPETENCY

The program uses a method by which all procedures will be supervised and evaluated and kept in an online database called New Innovations. The program has devised a credentialing process to establish whether or not a resident is competent to perform specific procedures. Residents will document their procedural experience, including the name of the procedure, age and gender of patient. The supervising physician can document the level of performance (e.g., progressing toward independent performance) within New Innovations. Procedural teaching includes didactic presentations, indications and contra-indications, risks and benefits, informed consent, appropriate coding and charging, sterile technique, management of aftercare and complications,

sterile technique, and acquisition and maintenance of skills. The academic advisor will review their assigned residents' procedure log bi-annually and discuss the progress of their training.

The following includes the procedural competencies for each area of residency training along with the number of procedures required prior to completion of the residency program. Also listed is the number of procedures required before independent status is granted.

Preceptors can use New Innovations to document the supervision of each procedure and to rate the level of resident performance using the following code: **1**= required significant assistance; **2**= required minimal assistance; **3**= procedure performed satisfactorily without assistance. Resident must perform the minimum number of procedures as outlined below and demonstrate level 3 performance on at least 2 occasions to be considered competent.

After a resident demonstrates proficiency, a preceptor will still need to observe future cases during the key part according to MediCare supervision guidelines for billing purposes.

For more information about Procedure Requirements at MFHC, go to this section of the Resident Handbook found under the heading **ADDENDUM - MFHC CLINIC MANUAL**

Procedure Requirements for Graduation and Initial Appointment of Hospital Privileges						
Mercy Medical Center Redding						
Procedures			Minimum required to graduate	MMCR required for Privileges	Notes	Resident's # to Date
Critical Care						
ICU Admissions			4 wk rotation	30		
Arterial catheterization			0	15		
Central venous catheters			0	25	any combination	
Chest tubes			0	10		
Intubation or extubation			0	15	any combination	
Paracentesis			0	5		
Lumbar puncture (adult)			0	5		
Thoracentesis			0	5		
Ventilator care, uncomplicated			0	15		
Newborn Care						
Newborn transitional care			0	10		
Newborn lumbar puncture			0	5		
Circumcision (any technique)			0	20		
Obstetrics						
Deliver vertex NSVD (low and intermediate risk)			25	25		
Repair of perineal lacs (1st or 2nd degree)			0	*		
Repair of 3rd degree perineal lacerations			0	*		
Miti-vac vacuum extraction			0	2		
Dilatation and curettage			0	10		
<i>*Items above with asterisk are included in Ob Management Privileges</i>						
Musculoskeletal Medicine and Outpatient Procedures						
Casting/Splinting arm or leg			3	N/A		
Digital block			0	N/A		
Colposcopy			1	N/A		
Cryotherapy (including for skin lesion)			5	N/A		
Excision of lesion			5	N/A		
Abscess incision, drainage, and packing			1	N/A		
Joint injection or aspiration			3	N/A		
Lacerations repair - skin			5	N/A		
Punch biopsy/Shave Biopsy			3	N/A		
Surgery						
Surgical first assist			10	10		
Revised 10/14/19						

PROFESSIONALISM

ACGME requires that programs provide educational experiences as needed in order for their residents to demonstrate compassionate, appropriate, and effective patient care, Interpersonal and communication skills that result in the effective exchange of information and collaboration with

patients, their families, and other health professionals; and a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds. Residents will receive training in professionalism through lectures, and longitudinally during each of their clinical rotations. Competency in this area will be assessed during the evaluation process and reviewed during academic counseling. Examples of these areas include:

- Integrity
- Respect for Others
- Altruism
- Communication – appropriate and timely
- Commitment
- Honesty
- Teamwork
- Personal Hygiene/ Dress/ Composure
- Patient Care
- Administrative Tasks
- Rotation Attendance and preparedness
- HIPAA Compliance
- Work Hour Compliance
- Appropriate use of social networking

Medical Staff Expectations for Professional Behavior

Residents are expected to adhere to the professional standards outlined in the medical staff policy Professional Conduct, Prohibition of Behaviors that Undermine a Culture of Safety:

All Medical and Allied Health Professional Staff members shall conduct themselves at all times while on Hospital premises in a courteous, professional, respectful, collegial, and cooperative manner. This applies to interactions and communications with or relating to Medical Staff colleagues, Allied Health Professionals (“AHP”), nursing and technical personnel, other caregivers, other Hospital personnel, patients, patients’ family members and friends, visitors, and others. Such conduct is necessary to promote high quality patient care and to maintain a safe work environment. Behaviors that undermine a culture of safety including behavior which can be construed as discriminatory or harassing, as defined below, are prohibited and will not be tolerated.

Definitions of Types of Behaviors that Undermine a Culture of Safety

- A. Behavior that undermines a culture of safety is marked by disrespectful behavior manifested through personal interaction which:
1. Interferes, or tends to interfere with high quality patient care and patient safety or the orderly administration of the Hospital or the Medical Staff; or

2. Creates a hostile work environment; or
 3. Is directed at a specific person or persons, would reasonably be expected to cause emotional distress, and serves no constructive purpose in advancing the goals of health care.
- B. “Discrimination” is conduct directed against any individual that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual’s race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, or sexual orientation.
- C. “Sexual harassment” is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory or sexual-themed cartoons, drawings or posters). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct interferes with the individual’s employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.
- D. Other Prohibited Harassment includes behavior which creates a hostile or offensive work environment based upon other protected characteristics, included but not limited to, race, sexual orientation, medical condition or age.

Examples of Prohibited Conduct

Examples of prohibited, disruptive conduct may include, but are not limited to, any of the conduct described below if it is found to interfere, or tend to interfere, with patient care or the orderly administration of the Hospital or Medical Staff; or, if it creates a hostile work environment; or, if it is directed at a specific person or persons, causes physical or emotional distress:

- A. **Refusing to respond to a request by any caregiver for orders, instructions, or assistance with the care of a patient, including, but not limited to, repeated failure to respond to calls or pages;**
- B. Any conduct that would violate Medical Staff and/or Hospital policies relating to discrimination and/or harassment;
- C. Throwing instruments or other objects in a patient care setting;

- D. Yelling or screaming directed at Hospital personnel or others;
- E. Any striking, pushing, or inappropriate touching of Hospital Staff or others.
- F. Use of racial, ethnic, epithetic, or derogatory comments, or profanity, directed at Hospital personnel or others;
- G. Inappropriate comments written in the medical record;
- H. Unauthorized use and/or disclosure of confidential or personal information related to any employee, patient, practitioner, or other person;
- I. Use of physical or verbal threats to Hospital personnel or others;
- J. Intentional filing of false complaints or accusations;
- K. Any form of retaliation against a person who has filed a complaint against a practitioner alleging violation of the above standard of conduct;
- L. Persisting to criticize, or to discuss performance or quality concerns with particular Hospital personnel or others after being asked to direct such comments exclusively through other channels;
- M. Persisting in contacting a Hospital personnel or other person to discuss personal or performance matters after that person or a supervisory person, the Chief Executive Officer (“CEO”), or designee, or Medical Staff leader, has requested that such contacts be discontinued. Medical Staff members are always encouraged, however, to provide comments, suggestions and recommendations relating to hospital employees, services or facilities, where such information is provided through appropriate administrative or supervisory channels.
- N. Obstructing the peer review process by intentionally refusing, without justification, to attend meetings or respond to questions about the practitioner’s conduct or professional practice.
- O. Engaging in outrageous, intimidating or threatening conduct that interferes with an individual’s employment or ability to carry out their work obligations, or interferes with the patient care team.

Resident Responsibility: Program Deadlines & Compliance

Residents are expected to proactively manage their professional obligations and adhere to all program and institutional policies. While Program Coordinators provide administrative support and may offer deadline reminders as a courtesy, residents remain individually responsible for:

- **Tracking Deadlines:** Meeting all deadlines for evaluations (giving and receiving), case logs, duty hour attestations, licensure, and board certification applications. (Courtesy reminders are not guaranteed).
- **Policy Knowledge:** Familiarizing themselves with the program's policies and procedures manual.
- **Updates & Clarifications:** Keeping contact information and leave requests current, and proactively seeking clarification on any program requirement.

Utilizing personal organizational tools is strongly encouraged to ensure compliance.

Maintaining Professional Boundaries and Respecting Patients' Privacy during Patient Examinations

AMA Statement on Professional Boundaries:

The American Medical Association Council of Ethical and Judicial Affairs (1989) addressed professional boundaries and stated that sexual misconduct violates the trust that a patient places in the physician and is unethical.¹²¹ This position was further modified in 1991 to add that a sexual or romantic relationship with former patients is unethical if the practitioner uses or exploits trust, knowledge, emotions, or influence that was derived from a previous professional relationship.

Addressing Patients' Perceptions:

Patients may perceive misconduct if proper communication does not occur or if extra measures are not taken to protect their privacy. The California Medical Board has received numerous complaints regarding improper physician conduct that could have been avoided with proper communication and use of safeguards, including the following:

1. Proper explanation ahead of time regarding the scope, nature, or necessity of examinations which included touching private body parts.
2. Allowing adequate private time for the patient to undress and cover properly.
3. Limiting examination to required areas of focus based on patient complaint and ensuring adequate covering during the examination.
4. Using appropriate chaperones during examination of private body parts, especially during breast and pelvic examination.
5. Carefully considering language and questions during the interview and examination.
6. Behaviors should not be pursued that would not pass the "colleague disclosure test".

Addressing Sexual Tension:

Erotic undercurrents may occur between patients and physicians and need not end the physician–patient relationship. Although sexual undercurrents are not uncommon in the doctor–patient interaction, sexual behaviors are always inappropriate and may result in disciplinary actions for sexual misconduct. Ways to address sexual tension include:

1. Explaining reasons for sexually related examinations or questions and encouraging patient questions, while maintaining appropriate boundaries.
2. Responding to patients who express erotic feelings in a matter-of-fact manner, emphasizing the doctor–patient relationship, the importance of objectivity, and the physician's desire for it to remain that way.
3. Explaining that rejection of the patient's inappropriate requests or comments does not mean the physician does not care for the patient or does not wish to work with them.
4. If a patient persists with inappropriate requests, or comments, or becomes extremely angry, the physician should respond calmly and with sincere regret that this behavior will cause termination of the relationship.
5. Physicians should seek to understand their personal reactions and attitudes toward sexual issues.
6. Patients who persist in acting out erotic feelings should be transferred to another physician and, pending transfer, sexually related issues should be avoided.
7. The physician should explain the change as related to the persistence of the behavior and the physician's decision that it is in the patient's best interests not to continue.
8. Admitting attraction or other feelings for the patient is discouraged as inappropriate disclosure on the part of the physician.

Key Points

- Boundaries between physician and patient permit the unique intimacy of the physician–patient relationship.
- Sexual contact crosses these boundaries and violates the relationship.
- Erotic feelings are signs of potential boundary crossings.
- Physicians and patient erotic feelings and behaviors can be constructively managed.
- It is highly recommended to consult with a faculty member or trusted colleague when potential boundary issues of any kind are detected, and to practice prevention before problems emerge.

Male providers are required to have a female chaperons present for female breast, pelvic, and rectal examinations.

PSYCHIATRIC TEMPORARY CUSTODY (5150)

Any discussion about a 5150 for an inpatient needs to occur between the patient's attending physician and the Shasta County Mental Health Department or the Redding Police Department (police have the 5150 privilege).

REPORTABLE CASES:

California law mandates that all healthcare practitioners make a formal report to the relevant authorities by telephone immediately or as soon as practically possible followed by a written report when providing medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person is suffering from:

- Any wound or physical injury inflicted by a firearm or assault or abusive conduct
- Sexual assault/rape
- Incest
- Child abuse or endangerment
- Elder abuse
- An injury or condition resulting from neglect or abuse in a patient transferred from another health facility resulting from neglect or abuse

Reportable Diseases and Conditions: Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5- 2643.20, and §2800-2812 Reportable Diseases and Conditions* (Communicable diseases, STDs, Hepatitis, TBC, etc.): Telephone, fax and/or written reporting of certain diseases to the Shasta County Public Health Department are mandated. A reporting form is available at MFHC and in the hospital that delineates the specific reportable diseases and provides a listing of the required reporting modes (e.g. some diseases require immediate telephone reports, other require reports by phone and by mail, etc.).

Reportable Noncommunicable Diseases and Conditions:

Disorders Characterized by Lapses of Consciousness

Pesticide-related illness or injury (known or suspected cases)

Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix)

Additional information or reporting requirements may be found in the **California HealthCare Association Consent Manual**; these are available for review at MFHC, Hospital Administration, and from departmental nursing supervisors. Note that simple, standardized forms are available in the family health center (MFHC) and in the hospital (obtained from the nursing staff) for use in fulfilling the written reporting requirements described above. All residents should feel welcome and comfortable obtaining guidance and assistance from a faculty member, attending or nursing staff in any case in which potential reporting requirements exist. Consulting and coordinating in these situations is often indicated in order to ensure that sensitive legal and ethical requirements are fulfilled.

RESIDENT IMPROVEMENT PLANS AND RESIDENT CONFIDENTIALITY

1. In the event that a junior resident requires additional training and supervision in one or more area, the senior resident(s) supervising the junior resident will be informed by the Program

Director or another faculty member. With the intent of promoting better education and patient safety, this briefing will include the aspects of the junior resident's improvement plans as it relates to senior residents functioning as the supervising resident.

2. In addition, residents may be involved in confidential discussions about other residents' performance when serving in their role as the chief resident, assistant chief resident, or as a member of the promotions committee.

RESTRICTIVE COVENANTS

Policy: Per ACGME Institutional requirements, the Sponsoring Institution must maintain a policy which states that neither the Sponsoring Institution nor any of its ACGME-accredited programs will require a resident/fellow to sign a non-competition guarantee or restrictive covenant.

Purpose: The purpose of this policy is to ensure that the Graduate Medical Education Committee (GMEC) is providing appropriate oversight regarding the use of non-competition guarantees or restrictive covenants in trainee agreements per Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements.

Definitions:

Restrictive Covenant: a non-competition guarantee. A restrictive covenant, in its broadest sense, is a provision that precludes an employee from competing with the employer and/or from working for a competitor of the employer, for some period of time after the employment has been terminated. The Accreditation Council for Graduate Medical Education (ACGME) specifically prohibits the use of restrictive covenants in trainee agreements and requires the Sponsoring Institution to maintain a policy that prohibits programs from requiring a Resident/Fellow to sign a non-competition guarantee or restrictive covenant.

Procedure:

MMCR does not require any Restrictive Covenants as a condition of resident participation in Graduate Medical Education Programs. Neither the Sponsoring Institution nor its ACGME-accredited programs will require residents to sign a non-competition guarantee or restrictive covenant.

Reference: ACGME Institutional Requirements

SCHEDULES, CALL, and SIGN-OUT

Any change in your schedule including master schedule (rotations), daily schedule, or call schedule must be reported and/or coordinated with the residency office as soon as possible. Changes in the schedule without approval from the residency office may result in a loss of credit for the rotation. A call hierarchy exists in which junior residents have primary responsibility for coverage of the inpatient services. They are supervised by more senior residents who are responsible for overseeing admissions and care of all patients admitted to the resident services. The attending physician is responsible for supervising all resident care, answering questions, and addressing problems. At least two residents are on call each night or weekend, providing 24 hours resident coverage. It is extremely important that patients are signed out appropriately. Upper level and first residents need to be present at sign-out which occurs weekdays Monday

through Friday at 1700. **Patient care and precepting must be completed at the family health center prior to residents returning to the hospital for call.**

CALL EXPECTATIONS / CONSIDERATIONS

Total Expected Call Numbers for each PGY Class:

- PGY-1 = 20-24
- PGY-2 = 16-18
- PGY-3 = 6-8

*Inpatient Rotations = Med, FPS, Ped, OB, NFM, OBNF. All other rotations, whether hospital or clinic based, are referred to as “Outpatient” for scheduling purposes.

CALL SCHEDULING CONSIDERATIONS

Jeopardy for Inpatient coverage needs: Interns are NOT scheduled for Jeopardy Weekend/day Call

- Jeopardy Weekend Call: PGY-2/3 that is scheduled must be available and within 1hr of the hospital in case of immediate Senior or Intern coverage emergencies. *If a coverage issue is identified far enough in advance (i.e several days), a coverage solution may be implemented that does not utilize Jeopardy, but the next available resident with the below considerations being met (Ideally, Interns to cover Interns and Seniors to cover Seniors).*
- Jeopardy Weekday Call: Reserved for nighttime coverage only. *Weekday daytime emergency coverage needs are addressed with the next available resident on an outpatient rotation.*
- There is no set number of expected total Jeopardy Calls per resident. However, total Jeopardy Call numbers will be considered for scheduling in an effort to create a fair and balanced distribution among the PGY-2 and PGY-3 classes.

General ACGME REQUIREMENTS: Never violated (except in the instance of a continuity OB delivery/management)

- Minimum 4 “days off” per 4-week rotation block
- Post-Call does NOT count as a “day off”
 - Saturday is considered Post-Call after Night Float (shift ends Saturday AM)
- Jeopardy Call IS considered a “day off”, unless the resident is called in.
 - HOWEVER, to ensure no one is at risk of not meeting the 4 “day off” requirement, we generally do not include Jeopardy Call in the “day off” count when building the schedule.
- Pre-approved trainings (ex: ALSO training) and conferences attended that are held on a Saturday (ex: AAFP, CAFP), do NOT count as a “day off”
- A resident cannot work over an average of 80 hrs/wk in any 4-week rotation block.

- There will occasionally be circumstances when a resident works 80+ hrs in a single isolated week.
- Vacation weeks are removed from the denominator for this calculation. (ie. If you have 2 weeks of vacation for ration 7a, it would be a violation for you to work an average of 80+ hrs a week for the 2 remaining weeks of rotation 7b)

General “Nuances”: Violated in RARE circumstances.

- A resident cannot be on weekday Jeopardy Call while on an Inpatient Rotation.
- MFHC C1 – NO Sunday Call/Jeopardy Call
- MFHC C2 – AVOID Sunday Call/Jeopardy Call
- SCHC Rural – NO Sunday Call prior to start (clinic on Monday), NO weekend call in middle of rotation.
- SCHC UCD Peds ER – NO Sunday Call prior to start (clinic on Monday), NO weekend call in middle of rotation
- Vacation and AWE – NO call on weekend that splits Vacation/AWE weeks, or last weekend of Vacation/AWE
- Night Float – NO Weekend, Jeopardy, or Holiday call prior to or after NF
 - *Unless* voluntarily signed up for Holiday Call AND doesn’t violate hours

General “Courtesies”: Violation of these circumstances will occasionally be unavoidable and *expected* throughout the year.

- Generally avoid scheduling a resident for a call on the weekend prior to the start of Vacation/AWE.
 - Note, weekends prior to vacation are not considered vacation days. Chief Residents attempt to not put residents on call these weekends, but this cannot be guaranteed
- Generally avoid scheduling a resident for Sunday call (post-call Monday) prior to the start of Inpatient Rotation.
- Generally avoid scheduling a resident for call on a Sunday and the immediately following Saturday
- Generally avoid scheduling a resident for back-to-back Saturday calls in consideration of burnout and wellness

“Solo” Weekend Call Season: Typically starts the 2nd weekend in April. There are 2 options for scheduling each weekend call shift during “Solo” season (**Option 2 is a special circumstance and expected to only be utilized in specific situations**). More information on roles and expectations will be defined and sent out as the season approaches.

Option 1: 2 interns and 1 “super senior” (PGY-2/3) to cover “inpatient” services.

- 1 PGY-1 to manage ALL FPS/Peds and 1 PGY-1 to manage ALL OB
- 1 PGY-2/3 to supervise both interns and provide assistance when needed.

- Due to the need to oversee 4 services, the super senior will always be available for assistance throughout the 24 hour call, but will not be actively managing patients. Interns are responsible for taking all calls, doing admits, and managing the patients on their respective services. Seniors are expected to closely monitor the more critically ill/sick patients. Seniors do not have to go to all rounds, and can go to ones based on how sick patients are or the census of the list.

- Requires 1 Jeopardy Call (PGY-2/3)

Option 2: 2 PGY-2/3s to cover ALL “inpatient” services + 1 Short Call

- 1 PGY-2/3 to cover FPS/Peds and 1 PGY-2/3 to cover OB
- 1 PGY-2/3 for Short Call
- Still Requires 1 Jeopardy Call (PGY-2/3)

“Requests” for Schedule Changes: To be utilized for various reasons *after* initial “Call” and “Master” schedules have been approved and sent to residents.

1. Mercy AND Shasta Residents: Please find the attached PTO Form, Master Schedule Change Request Form, and Call Schedule Request Form.
 - Please use these mechanisms for requests and submit to the appropriate staff for review
 - The schedule change/request must be approved by the program respective Chief + PD + Residency Coordinator + Clinic Manager and agree with the above stated considerations.
 - As the requestor, ideally you should coordinate coverage and shift changes with residents in your cohort, providing a solution along with your request.
 - If the schedule change or off request involves residents from both programs, it will require approval of the Chief + PD + Clinic Manager from both programs as well.
 - Please understand that a request that is approved other than through PTO is NOT a 100% guarantee, and the approved requester would still theoretically be on a list of residents available for coverage emergencies if we are presented with one.
 - If you REQUIRE to have a 100% guarantee for a weekend day off, you will need to file a formal PTO request through the Program Director/Residency Office, which if approved would extend your residency by 1 day (or for the number of days requested off for PTO)

Morning sign-out occurs

OB/NB 6:30am & 5:30 pm; FPS/PEDS 7am & 5:30pm. Medicine starts at 7AM without any sign out as we do not cover weekends or nights. Residents will leave the hospital when their work is completed and they have adequately signed out. On Monday, the Sunday FPS/Peds call team needs to wait until 7 a.m. to sign out FPS.

SIGN OUT & COMMUNICATION

(This information can also be found in the Resident Survival Manual)

General Guidelines

- Be on time, ready to sign out if you are the outgoing team, and ready to work if you are the incoming team. Notify the outgoing team ASAP if you anticipate being late to sign out.
- If you are the senior resident and will be unavailable to the team during all or part of the day, ensure there is another senior for back up and you have signed out to your backup.
- Outgoing residents will help see patients before they leave if their night float or call shift ends on a weekend or holiday.
- It is expected that any new patient for a service received within 30-45 min of sign out will be assigned to the incoming team to be seen. Pre-populate the sign out list with known patient info in these cases. Bonus points for anticipating admits and newborns and getting these patients on a list.
- Be sure you are personally accounting for all inpatient encounters and procedures as instructed by your residency program.

Medicine/FP

- Medicine and FP services are managed by separate teams of residents during weekdays
- Weekends FPS is managed by a single resident team on nights, weekends and holidays. MED is managed by a hospitalist on weekends.
- FP includes any adult or pediatric patient of MFHC faculty and residents as well as adult and pediatric patients of SCHC residents. Resident continuity newborns are also admitted to this service.
- There is limited to 8 patient load.
- Any other patient should be admitted to the resident Medicine service if capacity allows.
- Sign out location is the LLCR unless agreed elsewhere.
- Medicine interns are expected to carry at least 5 patients each, on average, per ACGME requirements.
- Combined census for both services on weekends and holidays should approximate 12-15 patients, or as otherwise directed by senior residents. Individual attendings may further direct patient volumes.

Peds/OB

- Pediatrics and OB services are managed by separate teams of residents during the week, Newborns are managed by the OB/NB night float resident on nights, and the FPS/Peds team on weekends and holidays, pediatric patients are managed by the Med/FPS/Peds night float resident on nights, FPS/Peds team on weekends and holidays.

- The Peds service includes any pediatric patients not covered by private pediatricians or residents.
- The OB service includes any OB/GYN patients not covered by private OB/GYN physicians.
- Sign out location is in LLCR
- Again, residency pediatric patients and continuity newborns will be covered on the FP service as identified above.

SIGN OUT LIST ELEMENTS

(This information can also be found in the Resident Survival Manual)

*see individual sign out lists for further guidance

MED/FP/PED

Dr: Your name Code: Keep Code status current! Attending:

Consults: List name (specialty)

Dx: (age) old (sex) p/w (signs/symptoms and duration)

PMHx: fit in the pertinent

IVFluids: Try to keep current, Diet: NPO, ADAT or type of diet ordered

Weight: in kg

Studies: List pertinent x rays, US, CT, MRI, etc.

Labs: CBC and BMET will show up on the printed list. Put things that need to be trended here or are abnormal for quick reference.

PMD: List and try to put phone number here if from out of town

SIGN OUT: (date) then list problems by # and give txs for each one.

OB

*Dx: (age) yo G(#P(#) @(#)wks by LMP(or unk) c/w (#) wk US p/w...PNC began #wks.
PNC c/b : List*

IVFluids: Put membrane status here-intact, ruptured, duration

Labs: List prenatal panel for mom and utox on admit

Sign Out: (date) PPD or POD #(0-3)time and date of delivery, list if PPH or tears. If peripartum add SVE (3/70/-2)

NEWBORN

*Dx: (weight)gm NB(F/M) born via (NSVD/pLTCS) @(time) on (date) to a (age) GxPx
@ #wks. PNC began #wks.*

PNC c/b: list

IVFluids: put AROM/SROM, duration ruptured,fluid-clear or mec

Studies: List apgars w/pof (tone, color, etc)

Labs: Mom's prenatal panel and utox

Baby's blood type and coombs status

PMD: list doc or clinic to help fill out discharge paperwork

*Sign Out:(date) PPD/POD #(0-3) NSVD/pLTCS/rLTCS on (date)
Anything abnormal about exam, breast/bottle feeding,*

Admission timing guidelines:

The program must have a consistent set of guidelines to ensure the patient's safe transfer of care to the in-patient service and to avoid unnecessary resident conflict over "who is responsible for this patient." The times listed refer to the time the ED notifies the on-call resident of the admission.

All mornings: The on-call resident will manage Admissions from the ED at 6:29 am or earlier. From 6:30am on, the admission will be held for the incoming resident at 7 am. Incoming residents may accept patients from earlier than 6:30am if they so choose. If there is an urgent need to see the patient during the 6:30-7:00am interval, then the on-call resident will be responsible. Patient safety is always the major determinant.

Monday through Friday evenings: Admissions from the ED up to 5:00 remain the responsibility of the day team. From 5:00 pm on the admission goes to the appropriate on-call resident. If there is an urgent need to see the patient during the 5:00-5:30 interval, then the on-call resident will be responsible. Patient safety is always the major determinant.

For patient safety and efficiency, the upper level resident should always exercise their best judgment when assigning admissions around the change of shift times. That decision may overrule the above guidelines concerning times and which call accepts the admission (e.g., circumstances may make assigning the Peds call resident a medicine admit at 6:45 am). In the event of a disagreement, the upper level resident's decision is the one that applies. Residents may subsequently discuss the issues with the Chief Residents and/or the Program Director, but after the care is rendered and the crisis is over.

Changes to the written call schedule:

All resident parties involved must agree upon changes. The resident originally assigned the call remains ultimately responsible for coverage. All changes must be reported to the residency office. This is the responsibility of the resident originally assigned the call. In the event a resident is unable to take an assigned call day due to an acute illness, a family emergency, etc., that resident is responsible for contacting the chief resident and the residency office. The chief resident will assist them with arranging coverage. Changing calls cannot interfere with coverage of previously scheduled hours in the family health center or specialty clinics during the post-call period. If the jeopardy call resident takes call, he/she should immediately notify the resident office and any post call clinics that may be affected. (I.e. MFHC, community preceptors, etc.)

Jeopardy call:

Jeopardy call is scheduled as a separate roster. Residents assigned to jeopardy call must be available by beeper to cover in the event of illness or emergency that prevents the on call resident from working. They should remain available to work on a half-hour notice when contacted by

the chief resident or acting chief. A jeopardy call is defined as any call that a resident is unable to perform within 24 hours of the start of the call regardless of the reason. If the jeopardy call resident takes call, he/she should immediately notify the resident office and any post call clinics that may be affected. (I.e. MFHC, community preceptors, etc.) If a jeopardy resident is unable to do a call and knows this >24 hours from the start of the call, it is that resident's responsibility to find a replacement. A "time for time" trade policy for jeopardy call is in effect. Thus, if the jeopardy call person is called in to do a call, the resident who called in sick will repay the call later in the year. This reimbursement call is to be arranged between the two residents involved. If they can't agree, the chief resident will assign the call in a future call schedule. If the jeopardy call person is unable to perform a jeopardy call (for any reason) it remains the jeopardy call person's responsibility to find a replacement. Extended sick leave is to be dealt with on a case-by-case basis. Call in those instances will generally be redistributed throughout the residency without payback.

SENTINEL EVENTS

Hospital and Medical Staff Policies can be found on all hospital computers under the Policy Manager icon and/or the Medical Staff Service Department.



SICK LEAVE

Residents are responsible to notify the Chiefs, Residency Coordinator, Clinic Manager, and Program Director if you are unable to work due to illness or if you have a medical/dental appointment. The coordinator will notify your service and health center for coverage as appropriate. A few hours out during a workday is not considered PTO, but you do need to manage the appropriate notifications so your work is covered. After hours and on weekends, the core faculty member on Family Practice Service should be notified in the event of an emergency absence. Sick days are detracted from your PTO pool; please refer to section on Paid Time Off. If the jeopardy call resident takes call, he/she should immediately notify the residency office and any post call clinics that may be affected (i.e. MFHC, community preceptors, etc.). Sick leave is considered time away from residency training by the ABFM.

Residents may be required to use scheduled vacation time to make up for missed rotations if it is clear that they will exceed the allowed 30 days per academic year away from residency training. This is only allowed during the same academic year. Hospital PTO will not be used in these circumstances. If all vacation time has already been used, then the residency training and the resident's graduation date will be extended.

For COVID days see the *COVID Quarantine Elective* section.

SPECIAL REVIEW POLICY

Policy: It is the policy of Mercy Medical Center Redding (MMCR) to comply with the ACGME requirement for a Special Review Process in order to ensure effective oversight of underperforming Graduate Medical Education programs by the Sponsoring Institution via the DIO and GMEC.

Purpose: The Special Review - GMEC Policy is designed to support the mission and vision of Mercy Medical Center Redding as the institution that sponsors Graduate Medical Education (GME) with the Graduate Medical Education Committee (GMEC). The GMEC is responsible for establishing and implementing policies and procedures regarding the quality of education and the work environment for residents in GME programs. This policy will be reviewed and revised by the GMEC on a regular basis.

This Special Review policy is to ensure effective oversight of underperforming Graduate Medical Education programs by the Sponsoring Institution via the Designated Institutional Official (DIO) and the Graduate Medical Education Committee (GMEC.) Specifically, this policy will (1) establish criteria for identifying underperformance (2) address the procedure to be utilized when a residency/fellowship program undergoes a Special Review and describe Quality improvement goals, corrective actions, and GMEC outcome monitoring. MMCR GMEC has authorized a subcommittee on Special Review which is comprised of the DIO, a peer-selected resident, and at least 3 other individuals appointed by the DIO.

Scope: It is the responsibility of the GMEC, DIO, and Residency Department to comply with this document.

Definitions:

Underperformance by a program can be identified through a wide range of mechanisms. These may include, but are not limited to:

1. Deviations from expected results in standard performance indicators:
 - Program Attrition
 - Program Changes
 - Scholarly Activity
 - Board Pass Rate
 - Clinical Experience
 - Resident or Faculty Survey
 - Milestones
 - Competencies
2. Communications about or complaints against a program indicating potential

egregious or substantive noncompliance with the ACGME Common, specialty specific Program, and/or Institutional Requirements; or noncompliance with institutional policy;

3. A program's inability to demonstrate success in any of the following focus areas:
 - Integration of residents into Institution's Patient Safety Programs;
 - Integration of residents into Institution's Quality Improvement Programs and efforts to reduce Disparities in Health Care Delivery;
 - Establishment and implementation of Supervision policies;
 - Transitions in Care;
 - Duty hours policy and/or fatigue management and mitigation; and
 - Education and monitoring of Professionalism.
4. Self-report by a Program Director or Department Chair.
5. Criteria to identify underperformance also includes program accreditation statuses of initial accreditation with warning, continued accreditation with warning, and any adverse accreditation statuses as described by ACGME policies.

Procedure:

1. **Designation:** When a residency program is identified by the DIO or GMEC to have met the established criteria for designation as an underperforming program, the DIO/Chair of the GMEC shall schedule a Special Review. Special Reviews shall occur within 60 days of a program's designation as 'underperforming.'
2. **Special Review Panel:** Each Special Review shall be conducted by a panel including at least one member of the GMEC who shall serve as Chair of the panel, one additional faculty member, and one resident/fellow. Additional reviewers may be included on the panel as determined by the DIO/GMEC. Panel members shall be from within the Sponsoring Institution and the program since we are a single site sponsoring institution. Panel members/consultant may be from an external source.
3. **Preparation for the Special Review:** The Chair of the Special Review panel, in consultation with the DIO/GMEC and/or other persons as appropriate, shall identify the specific concerns that are to be reviewed as part of the Special Review process. Concerns may range from those that broadly encompass the entire operation of the program to single, specific areas of interest. Based on identified concerns, the program being reviewed may be asked to submit

documentation prior to the actual Special Review that will help the panel gain clarity in its understanding of the identified concerns.

4. **The Special Review:** Materials and data that may be used in the review process shall include:
 - a. the ACGME Common, specialty/subspecialty-specific Program, and Institutional Requirements in effect at the time of the review;
 - b. accreditation letters of notification from the most recent ACGME reviews and progress reports sent to the respective RRC;
 - c. reports from previous internal reviews of the program (if applicable);
 - d. previous annual program evaluations;
 - e. results from internal or external resident surveys, if available; and,
 - f. any other materials the Special Review panel considers necessary and appropriate.

The Special Review panel will conduct interviews with the Program Director, key faculty members, at least one resident from each level of training in the program, and other individuals deemed appropriate by the committee.

5. **Special Review Report:** The Special Review panel shall submit a written report to the DIO and GMEC that includes, at a minimum, a description of the review process and the findings and recommendations of the panel. These shall include a description of the quality improvement goals, any corrective actions designed to address the identified concerns, and the process for GMEC monitoring of outcomes. The GMEC may, at its discretion, choose to modify the Special Review Report before accepting a final version.
6. **Monitoring of Outcomes:** The DIO and GMEC shall monitor outcomes of the Special Review process, including actions taken by the program and/or by the institution with special attention to areas of GMEC oversight, including:
 - a. the ACGME accreditation status of the Sponsoring Institution and its ACGME accredited programs
 - b. the quality of the GME learning and working environment within the Sponsoring Institution, its ACGME-accredited program, and its participating sites;
 - c. the quality of educational experiences in the ACGME accredited

program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty/subspecialty specific Program Requirements;

- d. the ACGME-accredited programs' annual evaluation and improvement activities; and,
- e. all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution.

Focused Special Review Process:

General - When the MMCR Family Medicine program is deemed to have specific concerns that could lead, if not corrected, to a designation as an underperforming program, the **DIO** shall schedule a "Focused -Special Review" process. Examples of areas subject to the use of a "Focused Special Review" process include:

Areas for improvement/concerning trends on ACGME Letter of Notification (LON); Review Committee (RC) citation that does not require additional resources to resolve; notice of ACGME Institutional Accreditation with warning.

As the Focused Special Review is a targeted review of a specific concern(s) of the program, the review process is less involved than a special review. The process for a focused review is described below.

- a. Focused Review Team: Each focused review team, depending on the issue(s) under review, shall be appointed by the DIO, and can include:
 - 1. The Family Medicine Residency Program Director
 - 11. Member(s) of the GMEC
 - 111. Additional participants at the discretion of the Designated Institutional Official (DIO) including the MMCR Chief Medical Officer and a peer selected Resident, if the content of the issues are directly relevant to their responsibilities.
- b. Preparation for Focused Special Review: As this is a focused special review, the DIO in consultation with the Program Director and Chief Medical Officer, will determine a list of documents to review. The MMCR Family Medicine Program will supply the documents deemed necessary within the requested timeline.
- c. Interviews and Document Review: The Focused Special Review Committee may administer surveys, conduct interviews of leadership (service and program), MMCR administrative and clinical support staff, faculty, and residents/fellow as necessary to obtain additional information to render a more direct assessment of the noted findings.
- d. Review Outcomes: The Special Focus Review Committee will generate a focused review report, including any action plans, timelines,

and monitoring procedures. The report will be submitted to the Program Director for review and feedback prior to submission to the GMEC for final review and approval.

- e. The DIO and the GMEC will monitor outcomes of the focused/special review process, including actions taken by the program and/or the institution.
- f. The Program Director will be asked to provide progress report(s) to the GMEC addressing areas of concern found by the panel. The timeframe for progress report(s) will be detailed in the final GMEC approved report and action plans. The GMEC may continue to ask for the program director to report on areas of concern on a regular basis until it is felt that the issues have been resolved.

References: ACGME Institutional Requirements

SUPERVISION AND CALL EXPECTATIONS

Policy: It is the policy of Mercy Medical Center (MMC) to maintain a Resident Supervision process that is consistent with the ACGME Institutional guidelines. There is clinical oversight of all Residents at all times. There is a stepwise supervision process where junior residents are supervised by senior residents with Attending oversight of all residents at all times in all clinical sites. There are mechanisms in place by which residents can report inadequate supervision and accountability in a protected manner that is free from reprisal. To promote oversight of resident supervision while providing for graded authority and responsibility, the program uses direct supervision, indirect supervision, and oversight supervision.

Purpose: To ensure compliance with ACGME Institutional Guidelines on Supervision of residents/fellows in the Family Medical Residency Program. Scope: This policy applies to all Residents participating in ACGME accredited programs at MMCR.

Definitions:

Accreditation Council for Graduate Medical Education (ACGME) – The ACGME is the body responsible for accrediting all graduate medical training programs for physicians in the United States. It is a non-profit council that evaluates and accredits medical residency and internship programs.

Sponsoring Institution – A Sponsoring Institution is an entity that oversees, supports, and administers a certain set of ACGME-accredited residency programs. A governing body (the DIO-Designated Institutional Official and GMEC-Graduate Medical Education Committee) have ultimate authority over the responsibility for graduate medical education (GME) in a Sponsoring Institution.

Direct Supervision – The supervising physician is physically present with the resident and patient.

Indirect Supervision – 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. 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.

Oversight – The supervising physician is available to provide review of procedures and encounters with feedback provided after care is delivered.

Procedure:

Supervision of residents is essential to quality graduate medical education and to the safe care of the patients we serve. Residency is an educational experience that, more than anything else develops judgment and skills and these qualities can only come from responsibility with feedback. Supervision not only involves an assessment of the resident's clinical knowledge and skills, but also interpersonal (professional and patient) skills essential to being an effective doctor.

Supervision (and evaluation) is a requirement of the ACGME, which certifies all graduate medical education programs, and now focuses on competency-based curriculum, which this program has embraced. Each rotation has the defined competencies, which family physicians (and at times family practice residents in this hospital) require to be effective and successful.

Supervision also has regulatory components affecting the supervising physician and his/her obligations as described in Mercy Medical Center Redding's Policy below. All issues of supervision policy are determined at Mercy's Graduate Medical Education Committee, which consists of attending physicians, faculty, and chief resident and administrative representatives (including the Chief Medical Officer).

Attending Supervision Requirements

For MMC attending supervision requirements, please see the Mercy Medical Center Redding Policy and Procedure: Supervision of Resident in Graduate Medical Education Program MS-102.

Resident Call Expectations and Resident-Resident Supervision Requirements

PGY1s on weekend call or night float:

- There is always a PGY2 or PGY3 in house to serve as back-up.
- PGY1s must notify the senior resident in-house of all admissions, discharges, or change in patient status (use the same guidelines we have developed for notifying your attending).
- PGY1s must assist with rounding on weekend mornings under the direction of the senior residents (please work with your senior resident to assure that you do not exceed work hour restrictions).

PGY2/PGY3 on weekend call or night float – supervision responsibilities:

- Monitor all resident admits, discharges, or changes in patient status – this allows you to provide education, back-up, and close the service when necessary.
- Obtain a brief check out from the senior resident checking out on the opposite service regarding service status (i.e., green – open and not busy, yellow – open and busy, red – closed) and information on unstable patients and patients that the PGY1 may need assistance with managing.
- Assist PGY1 with patient care if service becomes excessively busy.

Short Call PGY2/PGY3

- Round and supervise/manage PGY1s who are rounding
- Do not leave the hospital until PGY1 coming off call has completed rounding, checked out and left

Senior Call Requirement/Expectations

Beginning of the Year

- Be aware that PGY1s will all be coming in with different levels of comfort and experience.
- Check in with the intern at the beginning of the shift and ask what their experience/comfort level is. Make sure they know the following:
 - Senior residents are there to help them and answer questions. They should always feel comfortable reaching out.
 - Give them an effective way to contact the senior resident including an ASCOM
- Make sure that PGY1s are not getting overwhelmed and keeping up with work. If they are overwhelmed, help. For example:
 - Scribe for *them* on admissions
 - Take admissions and triages
 - Prep/complete discharges
 - Place orders

Peds

- See all newborns that have not been previously seen by a senior resident
- Computer round on all patients' both newborns and peds
- Round on all Peds patients (ideally the intern should be covering all Peds patients)
- See all Peds admits with the intern
- All plans for Peds admissions should be discussed with the intern before the attending is called

OB

- Computer round on all OB patients
- Prioritize giving the intern intrapartum and GYN patients (better learning)

- Be present for every delivery unless very unusual circumstances
- Be available to discuss plans to triage patients with intern before they call attending
- Be available to supervise and help interns with AROM, FSE placement, IUPC placement
- Be available and attempt to be present for all ED consults

Medicine (IM)/FPS

- Computer round on all patients and physically round on any unstable patients
- Attend all admissions at the beginning of the year
- Review all admission plans at the beginning of the year before intern presents to the attending
- Attend all rapid responses that are called on patients along with intern (intern should also attend all rapids even if it is on a patient the senior is covering)
- Review consult questions and sign out with intern before consultation at the beginning of the year, unless consult is emergent

On-Call Patient Numbers

- The goal for splitting patients should be roughly 60/40 (60% for interns and 40% for seniors)
- Later in the year splitting can be based off the size of lists and the intern's comfort level and if mutually agreeable
- Interns may choose to take more of the list as April approaches
- Senior should make sure that the intern is not getting overwhelmed and help get work/orders/notes completed in a timely manner to assure safe patient care

Call after April

- Interns are on call with a "super senior" – a PGY2/3 working with two PGY1s
- Super Senior Duties:
 - Assures PGY1s are keeping up with workflow and are not getting overwhelmed.
 - Follow all patients and round on all unstable patients and/or any patients the PGY1 is concerned about. Seniors do not have to completely round with attendings with PGY1 (Super Senior rounding is modified based on patient severity and census)
 - Be present for deliveries with attending as needed
 - Discuss/review all Med/FPS admissions with intern
 - Be available to answer questions and assist PGY1 when needed
 - Discuss patient plans of unstable patients with intern after rounds
- Night Super Senior and intern coming off service (Friday and Saturday) are each responsible for writing 10% of notes for OB/Peds. If the service is busy (i.e. laboring patients, triages, etc.), then the senior may do 20%. The oncoming super senior does 20% of medicine (IM)/FPS notes on stable patients (i.e. mom/baby couplets for OB/Peds and stable/placement patients on medicine).
- Due to the need to oversee multiple services, the Super Senior will always be available for assistance throughout the 24 hour call, but will not be the primary physician for managing patient care. PGY1s are responsible for taking calls, doing admits, and

managing the patients on their respective services. Seniors are expected to closely monitor critically ill/sick patients

- There will be no short call. Jeopardy will be scheduled each day.

Supervision criteria for senior residents supervising junior residents during low risk labor:

Attending notification guidelines apply to all levels of residency training, PGY1-PGY3. All deliveries must be supervised by the attending.

Senior residents will be required to meet specific criteria prior to supervising junior residents during low risk labor. They will have to successfully complete their intern year obtaining the intern certificate and advancement to second year status. They will also need to complete specific OB requirements. They will need to have completion of and continued ALSO (Advanced Life Support in Obstetrics) certification. They must have a minimum of 30 vaginal deliveries documented. OB rotation evaluations must be overall satisfactory and include the “By the end of PGY1- competent to supervise first year residents” performance portion to be satisfactory or above.

When first year residents begin participating in the Night Float Obstetrics rotation, they must work closely with the senior resident on the Night Float Medicine Rotation. For the purposes of resident education, supervision requirements, and patient safety, the following procedures must be followed:

- **Senior Residents must be notified of all admissions, pending deliveries, or significant change in patient status. Any item that requires attending notification (see below) also requires communication with the senior resident. The PGY1 resident should provide this notification immediately after evaluating the patient – sooner in emergent or urgent situations**
- **The senior resident must be notified of all pending deliveries and is expected to be present for these deliveries**

It is important for both PGY1 and senior residents to follow these procedures. Failure to follow these procedures may result in cessation of the rotation, possible delay in residency advancement, and loss of future elective time while the rotation is made up. It is expected that all residents will continue to follow the usual attending notification guidelines as outlined below:

Attending Notification Guidelines

Attending notification guidelines identify specific criteria that should trigger a phone call by a resident to an attending physician to inform the attending of a change in patient condition. It is expected that the attending will be notified ASAP, following appropriate assessment and stabilization of the patient if necessary, for the following conditions/ circumstances:

1. All Admissions

2. Any significant change in condition
3. Critical labs that may change the course of action of patient care
4. Rapid Response Team call, Code, cardiac or respiratory arrest
5. Unplanned intervention or transfer to higher level of care
6. Iatrogenic event: serious complication from medical intervention
7. Initiation of restraints
8. Discharge AMA
9. Unanticipated death
10. At request of staff member, patient or family member

In Addition: Obstetrics:

1. All imminent deliveries
2. All non-labor patients after evaluation prior to discharge
3. Any significant or unclear FHT or TOCO that may require urgent evaluation and/or treatment
4. Unexpected blood transfusion pre or post-delivery without prior attending knowledge or instruction
5. Fetal demise

In Addition: Normal Newborns:

1. Any concern or complication
2. Any potential NICU transfer

Note: According to hospital Maternity Service Structure Standards normal newborns must be seen by attending within 18 hrs of delivery

References:

ACGME Institutional Requirements
Mercy Medical Center Redding Policy and Procedure: Supervision of Resident in Graduate Medical Education Program MS-102.

**STATEMENT ON GRADUATE MEDICAL EDUCATION PROGRAM
MERCY MEDICAL CENTER REDDING
SUPERVISION OF A RESIDENT**

1. Attending staff physicians who agree to supervise residents do so under privileges granted to the attending by the medical staff. Residents themselves do not have privileges at Mercy Medical Center Redding. Accordingly, in accepting the attending role, a medical staff member agrees to assume responsibility for appropriate supervision of the residents' patient care. Medical staff members have the option of not participating in resident supervision and/or teaching.
2. The attending physician is responsible to round with the resident team everyday he/she is on service. The attending physician is responsible to review the clinical records of all patients on

his/her service, checking the work-up and progress notes of the residents. This monitoring should include attention to the resident's ability to structure a differential diagnosis and diagnostic plan, review of therapeutic options and approval of all medications and therapies prescribed by the resident. The attending physician is responsible for signing off on the clinical records including discharge summaries of all patients admitted to their service. The attending physician will complete a brief admission note or authenticate the residents' admission note within 24 hours of admission. H&Ps will be authenticated by a preceptor within 24 hours. For all admissions, the attending will review the resident progress notes daily and authenticate or complete a separate note. Individual orders, including orders for initiation or renewal of patient restraints, are monitored by the attending physician. For billing it is the attending physician's responsibility to follow insurance (i.e. Medicare, Medi-Cal, etc.) requirements for supervision and documentation.

3. Procedure performed by the residents must be supervised in accordance with 1st, 2nd, and 3rd year Description of Duties. Obstetrical faculty is responsible to be present for each resident delivery. It is the responsibility of the delivering resident to notify the attending physician of the impending delivery. For billing it is the attending physicians' responsibility to follow insurance (i.e. Medicare, Medi-Cal, etc.) requirements for supervision and documentation.
4. The attending physician is responsible for notifying the program director of any deviation from appropriate professional standards by the resident. This includes any behavioral issues that affect a resident's ability to perform his/her duties in an effective manner. The program director has the ultimate responsibility to assure that residents meet the standards set in this regard. In cooperation with the faculty, he will determine a course of action to correct the problem and provide supervision with any remedial help required.
5. The attending physician agrees to provide each resident with a written evaluation at the end of each rotation. This may include a formal exit interview at the discretion of the attending. The program director or the resident's faculty advisor will meet with each resident at least two times a year to review these evaluations and address any perceived deficits.
6. If a resident physician is asked to see a private patient on an emergency basis, the care that is provided comes under the supervision of the staff physician responsible for the patient. Staff physicians should approve the resident's involvement whenever possible and resume direct patient care as soon as circumstances permit.
7. The attending physician is responsible to report unexcused resident absences to the program director. The program director is responsible for assuring that patient care responsibilities are covered.
8. The Program Director will routinely report to the Medical Executive Committee of the Medical Staff, as defined in the Bylaws, and Board of Directors on the quality of care, treatment, and services being provided as well as any educational needs.

Mercy Medical Center Description of Duties for Residents for PGY1, PGY2, and PGY3

This list represents duties of the resident as delineated in the resident job description. Residents are NOT members of the Medical Staff. Their duties and responsibilities are determined by the Accreditation Council for Graduate Medical Education and by the Residency Review Committee in Family Practice. Residents always function in the hospital and clinics under the authority and direction of the attending physician as defined in the hospital policies, (Criteria for advancement

are contained elsewhere in the resident manual.)

This list is provided for information to the clinical areas.

Procedural Skills:

All procedures performed by a resident require the direct oversight and presence of the attending physician.

Medical Management and Diagnostic (Cognitive):

1. Performs physical examinations of patients, diagnoses diseases and disorders, and prescribes and administers treatment.
2. Assists in surgical operations.
3. Confers with the attending physician on the examination, care, and treatment of patients, and any substantial change in condition.
4. Confers with relatives of patients concerning condition and treatment.
5. Obtains and records medical histories, physical examinations, and progress notes on all patients examined and treated.
6. Makes rounds of the wards and reports on the condition and progress of patients.
7. Exercises medical judgment in the proper diagnosis, care, and treatment of patients in Mercy Medical Center and the Family Practice Clinic.
8. Makes recommendations to the Director of Family Practice Residency on policy matters.
9. Explains the services available at Mercy Medical Center to members of the general public.
10. Orders and interprets laboratory examinations, analyses, and x-rays.
11. Writes medication orders.
12. Assists in the instruction and supervision of nurses, technicians, and personnel assigned for special training.
13. Attends and participates in clinics and staff conferences on the discussion of surgical, medical, and mental conditions of various patients and their diagnoses and treatment.
14. Prepares case histories, reports, and related correspondence.

VENDOR POLICIES

Mercy Medical Center vendor policies can be found on all hospital computers under the Policy Manager icon:



WORK HOURS POLICY

Policy: It is the policy of Mercy Family Health Center to monitor and maintain Clinical and Educational Work Hours consistent with the ACGME Institutional guidelines

Purpose: To ensure compliance with ACGME Institutional guidelines work hour restrictions

Scope: This policy applies to all residents participating in ACGME accredited programs at Mercy Medical Center Redding (MMCR).

Definitions:

Accreditation Council for Graduate Medical Education (ACGME) – The ACGME is the body responsible for accrediting all graduate medical training programs for physicians in the United States. It is a non-profit council that evaluates and accredits medical residency and internship programs.

Sponsoring Institution – A Sponsoring Institution is an entity that oversees, supports, and administers a certain set of ACGME-accredited residency programs. A governing body (the DIO-Designated Institutional Official and GMEC-Graduate Medical Education Committee) have ultimate authority over the responsibility for graduate medical education (GME) in a Sponsoring Institution.

Procedure:

Residency Work Hours are monitored by the residency office. Residency rotation, clinic, conference attendance, and call expectations are structured to meet the work hour restrictions. The chief resident makes the monthly call schedules which are reviewed by the program director to assure compliance. Resident's document hours worked using an on-line program - New Innovations. In the event of a work hour violation, the program director explores the circumstance with the goal of preventing further occurrences. Work hour violation reports are presented to the GMEC.

The Mercy Redding Family Practice Residency Program follows The ACGME Approved Standards for residency work hours:

Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period or rotation (if shorter than 4 weeks), inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Clinical Work and Education

The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.

Residents should have eight hours off between scheduled clinical work and education periods.

There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.

Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Clinical Work and Education Period Length

Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.

Additional patient care responsibilities must not be assigned to a resident during this time.

Clinical and Educational Work Hour Exceptions

In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

- to continue to provide care to a single severely ill or unstable patient;
- humanistic attention to the needs of a patient or family; or,
- to attend unique educational events.

These additional hours of care or education will be counted toward the 80-hour weekly limit.

Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety.

Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.

PGY-1 residents are not permitted to moonlight.

In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.

Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

At-Home Call

Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly 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 clinical work and education, when averaged over four weeks.

At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

References:

ACGME Institutional and Program Requirements

IV: ADDENDUM: Mercy Family Health Center Clinic Manual

THE FAMILY PRACTICE CENTER

Mercy Family Health Center is intended to function like a physician group practice within the parameters of educational and supervisory mandates. Residents develop panels of patients for which they are responsible as the Primary physician, and develop strong relationships as well as provide continuous, comprehensive and compassionate care.

Residents are an integral part of the operations at the health center and participate in the clinic meetings designed to review and improve both the clinical and business performance of the centers.

Whenever a resident's patient is admitted to the hospital, he/she is expected to make daily rounds and work with the in-patient team in clinical decision-making and disposition unless the resident is on an away elective, vacation, or in-patient service that precludes such visits. Each upper level resident will have a number of obstetric patients for whom he/she is responsible throughout the pregnancy, labor and delivery.

OFFICE ADMINISTRATIVE STAFF

Clinic Manager:	Sharon Babcock, RN
Supervisor of Clinic Operations:	Roseanne Flaherty, RN
Administrative Assistant:	Jessica Cardoza-Johanson
Data Coordinator:	Jennifer Curtis
Medical Director:	Steve Namihas, MD
Program Director	Duane Bland, MD

CORE FACULTY

Duane Bland, M.D., Family Physician, Residency Program Director
Jennifer Moranda, MD Family Physician
Steven Namihas, M.D., Family Physician, Assoc. Program Director

Laura DiPaolo, M.D. Family Physician
Jill Shaw, MD Family Physician
Sharon Joo, D.O., M.P.H. Pediatric Hospitalist

Dan Rubanowitz, Ph.D., Behavioral Science Coordinator
Christine Woroniecki, M.A., Behavioral Science
Sharon Babcock, RN, MFHC Clinic Manager

I. CLINIC SCHEDULE AND TIMES

Over the three years of residency training, residents spend progressively more time in their center, with one or two half-day per week in the first year, two or more half-days per week in the second year, and three or more half-days per week during the third year. While office hours may vary somewhat according to the resident's rotation, it is essential that the resident sign out from hospital duties in time to be in the center for the first appointment. When a resident is not in clinic, a fellow resident or faculty will care for his/her patients.

Residents who are not on vacation or away electives are expected to check their Cerner EHR messages daily and their boxes at MFHC at least twice weekly to complete all prescription refills, review lab results, and attend to any messages from patients, staff, or faculty. Appointments are scheduled from 7:45 - 11:15 a.m. and 1:30 - 4:15 p.m. Residents who have completed all other patient care responsibilities are expected to be available in the clinic to see patients up to these times. To assure that all walk-in patients are seen, residents must check with both the preceptor and the desk nurse when leaving the morning clinic before noon or the

afternoon clinic before 5 pm. Residents leaving the clinic early without checking-out as above will be scheduled for additional clinic time.

Processing patients requires 15 minutes of Clerical, RN and MA time. Residents are responsible to be in the clinic, ready to work by 8 am and 1:45 pm without regard to the patient schedule in Cerner. Add-on appointments may be scheduled. For those residents on inpatient rotations, the morning clinic starts at 9:45 a.m. Afternoon clinic starts at 1:45 p.m. Please notify Sharon Babcock, RN, the clinic manager if you are going to be late so arrangements can be made.

Residents will be assigned a maximum number of patients per clinic according to their year of residency training:

PGY1: 3-6

PGY2: 6-8

PGY3: 8-12

Additional patients may be added to the schedule if residents have less than the maximum number of patients scheduled before the start of their clinic. The front office will continue to schedule these “fill-in” appointments until each residents’ schedule reaches the maximum amount indicated above, providing the “fill-in” patient can be seen by the time the fill-in slot is available.

In addition to “fill-in” appointments, residents and faculty are expected to see up to one additional “work-in” patient per clinic to accommodate patients with urgent healthcare needs who would have to be sent to the emergency room. As much as possible, the front office staff will schedule these “work-in” appointments during the beginning of the clinic.

Residents will not be scheduled the day after call. Preceptors are available in the clinic during all times of resident patient care.

GENERAL GUIDELINES

- 1. Confidentiality:** must be maintained by keeping patient information face down and keeping discussions about patients confined to the preceptor room.
- 2. Food and drinks:** are not allowed in patient care areas or the preceptor room. Covered beverages will be allowed in the preceptor area.
- 3. Privacy:** Knock before entering into any patient's room in the clinic and wait for an appropriate response.
- 4. Timeliness:** Residents are expected to attend their clinics regularly and in a timely fashion. If late for any reason, residents must notify the Clinic Manager first (530.225.7836), or the Desk Nurse if the Clinic Manager is unavailable (530.225.7850).
- 5. The Procedure Log:** Use New Innovations to document all procedures.
- 6. Encounter Log:** Use to log patient visit numbers by specific category.

II. CLINICAL AREAS

CLIA OUTPATIENT LABORATORY PROFICIENCY TESTING

All providers at MFHC are required to undergo yearly outpatient laboratory proficiency testing according to the Clinical Laboratory Improvement Amendments (CLIA) established by the US Department of Health and Human Services. This is accomplished during a noon conference review and test. Review materials are provided ahead of time.

CLINIC I and CLINIC II ROTATIONS

A. Service Goals

The Clinic I and Clinic II Rotations are unique and valuable sets of ambulatory family practice and specialty experiences scheduled at MFHC and SCHC. The general goal is to provide the resident with hands-on, longitudinal experience in various specialty areas (Colposcopy, Dermatology, Family & Community Medicine, Sports Medicine, Procedure Clinic, and HIV clinic) as defined below under the supervision of the relevant attending. The resident also develops a higher level of involvement and responsibility for the daily operations of the FHC, seeing acute add-on patients, participating in office management, ancillary services, review of patient care studies, and process improvement.

B. Service Description

The Clinic I (C1) rotations occur once in the PGY II and PGY III years. The Clinic II (C2) rotation occurs twice in the PGY II year. (See the Specialty Clinic descriptions under section D). Each month, the C1 & C2 clinic schedule may vary slightly, so the resident must consult the published schedule.

WARFARIN PROTOCOL

All patients having their warfarin anticoagulation therapy managed at MFHC will be enrolled in a management program to assure proper use and monitoring of this medication.

Providers will refer these patients to the nursing staff who will take the following actions:

1. Enter the patient into the Warfarin Log used to track these patients.
2. Give the patient educational material, including Anticoagulation Patient Education and Warfarin – Effects of Foods and Supplements.
3. Have the patient sign the Warfarin Therapy Agreement which addresses the use of warfarin, including risks and benefits and the need to take as directed and perform blood testing as directed.
4. Initiate a Warfarin Flow Sheet which will be added to the patient's chart. The flow sheet will be used to document
 - each PT/INR result
 - date drawn

- any adjustment made to the warfarin dose
- time for the next draw
- patient current phone number
- patient notification.

The provider will fill the following information on the Warfarin FlowSheet:

1. Indications for warfarin
2. Document why the patient is not a candidate for a NOAC
3. INR goals for therapy
4. Duration of use
5. Initial warfarin dose
6. Time for next PT/ INR draw

Providers will also give patients a six month standing lab order for Protime (PT/INR) with 3x/week maximum frequency

Once patients are entered into the Warfarin Log, the nursing staff will track patients on a weekly basis to see which patients are in need of PT/INR.

The data coordinator will send out a quarterly report to providers so they can verify that all of their patients who take warfarin have been entered into the log. Nursing staff will also receive a copy.

PT/INR lab results will be processed as follows:

1. When patients have their PT/INR drawn, nursing staff will put lab results in the clinic doctor's box along with a pink Warfarin Chart Flag.
2. C1 Clinic doc for review.
3. The C1 Clinic Doc will indicate any warfarin dose adjustments and when the next PT/INR should be drawn.
4. Residents are required to present their Warfarin plan with a core faculty member before giving to the nurses.
5. The lab results will then go to the Nursing Desk.
6. The Desk Nurse will contact the patient and provide instructions for the patient, and document in the Warfarin FlowSheet. Documents will be scanned into patients EMR record.
7. Faculty patient results will be processed in the same fashion, with faculty covering their own patients and those assigned to other faculty members who are unavailable (according to the "Faculty Covering Labs for Faculty" schedule).
8. All patients residing in a care facility must have a physician signed 'MEDICATION ORDERS/CHANGES' sheet that will be faxed to the facility.

All new warfarin patients will be given an Rx for Vitamin K 5 mg to be filled only as advised by a MFHC physician. The following guidelines may be used for the management of significantly elevated warfarin:

1. For PT/INR 5.0 to 8.9 and no significant bleeding: Omit 1 to 2 doses of warfarin; reduce dose 10 to 20 percent; monitor frequently. Alternately consider Vitamin K: 2.5 mg orally.
2. For PT/INR ≥ 9.0 and no significant bleeding: Hold warfarin therapy; give Vitamin K: 5 mg to 10 mg orally; monitor frequently. Resume at lower dose when INR is therapeutic.
3. Serious bleeding, any INR: Hold warfarin and refer to the Emergency Department.

Although warfarin management can be done by phone, patients must be seen for evaluation no less than once every 6 months.

MEDICATION ORDERS/CHANGES
For Patients Residing in Care Facilities

Patient Name:

Date:

Care Facility:

MFHC Medical Record Number:



New Medication:

Dose:



Existing Medication:

Current dose:

Change dose to:

Labs needed and next draw date:

Physician's signature:

Faxed to:

Date faxed:

Initials:

Any questions, please contact us:

Phone (530)225-7800

Fax (530)225-7889

OUTPATIENT ANTICOAGULATION FLOWSHEET

Patient's name: _____ Date of birth: ____/____/____ Medical record #: _____

Indication for anticoagulation (check one): ☐ Atrial fibrillation ☐ Deep vein thrombosis ☐ PE ☐ Mechanical valve ☐ CVA ☐ other

Target International Normalized Ratio (INR)*: ☐ 2.0 to 3.0 ☐ 2.5 to 3.5 ☐ Other: _____

Start date: ____/____/____ Therapy duration: ☐ 3 months ☐ 6 months ☐ 1 year ☐ Indefinite ☐ other: _____

Educational materials and Vitamin K prescription given and contract signed: ☐ Patient

Phone _____

Contact Person Name _____ Phone _____ Facility Name _____ Fax
number

Date:	Current warfarin dose:	INR:	Inter-acting Med:	New warfarin dose:	Next INR:	Patient notified by:	Date Re-Notified:

MANAGEMENT OF SIGNIFICANTLY ELEVATED INR WITH OR WITHOUT BLEEDING	
INR 5.0 to 8.9, no significant bleeding:	Omit 1 to 2 doses; reduce dose 10 to 20 percent; monitor frequently. Alternatively consider vitamin K 2.5 mg orally.
INR $\geq$ 9.0, no significant bleeding:	Hold warfarin therapy; give vitamin K 5 mg orally; monitor frequently. Resume at lower dose when INR is therapeutic.
Serious bleeding, any INR:	Hold warfarin; refer patient to the Emergency Department

Anticoagulation Patient Education:

Your provider has prescribed an **Anticoagulant Medication**. The name of the medication is:
(*provider to circle the medication prescribed*)

Warfarin (Coumadin): an oral tablet

Enoxaparin (Lovenox): a small injection into the skin

Benefits:

Anticoagulant therapy is used to make your blood “thinner” than normal to treat or prevent complications of a disease. “Thinning” the blood dissolves or prevents clots from forming and blocking blood vessels. This decreases the chance of stroke, heart attack and other problems from blocked vessels including in the lungs, brain and legs.

Risks:

Potential complications and side effects of anticoagulant therapy include:

Bruising of the skin

Irritation at the site of injection (Enoxaparin)

Bleeding from the nose, urinary tract, stomach, or colon. Bleeding may also occur in or around the brain (intracranial). In extreme cases, bleeding can result in death.

Contact the clinic staff or seek emergency care immediately if any of the following occur:
severe headache, dizziness, any abnormal bleeding including from the nose, urinary tract, stomach, or rectum.

Your lab values will be monitored frequently while you are on this medication. It is important that the medical staff know what your values are so the medication can be adjusted as needed.

The risk of bleeding can be increased if you are taking certain other medication or herbal products. Make sure that your provider and nurse have a complete list of all the medications and herbal products that you take. **Contact your provider if you begin a new drug or supplement to see if additional testing is necessary.**

See below for some information on drug, food and herbal interactions.

Enoxaparin (Lovenox) : Herb/Nutraceutical: Avoid cat's claw, dong quai, evening primrose, feverfew, garlic, ginger, ginkgo, red clover, horse chestnut, green tea, ginseng (all may increase the risk of bleeding).

Warfarin (Coumadin): Foods high in vitamin K inhibit the anticoagulant effect of warfarin including beef liver, pork liver, green tea, and leafy green vegetables. Do not change dietary habits once stabilized on warfarin therapy. A balanced diet with a consistent intake of vitamin K is essential. Avoid large amounts of alfalfa, asparagus, broccoli, Brussels sprouts, cabbage, cauliflower, green teas, kale, lettuce, spinach, turnip greens, and watercress. It is recommended that the diet contain a CONSISTENT vitamin K content of 70-140 mcg/day. Check with healthcare provider before changing diet.

Warfarin – Effects of Foods and Supplements

What you eat can have an important effect on how much warfarin you need to maintain the proper amount of anticoagulation. You should continue to eat your normal diet. Do not make any major changes such as: starting a weight loss diet, going on an eating binge, begin taking vitamin and mineral supplements, or alter the amount of alcohol you ordinarily drink. If you plan to make a change in your eating or drinking habits, check with your provider first.

Vitamin K can also alter your anticoagulation therapy when taking warfarin. Below is a list of foods high in Vitamin K. TRY NOT TO CHANGE YOUR USUAL CONSUMPTION OF THE FOLLOWING FOODS:

Beef liver	Garbanzo beans	Seaweed
Broccoli	Green tea	Soy milk
Brussels sprouts	Egg yolks	Soybeans
Cabbage	Lentils	Soybean oil
Cauliflower	Lettuce	Soy products
Collard greens	Mung beans	Spinach
Turnip greens	Green Peas	Kale

Some herbs, vitamin mineral supplements, and non-prescription medications may also alter anticoagulation and **probably should be avoided**. Below is a list of some of the common ones used. If you are taking these or any other herbs or supplements discuss them with your doctor, dietitian, or pharmacist.

Chamomile	Feverfew	Garlic
Ginseng	Ginger	Ginkgo
Saw palmetto	St. John's wort	Kava
Vitamin E	Chondroitin Sulfate	Turmeric
Cranberry products	Bilberry	Bromelains
Coenzyme Q-10	Dong quai	Danshen
Horse chestnut	Meadowsweet	Willow

Warfarin Therapy Agreement:

I have been given instructions in the use of warfarin for anticoagulation therapy and have had the opportunity to ask questions and discuss the use of this medication with my physician to my satisfaction.

I understand the risks and benefits of this medication and have received a copy of the Anticoagulation Patient Education.

I understand the importance of my participation in the proper use of this medication.

- Taking prescribed dose as directed
- Having blood work (PT/INR) done on time as ordered by physician
- Notifying my MFHC Provider if I start any new medications or supplements as these may change my warfarin level, requiring additional testing of my PT/INR
- Keeping in close contact with physician concerning blood test results (PT/INR) and possible adjustment of warfarin
- Contacting the clinic for results and further directions if I have not heard from the clinic within a day of having blood work (PT/INR) (All blood draws should be done Monday through Thursday, avoiding the day before a holiday or weekend, unless special arrangements have been made)
- Seeking medical attention for any signs of bleeding, trauma or significant changes
- Keeping my physician informed of my current phone number
- Giving permission to leave messages concerning my PT/INR and warfarin dosage on my answering machine (or my contact person's answering machine) if necessary
- Seeing my primary care doctor a minimum of every six (6) months

I have read, understood and agree to the above.

Patient Signature _____

Guardian Signature _____

Date _____

Witness _____

DUTIES OF THE C1 CLINIC DOCTOR

Revised Aug 2024

1. Overview

- a. The C1 Rotation involves continuity care and specialty clinics, from 8:00 a.m. to 5:00 p.m., Monday - Friday.

- b. In addition to outpatient training, the C1 Clinic Doc is responsible for covering for residents who are away. (AWE, VAC, Rural, Night float physical inbox).
- c. The C1 resident may also be asked to follow-up on issues pertaining to specialty clinics the week after their C1 rotation since the C1 resident is the most familiar with those patients. **For example, follow up on path reports for excisions / biopsies done the week prior even if you are no longer on C1 rotation. See Procedure Clinic below for more information.**

2. Review Cerner Proxy daily

- a. Check the Master Schedule to see which residents are away on rural rotation, away elective, or vacation. These residents should have a **sheet** of paper on their MFHC box indicating the time they will be away. If not, fill out a sheet and put it on their box so the staff will not put Rx refills and other urgent patient requests in their box while they are gone.
- b. **Check and address abnormal labs and other messages on Cerner** using the proxy for residents who are away. Residents on night float are expected to manage their own Cerner messages.
- c. Also check the **clinic box marked C1** into which the office staff put abnormal labs, Rx refills, and other messages.
- d. When the C1 resident finds an abnormal result, he or she may contact the patient, or send a Cerner communication to the staff to schedule a f/u visit with PMD upon their return, or leave the result in the PMD's message box so they can deal with it upon their return, depending on the severity of the result.
- e. If a patient needs to be seen sooner, send a Cerner communication to the Front Office staff to schedule an appointment as indicated.
- f. For all **abnormal PAP tests**, please **send a Cerner message to Jennifer Curtis with instructions for appropriate f/u** so she can track these and assure the patient is scheduled for appropriate follow-up.
- g. If Pap is normal, you may let the patient know through the Cerner patient portal or through staff communication.
- h. **PT/INR results must be addressed as soon as they come in, especially if results are not in therapeutic range.**
Please be diligent in addressing this! Please discuss with core faculty members you plan to address any value outside of therapeutic range. Note any changes to warfarin dose. Indicate the date for follow-up PT/INR. Then give the lab report to the nursing staff who will contact the patient.

2. Review and Refill Prescriptions

- a. The Clinic doc will review all prescriptions refill requests using Cerner proxy for residents who are away. Sometimes Rx refill requests are faxed to our clinic. Complete medication refill requests through Cerner (not on paper) to assure future requests will be sent to our clinic electronically.
- b. For licensed residents with DEA numbers, **controlled medications eRxs** can be sent with the use of Okta Verify for confirmation.

- c. For residents who do not have their DEA number, have the preceptor sign your prescriptions if you are seeing patients in clinic, otherwise, send the eRx to your academic advisor. If you are covering for a resident who is away and needing to refill a Rx for one of their patients, **send the proposal to the academic advisor of that resident for whom you are covering.**
 - d. **Patients must be seen at least once a year** in order to receive non-controlled prescription medications, once every 6 months for warfarin and other anticoagulants, and once every 1-6 months for controlled medications.
 - e. For patients who have not been seen in a timely manner, please consider prescribing a limited quantity to allow time for the patient to be seen without running out. Then send a Cerner message to the MFHC Front Office Staff, "Patient needs routine medication follow-up appointment in 1-4 weeks."
 - f. Do not authorize refills if you are not clear why the patient is taking medication or if the medication is not documented in the record, or if it does not appear to be a MFHC patient. Ask clinic staff or clinic director to assist and clarify as needed.
 - g. Only refill specialty clinic prescriptions if the patient is seen on an ongoing basis in our specialty clinic otherwise have the pharmacy send the refill request to the non-MFHC PMD if the patient has a provider outside of our clinic.
3. **Filling out paperwork for primary care provider**
- a. Occasionally paperwork that cannot wait until the PCP returns in which case the clinic doc must complete this.
 - b. As needed, the C1 resident may have the office staff schedule the patient for an appointment to accomplish this.
 - c. Examples include temporary disability, time off work, release back to work, and use of meds at school.
4. **Specialty Clinic Referrals and Tests**
- a. Determine if referrals to specialty clinics are complete and appropriate. MFHC does not Rx Accutane. Instead, these patients must be referred to Dr. Reece.
 - b. Follow-up on tests ordered during the specialty clinics.
5. **Clinic Responsibility and Practice Management**
- a. The C1 must complete all responsibilities prior to leaving the clinic and must not leave before 4:45 pm. The last work-in can be scheduled up to this time. Check with the attending, nursing, and front office staff before leaving.
 - b. **Collaboration and teamwork are important.** Office staff look to Clinic Doc for taking a lead role in patient care and for being responsible and maintaining a good attitude.
6. **Specialty Clinics and Clinic Times**
- a. Generally, all clinics including specialty clinics start at 8 am or 1:45 pm.
 - b. Residents are asked to be prompt since most of our specialists are volunteering their time.

- c. Continuity patients are limited to allow time for covering other residents' labs and Rx refill requests.
- d. **If specialty clinics are offsite, the C1 resident is expected to return to MFHC later that day to check for PT/INRs and refill prescriptions.** If you are unable to return to clinic, leave your mobile number with the desk nurse so she can contact you with any important patient care issues that can't wait until the next morning.
- e. **If you are unable to attend a specialty clinic or if you are going to be late, please inform Steve Namihas, and the residency office staff ahead of time. Also, please let the specialty clinic supervising physician know ahead of time to prevent them from having to call the residency office to see if you are still coming.**

SPECIALTY CLINICS

Dermatology Clinic (MFHC):

The resident will gain experience in the recognition and proper management of common dermatological problems and perform minor surgical procedures. All extensive surgical procedures are referred to the Minor Surgery Clinic or Plastic Surgery Clinic using the appropriate *paper* referral form. The resident on Dermatology does biopsies while excisions are referred to the Minor Surgery or Plastics. Dr. Reece expects resident clinic notes to be done before he leaves at the end of Derm clinic.

HIV Consultation Clinic (SCHC):

During this clinic, you will learn diagnoses and treatment of HIV disease and its complications. This clinic is conducted at SCHC.

Procedure Clinic (MFHC)

Residents will work with Dr. Namihas, learning how to perform minor surgical procedures common in family medicine, including punch biopsies, shave biopsies, excisions, curettage and desiccation, and a variety of suture and closure techniques. Review the training video prior to the clinic. See Google Drive and look for "Training Videos".

Residents will also be scheduled to perform circumcisions during this clinic. Review proper technique prior to the clinic by reviewing the training video and using Pfenninger's Procedures for Primary Care Physicians, a book which can be found in the preceptor room.

Residents who perform excisions or biopsies during Procedure Clinic (and Derm Clinic) will be sent the pathology report. If the patient is not scheduled for a post-op clinic visit, the resident will contact the patient to inform them of the path results and if needed will refer the patient to the appropriate clinic for definitive

treatment. Dr. Namihas is available to discuss with the resident appropriate follow-up. If the resident who performed the procedure is on vacation or otherwise not available, the resident currently assigned to C1 Clinic doc rotation will be responsible for contacting the patient regarding the path report and making the appropriate referral. The resident will also document in Cerner indicating that the patient was contacted and referral made. A copy of this documentation will be sent to the PCP who will also get a copy of the Procedure Note.

Pediatric Cardiology (MFHC)

During this clinic, the C1 resident will work with a pediatric cardiologist from UCDMC if a resident is not on EOU rotation.

Plastic Surgery Clinic (MFHC)

This clinic occurs once a month and is supervised by Dr. Wong. Residents will learn how to perform complex or cosmetically sensitive minor surgical procedures. Review training videos prior to this clinic.

Practice Management (Private/Group office)

This involves spending two half days at SCHC, with opportunities to meet with the various office staff and physicians to learn how to provide patient care efficiently and effectively in a private practice or group practice setting.

Vas Clinic - SCHC

The SCHC Vasectomy Clinic is precepted by Dr. Namihas or Dr. Jesse Curan. Residents will learn to perform vasectomies including counseling, pre-op exam, and post-op care. Review the training video prior to the clinic to be better prepared.

Tips for Minor Surgery – Procedure Clinic

1. Review minor surgery training videos ahead of time.
2. **Make sure you have created a copy of the procedure note dot phrase prior to the procedure clinic.** The procedure note can be found in the C1 orientation email.
3. Look at the referral sheet in Cerner to see why the patient is being referred to Minor Surgery, lesion location, indication, etc. Look at photos to confirm location.
4. Create a clinic note once the patient checks in. Insert procedure note dot phrase into clinic note.
5. Review medical history in detail looking for specific items which might affect surgery.
 - a. Does the patient have HIV, Hep C, syphilis or any other infectious disease that would be good to know before surgery?
 - b. Does the patient have a pacemaker or any metal plates from ORIF? If so, then bipolar cautery must be used instead of the usual hyfrecator.

- c. Is the patient taking any meds which might increase bleeding risk like aspirin?
 - d. Any allergies to lidocaine, betadine, or adhesives?
- 6. Discuss with the patient all aspects included in the informed consent and make sure the patient is comfortable with risks and agrees.
- 7. **Enter order “Obtain Consent”** and enter the name of the procedure and location such as “excision of skin lesion on right lower back”.
- 8. **Avoid using the term “biopsy” or “sampled” in the consent, procedure report, or billing unless you are actually doing a 3 mm punch biopsy.** If you perform a complete excision of a 1 cm lesion but call it a “biopsy” it implies that you took a 3 mm sample as opposed to a complete excision with an appropriate margin. Reimbursement is significantly greater for the excision compared to 3 mm punch biopsy.
- 9. When completing the procedure note, be sure to use the diagnosis “skin lesion”. You can add “concern for BCC” or “...SCC” or “...melanoma”, but **we cannot make an official diagnosis until the path report comes back, unless the lesion has already been biopsied.** If the wrong diagnosis is made prior to the path report showing the correct diagnosis, the procedure note must be updated to avoid having the wrong diagnosis remain in the chart.
- 10. When measuring the lesion, use a mm ruler which can be found in the drawer in the procedure room. Measure and record the size of the lesion and also the size of the area excised which is usually going to be 4-6 mm wider to allow a proper margin beyond the visible lesion. **For billing purposes, use the size of the excision,** which is typically larger than the size of the lesion.
- 11. When completing the path form, we generally check the box for “evaluation of margins for complete removal” unless only part of the lesion was removed using a 3 mm punch. When filling in the part of the form asking for clinical information, put “concern for BCC or SCC or melanoma” unless you have already biopsied the lesion and you know what it is in which case you would put, “re-excision of BCC” etc. See copy of form attached.
- 12. The 5 digit codes billing can be found in the preceptor room or in the C1 orientation email.
- 13. Consider writing the measured size of the skin lesion on the paper mm ruler and saving it for future reference when writing your procedure note.
- 14. Consider saving the packages of the suture material to assure that you record the correct type and size of suture material in your procedure note.
- 15. If seeing a patient for suture removal for a procedure done at MFHC, the patient does not get charged since suture removal is included in the global fee. Use billing code 99212 for suture removal done for offsite wound closure. Because an E&M code is used, the preceptor does not need to supervise suture removal unless the resident has a question about it.

CLINIC REFERENCE BOOKS AND ONLINE RESOURCES

A library is available in the health center with reference texts and computer resources. Please use it and feel free to suggest new acquisitions. All library resources must remain in the clinic.

CONTINUITY OBSTETRICS EXPERIENCE

A. Goals:

Maternity care experience includes rotations on the OB (Obstetric) hospital service and continuity experience through Mercy Family Health Center. Managing a family medicine continuity maternity patient is considerably different than managing patients who are not yours. Following that patient and child is part of what makes family medicine OB unique. The continuity experience is intended to acquaint the resident with maternal-child care from prenatal care through labor and delivery and the post-partum period. The biopsychosocial elements of a normal pregnancy are important aspects of this experience.

B. Description:

Residents will follow family medicine continuity patient pregnancies over their three years of training. The residency program will track each resident's continuity OB patients and deliveries. Residents will be responsible for reporting to the program all completed deliveries of continuity OB patients.

The primary goal of continuity OB care at the Mercy Family Health Center is for education and exposure to family medicine maternity care through the entire pregnancy including postpartum care of the patient and the newborn. The obstetrics hospital service that is staffed by the family medicine resident physicians provides significant OB inpatient management experience which includes prenatal, intra-partum, and post-partum care but is arguably not the same as the continuity care experience. The program has set education goals as agreed upon by the program director and faculty that constitutes a reasonable family medicine maternity care experience for both inpatient OB service rotations and continuity OB care.

Continuity OB patients will be assigned to residents by clinic staff on a rotating basis -- up to a maximum of 5 patients per resident through their duration of residency dependent on continuity patient care demands at Mercy Family Health Center. Patient assignment will start approximately at the beginning of the 2nd year of training but as soon as the latter half of the first year. When a new pregnant patient enters the clinic or a resident's established continuity patient becomes pregnant, the patient will be evaluated to make sure she is an appropriate low risk OB patient for the Mercy Family Health Center. Otherwise, the patient may require transfer of care to the Shasta Community Maternity Clinic for high risk care if indicated. The resident may continue to be part of the prenatal care if at all possible. If the patient is deemed high risk, the resident may have the option of following along with the obstetricians at the OB clinic and attending the delivery.

Academic advising will provide feedback regarding OB continuity cases and deliveries. Inpatient precepting of all deliveries will occur with contracted community Family Medicine physicians or with the Mercy Medical Center contracted Obstetricians. MFHC prenatal patients will have chart audits every trimester. Cases of interest may be presented at periodic noon OB Conference or Morning Report by the continuity provider or the OB back up partner.

C. Duties:

The following program guidelines outline maternity care goals and duties for the family medicine resident. An education goal for residents of this program is to achieve competency of basic maternity care through the hospital maternity service and continuity care experience. The recommended numbers set forth are not strict to represent competency for providing maternity care. Competency is ultimately determined separately for each individual resident. The overall maternity care education at this program is robust through the hospital maternity service alone.

Current program inpatient service care and clinic care obligations DO NOT allow an individual resident to selectively cease maternity care services once they have achieved the Basic Maternity Care competency level.

	<u>Basic</u> Maternity Care	<u>Comprehensive Maternity</u> Care
Pregnancy-related care	200 hours/2 months	400 hours/4 months
Continuity Deliveries	3	3
Vaginal Deliveries	20	N/A
Total Deliveries	N/A	80

* Mercy Medical Center Redding - current requirement for Family Medicine Obstetrics delivery privileges is a minimum of 50 low to intermediate risk vaginal vertex deliveries.

1. **OB Partners:** Residents will be assigned OB partners generally within their own residency class and in pairs. Occasionally a partner group may need to be comprised of 3 residents. Each resident is expected to assist their OB partner throughout each other's OB continuity patient care needs regardless of any one partner's status in completion of the minimum required numbers -- e.g. an OB partner cannot say they will not cover their partner simply because they feel they have completed their own requirements.
 - a. OB resident partners may be required to serve the purpose of periodic peer review of care through chart audits as well as continuity care clinic visits and deliveries, post- partum care, and newborn care as arranged through the partners. The partner's name(s) should be noted in the chart – the most appropriate locations to

note the OB partner in Cerner are the OB To-Do-List and/or list the OB partner at the top of each visit note.

2. **Continuity Care Case Credit:** Residents must follow a minimum of 3 continuity patients. Two OB antepartum visits will constitute a minimum requirement for continuity of care case credit for patients seen at Mercy Family Health Center or SCHC Maternity Clinic. Each partner may receive credit for a continuity case if they have *each* seen the patient at least 2 times during the pregnancy for antepartum care. Continuity patient triage visits on L&D may count toward overall prenatal care totals but not toward Continuity Care Case credit. This allows courtesy triage of continuity patients on L&D by the on-call resident even if they are not the OB partner.
3. **Continuity Deliveries:** It is expected that each resident will attend a minimum of 3 deliveries of their OB continuity patient panel. Patients should be familiar to an OB partner even if they have not seen the patient in the clinic. A continuity patient who is delivered by a covering resident on the OB service team (who is not the OB partner) at the time of delivery will NOT count as a continuity care delivery for anyone -- this is to encourage a true continuity care experience for resident training and for patients. Such a delivery however, would still count as a general delivery for the covering resident. Residents are encouraged to attend as many of their own continuity patient deliveries as possible - not just the minimums. The continuity care experience is healthy for the patient, educational for residents, and establishes on-going care needs as well as additional patient recruitment for the clinic when a patient has a good care experience to share with friends and family.
4. **Call Coverage for Continuity OB Patients:** For continuity OB patient care, the primary resident physician has a professional responsibility to maintain knowledge of their obstetrical patients' gestational dating and care plans and anticipate needed communication with their OB partner. It is each resident's responsibility to make appropriate arrangements for coverage of their continuity patients with their OB partner. THIS MEANS COMMUNICATING OFTEN WITH THE OB PARTNER WHEN A MATERNITY PATIENT IS APPROACHING TERM. The OB inpatient service team may be utilized in situations when the primary resident physician and the partner are known to be unavailable to attend an expected term delivery or in unanticipated scenarios (i.e. preterm labor). The assigned resident may not be immediately available for such scenarios and the patient should be deemed high-risk. Transfer of care to the inpatient OB team should occur. While not required after transfer of care, the primary assigned resident can still follow through with the care if they are able to do so.
5. **Missed Continuity Deliveries.** Residents will inform the program of any missed continuity deliveries and the reason. Acceptable reasons for a missed delivery may include being on vacation, away elective rotation, post-call status, illness, or off duty and out of town - for the primary resident AND OB partner with prior notice to the OB service team. Other reasons that may be considered acceptable will be determined by the residency program director and faculty on a case by case basis. A trend of repetitive use

of the “off duty and out of town status” for missed deliveries by both the primary resident AND OB partner will be addressed at the discretion of the program director and faculty. See item 9.

6. **Assuming Care or Transfer of Care.** Residents are expected to assume care of their postpartum patient and newborn if they miss the delivery for reasons as stated above but otherwise are available in the following days. If a resident needs to transfer the post-partum care of their patient and newborn to their OB partner or other resident service for appropriate reasons, verbal communication of that transition is expected.

7. **Continuity Newborn Care.** Newborns of continuity OB patients will be cared for by the continuity doctor (unless unavailable for other reasons as stated above) in the hospital as part of the Family Medicine inpatient service. The delivering resident shall inform the Family Medicine attending immediately following delivery and assessment of the newborn.

8. **High Risk Patients.** Prenatal patients who become high risk or with whom questions arise should be appropriately discussed with an OB attending and/or referred to the Shasta Community Maternity clinic for care as appropriate.

9. **Consequences of deviation from established program guidelines.** Guidelines of residency training are intended to establish competency for medical knowledge and independent practice upon completion of the program. This competency includes professionalism. Consequences of deviation from the program guidelines may include additional call duties, reduced elective rotation time, and/or pursuing the due process procedure as outlined in the Residency Handbook.

NEWBORN CARE

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

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

If a patient is not established at MFHC and has not pre-arranged for a MFHC resident/physician to provide newborn care for her baby, then the newborn care is provided by the Pediatric Service, with the Pediatric/Nursery attending as back-up.

OSTEOPATHIC MANIPULATION THERAPY

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

- Osteopathic medical students will only be allowed to do OMT under the direct supervision of osteopathic faculty
- Only osteopathic residents, who have graduated from accredited Osteopathic schools, have had the appropriate basic and applied training to perform OMT, and have demonstrated proficiency in OMT are eligible to perform OMT as residents in our program
- Basic OMT competency is an expectation of graduation from an accredited Osteopathic Medical school. The residency program will assess competency of OMT in practice with completion of a OMT Procedural Competency Assessment Tool (PCAT) for D.O. residents who wish to utilize OMT in clinical practice
- Periodic direct supervision, or more frequently as deemed appropriate, will occur by osteopathic faculty

PRACTICE MANAGEMENT

Residents are an integral part of the operations at the health center and participate in the bi-monthly Clinic Staff / Resident Meetings designed to review and improve both the clinical and business performance of the center, and provide a forum for practice management teaching.

Topics covered in precepting at the Family Practice Center and in Resident/Staff meetings include team functioning, nursing responsibilities, scheduling, billing, chart management, quality control/peer review, laboratory, staffing, and equipment purchase and upkeep.

The experience will primarily focus on Practice Management, with opportunities to meet with the various office staff and physicians to learn how to provide patient care efficiently and effectively in a private practice setting. Residents will learn the following skills:

- Effective billing
- Designing a budget and managing overhead costs
- Collections for various insurance carriers
- Assessing practice staffing needs
- Understanding of office manager function
- Personnel management and labor issues
- Employment law and procedures
- Integrating new technologies into one's practice
- Determining value of patient care in one's community
- Assessing customer satisfaction
- Measuring clinical quality

- Tort liability and risk management
- Office scheduling systems
- Use of computers in practice
- Alternative practice models

(See - Management of Health Systems above).

PROCEDURE REQUIREMENTS AT MFHC

Prior to performing procedures at MFHC, providers will perform and document in the clinic note the following:

1. Review the patient's past medical history and comorbidities and perform a physical examination (including heart and lung exam) to assure no contraindications for the procedure.
2. After discussing and reviewing risks, benefits, and alternatives of the procedure with the patient, write an order in the chart requesting the nurse to have the patient sign a consent form for the procedure(s). The order will specify the name of the procedure(s) and the site(s), if applicable.
3. Perform a surgical "time out" to confirm the following: the patient's identity using two identifiers, the correct procedure, the correct site and side (if applicable), the correct position of the patient, and the correct equipment available in the room. All members of the healthcare team must be in agreement and their names will be listed on the Procedure Note.
4. Document the following in the procedure note: the date, time, pre- and post- procedure diagnosis, attending, resident, anesthesia, findings, complications, EBL, and informed consent, including risks, benefits, and alternatives. If applicable, it will also include sedation, drains, and specimens.

These steps will be taken for the following procedures:

- Nail Removal
- Excision of Lesion
- Curettage & Desiccation
- Punch Biopsy
- Shave Biopsy
- Endometrial Biopsy
- Circumcision
- Colposcopy
- Abscess Incision and Drainage

SKILLED NURSING FACILITY VISITS

Each second and third-year resident is required to follow a minimum of two SNF patients. Dr. Nena Perry coordinates the patient assignments; she and other faculty provide back-up. SNF patients should be seen each month at their facilities. These visits are to be documented in New Innovations. Billing forms will be available as well when the patient is seen with or by an attending. Nena Perry, MD will co-sign Skilled Nursing Facility patient notes

SPECIALTY CLINICS

Dermatology Clinic (MFHC):

You will be working with Dr. Reece. During this outpatient rotation the resident will gain experience in recognition and proper management of common dermatological problems and minor dermatological surgical procedures. The residents see patients and present them to the dermatologist, discuss management and strategy. All extensive surgical procedures are referred to the Minor Surgery Clinic or Plastic Surgery Clinic using the appropriate referral form. The resident on Dermatology does biopsies while excisions are referred to the Minor Surgery Clinic.

HIV Consultation Clinic (SCHC):

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

Procedure Clinic (SCHC)

The SCHC Procedure Clinic is precepted by family physicians. Residents will learn to perform vasectomies and other minor surgical procedures. Training includes counseling, pre-op exam, and post-op care. Training video and model/instruments are available for the resident to review and practice prior to the clinic, provided by Dr. Namihas.

Practice Management (Private office)

This rotation will be incorporated into the master schedule with a half day during the spring PGY2 year.. It will take place at SCHC or a private family physicians office in Redding. The experience will primarily focus on Practice Management, with opportunities to meet with the various office staff and physicians to learn how to provide patient care efficiently and effectively in a private practice setting.

Procedure Clinic (MFHC)

During this clinic, residents will work with either Dr. Namihas or other faculty, learning how to perform minor surgical procedures common in family medicine, including punch biopsies, shave biopsies, excisions, curettage and desiccation and a variety of suture and closure techniques. Training videos are available on the Google Drive for review prior to the clinic.

Plastic Surgery Clinic

This clinic occurs once a month and is supervised by Dr. Wong. Residents will learn how to perform minor surgical procedures which are more complex or cosmetically sensitive.

List of Specialty Clinics:

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

Clinic I Specialty Clinic Monthly Frequency

Dermatology:	1x
HIV:	1x
Procedure Clinic/Plastics:	3x
Vasectomy:	1-3x

Clinic II Specialty Clinic Monthly Frequency

Behavioral Science:	2x
Colposcopy:	5x
Dermatology:	4x
GYN:	2x

Behavioral Science (C2 – MFHC,)

This involves seeing mental health patients with a psychiatrist.

Colposcopy Clinics (C2 – MFHC and SCHC):

Training is provided in the management of abnormal cervical pathology under the supervision of family practice faculty. Procedures include Colposcopy, cryotherapy and LEEP. Colposcopy clinic is held four times per month at Shasta Community Health Center.

Dermatology Clinic (C1, C2 and SpC MFHC):

During this outpatient rotation the resident will gain experience in recognition and proper management of common dermatological problems and minor dermatological surgical procedures. This rotation is a “hands-on” experience that depends on the residents to provide direct care, so residents must be present in the dermatology clinic at all times during this rotation. The residents see patients and present them to the dermatologist, discuss management and strategy. All extensive surgical procedures are referred to the Minor Surgery Clinic. The resident on Dermatology does biopsies while excisions are referred to the Minor Surgery Clinic.

GYN Clinic (C2 – SCHC):

You will be working with community gynecologists at SCHC and private gynecologists’ offices approximately 15 half-days/month developing appropriate experience in, recognition of, and

proper management of common GYN problems and procedures. The resident will see patients and present them to the gynecologist as appropriate to discuss diagnosis and management.

HIV Consultation Clinic (C1 – SCHC):

This clinic is designed to promote resident and community understanding of the diagnosis and treatment of HIV disease and its complications. This clinic is conducted at SCHC and run by Drs. Coe and Shiu. The Resident participates in the work-up and management of HIV patients on a consultative basis developing their knowledge and skills in the management of HIV patients in their own practice.

Vasectomy Clinic (C1 – FPI)

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

VI. POLICIES AND PROCEDURES

ADMISSIONS AND CONTINUITY OF PATIENT CARE

When a resident (or faculty member) sees and admits his/her continuity patient from MFHC, it is the responsibility of that PCP (Primary Care Physician) in the clinic to write admit orders and the admission H&P. If another provider is seeing the patient and the FP service resident is available, the FP service resident should place admit orders and perform the H&P. If the FP service resident is not available, then admit orders and the H&P are to be done by the provider seeing the patient at the clinic. It is the duty of the physician writing the admission orders to contact the FPS preceptor at the time of admission.

Whenever a resident's patient is admitted to the hospital, he/she is expected to make daily rounds and work with the in-patient team in clinical decision-making and disposition unless the resident is on an away elective, vacation, or in-patient service that precludes such visits.

APPEARANCE

A Physician's appearance has a significant impact on how others gauge professional competence, and judge the residency and hospital. Residents will present a professional appearance during working hours in compliance with the Mercy Medical Center Human Resources Policy Manual.

BILLING AND DOCUMENTATION

MFHC Clinic Note Expectations

Policy: Resident Clinical Documentation and Inbox Management Compliance

Policy Statement

The Family Medicine Residency Program is committed to fostering comprehensive, timely, and high-quality patient care. This policy outlines expectations for timely completion of clinical documentation (clinic notes), efficient management of Electronic Health Record (EHR) inbox tasks, and timely completion of residency administrative tasks. Adherence to these standards is crucial for patient safety, accurate billing, continuity of care, and resident professional development. Residents who consistently fail to meet these expectations will be subject to mandatory "Saturday Session" remedial sessions to address identified deficiencies.

Purpose

To ensure timely and accurate clinical documentation within the EHR.

To promote efficient management of resident EHR inboxes.

To provide structured support and remediation for residents struggling to meet documentation and inbox management standards.

To uphold patient safety and quality of care.

To ensure compliance with billing and regulatory requirements.

Policy Details

- **Clinic Note**

Completion Expectations:

Standard: All clinic notes are expected to be completed and signed within forty-eight (48) hours of the patient encounter.

Monitoring: A clinic note completion report will be generated and reviewed on a monthly basis.

Trigger for Saturday Session: If the monthly report identifies any clinic notes outstanding beyond the 48-hour completion window for a resident, that resident will be assigned to Saturday Session. The specific outstanding notes will be documented.

- **EHR Inbox Management**

Expectations:

Standard: All items in a resident's EHR inbox as well as residency administrative tasks are expected to be addressed, completed, or appropriately delegated within seven (7) calendar days of their receipt.

Monitoring: Each resident's EHR inbox will be monitored weekly by their Academic Advisor.

Trigger for Saturday Session: If the weekly monitoring identifies any outstanding EHR inbox items exceeding the 7-day completion window for a resident, or the residency office informs the academic advisor of any outstanding administrative tasks, that resident will be assigned to Saturday Session.

- **Saturday Session Details:**

Assignment: Assignments to Saturday Session will be communicated to the resident by the program coordinator.

Duration: Each Saturday Session session will be four (4) hours in duration, held on a designated Saturday morning.

Purpose: The primary purpose of Saturday Session is to provide dedicated, uninterrupted time for the resident to complete all outstanding clinic notes and address all outstanding EHR inbox items that led to their assignment, as well as any other current outstanding administrative tasks.

Logistics: Saturday Session may be completed in a location of the resident's choosing. The resident assigned to Saturday Session will be responsible for ensuring they have all necessary access and tools. Residents are expected to utilize this time productively to complete their outstanding tasks. No clinical duties, other than the completion of outstanding tasks, will be assigned during Saturday Session hours.

- **Academic Advisor Meeting (First Saturday Session Assignment):**

Any assignment to Saturday Session, regardless of the trigger (clinic notes or EHR inbox), requires a mandatory meeting with the resident's Academic Advisor.

This meeting should occur as soon as reasonably possible after the Saturday Session assignment is communicated, and ideally before the Saturday Session session itself.

The purpose of this meeting is to: Review the specific deficiencies that led to the Saturday Session assignment. Discuss potential barriers or challenges the resident may be experiencing. Develop a personalized action plan for improvement and prevention of future assignments. Offer resources and support as needed (e.g., time management strategies, EHR tips, mentorship).

- **Program Director Review (Second Saturday Session Assignment):**

If a resident is assigned to two (2) Saturday Session sessions within a single academic year, a mandatory meeting will be scheduled with the resident, their Academic Advisor, and the Program Director.

This meeting will serve to:

Re-evaluate the effectiveness of previous interventions.
Discuss the persistent nature of the documentation/inbox management issues.
Explore more intensive remediation strategies, which may include, but are not limited to:
Development of a formal individualized performance improvement plan (PIP).
Increased direct supervision of clinical documentation.
Referral to resident well-being resources.
Review of progress at subsequent Clinical Competency Committee (CCC) meetings.

- **Responsibilities**

Residents: Adhere to all clinic note completion and EHR inbox management standards. actively participate in Saturday Session and work with their Academic Advisor to address deficiencies.
Academic Advisors: Monitor resident EHR inboxes weekly. Meet with residents assigned to Saturday Session and assist in developing improvement plans.
Program Administrator: Generate and review monthly clinic note completion reports.
Communicate Saturday Session assignments.
Program Director: Oversee the implementation and enforcement of this policy. Meet with residents on their second Saturday Session assignment to discuss further remediation strategies.

- **Non-Compliance**

Failure to attend an assigned Saturday Session session or failure to make satisfactory progress on outstanding tasks during Saturday Session will be considered unprofessional behavior and may result in further disciplinary action, up to and including formal remediation plans, imposition of additional training, or in severe cases, dismissal from the program, in accordance with the Residency Program's due process policies.

EVALUATIONS

MFHC conducts a health center patient evaluation annually. The health center staff evaluates the residents on communication (Milestone C-3). The resident on the Clinic I rotation completes an evaluation assessing the quality of the clinic experience, including issues such as staff support, clinical experience, rotation structure. In addition, there are health center management meetings held throughout the year with resident participation, to discuss ongoing clinic issues.

HOLIDAYS AND VACATIONS

The Mercy Family Health Center is closed on hospital holidays. Mercy Medical Center observes these holidays:

- New Year's Day
- Martin Luther King Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving
- Day after Thanksgiving
- Christmas Day

Appropriate "leave forms" must be completed and authorized by the Residency Director and the Clinic Manager at least twelve weeks prior to when the leave is effective.

In addition to scheduled vacation time, residents have two Personal Days (mental health days) each year (July 1-June 30). For more detailed information about Vacation Days and Personal Days, see the above section on PTO. Only one Personal Day is allowed during a given rotation. Scheduled health center clinic time must be covered.

Once a year, however, residents may make one unscheduled clinic change with at least 10 working days' notice so staff can contact patients prior to their appointments. One-time clinic changes may be done for personal time off (PTO), or work reasons: CME, interviewing for a future job, or elective rotation time. Additionally, the change must be approved by Sharon Babcock, RN to make sure that it will not affect clinic staffing. The residency office has the appropriate paperwork. We ask that you begin the paperwork as soon as possible to make these days as smooth as possible for all concerned.

Completing Clinic Work Before Away Time

Before going onto NF, vacation, or away rotations residents must complete important paperwork in their Cerner Inbox and their MFHC physical box in the preceptor room. Not doing so leads to patient complaints, increased work for the C1 clinic doc, and delays in patient care.

To facilitate this, the faculty and chief residents developed the following policy. Before going on vacation, NF, or away rotations, residents are expected to fill out and place on their physical box in the MFHC preceptor room a half-sheet, white form indicating when they plan to leave and return to clinic and verifying that all important paperwork, prescriptions, etc. have been addressed in both their Cerner Inbox and MFHC physical box. **A copy of the form is below.**

Residents who do not follow through as described above, will be provided an initial warning. The second time it occurs will result in an additional assignment to C1 clinic doc duty during their next OP rotation to help reduce the work burden of the scheduled C1 clinic doc.

DR. _____ on:
VACATION
NIGHT FLOAT
RURAL HEALTH
OTHER:
GONE FROM:
BACK TO WORK ON:
Staff: Any important information should go to the C1 Clinic Doc.
Resident: Before leaving clinic, I have addressed all important paperwork, prescriptions, disability paperwork including my:
Resident Initials: _____

MEDICAL STUDENTS

Students rotating through the residency program are coordinated through the residency administrative office in conjunction with the Medical Staff office. Mercy policies regarding medical students may be found under the Policy Manager icon on hospital computer desktops:



Rotation specifics are coordinated through the residency office. We only take senior students, or third year students who have completed core rotations and are from LCME or AOA approved schools. Most clerkships involve two weeks of Family Practice Clinic and two weeks of inpatient care.

Students should always be introduced to the patient by the resident or attending, acknowledging that he/she is a medical student on a clerkship with us, and requesting the patient's consent to have the student participate in his/her care.

History and exam findings must always be discussed with, and verified by, the resident or attending. Student chart entries are not acceptable documentation – supervising residents and attending physicians must provide their own documentation of care.

Tips for Teaching Medical Students

- The resident / preceptor should offer guidance prior to the patient encounter by reviewing the problem and drug list in the chart and making any comments about the patient and the focus of this visit.
- The student will observe your patient encounters. When considered ready, the student will take the lead role of gathering the data. The student should be observed and guided at all times. Once the preceptor is comfortable with the student's ability he/she may then have the student see selected patients before his/her personal evaluation. Introduce the student to the patient and tell the patient you will return.
- Students should write up the encounter using the SOAP format and the preceptor (resident and/or attending) will review and critique the student's note. The preceptor (resident and/or attending) must chart a complete note on the same page as the student and/or dictate on the patient. Attendings must provide resident and patient care oversight as usual.
- Feedback should be given to the student on each case and suggestions for improvement made.
- By the end of the rotation, the residents and preceptors will evaluate and grade the student, using the copy of the school's evaluation form. This should be discussed with the student for their benefit or done after the rotation.
- Students should always be assigned to work with a core faculty member or Mercy Medical Center Resident under the supervision of the attending physician

Evaluation of Medical Students

Immediate feedback (Formative Evaluation) to the student from the supervising resident or attending is always encouraged as part of the learning process.

In addition, the evaluation form provided by the medical school will guide the official feedback process (Summative Evaluation). Dr. Namihas will be responsible for completing MFHC evaluation

Supervision of Medical Students

Patient care provided by medical students, and FNP/PA students shall be under the supervision of clinical teaching faculty. Such care shall be in accordance with the provisions of the Mercy Redding Family Practice Residency Program approved by and in conformity with the Accreditation Council of Graduate Medical Education.

All students documenting in the medical records will indicate their student status (e.g. “MS IV, PA-S, and FNP-S”). Student notes do not suffice for adequate clinical documentation. Student notes must be reviewed, corrected and countersigned by the attending or resident physician providing supervision. **The only documentation by medical students that may be used by the teaching physician is their documentation of the review of systems (ROS) and past family social history (PFSH). The teaching physician may NOT refer to a medical student’s documentation of physician exam findings or medical decision-making in his/her personal note. The teaching physician must verify and re-document the history of present illness (HPI) as well as perform and re-document the physical exam and medical decision-making activities of the visit service. This rule also applies to the documentation by other kinds of students, e.g., physician assistants and nurse practitioners.** The attending or senior resident physician must countersign all orders written by medical students before being accepted by the nursing staff. Students may not perform any examinations, diagnostic tests, procedures (including surgical assisting), or therapy on any patients without the approval of the attending physician. A qualified resident or attending physician must directly supervise all procedures.

Students participating in clerkships with the Mercy Redding Family Practice Residency Program shall be currently enrolled in a school approved by the Liaison Committee on Medical Education, the American Osteopathic Association, or the Commission on Accreditation of Allied Health Education Programs. Medical Students shall provide certification of malpractice and liability coverage from their sponsoring institution prior to clerkship participation, as well as written approval from the Medical School Dean’s Office. The Medical School must have a written agreement with Mercy Medical Center. The School must provide any evaluation requirements.

Student rotations sponsored by the Residency Program will be coordinated and managed by the residency office. All involved **attending physicians and** nursing units will be notified of students and their dates of rotation at Mercy Medical Center Redding prior to their arrival.

LIMITING NURSING CALL BACKS TO PATIENTS

Please limit nursing telephone call backs to patients to no more than 2-3 lines of information and no more than a minute or two time for the phone call.

The following examples of nursing calls are appropriate:

- To let patients know test results were normal or negative
- To see if patients are getting better or responding to treatment
- To inform patients that certain anticipated test results (for transient conditions) were positive, such as COVID or Strep and that they should start treatment as previously discussed or self isolate

In other situations, it is better to have the front office schedule a clinic appointment for a more detailed discussion.

In these cases, please let the front office staff know the reason for the appointment, i.e. "discussing test results" or "discussing treatment".

For more urgent issues that can't wait until the next appointment, the physician should call the patient directly.

The following are examples that would best be handled by scheduling a clinic appointment or having the physician call the patient directly:

- Detailed patient education regarding diet and exercise for a medical condition
- Starting a new medication such as a statin, bisphosphate, anticoagulant, or BP medication
- Positive test result indicating a new chronic diagnosis or serious concern like GI bleed or cancer
- Test result or condition requiring a referral to a specialist
- Any conversation which will require more than 2 minutes or a detailed explanation or any issue that will raise questions which are best answered by the physician

NURSING ORDERS

Verbal nursing orders should only be used in emergency situations. All non-emergent nursing orders must be entered in the appropriate patient electronic health record/chart. After signing the order, the provider should then turn on the white flashing nurse call button in the patient's room, and take the chart to the nurses' station and place it in the chart holder that corresponds to the room number. After completing the order, the nurse will return the chart to the provider or place it in his/her box.

PAP TEST WITHOUT ENDOCERVICAL CELLS

Follow current ASCCP guidelines for Pap testing. Due to periodic changing guidelines, frequent review of the most current recommendations is advised. Formerly, Pap tests without endocervical cells were deemed unacceptable for reliable results. As of 2019, age based criteria and co-testing for HPV allow *some* pap samples without endocervical cells to be acceptable.

Documenting Follow-Up

If a repeat pap test is needed, note in the electronic health record when the patient was contacted and when she was advised to schedule the repeat Pap test. Give a copy of the report to Jennifer Curtis (clinic administration) who will place the report in a reminder file to assure follow-up.

Possible Reasons for No Endocervical Cells On Pap Collection

This may occur in pregnant or postmenopausal patients or may occur due to poor sampling technique.

Proper Sampling Techniques can improve collection of endocervical cells

Broom-like Device

- When using the **broom-like device**, place central bristles into the endocervical canal and **rotate clockwise 5 times**.

Endocervical Brush

- Increases the yield for collecting endocervical cells.
- Place brush so bristles closest to the examiner are inserted to the level of the external cervical os.
- **Rotate 180 degrees in one direction.**
- The endocervical brush sampling should be done **after** using the plastic spatula or the broom-like device to minimize bleeding done during sample collection.

Follow Current Asccp Recommendations

It is important to document “Endocervix clearly visualized and sampled during Pap test” when you document in the patient record.

PATIENT DELIVERED PARTNER THERAPY

Although it is ideal for the partner to be seen by a medical provider before receiving antibiotic treatment, groups such as the AMA recognize the benefits of patient delivered partner therapy (PDPT). The effectiveness of this practice was published in the New England Journal of

Medicine: Golden MR, Whittington WL, Handsfield HH, et al. Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or chlamydia infection *N Engl J Med* 2005;352:676-85. **Be sure if you choose to write a prescription for PDPT at MFHC, please make sure that a separate prescription is written for the patient's partner.** Do not add extra pills onto the patient's prescription. A patient handout to give to a partner explaining Chlamydia and its treatment can be found in the preceptor room at MFHC. The icon for the handout has been placed on the "desktop" screen of the preceptor's computer. Click on the icon and print the handout.

PHONE MESSAGES AND RESPECTING PRIVACY – HIPAA

The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care at their homes, whether through the mail or by phone or in some other manner. In addition, the HIPAA Privacy Rule does not prohibit healthcare providers from leaving messages for patients on their voicemail or answering machines. However, to reasonably safeguard the individual's privacy, covered entities should take care to limit the amount of information disclosed on the answering machine, voicemail or answering service. The HIPAA Privacy Rule permits health care providers to leave a message with a family member or other person who answers the phone when the patient is not home, and to disclose only limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present.

Healthcare providers should also use professional judgment to assure that such disclosures are in the best interest of the individual, and limit the information that is disclosed.

Don't-Leave a message with a third party that provides any identifying details about the patient or their condition, whether speaking on the phone to an individual, via voicemail or an answering machine. This is a breach of confidentiality. When calling a physician about a patient, never leave a message with a third party, on voicemail or an answering service that provides any identifying details about the patient or their condition.

Do-Leave a brief message requesting a call back from the patient. Leave a message for the physician requesting a call back (urgent or not urgent) regarding a patient matter.

In situations where a patient has requested that the healthcare provider communicate with them in a confidential manner, such as by alternative means or at an alternative location, the healthcare provider must accommodate that request, if reasonable. For example, the U.S. Department of Human Services (DHS) considers a request to receive mailings from the healthcare provider in a closed envelope rather than by postcard to be a reasonable request that should be accommodated. Similarly, a request to receive mail from the healthcare provider at a post office box rather than at home, or to receive calls at the office rather than at home are also considered to be reasonable requests, absent extenuating circumstances.

Calls to MMC Operator requesting to talk with a Resident Physician								
Caller: PHYSICIAN			Caller: PATIENT			Caller: LAB/RADIOLOGY with CRITICAL VALUES		
Specific Resident Requested			Mercy Family Health Center Pts			Mercy Family Health Center Pts		
<i>For outside physicians calling operator See resident photo sheet For appropriate ascom numbers</i>			(Includes patients followed by Residents and core faculty including Drs. Bland, Namihas, Moranda, DiPaolo, Shaw and Evans)			(Includes patients followed by Residents and core faculty including Drs. Bland, Namihas, Moranda, DiPaolo, Shaw and Evans)		
			Weekdays between 7:30 am - 5 pm: <i>Instruct patient to call MFHC @ <u>225-7800</u></i>			Weekdays between 7:30 am - 5 pm: <i>Call MFHC @ <u>225-7850</u> or</i>		
			Holidays, Nights, Weekends: <i>Operator to call resident at Ph# 530-215-8386 Leave a message on phone briefly explaining reason for call.</i>			Holidays, Nights, Weekends: <i>Operator to call resident at Ph# 530-215-8386 Leave a message on phone briefly explaining reason for call</i>		
			<u>Shasta Community Health Center Resident Patients</u>			<u>Shasta Community Health Center Resident Patients</u>		
			All days/times: <i>Instruct patient to call SCHC @ <u>246-5710</u> and pick appropriate option</i>			Weekdays between 8 am - 5 pm: <i>Call SCHC @ <u>229-5169</u></i>		
						Holidays, Nights, Weekends: <i>Call SCHC @ <u>246-5710</u> for the after-hours nurse line</i>		
			<u>Shasta Community Health Center Maternity Clinic Patients</u>			<u>Shasta Community Health Center Maternity Clinic Patients</u>		
			<i>Call <u>225-7480</u></i>			<i>Call <u>225-7480</u></i>		
			<u>Not followed at MFHC or by Residents at SCHC:</u> <i>Patient should contact their own physician</i>			<u>Not followed at MFHC or by Residents at SCHC:</u> <i>Contact patient's own physician</i>		
Updated 08/07/2025								

MERCY FAMILY HEALTH PRESCRIPTION REFILL GUIDELINES

Objectives for prescription refills:

1. **Patient access to system.** Starting with preferred primary: pharmacy, EHR patient portal, and phone.
2. **Communication with the pharmacy.** Primarily by fax or electronic prescribing via EHR.
3. **Decision-making.** Primary decision making for refills will be with the physician. All resident patient refill requests shall be done by the patient's assigned primary resident or

the covering clinic doctor resident when the former is otherwise unavailable. Secondary decision making may be done by qualified nursing staff within the outlined guidelines for faculty physician patients (with the exception of controlled substances which should only be determined by the physician).

4. **Notification of the patient.** The pharmacy will be the primary entity to notify the patient regarding a prescription refill. The physician or clinic staff may additionally notify the patient if there is reason for a denied refill due to other needs such as a prolonged interval since the last office evaluation and therefore need for a follow-up patient visit at the clinic.
5. **Documentation.** Done within the EHR by the decision-maker at the time a prescription refill is granted or denied.

General Guidelines:

Please note these are *guidelines only* and not strict rules to supplant good clinical judgment.

1. All schedule II controlled substances require a secure electronic prescription transmission through the EHR.
2. One month prescription of controlled schedule II substances for pain management medications may be given to patients in accordance with the clinic's pain management policy when appropriate for the patient. Schedule II stimulant medications may be prescribed in a similar fashion.
3. Before initiating a controlled substance, a patient must have one of the core faculty members review prior to prescribing. Must check with the patient's continuity doctor before increase the dose.
4. All patients must have a Controlled Substance Agreement signed annually.
5. All other prescriptions e-prescribed via the EHR for the patient to carry to the pharmacy, hand written for the patient.
6. All patients on a chronic prescribed medication (non-controlled substances) should be seen for an office visit evaluation **at least once annually**. Chronic prescribed medication shall include any medication that is taken daily, weekly, or monthly on a regular basis. Some medications and medical conditions may require more frequent visits such as anticoagulation management, chronic substance management with opiates for chronic pain, uncontrolled or poorly controlled diabetes, poorly controlled hypertension, poorly controlled lung disease, etc.
7. Some medications require periodic basic laboratory monitoring via blood and or urine testing. The guidelines are intended to represent a **MINIMUM** expectation of monitoring for some common conditions. Physicians will need to assert clinical judgment for more frequent monitoring on a case-by-case basis.
8. Three months quantity for some prescriptions is appropriate when allowable by insurance and stability of the medical condition for which the medication is being prescribed. Maximum refills for any medication can be up to a year with the exception of schedule II substances which can be no more than 3 months. Some patients on lower than Schedule II controlled substances with clinically stable conditions may be allowed greater than 3 months of refills on a case-by-case basis at the provider's discretion. It is encouraged

however that any patient on a scheduled medication lower than schedule II should be having more frequent office visits than the once annual minimum as stated above.

9. In regards to refill requests on medications in which the patient was last seen a year or more previous, refills may be provided in 30 day supply or less (non-controlled substances) until the patient can be seen for re-evaluation. Some exceptions may apply on a case-by-case basis and should be reviewed with an attending faculty physician.
10. If a patient requests refill on a medication, and based on chart review the patient has not been compliant with taking the medication or may have had care elsewhere and now returning to this clinic, the medication refill should be denied and the patient should be required to have an office visit. This may also apply to an established patient requesting a refill of a medication that is no longer on their active medication list.

Refill Guidelines by medication/condition

These are the MINIMUM requirements as related to refills of prescribed medications. Many conditions need more steps in management to achieve best clinical practice. Please consider patient compliance and stability of their medical condition(s) when making refill decisions. If in doubt, please ask the advice of an attending physician.

All chronic controlled substance medication prescribing requires a CURES check through the California Prescription Drug Monitoring Program (oag.ca.gov/cures) a MINIMUM of every 4 months.

Indicated maximum refill durations include the first prescription (Rx).

Example: 1 month quantity of a medication with 5 refills would account for 6 months of medication.

Medication Types	Common associated medical conditions	Quantity per Rx	Max duration on refills	Minimum Requirements
ACE inhibitors ARBs	Hypertension Heart Disease Renal Disease	Max 3 month supply per fill	1 year	Min annual visit if controlled condition. Min annual Basic Metabolic Panel and urine protein (UA).
Benzodiazepines	Anxiety Acute seizure management	Max 1 month supply per fill*	3 months	Min Q 3 month office visits. * Some historically stable patients may have reason for less frequent visits.
Beta-Blockers	Hypertension Heart Disease Migraine Prophylaxis	Max 3 month supply per fill	1 year	Min annual visit if controlled condition. Min annual Basic Metabolic Panel and urine protein (UA) for HTN or heart disease.

Birth Control	Birth Control Menstrual Dysfunction	Max 3 month supply per fill	1 year	Min annual office visit. Pelvic and pap exam as per national guidelines.
Calcium Channel Blockers	Hypertension Heart Disease Migraine Prophylaxis	Max 3 month supply per fill	1 year	Min annual visit if controlled condition. Min annual Basic Metabolic Panel and urine protein (UA) for HTN or heart disease.
Hypnotics (controlled ex: Ambien, Lunesta, temazepam) (non-controlled ex: diphenhydramin e, doxylamine, trazodone, melatonin)	Insomnia Sleep Disturbances	Max 1 month supply per fill controlled substances 3 month supply non-control led substances* *	6 months	Min Q 6 month office visits.**
Insulin	Diabetes	Max 3 month supply per fill*	1 year	Min Q6 month office visits.* Min Q 6 month HgbA1C and annual urine microalbumin with protein/creat.
Neuropathic (ex: gabapentin, Lyrica, amitriptyline or other TCAs. Please note Lyrica is a schedule V controlled substance.)	Neuropathy Diabetes Idiopathic Post herpetic Neuralgia Chronic pain management	Max 3 month supply per fill	6 months	Min Q 6 month office visits. Labs as per diabetes guidelines if DM diagnosis. Documented monofilament testing annually for diabetics.
Oral diabetes medications	Diabetes	Max 3 month supply per fill*	1 year	Min annual office visit.* Min annual HgbA1C and urine micro-albumin with protein/creat.
Psychotropics (non-controlled antidepressants, anxiolytics such	Depression Anxiety Mood Disorders Psychosis	Max 3 month supply per fill*	1 year	Min Q 6 month office visits. Exceptions for once annual visits may exist for some patients but will be rare in our clinic setting. *

as buspar or hydroxyzine, mood stabilizers, antipsychotics)				1 st gen antipsychotics and some 2 nd generation require blood monitoring – please discuss with an attending physician.
Schedule II controlled substances (ex: opiates, stimulants)	Pain Management ADHD / ADD	Max 1 month supply per fill***	3 months	Min Q 3 month office visits. Min annual urine drug screening for chronic pain management. See chronic pain management policy.
Statins	Hypercholesterolemia	Max 3 month supply per fill	1 year	Min annual office visit. Consider annual Lipid panel but not required. LFTs only if clinically indicated.
Thyroid Replacement	Hypothyroidism	Max 3 month supply per fill	1 year	Min annual office visit. Min TSH lab test annual.

*Some patients with chronic conditions such as diabetes and hypertension may have good control of their conditions which can be seen in their history. A once annual office visit can be appropriate for these patients. This may include some patients that take a benzodiazepine for acute anxiety but historically their usage pattern is very much limited to as needed and as an example a prescription of #20 lorazepam with 1 refill lasts a year. However, please keep in mind our clinic setting which tends towards more patients with uncontrolled conditions and therefore need for more frequent office visits such as quarterly or more frequent. Good clinical judgement is always required.

**Please consider more frequent office visits (such as Q 3 months) than the stated minimum with controlled hypnotics such as Ambien (zolpidem).

***If a treating physician is seeing a patient for controlled substance management whose primary care doctor is otherwise unavailable, it is recommended that only 1 month of a chronic controlled medication be prescribed until the patient can follow-up with their primary doctor. Some exceptions may certainly occur -- acute change in condition or previously well outlined plan of medication adjustment in the prior chart documentation -- but in most cases there should be *no changes in dosing or quantity* of the 1 month supply of a chronic controlled medication by the covering physician.

Medical Marijuana

In agreement with Federal Law, MFHC providers will not write prescriptions for medical marijuana.

PATIENT DISABILITY PAPERWORK

To improve resident education and provide appropriate care for patients, residents will follow the following plan for completion of disability paperwork at MFHC.

1. Patients will need to schedule an in office visit to complete disability paperwork or extension of time off, unless they were just seen for the same condition but did not have the paperwork at that time.
2. Residents will review all disability paperwork with a core faculty member, preferably their academic advisor.
3. If surgery is required, the surgeon will be responsible for completing disability paperwork during the post-op period.
4. If a patient needs their disability extended due to a surgical complication, the surgeon will preferably be responsible for completion of paperwork.

PRODUCTIVITY AND PATIENT PANELS

1. According to the ACGME program requirements:

Each resident's panel of continuity patients must be of sufficient size and diversity to ensure adequate education, as well as patient access and continuity of care. Programs must ensure that each graduate has completed a minimum of 1,000 hours dedicated to caring for FMP patients. Annual patient-sided continuity should be at least 30 percent at the end of the PGY-2 and 40 percent at the end of the PGY-3. Annual resident-sided continuity should be at least 30 percent at the end of the PGY-2 and 40 percent at the end of the PGY-3. Panels must include a minimum of 10 percent pediatric patients (younger than 18 years of age). Panels must include a minimum of 10 percent older adult patients (older than 65 years of age). Panel size and composition for each resident must be regularly assessed and rebalanced as needed. Resident panels should be calculated and readjusted for the appropriate size and diversity (demographics and medical conditions) required for optimal education, patient access, and continuity of care every 12 months. The FMP should utilize team-based coverage for patients when the Family Medicine continuity resident is unavailable. Residents must be able to maintain concurrent commitments to their FMP patients during rotations in other areas/services required by the program.

REFERRAL PROTOCOL

Consultants may refuse referrals if there is lack of pertinent information when patients are referred from MFHC. To address issues of refused referrals, which all clinic providers must follow a referral protocol when obtaining consultation **outside** of the residency clinic.

1. Resident cases must be discussed with the clinic attending physician prior to referral.

2. Residents must complete the Cerner referral form and have the clinic note sent with the referral so the consulting physician will have pertinent information when seeing the patient.
3. The clinic note accompanying the referral note must include the following *pertinent* information:
 - a. The patient's general medical condition and current medical status
 - b. Past medical information
 - c. Medication list
 - d. Prior studies, treatments, and procedures
 - e. Any other information that would assist the consultant

REPORTABLE CASES

California law mandates that all healthcare practitioners make a formal report to the relevant authorities when encountering cases in which there is:

- Suspected Child Abuse: (physical, emotional, neglect, etc.): A telephone report is required immediately or as soon as practically possible to the Child Protective Services Agency of Shasta County, and a follow-up written report is to be made within 36 hours.
- Suspected Dependent Adult/Elder Abuse: (physical, neglect, abandonment, fiduciary, etc.): A telephone report is required immediately or as soon as possible to the Adult Protective Services Agency of Shasta County, and a follow-up report is to be made within two (2) working days.
- Suspected Violent Injury: (homicide, assault, gunshot, stab wound, choking, lacerations, bruises, etc.): A telephone report of previously unreported injuries must be made immediately or as soon as practically possible to the law enforcement agency (i.e. police) in the jurisdiction in which the injury occurred, and a follow-up written report is to be made within two (2) working days.

Note that simple, standardized forms are available in the family health center (MFHC) for use in fulfilling the written reporting requirements described above.

- Reportable Diseases and Conditions: (communicable diseases, STDs, Hepatitis, TBC, etc.): Telephone, fax and/or written reporting of certain diseases to the Shasta County Public Health Department are mandated. A reporting form is available in each family health center and in the hospital that delineates the specific reportable diseases and provides a listing of the required reporting modes (e.g. some diseases require immediate telephone reports, others require reports by phone and by mail, etc.).

SURGICAL ASSISTING POLICY

One of the ways the program provides surgical training is by having residents assist in the surgeries for surgeons involved in teaching our residents. These patients may or may not be seen at MFHC for their primary care. The order of priority for determining which resident will provide this service is as follows:

1. Resident who may be providing primary care for that patient
2. Resident on surgical rotation
3. FPS resident if not the only senior covering inpatient services

At times, the program may not be able to identify a resident who is available to assist surgeons operating on patients not seen at MFHC. The clinic manager or clinic director will make the final determination.

But when patients who do receive their primary care at MFHC are referred for surgery, these patients are the responsibility of the clinic. A surgical assistant will be located using the following order of priority:

1. Primary care provider for that patient
2. Resident on surgical rotation
3. FPS resident if not the only senior covering inpatient services
4. Residents on outpatient rotations

The clinic manager or clinic medical director will make the final determination in cases that are unclear.

SUPERVISION REQUIREMENTS FOR MEDICAL

Dignity Health Graduate Medical Education Uniform Policy for California Hospitals

The requirements effective as of 2004 are more stringent than the Medicare billing requirements. We do not employ the 6-month Medicare exemption. Instead, we must have the *teaching physician present for all billable patient care services performed by unlicensed residents*. This includes all interns and all second year residents who have not received their licenses. More details about supervision guidelines are included below:

As of 2020, California requires a Physician Training License for all R-1 resident physicians in training. This license is obtained within the first 6 months of starting training. Program supervision guidelines will follow appropriate CMS rules, CommonSpirit Health post-graduate training guidelines, and individual program rules of competency based promotion – as determined by the Program Director, Promotions Committee, and Core Faculty.

First Year Residents

- All patients must be verbally presented in detail to the preceptor.

- *All patients seen by PGY1s must be physically seen and evaluated (or spoken to if via telehealth) by the preceptor with care documented in the chart.*
- The preceptor must directly supervise all procedures.

Second and Third Year Residents

- For all PGY2's and PGY3's, having met appropriate program promotions criteria, all patient care must be reviewed with the preceptor during or immediately after each visit.
- E/M codes 99201, 99202, 99211 99212, 99203, and 99213 qualify for an exception and need not be seen by the preceptor unless clinically warranted.
- *The preceptor must see all patients seen by residents (regardless of PGY promotion status) on visits with E/M codes 99204, 99214, 99205 and 99215.*
- *The preceptor must directly supervise all procedures*

Preceptor Responsibilities

- May supervise no more than four residents (or other students) at any given time.
- Must be on site and immediately available.
- Must assume responsibility for care given by residents.
- Must have no other responsibilities at the time of teaching (including supervision of other personnel or clinical duties). An exception will be made when there is only one resident in the clinic, during which time the preceptor may see one patient per hour.
- Must review each patient's care with each resident in a timely manner and appropriately document the extent of his/her participation in the review and direction of care.
- *The preceptor must be present during all critical and key portions of all procedures.*
- Must document his/her role in supervision on the resident's chart note. If the note is dictated, he/she documents on the resident's handwritten note.
- Additional preceptor responsibilities include reviewing residents' charts for proper completion of the Medication List, Problem List, HCM, and Billing.

Approved:

Duane Bland, MD

Residency Director

_____ Date _____

Steve Namihas, MD

Associate Director

_____ Date _____