

# **THE RESIDENT'S MANUAL**

**CHRISTUS SANTA ROSA FAMILY MEDICINE RESIDENCY PROGRAM**

**San Antonio, Texas**

2008-2009

*Revised June 2008  
Curriculum Year 2008-2009  
Available online at <http://www.new-innov.com/>*

# MISSION AND OVERVIEW

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## MISSION AND OVERVIEW

### **Our Heritage**

CHRISTUS Health is sponsored by the Sisters of Charity of the Incarnate Word of Houston and the Sisters of Charity of the Incarnate Word of San Antonio. These orders were founded more than 130 years ago in response to Bishop Claude Marie Dubuis' call: "Our Lord Jesus Christ, suffering in the persons of a multitude of sick and infirm of every kind, seeks relief at your hands."

### **Mission**

- ❖ To extend the healing ministry of Jesus Christ.

### **Core Values**

- ❖ Dignity: Respect for the worth of every person with special concern for the poor and underserved.
- ❖ Integrity: Honesty, justice and consistency in all relationships.
- ❖ Excellency: High Standards of service and performance.
- ❖ Compassion: Service in a spirit of empathy, love and concern.
- ❖ Stewardship: Wise and just use of talents and resources in a collaborative manner

### **What We Are Striving To Do**

The Vision of CHRISTUS Health, a Catholic, faith-based ministry, is to be a leader and advocate in creating exemplary health care services, processes, and structures, improve the health of individuals and of local and global communities so that all may experience God's healing presence and love.

### **Code of Ethics**

The *Code of Ethics* describes the expected behaviors of CHRISTUS and all who serve as Associates and health care partners (physicians, residents, fellows, students, etc.). The *Code of Ethics* calls CHRISTUS, its associates and health care partners to adhere to all system policies, management directives, guidelines, and procedures; to comply with governmental laws and regulations; to meet the standards of JCAHO; and to observe the Catholic moral tradition, the *Ethical and Religious Directives for Catholic Health Care Services* approved by the National Conference of Catholic Bishops, and the relevant requirements of the *Code of Canon Law*. You will receive a copy of the CHRISTUS Health *Code of Ethics* booklet during orientation for your reference and review.

**Organizational Chart here**

## **Decision Making Process**

CHRISTUS Santa Rosa Health Care is a faith-based healthcare system. The decisions we make are grounded in the mission and values that CHRISTUS Santa Rosa Health Care strives to embody. When called upon to make significant decisions – either in teams, on committees or individually – the process helps guide us in the CHRISTUS Santa Rosa Health Care spirit.

### **1. Define/clarify the issue or problem.**

- ❖ Have all aspects of the issue been considered?
- ❖ Is any information missing?

### **2. Who will be affected by the decision?**

- ❖ Persons we serve
- ❖ Our community
- ❖ CHRISTUS Health Associates

How will they be affected?

Have they been consulted?

### **3. Consider the issue or problem in light of:**

- ❖ CHRISTUS Health Mission
- ❖ CHRISTUS Health Core Values and Vision
- ❖ CHRISTUS Health Associate Covenant
- ❖ CHRISTUS Health Code of Ethics

Are they promoted or hindered? Is there any conflict of values?

### **4. Develop possible solutions/courses of action**

### **5. Quiet Reflection and Prayer**

- ❖ Have I listened to the viewpoints of others?
- ❖ Have I opened myself to God's Spirit?
- ❖ Are there further insights to share?

### **6. Make the decision and determine the course of action.**

- ❖ Is there a sense of peace with the decision?

## **FAMILY MEDICINE RESIDENCY PROGRAM MISSION STATEMENT**

The CHRISTUS Santa Rosa Family Medicine Residency Program will provide an environment which protects and fosters the scholarship of discovery, integration of knowledge, teaching, and application. This program will provide comprehensive, longitudinal, family oriented training, using both didactic instruction and supervised clinical experience, to produce residents who are proficient at providing high quality, cost-effective, compassionate care to their patients. Graduates of the residency program will have gained the appropriate knowledge base, clinical skills and caring attitude to enable them to deal with their patients' physical and emotional needs. They will be able to serve as the reference point and coordinator of subspecialty care and act as the source of information and reassurance for those patients who enter the world of highly

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technical, tertiary care medicine.

## **CORE COMPETENCIES DEFINITIONS**

1. **Patient care** - Residents provide compassionate care that is effective for the promotion of health, prevention, treatment and care at the end of life.
2. **Medical knowledge** - Residents demonstrate knowledge of biomedical, clinical and social science, and applies that knowledge effectively to patient care.
3. **Systems based knowledge** - Residents demonstrate an understanding of both contexts and systems in which health care is provided and applies their knowledge to improve and optimize health care.
4. **Practice based learning** - Residents use evidence and methods to investigate, evaluate and improve patient care practices.
5. **Interpersonal and communication skills** - Resident demonstrates these skills to establish and maintain professional and therapeutic relationships with patients, and healthcare team.
6. **Professionalism** - Residents demonstrate behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to diversity, and responsible attitudes.

## **PROGRAM GOALS**

Responsibilities of the training program are:

### **Patient Care**

- To provide comprehensive training in all areas of family medicine, allowing residents to practice the full scope of family medicine, while emphasizing continuity in longitudinal patient exposure.
- To teach the principles of preventive medicine, health maintenance and wellness, enabling residents to be a source of health promotion for the community that they serve.
- To validate caring and continuity as the cornerstones of family medicine.
- To emphasize the importance of the patient's nuclear family extended family and social support systems in health and disease.
- To address the health care needs of the under served population of Texas.

### **Medical Knowledge**

- To provide a knowledge base that prepares the resident to sit for and excel in the American Board of Family Medicine certification exam.

- To emphasize the importance of ongoing, lifelong continuing medical education.
- To teach the mechanisms necessary to critically evaluate the medical literature, including training in the retrieval of medical information, the evaluation and discussion of medical literature and the clinical application of this evaluation into the resident's future medical practice.
- To teach the process of research design in the development and completion of a research project.

**Systems based knowledge:**

- To provide appropriate sub-specialty training and exposure in those areas of medicine which will equip residents with the knowledge base and clinical expertise needed to make intelligent, timely and appropriate subspecialty consultations and referrals.
- To expose the resident to the high technological arena of tertiary care medicine so that the resident will be able to serve as provider and coordinator of care and patient advocate in that complex world.
- To teach through didactic instruction and longitudinal exposure the role of government agencies, regulatory bodies, managed care companies and insurers in health, illness and long-term care for patients.
- To teach residents the facets of practice in a world of managed care where containment and quality cost must coexist in captivated delivery systems.
- To emphasize a multi-disciplinary approach to the delivery of health care, including the role of mid-level practitioners and ancillary personnel.
- To teach the problem-oriented approach to patient care and record keeping.

**Practice based learning:**

- To expose the resident to the high technological arena of tertiary care medicine so that the resident will be able to serve as provider and coordinator of care and patient advocate in that complex world.
- To provide access to areas of special interest through provision of sufficient elective time and topics, allowing residents the option of customizing their education to fulfill their vision of family medicine.
- To educate the resident about the dynamic changes in the health care system and to enhance his or her ability to adapt to these changes and develop with the future practice of family medicine.
- To emphasize the positive aspects of quality assurance, practice guidelines and utilization review as educational tools that help improve quality of care.

**Interpersonal & communication skills:**

- To instruct the resident in the development of professional communication and presentation skills.

**Professionalism:**

- To teach the importance of personal balance in maintaining physical, emotional, spiritual and family well-being.

**PROGRAM REQUIREMENTS FOR RESIDENCY EDUCATION IN**  
**FAMILY MEDICINE**

**PGY-I YEAR OVERVIEW**

During the PGY-I year, most of the rotations are inpatient services. The outpatient clinic practice consists of one to two half days of clinic per week. First year residents will start to build a panel of patients and families whom they will see throughout their residency training with patient visits totaling +150. Building doctor-patient relationships, learning the systems of the hospitals and the clinic, and exploring how to effectively and beneficially utilize one's medical and world knowledge are key elements of this and each year of the program. Also during this year, the residents will begin the research and scholarly activity projects required for the residency program.

**PGY-II YEAR OVERVIEW**

During the PGY-II year, the residents will have more time, two to three half days, in the Family Health Center to see their patient population, while rotating on both inpatient and outpatient services. Second year residents will build upon their first year knowledge & experience and will begin to have more teaching responsibilities for medical students and first-year residents. The data collection phase of the research projects is to be completed this year.

**PGY-III YEAR OVERVIEW**

During the PGY-III year, the residents will have several weeks of elective time to experience a variety of practice environments of interest to the individual resident. They will have three to four half days in the Family Health Center to complete the 1650 patient visits for the combined three years. The third year residents will be expected to demonstrate more supervisory and administrative responsibility while continuing to develop teaching expertise with medical students, residents, and the community. All research projects will be completed and presented at the end of this year.

# **PROGRAM REQUIREMENTS ACGME & ABFM**

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# PROGRAM REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION IN

## FAMILY MEDICINE

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\*Bold text indicates new changes in the program requirements effective July 2006\*

## **PROGRAM REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION IN FAMILY MEDICINE**

### **I. Introduction**

#### **A. Duration of Training**

Residencies in family medicine must offer 3 years of training after graduation from medical school which must be structured so that a coherent, integrated, and progressive educational program with progressive resident responsibility is ensured.

#### **B. Scope of Training**

The goal of the family medicine program is to produce fully competent physicians capable of providing high quality care to their patients.

Family medicine residency programs should provide opportunity for the residents to learn in multiple settings (e.g., hospital, ambulatory settings, emergency rooms, home and long-term care facilities), those skills and procedures that are within the scope of family medicine. Residencies should prepare residents for lifelong learning.

### **II. Institutions**

#### **A. Sponsoring Institution**

**One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions.**

Since family medicine programs are dependent in part on other specialties for the training of residents, the ability and commitment of the institution to fulfill these requirements must be documented. Instruction in the other specialties must be conducted by faculty with appropriate expertise. There must be agreement with specialists in other areas/services regarding the requirement that residents maintain concurrent commitment to their patients in the Family Medicine Center (FMC) during these rotations.

## **B. Participating Institutions**

- 1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.** These affiliated hospitals may not be at such a distance from the primary teaching sites that they require excessive travel time or otherwise fragment the educational experience.
  - a) Participation by an institution that provides 6 months or more of the 36 months of training in the program must be approved by the Residency Review Committee (RRC).
  - b) A program must provide all of the facilities required for the education of residents in sufficient proximity to the primary hospital, particularly the Family Medicine Center(s), to allow for the efficient functioning of the educational program.
  
- 2. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**
  - a) **Identify the faculty who will assume both educational and supervisory responsibilities for residents;**
  - b) **Specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
  - c) **Specify the duration and content of the educational experience; and**
  - d) **State the policies and procedures that will govern resident education during the assignment.**

These documents should be available for review by the site visitor each time there is a site visit and review of the program.

### III. Program Personnel and Resources

#### A. Program Director

1. **There must be a single Program Director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either Program Director or department chair, the Program Director should promptly notify the executive director of the RRC through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education (ACGME).**
2. **The Program Director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the Program Director and faculty are essential to maintaining such an appropriate continuity of leadership.**
  - a) The Program Director must devote sufficient time to the residency program (i.e., at least 1400 hours per year spent in resident administration, resident teaching, resident precepting and attending duties, and exclusive of time spent in direct patient care without the presence of residents).
  - b) The Program Director must have a specific time commitment to patient care to maintain his or her clinical skills.
  - c) In a program that operates in the 1-2 format with year one in a related three year program, there must be a separate site director at the remote site unless that is where the Program Director is based.
3. **Qualifications of the Program Director are as follows:**
  - a) **The Program Director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.** The director should be actively involved in the care of patients and, prior to assuming this position, must have had a minimum of 2 years full-time professional activity in family medicine as well as teaching experience in a family medicine residency.
  - b) **The Program Director must be currently certified in the specialty by the American Board of Family Medicine, or possess qualifications judged to be acceptable by the RRC.**

- c) **The Program Director must be appointed in good standing and based at the primary teaching site.**
- d) An acting or interim director should be similarly qualified.

**4. Responsibilities of the Program Director are as follows:**

- a) The Program Director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating **institutions**.
- b) **The director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System (WebADS).**
- c) **The Program Director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**
- d) The Program Director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:
  - (1) The addition or deletion of a participating institution;
  - (2) A change in the format of the educational program;
  - (3) A change in the approved resident complement for those specialties that approve resident complement;
  - (4) A major curricular change; and
  - (5) The use of a new or significantly remodeled FMC.

**On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.**

With the exception of changes in the FMC, proposed changes should be initially submitted electronically through the Web ADS, with follow-up correspondence sent to the Executive Director of the RRC. A special packet of information must be submitted in support of proposals for use of a new FMC.

## **B. Faculty**

- 1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program**, including family physician faculty with admitting privileges in the hospital(s) where the FMC patients are hospitalized. The faculty must comprise teachers with the diversified interests and expertise necessary to meet the various training responsibilities of the program.
  
- 2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member.**

a) Faculty/resident ratio

There must be a sufficient number of hours contributed by a critical mass of family physician faculty to prevent fragmentation of the learning experience. In addition to the Program Director, there must be at least one full-time equivalent (FTE) family physician faculty for each 6 residents in the program. Any program in operation must have at least 2 family physician faculty members, including the director, regardless of resident complement. By the time a program offers all three years of training with the required minimum number of resident positions (i.e., 4-4-4) at least one of the additional family physician faculty must be full time. A full-time commitment is at least 1400 hours per year devoted to the residency spent in resident administration, resident teaching, resident precepting and attending duties, exclusive of time spent in direct patient care without the presence of residents. As the resident complement increases beyond the minimally acceptable size, additional full-time family physician faculty will be needed to provide a core group of family physician faculty. Where part-time faculty members are utilized, there must be evidence of sufficient continuity of teaching and supervision.

b) Faculty Role Modeling

As is expected of the Program Director, the family physician faculty should have a specific time commitment to patient care in order to enable them to maintain their clinical skills. Some family physician teaching staff must see patients in each of the FMC's that are used in the program to serve as role models for the residents.

c) Faculty Development

There must be a structured program of faculty development that involves regularly scheduled faculty development activities. Since family medicine faculty should demonstrate the same skills, knowledge and attitudes that are expected of the residents, faculty skill development and update are an important part of faculty development. The program is expected to address clinical, educational, administrative, leadership, research and behavioral components of faculty performance. It should involve at least annual departmental, residency and individual faculty needs assessments, and may include structured group and individual activities.

Although clinical update is important, faculty development should provide experience to improve teaching in all settings. This should be measurable and documented in evaluations by residents.

d) Other Specialists

Physicians in the other specialties must devote sufficient time to teaching and supervising and to providing consultation to the family medicine residents in order to ensure that the program's goals for their specialty areas are accomplished.

**3. Qualifications of the physician faculty are as follows:**

**a) The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**

Programs should assess the skills and credentials of individual faculty to perform procedures and care for the types of problems they will be teaching the residents. The professional

skills of the teacher should always be documented as up to date and meeting the criteria for credentials and privileges of the primary hospital.

- b) **The physician faculty must be certified in the specialty by the American Board of Family Medicine, or possess qualifications judged to be acceptable by the RRC.**
  - c) **The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**
4. **The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty and an active research component must be included in each program. *Scholarship* is defined as the following:**
- a) **The scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**
  - b) The scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;
  - c) The scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society **meetings.**

**Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.**

5. **Qualifications of the non-physician faculty are as follows:**
- a) **Non-physician faculty must be appropriately qualified in their field.**
  - b) **Non-physician faculty must possess appropriate institutional appointments.**

### C. Other Program Personnel

**Additional necessary professional, technical, and clerical personnel must be provided to support the program.**

Additional teaching staff will be needed to provide training in areas such as behavioral science, nutrition, and the use of drugs and their interaction. Mid-level practitioners may teach family medicine residents in conjunction with other faculty in required curricular areas. Their qualifications should be provided.

### D. Resources

**The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.**

#### 1. Patient Population

Each residency must document that a patient population of adequate size, representing a broad spectrum of problems, with sufficient age and gender distribution is cared for in the hospital, in the FMC, and in institutions for long-term care or rehabilitation, as appropriate. A sufficient number of inpatients must be available to provide a broad spectrum of problems in any area listed in these requirements that involves inpatient care. The disease spectrum available for resident education must be that which is common to the general community. These experiences must include the opportunity to attain expertise in emergency initial care of unusual or life-threatening problems.

#### 2. Family Medicine Center

##### a) Introduction

The primary setting for training in the knowledge, skills, and attitudes of family medicine is the model office or FMC, where each resident must provide continuing, comprehensive care to a panel of patient families. The facility must be clearly and significantly identified as a *Family Medicine Center* and must be for the exclusive use of the residency program.

When other learners (e.g., fellows, residents from other specialties, medical students, nurses and other medical professionals) are being trained by family physicians in the FMC, additional personnel and space may be required. Efficiency and education of the family medicine residents must not be compromised by the training of other health care professionals.

A FMC must be in operation on the date the program begins. If a

temporary center is used, it must meet these same criteria. If multiple centers are used for training, each must be approved by the RRC and must meet the same criteria as the primary center. Although all of the FMCs used in a program need not provide the same experiences, the experiences at each must comply with the requirements. That is, the experiences may differ in various tracks within a program.

Programs that involve training in Community, Migrant Health Centers (C/MHCs) or Federally Qualified Health Centers (FQHC) must provide assurance that these facilities meet the criteria for an FMC, as outlined below, unless an exception is approved by the RRC.

b) Administration and Staffing

The Program Director must have control of the educational activities that occur in the FMC, and of the activities of the support personnel. The Program Director must participate in and provide leadership for decisions affecting the FMC. The FMC must be appropriately staffed with nurses, technicians, clerks, administrative personnel and other health professionals to ensure efficiency of operation and adequate support for patient care and educational requirements.

c) Location and Access

The FMC must be close enough to the hospital to require minimal travel time. It may not be at such a distance as to require travel that interferes with the residents' educational opportunities, efficiency, or patient care responsibility.

When a FMC is at such a distance from the primary hospital that the patients are hospitalized elsewhere, the Program Director must demonstrate how the residents will efficiently maintain continuity for their patients at one hospital while having their required rotations at another; the extent to which residents are able to participate in the program's educational activities, such as required conferences must also be demonstrated.

The facility must be designed to ensure adequate accessibility and efficient patient flow, be environmentally sensitive to patient care needs, and provide appropriate access and accommodations for the handicapped.

d) Required Areas

- (1) There must be a reception area, waiting room and business office that are consistent with the patient care and educational needs of the

residency.

- (2) A suitable resident work space and a separate private area for resident precepting, as well as an office library resource must be included. Computer access to electronic resources must be readily available for all of the physicians practicing in the Center.
- (3) Two examining rooms that are large enough to accommodate the teaching and patient care activities of the program must be available for each physician faculty member and resident when they are providing patient care. Additional space for individual and small group counseling must be included.
- (4) Faculty offices, if not in the FMC, must be immediately adjacent to the Center.
- (5) The program must have a conference room that is conveniently accessible and readily available, as needed, and that is large enough to accommodate the full program. In programs using multiple FMCs, there must be a meeting room within or immediately adjacent to each FMC that is large enough for smaller meetings of all faculty, residents, and staff who work at that site.

e) Equipment

There must be the following:

- (1) Appropriate diagnostic and therapeutic equipment in the FMC to meet the basic needs of an efficient and up-to-date family medicine office, and an acceptable educational program for residents in family medicine;
- (2) Diagnostic laboratory and imaging services in the FMC or nearby to afford prompt and convenient access by patients and residents for patient care and education; tests commonly included as waived or point-of-service (e.g., urine analysis and wet mounts) and which may require efficiency of physician interpretation should be available within the FMC.

f) Patient Access to the Family Medicine Center

The FMC must be available for patient services at times commensurate

with community medical standards and practice. When the Center is not open, there must be a well-organized plan that ensures continuing access to the patient's personal physician or a designated family physician from the FMC.

Patients of the FMC must receive education and direction as to how they may obtain access to their physician or a substitute family physician for continuity of care during the hours the Center is closed. Patients should have access to printed policies and procedures of the Center.

g) Record System

The FMC patients' records should be maintained in the FMC. However, if a centralized record system is used, easy and prompt accessibility of the records of the FMC patients must be ensured at all times, i.e., during and after hours. The record system should be designed to provide information on patient care and the residents' experience. These records must be well maintained, legible, and up-to-date, and should identify the patient's primary physician.

The record system must provide the data needed for patient care audit and chart review of all facets of family care, including care rendered in the FMC, in the hospital, at home, by telephone, through consultations, and by other institutions.

The resident must be taught patterns of record keeping that incorporate a comprehensive information base, retrievable documentation of all aspects of care, and mechanisms for promotion of health maintenance and quality assessment of care. This should include experience with electronic medical records.

Programs not currently using an electronic medical record system should document their plans for conversion to one in the near future.

h) Source of Income

The fiscal operation of the FMC must reflect an appropriate balance between education and service. Service demands must not adversely affect educational objectives. A plan should be in place to ensure fiscal stability of the program.

3. Inpatient Facilities

The inpatient facilities must be of sufficient size and have an adequate number of occupied teaching beds to ensure an appropriate patient load and variety of

problems for the education of the number of residents and other learners on the services. Inpatient facilities must also provide sufficient physical, human, and educational resources for training in family medicine. In determining the adequacy of the number of occupied beds in the primary and affiliated hospitals, the patient census, the types of patients and their availability for residency education, and the range of support services will be considered.

The medical staff should be organized so that family physician members may participate in appropriate hospital governance activities on a basis equivalent to that of physicians in other specialties. Where a hospital is departmentalized, there must be a clinical department of family medicine.

#### 4. Library Services

Residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions, so that a collection of appropriate texts and journals is accessible in each institution participating in a residency program. These must be readily available during nights and weekends. Library services must include the electronic retrieval of information from medical databases.

### IV. Resident Appointments

#### A. Eligibility Criteria

**The Program Director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.**

#### B. Number of Residents

The RRC may approve the number of residents based upon established written criteria that include the adequacy of the resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.

##### 1. RRC Approval

The letters of notification from the RRC for Family Medicine do not specify the number of approved positions. Each time a program undergoes review by the RRC, the Committee will evaluate the program's resources in relation to the number of resident positions reported by the program.

## 2. Minimum size

To provide adequate peer interaction, a program should offer at least 4 positions at each level and should retain, on average, a minimum complement of 12 residents. Except for periods of transition, the program should offer the same number of positions for each of the 3 levels of training. A family medicine program should endeavor not to function as a transitional year program. Those who are appointed to the program should be those who intend to complete the 3 years of training in the program. Those accepted into the first year of training should be assured of a position for the full 3 years, barring the development of grounds for dismissal. The degree of resident attrition and the presence of a critical mass of residents are factors that will be considered by the RRC in the evaluation of a program.

## 3. Special Tracks

In certain cases, such as programs that operate in the 1-2 format, the RRC may approve a smaller resident complement, but this should include at least one resident at each of the second and third levels or two residents at one of these levels to ensure peer interaction. Such programs are encouraged to arrange opportunities for the residents to interact with other residents (e.g., through didactic sessions at the parent program).

## 4. Change in Complement

The RRC allows programs to implement a modest change in complement without formal RRC review. Those desiring to change the resident complement between full program reviews should enter the information regarding the proposed change electronically into the ACGME Web Accreditation Data System (WebADS) for administrative review. If it is determined that RRC review is required, additional information may be requested.

## C. Resident Transfers

**To determine the appropriate level of education for residents who are transferring from another residency program, the Program Director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A Program Director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.**

## D. Fellows and Other Students

**The appointment of fellows and other specialty residents or students, must not dilute or detract from the educational opportunities available to regularly appointed residents.**

## V. Program Curriculum

### A. Program Design

#### 1. Format

**The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.** Programs in family medicine may propose using a non-rotational format for providing resident education in areas usually taught in block rotations. Such proposals must demonstrate that residents will have all of the required experiences during their training, including experience with an adequate volume and mix of patients, the required continuity of care experiences, and appropriate faculty supervision.

Programs using multiple sites and/or tracks must describe a core curriculum of at least 20 months in which all residents participate. If the remaining months are offered at more than one site, they may differ but each must comply with the requirements.

#### 2. Goals and Objectives

**The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.** This should include specific methodologies for teaching and competency-based evaluation.

### B. Specialty Curriculum

**The program must possess a well-organized and effective curriculum, both academic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.**

The curricula and plans for all rotations and experiences must be developed by the family medicine faculty, and family physicians must be utilized to the fullest

extent as teachers consistent with their experience, training, and current competence. Other specialty faculty may be consulted for assistance, as needed.

A variety of teaching methods may be used for residents to achieve the cognitive knowledge, psychomotor skills, interpersonal skills, professional attitudes, and practical experiences and competence required of physicians in the care of patients and families. Didactic as well as clinical learning opportunities must be provided as part of the curriculum, but the majority of time for any required experience should be clinical. Although lectures and workshops are helpful and may be required to supplement learning, residency experiences should include direct practice experience to enable residents to learn how to implement principles learned in the didactic curriculum.

Residents must receive training to perform those clinical procedures required for their future practices in the ambulatory and hospital environments. The residency director and family medicine faculty should develop a list of procedural competencies required for completion by all residents in the program prior to their graduation. This list must be based on the anticipated practice needs of all family medicine residents. In creating this list, the faculty should consider the current practices of program graduates, national data regarding procedural care in family medicine, and the needs of the community to be served.

The program must clearly document that each curricular area is addressed in a defined experience with measurable outcomes. If the curriculum involves longitudinal arrangements for some curricular elements, the program must clearly document how each resident is assured of the required educational experience.

## 1. Principles of Family Medicine

### a) Continuity of Care

Continuity of care is a recognized core value of the specialty of family medicine and must be a priority in each program. Continuity may pertain to individuals or to the practice in its entirety.

Resident panels must also include continuity patients requiring home care and care in long-term care facilities to provide each resident with continuity experience in those settings. Nursing home experience must consist of at least 2 patients as a continuity experience over a minimum of 24 consecutive months, in addition to that which residents might experience as part of a rotation.

Additionally, each resident must perform at least 2 home visits

with at least one being for an older adult continuity patient. Faculty must supervise all home and nursing home care either on site or by prompt chart review as is appropriate based on a resident's level of expertise and competence.

In order to coordinate and integrate each patient's care and to optimize each resident's continuity training, the program must require that each resident maintain continuity of responsibility for some of his or her patients in all settings when such patients require urgent or emergent care, home care, long-term care, hospitalization or consultation with other providers. Continuity of responsibility should include active involvement in management and treatment decisions, and interactive communications about management and treatment decisions. In the second and third years of residency, when other curricular responsibilities temporarily prevent a resident from providing continuity of responsibility in any of these settings, that continuity must be provided by another resident or faculty from the program (i.e., the inpatient team or the physician on-call for the practice). When a substitute physician, such as a member of a family medicine team, is involved in continuity of care, there must be a mechanism to transfer information clearly and expeditiously to the primary continuity physician.

b) Family-Oriented Comprehensive Care

Comprehensive care is important for the welfare of the patients as they function in the family, the community, and in the health care system. Principles of comprehensive care for patients include physician availability, accessibility, efficiency, and continuity.

The family physician assumes responsibility for the total health care of the individual and family, taking into account social, behavioral, economic, cultural, and biologic dimensions. Therefore, residents must learn to demonstrate cultural competence in caring for patients from varied ethnic and cultural backgrounds.

Residents must be given the opportunity to achieve high levels of competence in health maintenance and in disease and problem management, and to develop attitudes that reflect expertise in comprehensive patient management and education.

The program must provide the opportunity for residents to acquire knowledge and experience in the provision of longitudinal health care to families, including assisting them in coping with serious

illness and loss, and in promoting family mechanisms to maintain wellness of its members.

Essential elements to be integrated into the teaching of family care to residents include for the individual patient:

Health assessment, health maintenance, preventive care, acute and chronic illness and injury, rehabilitation, behavioral counseling, health education, and human sexuality.

Elements for the family include:

family structure and dynamics, genetic counseling, family development, family planning, child rearing and education, aging, end of life issues, epidemiology of illness in families, the role of family in illness care, family counseling and education, nutrition, and safety.

## 2. Family Medicine Center Experience

### a) Orientation

First-year residents must have an orientation period in the FMC to introduce the comprehensive approach to health care and to promote resident identity as a family physician. They must also have a regular patient care experience in the FMC throughout this first year.

### b) Faculty Supervision

Whenever residents are performing clinical duties in the FMC, there must be an appropriate number of family physician faculty who, without other obligations, are engaged in active teaching and supervision of the residents. The appropriate number of faculty must be determined in relation to the level of training of the residents, the number of patients being seen in a clinic session, and the competency of the residents. In general, there should be at least one supervising family physician faculty member who is freed of all other activities for every 4 residents working in the clinic at any given time. If only one resident is seeing patients in the FMC, a single faculty member may be engaged in other activities to a maximum of 50%, but the teaching and supervision of the resident must take priority. Faculty time involved with medical students and other learners under the faculty's clinical supervision should not dilute the supervision of residents.

c) Patient Care Experience

It must be the goal of the program that residents be scheduled to see their own patients (i.e., those with whom they have developed an on-going doctor-patient relationship). The program must document the availability of a stable patient population in the FMC of sufficient number and variety to provide all residents with an adequate experience in the comprehensiveness of the specialty. It should be documented that each resident has experience with all age groups having adequate gender distribution, in volumes sufficient to achieve competency in all aspects of family medicine.

Residents' FMC assignments over the course of 3 years of training must include progressive responsibility for increased patient visit volume and visit efficiency. The 3-year FMC experience for each resident must include a documented total of at least 1650 patient visits, with at least 150 visits occurring in the first year. The number of patient visits from resident participation at a second FMC and/or from other longitudinal clinics may be counted toward the total number of patient visits if these visits are supervised by family physician faculty and if it can be documented that these patients are seen in continuity by the residents.

Since continuity requires following patients to other settings, the continuity visit numbers may also include patients from the residents' panels who are seen at home, at long-term care sites, and patients seen in an OB continuity care setting.

In addition to meeting the minimum number of patient encounters noted above, the program must document that by the end of the third year, each resident has achieved the essential skills/competencies of both productivity and efficiency necessary to meet the expectations of independent clinical practice. This documentation must provide evidence of a variety of patient demographics and diseases, as well as a commitment to continuity.

d) FMC Continuity and Accessibility

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

experience continuity of care.

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

The FMC should provide a continuity experience for the residents, and ensure continuity of care and access for the patient. The FMC staffing, scheduling system, and hours of operation must assure FMC patients access to healthcare by their primary provider or the FMC health care team as backup if the primary resident is unavailable. The program must document that each resident has provided continuity of care in the FMC. This may be accomplished in a number of ways, and may include monitoring the number or percentage of visits by continuity patients to their continuity physician. The practice must also ensure 24 hour accessibility to care for their patients.

### 3. Medical/ Surgical Experiences

The program should implement a plan to ensure that residents retain their identity and commitment to the principles and philosophic attitudes of family medicine throughout the training program, particularly while they rotate on other specialty services.

Residents must have on-site supervision by an appropriately-qualified member of the program's faculty when the services or procedures needed exceed the capability of the most senior supervising resident, or when qualified senior residents are unavailable for supervision of more junior residents.

While the content of a rotation is more important than the time assigned to it, it is necessary to establish guidelines for the allocation of time segments to provide an objective measure of the opportunity provided for residents to achieve the cognitive knowledge, psychomotor skills, attitudinal orientation, and practical experience required of a family physician in each of the curricular elements. Time spent in the FMC seeing continuity patients may not be included when calculating the duration of the specialty rotations for which duration is specified. It is understood, however, that FMC time is included in the required rotations that are specified in months. A program that uses a longitudinal format instead of a block

rotation must document 100 hours of structured experience in lieu of a block month.

#### 4. Inpatient Experiences for Family Medicine Residents

The resident must develop the skills required to treat male and female patients of all ages and those having various levels of severity of illness who are hospitalized. In-patient care must include the continuity of care of adults and children from the residency patient panel. This inpatient experience should occur primarily on a family medicine or an internal medicine service, and must involve teaching and role-modeling by family physician faculty. Daily faculty rounds must occur to assure appropriate supervision and teaching. Each resident must also receive clinical experience caring for hospitalized patients in special care units including medical intensive care, coronary care, and newborn nursery. Additional experience will occur on other inpatient services.

The length, breadth, and intensity of the experience must assure that every resident becomes competent diagnosing and managing common inpatient problems of adults and children as seen by the family physician. Residents must demonstrate direct management of patients to include initial evaluation, admission of patients, repeat evaluations, development of a plan of care, ongoing management, performance of basic procedures of medicine, appropriate consultation and discharge planning and continuing care. Residents must demonstrate the ability to write appropriate admitting orders and to modify them daily according to changes in the patient's condition.

Residents are expected to maintain involvement in the care of their hospitalized patients whenever possible, even if the program uses the services of hospitalists. The residency must foster a team system that ensures continuity of care from the patient's perspective when the primary resident is unable to be present in both inpatient and outpatient settings. The continuity resident is expected to communicate daily with the hospital resident, and to provide long-term continuity care after discharge.

The residency must define and monitor the most common medical problems cared for by family physicians in the hospital where inpatient experience takes place. Residents must receive ample clinical experience in caring for these problems. There must also be a didactic curriculum that covers these common medical problems. This list of common diagnoses should be generally consistent with national data that are published about family medicine. The program must document how the residents' skills are progressing from care that is dependent on supervision by faculty toward unsupervised, independent care at the time of graduation. The

program must also document the residents' competency in providing supervision to others in a learning environment.

Upon completion of training, residents must be competent to provide hospital care. Assessment of resident hospital practice must be included in the required semiannual resident evaluation.

By the conclusion of the residency, residents should have developed competence in knowledge, attitudes, and skills to care independently for hospitalized patients without supervision, and to utilize appropriate consultation by other specialists. Procedural skill documentation should indicate when the resident is capable of independent performance of the procedure.

5. Specific Curricular Areas:

Experiences may be accomplished in block format or longitudinally. If in block format, no more than 5 half-days a week may be used for anything other than the focused experience. This includes time in the FMC, nursing home, and lectures. For each month that is accomplished longitudinally, the program must document 100 hours of structured experience.

a) Adult Medicine

The adult medicine experience must total 8 months, of which 6 are inpatient. The following curricular areas must be included in either longitudinal or block format:

Cardiovascular, neurology, endocrinology, pulmonology, gastroenterology, rheumatology, infectious, nephrology, and hematology diseases.

Residents must receive instruction and clinical experience in the prevention, counseling, detection, diagnosis and treatment of gender-specific diseases in women and men

(1) Women's Health

This must include structured experience in non-obstetrical, non-gynecologic care of women that deals with the study of gender differences and the diversity of women's health needs throughout the life cycle. Woman's health conditions are those that are unique or more common to women, including disorders

that differ in presentation or treatment of women.

(2) Inpatient

While caring for adults on the inpatient service, each resident is expected to manage the care of at least 5 patients, on average, at any one time. Senior residents who are functioning in a supervisory role may have direct responsibility for a smaller number of patients.

(3) Intensive Care

All residents must be taught skills in the care of critically ill patients. The program must document that during the 3 years of training, each resident has managed a substantial portion of the care for at least 15 critically ill patients.

(4) The Older Patient

Educational experiences must be in both common and complex clinical problems of older patients. The training must include the appropriate preventive modalities, functional assessment, the physiologic and psychological aspects of senescence, as well as the socio-cultural parameters of the patients and their greater community. The residents must have supervised clinical experiences dealing with common acute and chronic diseases of aging. The resident must learn about, and practically apply, a multidisciplinary approach to the care of older patients in the hospital, the FMC, the long-term care facility, and the home.

This experience must result in the competence of residents in preventive healthcare, promotion of independent living, and maximizing function and quality of life. Residents must develop competency in assessing and meeting the healthcare needs of declining elders, episodic, illness-related care, delivery of healthcare in the home, FMC, hospital, and long-term facility, and end-of-life care.

b) Care of Neonates, Infants, Children, and Adolescents

Residents must complete 4 months of structured experience in the care of infants, children and adolescents. The time must include experience in the following areas: neonates, infant care (both well-baby and ill), hospitalized children, ambulatory pediatrics, emergency care of children

and adolescent medicine. This may include experience gained on the Family Medicine Inpatient Service, in the emergency department, in the pediatric hospital and clinic, and experience in nursery care associated with OB experience, provided that appropriate documentation of such experience is maintained for each resident.

This experience must involve teaching and role modeling by family medicine faculty in the care of newborns and sick children. Residents and faculty must provide continuity of responsibility for hospitalized infants and children from their Family Medicine Center patient panel.

c) Maternity and Gynecologic Care

(1) Maternity Care

(a) Duration & Scope

There must be a minimum of 2 months of experience in maternity care, including the principles and techniques of prenatal care, management of labor and delivery, and postpartum care. Each resident must become capable of managing a normal pregnancy and delivery. Residents must be provided instruction in the biological and psychosocial impacts on a woman and her family of pregnancy, delivery, and care of the newborn. All programs must demonstrate that each resident acquires competency in the common problems of prenatal and postnatal care.

Residents must be trained in the recognition and initial management of the high-risk prenatal patient, including consultation and referral. Additionally, the residents must be taught to recognize and manage complications and emergencies in pregnancy, labor, and delivery. Residents also must receive training in genetic counseling. When appropriate for the resident's future practice and patient care, the resident must be trained in the management of the high-risk prenatal patient.

(b) Total Deliveries

Each resident must perform a minimum of 40 deliveries over the 3-year program, of which a minimum of ten must be continuity deliveries. At least 30 of the total deliveries must be vaginal deliveries. Two residents may be given credit for the same delivery if one of those residents is

supervising. The experience of each resident must be documented as to the role played in the delivery.

(c) Continuity Deliveries

For the minimum of ten continuity patient deliveries, each resident must assume responsibility for provision of antenatal, natal, and postnatal care during their three years of training. Whenever possible, these patients should be derived from the residents' panels of patients in the FMC. Where this is not possible, the continuity experiences may be met at other clinical sites with appropriate supervision. A list of these patients must be available in the resident's file.

(d) Supervision of Labor and Delivery

The program must have at least one family physician faculty who is engaged in providing these services and who can participate in supervising the residents and serving as a role model for them. Supervision of labor and delivery care must be immediately available. For deliveries, and for labor when risk factors are present, there must be on-site supervision in the delivery suite/labor deck by a family physician, an obstetrician, a senior resident in an ACGME obstetrics residency, a certified nurse midwife, or a third year family medicine resident who has had sufficient delivery experience. If supervision is provided by anyone other than a faculty member, it must be documented that this supervisor has had sufficient maternity care experience to function competently in this capacity, and this documentation should include the criteria used to make this determination. When the supervisor of the resident is reliant on others for c-section or emergency procedures outside the scope of his or her practice, procedures for emergency consultative relationships and back-up must be documented. Specific details must be available on the service at all times. In judging the adequacy of the supervision provided by a resident, the Program Director must consider the year of training and previous obstetrical experience, and documented competency of the supervising resident. When a resident provides the direct supervision, there must be on-site physician faculty supervision immediately available in the hospital.

(e) Advanced OB Elective

The program must make available additional training in maternity care as an elective within the 36-month curriculum. This elective experience must include high-risk maternity care, including the opportunity for residents to develop technical proficiency in appropriate operative procedures that may form a part of their future practice. Programs should provide training in ALSO, or similar advanced obstetrical training, for those residents interested in providing maternity care in their future practices.

(2) Gynecology

There must be one month of structured curriculum in gynecology. All residents must be trained to competency in normal gynecological examinations, gynecological cancer screening, preventive health care in women, common STD's and infections, reproductive and hormonal physiology including fertility, family planning, contraception, options counseling for unintended pregnancy, pelvic floor dysfunction, and disorders of menstruation, perimenopause, and post menopause, including osteoporosis. In addition, the program should provide adequate instruction and clinical experience in issues of sexual health, management of breast disorders, and management of cervical disease. Residents should become competent in the performance of appropriate procedures.

This structured experience must be in addition to the routine gynecologic care of continuity patients in the FMC and the gynecological experience gained during family medicine call. However, special sessions dedicated to gynecological care may be arranged in the FMC, provided that the residency can document that these sessions are used for gynecology care above and beyond the routine care provided by the continuity physicians.

d) Care of the Surgical Patient

The program must provide instruction with special emphasis on the diagnosis and management of surgical disorders and emergencies and the appropriate and timely referral of surgical cases for specialized care.

Residents must be taught to appreciate the varieties of surgical treatments and the potential risks associated with them to enable them to

give proper advice, explanation, and emotional support to patients and their families. The residents should also be taught to recognize conditions that are preferably managed on an elective basis.

The program must provide all residents with training in preoperative and postoperative care, basic surgical principles, asepsis, handling of tissue, and technical skills to assist the surgeon in the operating room. The residents should develop technical proficiency in those specific surgical procedures that family physicians may be called on to perform.

(1) General Surgery

The residents must be required to participate in a structured experience in general surgery of at least 2 months, including ambulatory care (non-inpatient care: e.g., surgical centers, emergency room and physician offices), operating room experience, and post-operative experience. Experiences in general surgery must be designed to provide opportunity for residents to achieve competency in the diagnosis and management of a wide variety of common surgical problems typically cared for by family physicians. Experiences are usually expected to be with general surgeons. If non-generalist surgeons are used for this experience, the Program Director must explain how this experience exposes residents to common surgical problems.

If surgical experience occurs in conjunction with a family medicine or internal medicine service, the program must document how each resident meets the required surgical experience.

(2) Surgical Subspecialties

In addition to the general surgery experience, residents must have adequately structured hands-on educational experiences in the following subspecialty areas: otorhinolaryngology, to include oral health, urology, and ophthalmology. This must be in addition to resident experience with continuity patients during routine care in FMC and must involve disorders that are commonly seen in a family physician's office.

e) Musculoskeletal and Sports Medicine

All residents must have 2 months experience in the care of patients with orthopedic and musculoskeletal problems, including experience in sports

medicine. The curriculum should include non-articular rheumatic disorders, infectious, supportive and degenerative arthritic conditions, acquired and congenital abnormalities of bones and joints, musculoskeletal and connective tissue disorders, evaluation and management of common sprains, fractures and dislocations, preventive care, rehabilitation and restorative function. Clinical experience should include acute evaluation of musculoskeletal trauma and acute pain syndromes. Sports medicine must be a clear and separate curriculum within the 2-month/200 hours of experience and must include non-orthopedic aspects of sports medicine with emphasis on care of athletes of all ages, both genders, and persons active or anticipating exercise activities. The care of the athlete includes performance of pre-participation sports physicals, assessment of common injuries, knowledge of treatment and rehabilitation. Both curricula must include performance of procedures common in the evaluation and care of orthopedic and sports medicine patients and participation in the rehabilitation required for these patients. These include interpretation of radiographs, aspiration and injection of joints, splinting and casting.

f) Emergency Care

There must be a structured educational experience to train the resident to deliver emergency care that includes didactic teaching, skills training, and clinical experience in caring for patients of all ages with acute illnesses and injuries in an emergency care setting. Residents should receive structured skills training in all standard current life support skills (e.g. ACLS and PALS), and should learn procedures for both trauma and medical emergencies in patients of all ages.

This clinical experience should encompass 200 hours of emergency medicine training.

The setting used for this training must offer the full spectrum of emergency services, and on-site faculty supervision must be available at all times. Suitable facilities and adequate support personnel must be present for resident training. The patients seen by family medicine residents should be representative of the patient population served by the emergency care facility overall.

g) Human Behavior and Mental Health

Knowledge and skills in this area should be acquired through a program in which behavioral science and psychiatry are integrated with all disciplines throughout the resident s' total educational experience. Training should be accomplished primarily in an outpatient setting through a combination of

longitudinal experiences and didactic sessions. Intensive short-term experiences in facilities devoted to the care of chronically ill patients should be limited. There must be faculty who are specifically designated for this curricular component who have the training and experience necessary to apply modern behavioral and psychiatric principles to the care of the undifferentiated patient.

Family physicians, psychiatrists, and behavioral scientists should be involved in teaching this curricular component.

There must be instruction and development of skills in the diagnosis and management of psychiatric disorders in children and adults, emotional aspects of non-psychiatric disorders, psychopharmacology, alcoholism and other substance abuse, the physician/patient relationship, patient interviewing skills, and counseling skills. This should include videotaping of resident/patient encounters or direct faculty observation for assessment of each resident's competency in interpersonal skills. This will require sufficient faculty who participate on an on-going basis in the program, and in the FMC, in particular.

h) Community Medicine

Each residency must have a structured curriculum in community medicine, including didactic and some experiential components. There must be a process to evaluate this curriculum and to document appropriate resident skill attainment in this area. The curriculum should include:

- (1) Assessment of risks for abuse, neglect, and family and community violence
- (2) Reportable communicable disease
- (3) Population epidemiology, and the interpretation of public health statistical information
- (4) Environmental illness and injury
- (5) School health
- (6) Disease prevention through immunization strategies
- (7) Disaster responsiveness
- (8) community-based disease screening, prevention, health promotion
- (9) Factors associated with differential health status among sub populations, including racial, geographic, or socioeconomic health disparities, and the role of family physicians in reducing such gaps

The program should also require that each resident participate in clinical experiences in community medicine including:

- (10) Experience in using community resources appropriately for

individual patients who have unmet medical or social support needs;

- (11) structured interaction with the public health system;
- (12) occupational medicine including disability determination; employee health and job-related illness and injury;
- (13) experience in community health assessment;
- (14) experience in developing programs to address community health priorities;
- (15) community-based health education of children and adults;

i) Care of the Skin

All residents must be exposed to diagnosis and management of common dermatologic conditions. These must include, but not be limited to, viral, bacterial, allergic and fungal infections, ulcers, rashes, malignant and pre-malignant skin lesions, and dermatologic manifestations of system disease. This training should include experience in the surgical excision of skin lesions and performance of other dermatologic procedures with supervision by a physician with documented competence in this area. This may include experience gained in the FMC, provided that appropriate documentation is maintained for each resident.

j) Diagnostic Imaging and Nuclear Medicine

The program must provide the residents with a structured opportunity to learn the appropriate application of techniques and specialty consultations in the diagnostic imaging and nuclear medicine therapy of organs and body systems. Instruction should include the limitations and risks attendant to these techniques. The format of the instruction should be adapted to the resources available, but must include radiographic film/diagnostic imaging interpretation and nuclear medicine therapy pertinent to family medicine.

k) Conferences

Conferences should reflect the needs of the program and the residents. At least one faculty should attend each conference given by residents, and residents must not be the majority of presenters.

Each program must have the following:

- (1) an educational rationale for use of conferences for the program;
- (2) a statement on how conferences are evaluated and how the resultant data are used by the program;
- (3) an explanation of resident involvement in conference design and

presentations.

l) Management of Health Systems

There must be at least 100 hours of management and leadership instruction to include both the didactic and the practical settings. This curriculum should prepare residents to assume leadership roles in their practices, their communities, and the profession of medicine. The residency must have specific strategies to demonstrate that residents have mastered these skills.

The FMC must be considered the primary site for teaching management and leadership skills, and should serve as an example on which residents may model their future practices. Each resident must receive reports of individual and practice productivity, financial performance, patient satisfaction and clinical quality, at least quarterly, as well as the training needed to analyze these reports. Residents must attend regular monthly FMC business meetings with staff and faculty to discuss practice-related policies and procedures, business and service goals, and practice efficiency and quality. They must participate in projects to improve the quality of care and service delivered to the FMC patient population.

The management curriculum should include current billing practices, designing and managing a budget, assessing practice staffing needs, the impact of new technologies on practice, determining value in the marketplace, assessing customer satisfaction, measurement of clinical quality, tort liability and risk management, office scheduling systems, computers in practice, alternative practice models, and employment law and procedures. Residents should also learn principles of public relations, media training, and personnel management.

The leadership curriculum should include training to provide leadership for a clinical practice, a hospital medical staff, professional organizations, and community leadership skills to advocate for the public health.

l) Electives

Electives are intended primarily to enrich the residents' training with experiences relevant to their plans for future practice or their interests as family physicians. There must be a minimum of 3 and a maximum of 6 months of appropriately supervised electives available to all residents. The choice of electives by the resident, including those for remedial purposes, must be made with the approval of the Program Director.

m) Documentation of Procedures and Diagnoses

The director and family physician faculty should devise a method by which all procedures are supervised and evaluated. They must also devise

a credentialing process to establish whether or not a resident is competent to perform specific procedures. The resident's documentation of procedural learning should include procedure, age and gender of patient, level of performance (e.g., progressing toward independent performance), and number of procedures performed before independent status granted. Procedural teaching should include didactic presentations, indications and contra-indications, risks and benefits, informed consent, appropriate coding and charging, management of aftercare and complications, and acquisition and maintenance of skills.

### **C. Residents Scholarly Activities**

**Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.**

Each program must provide supervised experiences for all residents in scholarly activities such as research, presentations at national, regional, state, or local professional meetings, or presentation and/or publication of review articles and case presentations. Formal instruction and practical experience must assure that each resident develops and demonstrates skills in locating sources of scientific data pertinent to the care of patients, analyzing the appropriateness of research design and statistical methods, obtaining information about diagnostic and therapeutic effectiveness, and applying evidence from pertinent clinical studies to patient care.

The program must provide a supervised, ongoing forum in which residents explore and analyze emerging scientific evidence pertinent to the practice of family medicine. Additionally, all residents must actively participate in scientific inquiry, either through direct participation in research, or undertaking scholarly projects that make use of the scientific methods noted above.

Residents must also have guided experiences in the application of emerging clinical knowledge applicable to their own patient panels. The training environment must be in compliance with accepted evidence-based practices.

### **D. ACGME Competencies**

**The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:**

- 1. Patient care that is compassionate, appropriate, and effective for the**

- 2. **treatment of health problems and the promotion of health;**  
*Medical Knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;
- 3. *Practice-based learning and improvement* that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
- 4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
- 5. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
- 6. *Systems-based practice*, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Specifically related to family medicine, residents must be taught to develop the skills necessary for career-long professional learning sufficient to maintain certification in the specialty. These should include:

- 1. Knowledge sufficient to pass the ABFM certification exam;
- 2. Ability to collect a complete initial data base and examination;
- 3. Ability to define and expand the differential diagnoses list;
- 4. Identification of the most likely diagnoses and the establishing of a plan for diagnostic and treatment modalities;
- 5. Ability to educate the patient and family about the diagnoses, evaluation and treatment of the disease, to obtain informed consent, and perform appropriate procedures;
- 6. Ability to practice in a team and with a systems-based approach;
- 7. Ability to present data to other members of the team and consultants;
- 8. cost-conscious ordering of diagnostic tests and therapeutics;
- 9. Construction of a medical record summary with accuracy and in compliance with expected format and in compliance with the hospital's medical records policies;
- 10. Formulate short and long term goals; and
- 11. The providing of guidance to patients regarding advanced directives, end-of-life issues and unexpected diagnoses/outcomes.

## **VI. Resident Duty Hours and the Working Environment**

**Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being.**

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**Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**

**A. Supervision of Residents**

- 1. All patient care must be supervised by qualified faculty. The Program Director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.**
- 2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.**
- 3. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**

**B. Duty Hours**

- 1. Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care; time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.**
- 2. Duty hours must be limited to 80 hours per week averaged over a four-week period, inclusive of all in-house call activities.**
- 3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.**
- 4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call. The RRC will not consider requests for a rest period of less than 10 hours.**

**C. On-call Activities**

**The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.**

1. **In-house call must occur no more frequently than every third night, averaged over a 4-week period.**
2. **Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.** For family medicine programs, the only outpatient activity allowed is the scheduled continuity office hours in the FMC, and/or self-directed activities. No other clinical duties are permitted. FM residents may not have continuity office hours in the afternoon or evening following an overnight call responsibility. Directors are responsible for anticipatory scheduling to avoid having to cancel patient appointments for afternoon FMC continuity sessions following overnight call.

For programs using a night block rotation, residents may have their continuity office hours in the FMC either before or after the night block hours, as long as there are 10 hours of rest between assigned duties and all other duty hour rules are addressed.

Residents should also be available for critical events in the lives of their continuity patients such as obstetrical delivery throughout their 3 years of training but with the understanding that their subsequent schedules should be adjusted, as necessary, to comply with the duty hour's restrictions.

3. **No new patients may be accepted after 24 hours of continuous duty.** Patients seen post call during a morning continuity session

In the FMC are not considered new patients.

4. ***At-home call (or pager call)* is defined as a call taken from outside the assigned institution.**
  - a) **The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.**
  - b) **When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**

- c) **The Program Director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.**

**D. Moonlighting**

1. **Because residency education is a full-time endeavor, the Program Director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**
2. **The Program Director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.**
3. **Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.**

**E. Oversight**

1. **Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.**
2. **Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.** Programs must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. There also should be a structured and facilitated group designed for resident support that meets on a regular basis.

**F. Duty Hours Exceptions**

**An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.** The RRC for Family Medicine will not consider requests for an exception to the limit to 80 hours per week, averaged monthly.

## VII. Evaluation

### A. Resident

#### 1. Formative Evaluation

**The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.**

- a) **Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**
- b) **Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.**
- c) **Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.**
- d) **The faculty must provide a written evaluation of each resident after each rotation, and these evaluations must be available for review by the residents and site visitor. The residency must document the inpatient clinical experiences of the residents and show how this prepares them to care for the patients in their community as defined by the program's written goals. This information should include the patient diagnoses seen and the procedures performed.**

#### 2. Final Evaluation

**The Program Director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's**

**permanent record maintained by the institution.**

**B. Faculty**

**The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.** This on-going faculty assessment/evaluation system should facilitate faculty development. Additionally, the program should use resident evaluations of the faculty to help determine their areas of special interest and appropriate teaching.

**C. Program**

**The educational effectiveness of a program must be evaluated at least annually in a systematic manner.**

- 1. Representative program personnel (i.e., at least the Program Director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.**
- 2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.**

**D. Evaluation of the Graduates**

Each program must maintain a system of evaluation of its graduates. The residency should obtain feedback on demographic and practice profiles, licensure and board certification, the graduates' perceptions of the relevancy of training to practice, suggestions for improving the training, ideas for new areas of

curriculum, and identification of which procedures are done in practice. The suggested format is a written survey after 1 year and every 5 years thereafter.

The data from the evaluation of the graduates should be used as part of the program's determination of the degree to which the program's stated goals are being met.

E. Evaluation of the Program by the RRC

The program will be evaluated by the RRC at regular intervals, at which time the RRC will judge the degree of its compliance with the Program Requirements.

One measure of the quality of a residency program is the performance of its graduates on the certifying examination of the American Board of Family Medicine. In its evaluation of residency programs, the RRC will take into consideration the information provided by ABFM regarding resident performance on the certifying examinations over a period of several years.

The committee will use scores for a minimum of 3 and a maximum of 5 years and will take into consideration noticeable improvements or declines during the period considered. Poor performance will be cited if more than 10% of a program's candidates fail on the first examination over a period of consecutive years and/or the program's composite score is consistently at or below the 25th percentile in the nation.

### VIII. Experimentation and Innovation

**Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.**

Requests for experimentation that deviate from the program requirements must be limited to innovative ways that the minimum requirements will be met and to how equivalent competency outcomes will be achieved.

### IX. Board Certification

**Residents who plan to seek certification by the American Board of Family Medicine should communicate with the office of the board regarding the full requirements for certification.**

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## The Family Medicine Residency

### **ABFM Residency Guidelines**

Program Directors are responsible for conducting their residency training programs in compliance with the "Institutional and Program Requirements for Graduate Medical Education in Family Medicine" of the Accreditation Council for Graduate Medical Education (ACGME). Directors should periodically review these requirements with their faculty, staff, and residents.

At the time of entry into a program, the Family Medicine resident is expected to be familiar with: the ACGME "Institutional Requirements", the "Program Requirements for Residency Education in Family Medicine", the "Requirements for Certification by the American Board of Family Medicine", and any additional requirements of the program into which the resident has entered. The ACGME and ABFM requirements are available at their respective websites.

It should be noted that any variance from the "Program Requirements for Residency Education in Family Medicine," or failure to comply with the ABFM Requirements for Certification, places the resident at risk of being unable to qualify for the ABFM's examinations. If there is any doubt regarding compliance with the "Program Requirements for Residency Education in Family Medicine" or ABFM Requirements for Certification, Program Directors are urged to consult with the ACGME and/or the Board.

### **Selection of Residents**

Only those physicians who possess the qualifications set forth in the section on "Eligibility and Selection of Residents" of the ACGME's Institutional Requirements are eligible to enter a Family Medicine residency training program.

Programs must make a special effort to confirm that all of the educational requirements for the M.D. and D.O. degrees have been completed prior to entry for U.S. graduates, and that international graduates have one of the following: a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, a full and unrestricted license to practice medicine in the U.S. licensing jurisdiction in which they are training, or completed a Fifth Pathway program of an LCME-accredited medical school.

The formal registration of all residents in ACGME-accredited Family Medicine residency programs is accomplished via the ABFM's web-based Resident Training Management System. This includes residents who have entered the program as first-year residents, as well as transfers and advanced level placements from other disciplines.

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## ***Advanced-Level Entry/Interprogram Transfers: United States and Canada***

Programs seeking to admit a resident into training with credit toward certification for other types of previous accredited training, including training in another ACGME-accredited Family Medicine program, are no longer required to obtain prior approval for transfer/advanced placement of 12 months or less for residents transferring from:

- ACGME-accredited Family Medicine programs
- other ACGME-accredited specialties
- American Osteopathic Association (AOA) approved programs
- Canadian programs approved by the College of Family Physicians of Canada

Transfer/Advanced Placement notification will be facilitated through the online Resident Training Management System. However, some transfer/advanced placement appointments will require **special attention**, requiring **prior approval** from the ABFM. Appointments requiring prior approval include: requests for credit in excess of 12 months, transfers associated with the closing of a program, transfers involving hardship circumstances, and advanced placement for international training.

Transfer/Advanced Placement credit may not exceed 12 months. The amount of credit normally recognized for each curricular area is listed below.

**TABLE 1—Maximum Amount of Transfer Credit**

<b>Curricular Area</b>	<b>Credit</b>	<b>Curricular Area</b>	<b>Credit</b>
Human Behavior/Mental Health	2 months	Community Medicine	1 month
Adult Medicine	12 months	Care of Neonates, Infants	5 months
Critical Care (ICU/CCU)	1 month	Children and Adolescents	
Cardiology	1 month		
Maternity and Gynecologic Care	3 months	Diagnostic Imaging and Nuclear Medicine	1 month
Maternity Care	2 months		
Gynecologic Care	1 month		
General Surgery	2 months	Physical Medicine and Rehabilitation	1 month
Genitourinary Disorders	1 month		
Disorders of the Eye, Ear, Nose and Throat	1 month		
Musculoskeletal and Sports Medicine	2 months	Practice Management	2 months
Emergency Care	1 month	Care of the Skin	1 month
Care of the Older Patient	1 month	Neurology	1 month
Anesthesiology	1 month	Electives	3 months

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If a physician is admitted into training at an advanced level, but the Program Director fails to notify the Board via the Resident Training Management System or other appropriate means prior to the entry of the resident into the program, the Board, at its discretion, may subsequently alter the amount of credit if there is disagreement with the amount or type of credit awarded.

If it is the intention of the program to use a portion of a resident's previous ACGME, AOA, or College of Family Physicians of Canada (CFPC) -accredited postgraduate education to meet residency program requirements while having the resident complete 36 months of education (e.g., applying the prior training to requirements to permit a greater amount of elective time), the program is NOT required to obtain authorization of credit from the Board.

Should a program recruit a physician for an entry level G-1 position and the physician begins training at that level, the resident will be expected to complete the full residency program of 36 months regardless of the amount of prior training or the performance of the resident after entry.

Transfer from one accredited Family Medicine residency program to another after the beginning of the G-2 year will be considered only when a residency training program closes or when there is evidence of the presence of a hardship involving a resident. **A hardship is defined as a medical condition or injury of an acute but temporary nature, or the existence of a threat to the integrity of the resident's family, which impedes or prohibits the resident from making satisfactory progress toward the completion of the requirements of the residency program.** In considering such transfers, the Board is concerned primarily with the requirements for continuity of care during the resident's second and third years of training as stipulated in the "Program Requirements." All requests must demonstrate the nature and extent of the hardship.

Any change that has not been approved by the Board and is at variance with the requirement for continuity will place the resident's application for the Certification examination in jeopardy.

### **Advanced-Level Entry/Interprogram Transfers: International**

Internationally-trained physicians with postgraduate training outside of the U.S. or Canada may be admitted to an ACGME-accredited Family Medicine program with advanced placement of 12 months or less. However, the program must obtain approval from the American Board of Family Medicine prior to the entry of the resident into training. Please refer to the general details described in the previous section.

Under no circumstances will transfer credit in excess of 12 calendar months be awarded, and such credit, if any, will be restricted to the G-1 year of residency training in Family Medicine. The Board may award credit only for experiences which are equivalent to training in Family Medicine and only in the amount compatible with the "Program Requirements for Graduate Medical Education in Family Medicine."

The physician under consideration must have completed a minimum of three years of international graduate medical education beyond the receipt of the M.D. degree to be considered for any credit.

Requests for transfer/advanced placement credit requiring special attention by the ABFM must include verifiable supporting documentation, including:

- Licensure in the state, province, and/or country of practice
- The medical school diploma (World Health Organization approved)
- Documentation of internship and residency training or equivalent including a description of the clinical rotation schedule or the number of months of specialty training completed
- Specialty and subspecialty certification
- Receipt of a currently valid Standard Certificate from the Educational Commission for Foreign Medical Graduates, or documentation of successful completion of a bona fide Fifth Pathway Program or demonstration of compliance with other ACGME requirements for entry into graduate medical education in the United States

The Board reserves the right to limit the duration of the authorization of credit should the resident fail to enter training at the expected time.

Physicians who are unable to provide all of the necessary documentation of their previous training and fulfill other requirements will be required to complete a full three years of ACGME-accredited residency training in Family Medicine in order to apply for certification.

### **Part-Time Residency in Family Medicine**

In order for a resident to qualify for the ABFM Certification Examination, a reduced or part-time curriculum must have PRIOR written approval of the Board and must meet the conditions listed below.

1. The part-time program and any subsequent changes in curriculum must be approved by the ABFM in advance. The residency must submit a description of the curriculum which outlines the manner in which the part-time program meets the ACGME "Program Requirements for Graduate Medical Education in Family Medicine."
2. The curriculum design for the part-time residency must meet the following guidelines:
  - It must be based on a satisfactory reason for being part-time.
  - It must meet the educational needs of the resident.
  - It must be fair to the other residents in the program.
  - It must include in its total extent AT LEAST the sum of clinical experiences and responsibilities acquired by a resident with a normal full-time schedule.

- It must include documentation of the manner in which the resident's patient-care responsibilities (continuity) will be discharged during off-duty periods and throughout the term of the training experience.
3. The part-time experience in the G-2 and G-3 years must provide continuity of training in the SAME Family Medicine program.
  4. During the G-2 and G-3 years, part-time residents are expected to complete comprehensive care for Family Medicine Center patients on a full-time equivalent basis. It is expected that clinical rotations/experiences and continuity clinic time will be integrated during the part-time schedule. Block clinic time without concurrent clinical rotations/experiences does not reduce the continuity of care requirement or the length of training time, but does serve to avoid violation of the continuity of care requirement. A Family Medicine Center approved by the Residency Review Committee must be used to fulfill the continuity of care requirement.
  5. Part-time residents are required to complete 24 months of continuing care for an undifferentiated panel of patients after the start of the G-2 year. After 24 months of continuity have been completed, family medicine center responsibilities will be expected during educational experiences but will not be required during "off" months.

### **Shared Residency**

In instances wherein two residents elect to share a single residency position and responsibility for the continuity of care of a panel of patients in a Family Medicine Center, the effort may be divided to assist physicians with unique personal circumstances that would otherwise prohibit full-time residency education. Such arrangements, known as "Shared Residency," must be made in compliance with Board policy regarding "Part-Time Residencies," and must have the PRIOR written approval of the Board. Requests for authorization must give a detailed description of the curriculum, the manner in which the continuity of care for the Family Medicine Center patients will be assured, and a statement defining how the sum total of the time requirements, as set forth in the "Program Requirements," will be met.

### **Double Boarding**

The pursuit of two specialty board certifications while training in one or both graduate training programs simultaneously, with some exchange of credit between programs reducing the time it would take to pursue each specialty certification separately, generally defines the process of "Double Boarding."

The policy of the ABFM on "Double Boarding" is in keeping with the Board's policies regarding qualifications for certification and is noted below.

- The candidate must have satisfactorily completed 36 full calendar months of ACGME-accredited training in Family Medicine.
- The G-1 year (12 calendar months) must conform to the ACGME "Program Requirements for Residency Graduate Medical Education in Family Medicine," as well as the American Board of Family Medicine criteria for transfer to an ACGME-accredited G-2 year in Family Medicine if the G-1 year is not in an ACGME-accredited Family Medicine program.
- The remaining 24 calendar months (the G-2 and G-3 years) must be in the same ACGME-accredited Family Medicine residency program, and the resident must be officially considered a resident in Family Medicine under the supervision of the Family Medicine Program Director.

Programs wishing to offer an opportunity for one or more residents to obtain certification by two specialty boards must have the curriculum approved by the ABFM and the second specialty board prior to any resident beginning training.

### **Absence from the Residency**

#### **Continuity of Care**

The requirements for continuity of care and the Family Medicine Center (FMC) experience are defined by the ACGME in its "Program Requirements for Graduate Medical Education in Family Medicine."

A resident is expected to be assigned to one FMC for all three years, but at least throughout the second and third years of training. The total patient visits in the FMC must be met, and residents must be scheduled to see patients in the FMC for a minimum of 40 weeks during each year of training.

#### **Vacation, Illness, and Other Short-Term Absences**

Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one (1) month per academic year.

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.

The Board recognizes that vacation/leave policies vary from program to program and are the prerogative of the Program Director so long as they do not exceed the Board's time restriction.

Time away from the residency program for educational purposes, such as workshops or continuing medical education activities, are not counted in the general limitation on absences but should not exceed 5 days annually.

### **Long-Term Absence**

Absence from residency education, in excess of one month within the academic year (G-1, G-2 or G-3 year) must be made up before the resident advances to the next training level, and the time must be added to the projected date of completion of the required 36 months of training. Absence from the residency, exclusive of the one month vacation/sick time, may interrupt continuity of patient care for a maximum of three (3) months in each of the G-2 and G-3 years of training. Leave time may be interspersed throughout the year or taken as a three-month block.

Following a leave of absence of less than three months the resident is expected to return to the program and maintain care of his or her panel of patients for a minimum of two months before any subsequent leave. Leave time must be made up before the resident advances to the next training level and the time must be added to the projected date of completion of the required 36 months of training. Residents will be permitted to take vacation time immediately prior to or subsequent to a leave of absence.

In cases where a resident is granted a leave of absence by the program, or must be away because of illness or injury, the Program Director is expected to inform the Board promptly by electronic mail of the date of departure and expected return date. It should be understood that the resident may not return to the program at a level beyond that which was attained at the time of departure.

Leaves of absence in **excess** of three months are considered a violation of the continuity of care requirement. Programs must be aware that the Board may require the resident to complete additional continuity of care time requirements beyond what is normally required to be eligible for certification.

### **Waiver of Continuity of Care Requirement for Hardship**

While reaffirming the importance of continuity of care in Family Medicine residency training, the Board recognizes that hardships occur in the personal and professional lives of residents. Accordingly, a waiver of the continuity of care requirement or an extension of the leave of absence policy may be granted when a residency training program closes or when there is evidence of the presence of a hardship involving a resident. **A hardship is defined as a debilitating illness or injury of an acute but temporary nature, or the existence of a threat to the integrity of the resident's family, which impedes or prohibits the resident from making satisfactory progress toward the completion of the requirements of the residency program.**

A request for a waiver of the continuity of care requirement or an extension of the leave of absence policy on the basis of hardship must demonstrate:

- that the absence from continuity of care does not exceed 12 months;
- the nature and extent of the hardship;

- that excused absence time (vacation/sick time) permissible by the ABFM and the program for the academic year has been reasonably exhausted by the resident;
- That a medical condition causing absence from training is within the Americans with Disabilities act (ADA) definition of disability.

For absences from training of less than 12 months, the amount of the 24-month continuity of care requirement completed prior to the absence will be considered a significant factor in the consideration of the request.

When the break in continuity exceeds 12 months, it is highly unlikely that waivers of the continuity of care requirement will be granted.

In communicating with the Board, the program should indicate the criteria it will use, if any, to judge the point at which the resident is expected to reenter. The resident may NOT be readmitted to the program at a level beyond that which was attained at the time of departure, but the resident may reenter the program pending a final decision by the Board on the amount of additional training, if any, to be required of the resident.

# **DIRECTORIES**

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[alice.worthington@christushealth.org](mailto:alice.worthington@christushealth.org)

### CLINIC PHONE NUMBERS

Side A: 704-4140  
Side B: 704-4130  
Side A FAX: 704-4142  
Side B FAX: 704-4132  
Preceptor Room Side A: 704-4161  
Preceptor Room Side B: 704-4134

#### Clinic Hours:

Monday 8:00 – 5:30  
Tuesday 8:00 – 5:30  
Wednesday 8:00 – 5:00 late clinic 5-7:00  
Thursday 8:00 – 12:30  
Friday 8:00 – 5:30

### RESIDENT PAGER NUMBERS

#### PGY I

Deborah Aguilar, MD	210-231-1066
Veronica Betancur, MD	210-231-1065
Sarah Bohn, MD	210-231-1063
Rebecca Campos, MD	210-231-1020
Nick Hanson, MD	210-351-1406
Tyson Purdy, MD	210-231-1707
Sabrina Solomon, MD	210-231-1064

#### PGY - II

Lieu Chau, DO	210-220-0739
Marisa Emmons, MD	210-220-0592
Rebekah Georges, MD	210-220-0079
Chris Larson, DO	210-220-0218
Andreea Livengood, DO	210-2200707
Ashley Summers, MD	210-220-7392
Megan Williams, MD	210-220-0591

#### PGY –III

Karina Wenzell-Botero, DO	210-220-8530
Emily Briggs, MD	210-220-8534
Erika Garza, MD	210-220-8538
Aurelio Laing, MD	210-220-8539
Rachel Lorenz, DO	210-220-8532
Marco Molina, MD	210-220-8536
Ben Stahl, MD	210-220-8540

On-Call Pager 231-1598  
OB Call Pager 230-0068

### **CHRISTUS Santa Rosa Family Health Center – Medical Center**

2829 Babcock Road Suite 236C 2<sup>nd</sup> Floor  
San Antonio, TX 78240

## **RESIDENT OFFICE ASSIGNMENTS**

SIDE A:

### Office 1:

Deborah Aguilar, MD  
Ben Stahl, MD  
Megan Williams, MD  
Erika Garza, MD

### Office 2:

Sabrina Solomon, MD  
Karina Botero-Wenzell, MD  
Chris Larson, DO

### Office 3:

Sarah Bohn, MD  
Nick Hanson, MD  
Rebekah Georges, MD

SIDE B:

### Office 4:

Tyson Purdy, MD  
Andreea Livengood, MD  
Ashley Summers, MD

### Office 5:

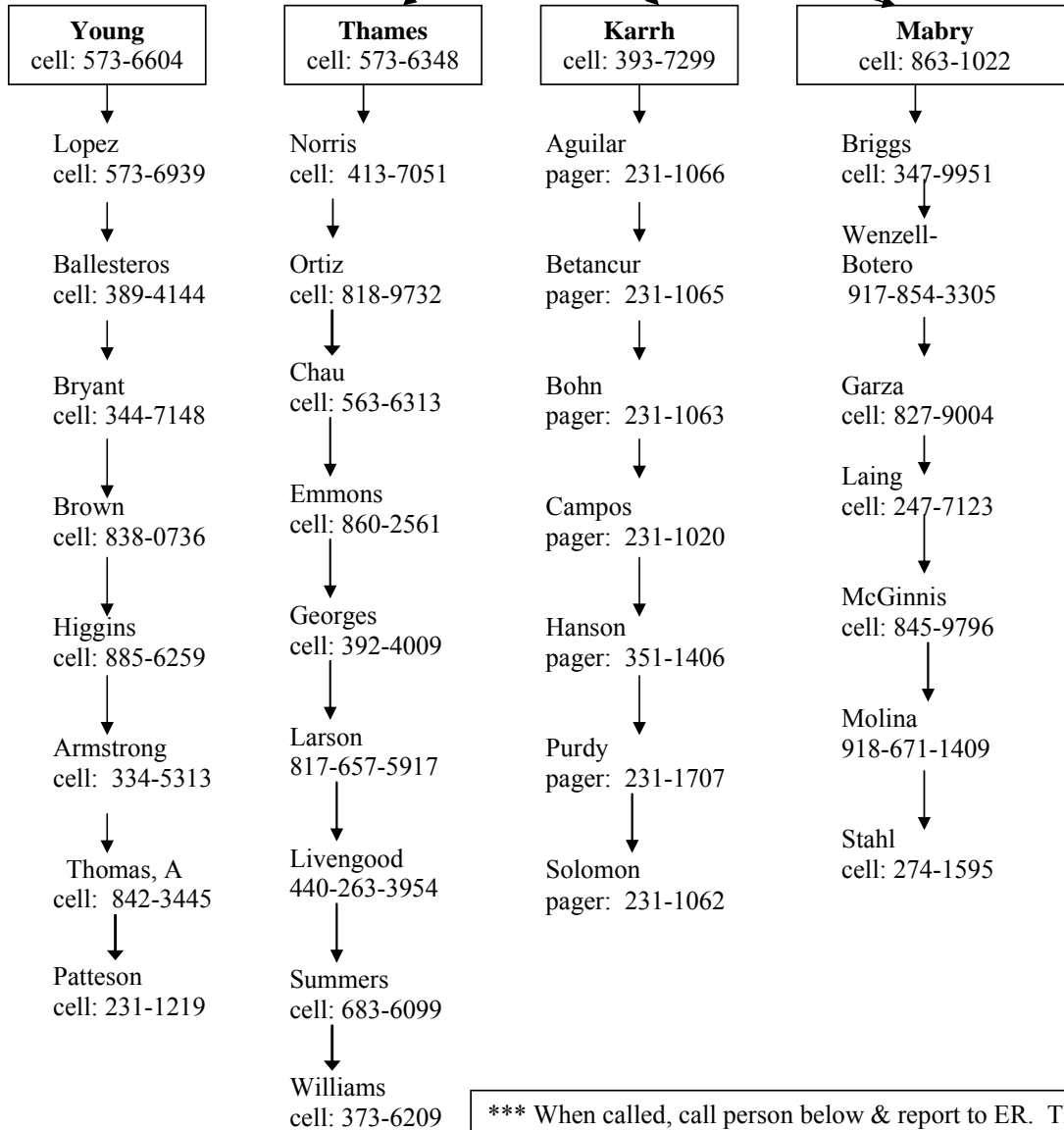
Rebecca Campos, MD  
Emily Briggs, MD  
Rachel McGinnis, DO  
Marisa Emmons, MD  
Marco Molina, MD

### Office 6:

Veronica Betancur, MD  
Lieu Chau, DO  
Aurelio Laing, III, MD

## ALERT ROSTER

James C. Martin / Lisa Marquise  
cell: 913-5838 / cell: 846-8037



\*\*\* When called, call person below & report to ER. The last person on the list calls first in line (e.g. Young, Thomas, etc.). Report to person how long to get to ER.

## **FREQUENTLY USED TELEPHONE AND FACSIMILE NUMBERS**

Answering Service	475-7148
Emergency Department	704-2251 and 704-2252 (City Centre) 704-3536 (Fast Track – Children’s Hospital)
Family Health Center	704-4140 (Side A), 704-4130 (Side B) (Front Desk) 704-4141 (A), 704-4131 (B) (Nurse's Station) 704-4142 (A), 704-4132 (B) (FAX)
FMRP Administration	704-2535 (Main Number - Veronica Rosas) 704-2551 (Administrative Assistant - Alice Worthington) 704-2575 (Residency Coordinator – Lisa Marquise) 704-2545 (FAX)
Laboratory/Pathology	704-2301 – Laboratory (City Centre) 704-2306 - Pathology (City Centre) 705-6469 – Laboratory (Medical Center) 705-6463 – Pathology (Medical Center)
Library	704-3785 (CSRHC)
OB - Labor & Delivery	704-2326 (Nurse’s Station)
Operator	704-2011 (From an outside line) 0 (Within the Hospital) 705-6300 (Medical Center)
Pharmacy	704-2351
Risk Management	704-2020 Cell # 393-5194
Security	704-2393 (City Centre) 704-5685 (Medical Center) 704-2393 (Dispatcher) 230-2030 (Supervisor's Pager) 704-2011 (After Hours Operator)
X-Ray Reports	704-5555 (City Centre) 705-2222 (Medical Center)

## **CHRISTUS SANTA ROSA HOSPITAL - UNIT LOCATIONS**

### **"A" Building (see map)**

Adult Emergency Services -1st floor (ext. 2251 / 2252)  
Postpartum Unit - 3rd floor, East (ext. 2419)  
Obstetrics - Postpartum – 4th floor, North (ext. 2326)  
Obstetrics - Labor & Delivery - 4th floor (ext.2326)  
Obstetrics- L & D Lounge - 4<sup>th</sup> floor (ext. 2794)  
Newborn Nursery- 4<sup>th</sup> floor (ext. 2424)  
Adult Dialysis Unit-4th floor (ext. 2471)  
Cath Lab - 5th floor (ext.3190)  
Telemetry-5th floor (ext. 3026)

### **"B" Building (see map)**

Radiology Services-2nd floor (ext. 2372)  
Laboratory Services-3rd floor (ext. 2301)  
Maternal -Fetal Medicine- 4<sup>th</sup> floor- (ext. 2392)  
Cath Lab - 5th floor (ext.3190) - take "B" elevators to Cath Lab  
Cancer Clinic (Children's)-8th floor (ext. 2561 inpt, ext. 2187 outpt.)  
Adult Oncology/Medical Unit-10th floor (ext. 2457)  
Adult Surgical Unit-11th floor (ext. 3840)

### **"C" Building (see map)**

Pediatric Emergency Services-1st floor (ext. 2190)  
NICU (Neonatal Intensive Care Unit)-4th floor (ext. 2474)  
Special Care Nursery-4th floor (ext. 2554)  
Surgical Services (Children's)-6th floor (ext. 2501)  
Medical Unit (Children's)-7th floor (ext. 2565)  
Hematology/Oncology Unit-8th floor (ext. 2561)

### **"D" Building (see map)**

Occupational Therapy - 2nd floor (ext.2361)  
Physical Therapy - 2nd floor (ext. 2361)  
Day Surgery & GI Lab-5th floor (ext. 2423 outpt. surg., ext. 2460 GI lab)

### **Surgical Tower (see map)**

Children's Outpatient Surgery (COPS) - 1st floor (ext. 2587)  
Adult Outpatient Surgery - 2nd floor (ext. 2423)  
Recovery Room - 2nd floor (ext.2508)  
Surgical Services - 2nd floor (ext. 2501 and 2502)  
GI Lab – 5th floor (ext. 2460)  
ICU's - 3rd floor - Adult (ext. 2421 and 2318), Pedi (ext. 2293 and 2965), Neonatal (ext. 2474),  
Cardiovascular (ext.2470), Surgical (ext. 3920 and 3955)

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**Center for Children & Families, Building F (see map)**

Pedi Specialty Clinics - 1st & 2nd floor (see comprehensive list following)  
Pedi Primary Care - 3rd floor - University Health Systems Clinics  
Family Medicine Residency - 4th floor (ext. 2535)  
Family Health Center - 4th floor (ext. 4140)  
Health Science Library – 5<sup>th</sup> floor (ext. 3785)

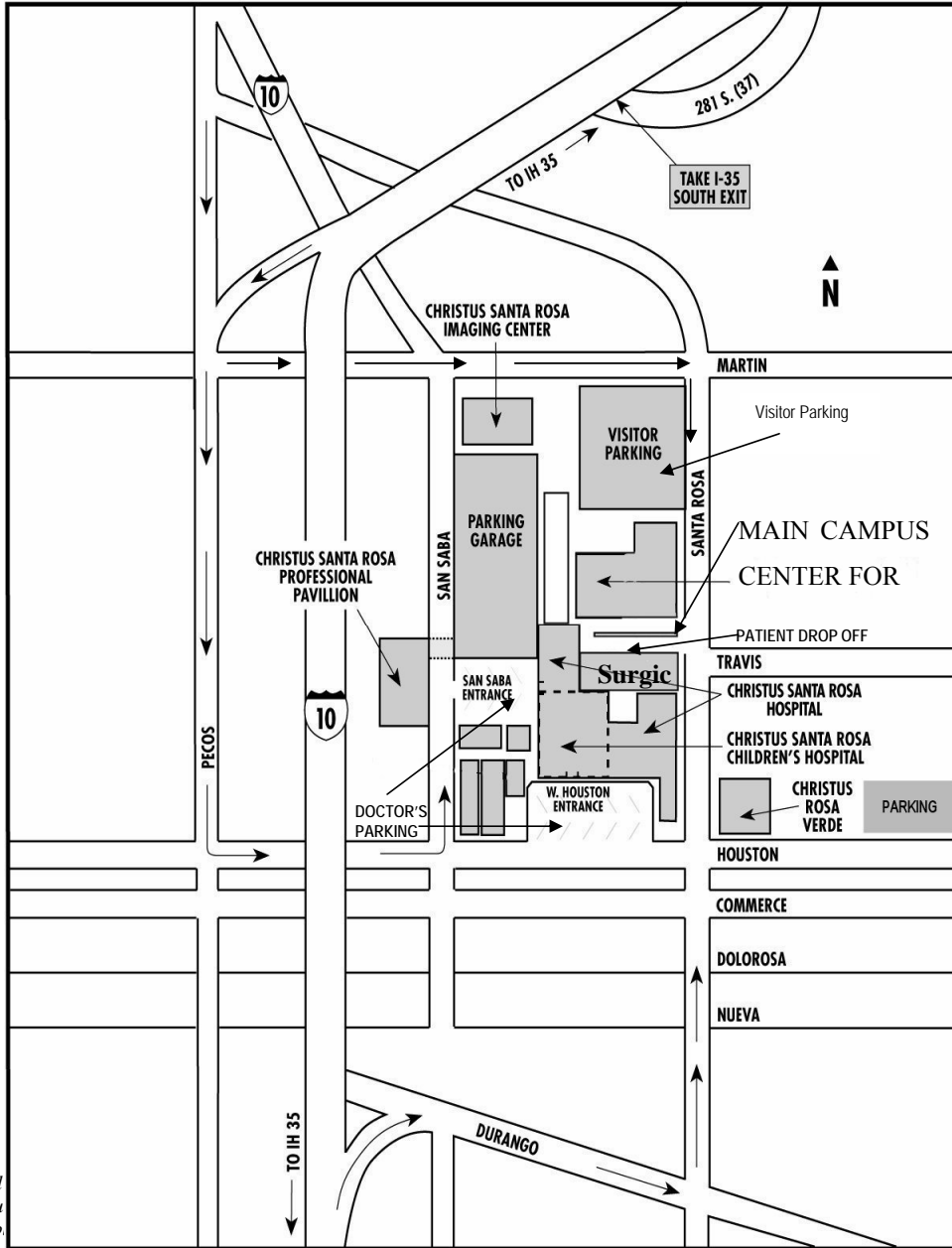
**CHRISTUS SANTA ROSA CHILDREN'S SPECIALTY CLINICS**

Any Baby Can (ext. 2222)  
Asthma Education (ext. 2465)  
Cardiology Clinic (ext. 2861)  
Center for Digestive Diseases and Nutrition (ext. 2207)  
Children's Cancer and Blood Disorders Center (ext. 2187)  
Craniofacial Anomalies Center (ext. 2963)  
Cystic Fibrosis and Chronic Lung Disease Center (ext. 2073)  
Dental Center (ext. 2206)  
Dermatology (ext. 2861)  
Endocrinology (ext. 3611)  
ENT (ext. 4092)  
Eye Center (ext. 2342)  
Family Health Center (ext. 4140)  
Genetics / Metabolic (ext. 2073)  
Hematology Research Center (ext. 2187)  
Hemophilia Center of South Texas (ext. 2187)  
Immune Deficiency Disease Center (ext. 2187)  
Juvenile Rheumatoid Arthritis Center (ext. 2963)  
Neonatal High Risk Follow-up (ext. 3796)  
Orthopedic Clinic (ext. 2044)  
Plastic Surgery (ext. 2342)  
Podiatry (ext. 2342)  
Psychiatry / Psychology (ext. 3007)  
Registration (ext. 2858)  
Rehab Clinic (ext. 3760)  
South Texas Epilepsy Center (653-5353)  
Spasticity (ext. 3863)  
Specialty Clinics (703-2335)  
Spina Bifida Evaluation Center (ext. 2963)  
Surgery (ext. 2335)  
Wheelchair Clinic (ext. 3760)

Maps included

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333 N. Santa Rosa Street □ San Antonio, TX 78207 □ (210) 704-2011



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## Directions to Christus Santa Rosa Hospital

### **CHRISTUS Santa Rosa Family Medicine Residency Program**

333 N. Santa Rosa St  
Center for Children and Families, F4703  
San Antonio, TX 78207  
Ph: 210-704-2535

From 281: Go south towards downtown. Get off on 35-south (Laredo Exit), take McCullough St. exit. At McCullough, take a left to St. Mary's intersection. Take a right on St. Mary's and drive until it curves south toward interior. Take a left on W. Martin Street to intersection of W. Martin and N. Santa Rosa. Take a left on N. Santa Rosa. We are on the right. Park in the visitor parking lot. Our Building (Center for Children and Families –CCF) is between the parking lot and the hospital. We are on the 4<sup>th</sup> floor Suite F4703.

From 35: the instructions are the same; just continue down 35 to the McCullough St Exit.

From I-10: Take 1-10 East; get off at Santa Rosa St. exit. Follow the curve to W. Martin St. Park in the visitor parking lot. Our Building (Center for Children and Families –CCF) is between the parking lot and the hospital. We are on the 4<sup>th</sup> floor Suite F4703.

## Cardiopulmonary Services

<u>Phone Numbers</u>	<u>City Centre</u>	<u>Medical Center</u>
<i>Main #</i>	704-2273	705-6291
<b>EKG</b>	704-2942	705-6291
<b>EEG</b>	704-2944	705-6291
<b>ECHO</b>	704-2946	705-6291
<b>Pulmonary Function</b>	704-2360	705-6298
<b>Location</b>	2 <sup>nd</sup> Floor	2 <sup>nd</sup> Floor

The Cardiopulmonary Departments at both CHRISTUS Santa Rosa City Centre and Medical Center campuses operate 24 hours/day to provide both inpatient and outpatient cardiac diagnostic and respiratory diagnostic/therapeutic services. Inpatient and outpatient pediatric cardiopulmonary services are provided through the Children's Hospital on the City Centre campus.

STAT testing should be reserved for critical patient situations where results are needed for immediate patient treatment or physician action. Cardiopulmonary exam results, except for EKGs, may be obtained through the electronic medical record (EMR) of Meditech. Final results are delivered to the Nursing Units and can also be auto-faxed to the physician's office through Meditech. Nursing unit personnel should be able to access all current and previous results using the workstation on each nursing unit.

## Wound Care and Hyperbaric Center

**Main Phone Number: (210) 705-5030**

The Wound Care and Hyperbaric Center at CHRISTUS Santa Rosa is located on the first floor of the Medical Center campus in Tower II, Suite 105. The Center is capable of providing comprehensive wound care services and hyperbaric oxygen therapy (HBOT) for both inpatients and outpatients. Wound care services include standard therapies, compression therapy for venous problems, and negative pressure dressings for patients with large draining wounds. HBOT is a medical treatment that involves administering 100 percent oxygen to patients in an environment of increased atmospheric pressure, known as a hyperbaric chamber. The process increases the oxygen level in both blood and tissue to promote healing.

Routine hours of operation are from 8:00 a.m. until 4:30 p.m., Monday through Friday, with Saturday treatments as needed.

## Laboratory Services

<u>Phone Numbers</u>	<u>City Centre</u>	<u>Medical Center</u>
<i>Main #</i>	704-2301	705-6469
<b>Blood Bank</b>	704-2308	705-6470
<i>Pathology Services</i>	704-2306	705-6463
<b>Location</b>	<b>3<sup>rd</sup> Floor</b>	<b>4<sup>th</sup> Floor</b>

The laboratories at both CHRISTUS Santa Rosa City Centre and Medical Center campuses operate 24 hours/day to provide most routine testing in the areas of Hematology, Chemistry, Transfusion Services, Serology, Microbiology and Cytogenetics. The majority of testing is done on site, but some specialized testing is performed by contract reference laboratory.

The Laboratories use current AMA CPT code testing / profile nomenclature. Please use that nomenclature in your orders when profiles are requested (i.e. comprehensive metabolic panel, basic metabolic panel, renal panel, electrolytes, and Hepatic function panel). We request that you do not use ambiguous or facility specific nomenclature for ordering tests (i.e. Chem 20 or Critical Care Profile). We need to know what specific tests you are requesting. You should have medical necessity documentation for each ordered test (when ordered singly or as part of a profile). Order individual chemistry tests rather than a profile if you do not need all tests in that profile.

Our in-lab turn-around-time for STAT testing is normally one hour or less. STAT testing should be reserved for critical patient situations where results are needed for immediate patient treatment or physician action. STAT results are printed directly to the printer in the nursing unit as soon as the technologist in the lab verifies the results. Lab results are obtained through the electronic medical record (EMR) of the Meditech HIS. Nursing unit personnel should be able to access all current and previous lab results using the workstation on each nursing unit. Morning lab work is usually available by 7am through the EMR. Cumulative summaries of all laboratory results for the admission are printed nightly and charted by 7am.

There is a pathologist on site from 8am-4pm weekdays and on call 24 hours. When scheduling a surgical case, please indicate when a frozen section will be needed to help avoid delays. Pathology reports are normally available by 5pm on the day following the procedure. Pathology reports are charted on the patient's chart, but are also available through the EMR. Please feel free to consult with a pathologist for either clinical or surgical pathology consultations / interpretations. The pathologist can be reached by calling 705-6463.

Outpatient laboratory testing is available. Signed physician orders must be sent with the patient or may be faxed to admitting ahead of time. The ICD-9 diagnosis code must be specified on the orders for each test requested. The patient should report to the Admitting Department on the first

floor to be admitted as a hospital outpatient. The patient will then proceed to the laboratory where the specimen will be drawn and testing performed. Results may be faxed if requested on the order. Outpatients are normally drawn in the lab from 8am to 5pm weekdays. Santa Rosa Outpatient Laboratory requisition forms are available if you would like a supply for your office.

### **Radiology Services**

<b><u>Phone Numbers</u></b>	<b><u>City Centre</u></b>	<b><u>Medical Center</u></b>
<b><i>Main/Diagnostic</i></b>	<b>704-2371</b>	<b>705-6261</b>
<b>Film Library (Adult)</b>	<b>704-2375</b>	<b>705-6262</b>
<b>Film Library (Pedi)</b>	<b>704-2956</b>	
<b>Location</b>	<b>2<sup>nd</sup> Floor</b>	<b>2<sup>nd</sup> Floor</b>

The Radiology Departments at both CHRISTUS Santa Rosa City Centre and Medical Center campuses operate 24 hours/day to provide both inpatient and outpatient Diagnostic, Therapeutic, and Interventional Radiology Services including CT, Nuclear Medicine, Ultrasound, MRI, and Special Procedures. The City Centre campus also provides Pediatric Radiology Services for the Children's Hospital.

In 2003 - 2004, significant improvements to our services included the installation of a new CT scanner and MRI at the City Centre campus and a new R & F suite at the Medical Center campus.

STAT testing should be reserved for critical patient situations where results are needed for immediate patient treatment or physician action. Preliminary and Final Radiology exam results are obtained through the electronic medical record (EMR) of the Meditech HIS. Final results are printed to the Nursing Units and are also auto-faxed to the physician's office through Meditech. Nursing unit personnel should be able to access all current and previous Radiology results using the workstation on each nursing unit.

There is a Radiologist on site from 7am-11pm weekdays, from 7am to 5 pm on Saturdays, and on call 24 hours. Please feel free to consult with a Radiologist for diagnostic, therapeutic, or interventional Radiology consultations / interpretations.

**The Picture Archive Communications System (PACS)** was implemented April 2005.

This new technology turns traditional x-ray films into digital images that can be displayed on a computer screen and stored in multiple locations. The images are available instantly on a web-based program and accessible by the internet from any computer. PACS computer stations are available throughout the hospital. This system requires physicians to gain a degree of expertise in usage, but is a dramatic improvement over film-based radiology. Over time, PACS will eliminate the loss of films.

A user name and password are required to gain access to images and reports. Username: pacsmid

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User password: pacsmid. Contact the CSRHC PACS Administrator - Radiology Department # 210-704-2745.

### **Pharmacy Services**

**Main Phone Numbers: City Centre 704-2351; Medical Center 705-6194**

Pharmacists are available to assist you with drug information and the safe use of medications. Pharmacists will contact you whenever they detect a potential problem with an order (i.e. allergy notifications related ordered medications, drug-drug interactions, and TPN formulations).

#### **Pharmacy Services include:**

- ❖ 24-hours a day—7-days a week. Decentralized services for select adult and pediatric floors.
- ❖ Dosing considerations related renal function and age appropriateness.
- ❖ Drug information services, drug utilization evaluations and monograph developments.
- ❖ Drug interaction awareness and notifications
- ❖ Routine monitoring of aminoglycosides, vancomycin and phenytoin.

#### **Safe Medication Order Practices**

- ❖ Legibility Matters!
- ❖ Please print and communicate clearly to the hospital staff to prevent errors.
- ❖ Print your name and phone number along with your signature with each order. This helps to facilitate order clarification in the event of an emergency.
- ❖ Utilize checklists, dictation, and preprinted orders whenever possible.
- ❖ Pediatric orders should include the dose in mg/kg.
- ❖ Prescribers should never write over a previously written medication ordered. Always make a new entry on the next available line.
- ❖ Unapproved abbreviations are VERY IMPORTANT and should always be avoided. See the next page for details.

#### **Verbal Orders**

- ❖ Use verbal orders only when absolutely necessary.
- ❖ The qualified person taking the order should write down the order and then read it back verbatim to the ordering physician.
- ❖ The physician should then verbally confirm the order is correct.
- ❖ The ordering physician must countersign verbal orders on the next visit.
- ❖ Verbal orders are not accepted for chemotherapy.

#### **Formulary**

Our formulary is not closed, but limited. For example, our preferred H<sub>2</sub>-receptor antagonist is Pepcid® (famotidine) and automatically convert other H<sub>2</sub>-receptor antagonist to famotidine. Other agents are restricted to a particular specialty, such as Zyvox® (linezolid) is restricted to Infectious Disease. We also use a predominance of generic agents. If an agent is not on formulary at the time of order, a petition can be made to our Pharmacy and Therapeutics committee's (pediatric or adult) for review and consideration to the drug formulary.

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	Please write ...	Unapproved Abbreviation	Intended Meaning	Misinterpretation
1	mcg	Ug	Microgram	Mistaken for "mg" when handwritten.
2	daily or every day	q.d. or QD	Every day	Mistaken as q.i.d., especially if the period after the "q" or the tail of the "q" is misunderstood as an "i."
3	Right, left, both <u>ears</u>	A.D., A.S., A.U.	Ears	Mistaken with eyes as A and O look similar when handwritten.
4	every other day	q.o.d. or QOD	Every other day	Mistaken as "q.d." (daily) or "q.i.d." (four times daily) if the "o" poorly written.
5	subcut or subcutaneous	Sub q	Subcutaneous	The "q" has been mistaken for "every" (e.g., one heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery).
6	subcut or subcutaneous	SC	Subcutaneous	Mistaken for SL (sublingual)
7	Unit	U or u	Unit	Mistaken as a zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as "40" or 4u seen as "44").
8	Unit	IU	International unit	Misread as IV (intravenous).
9	mL	Cc	Cubic centimeters	Misread as "U" (units).
10	Bedtime	HS	@ bedtime	Half strength
11	Do not use terminal or "trailing" zeros for doses expressed in whole numbers.	1.0	1 mg	Mistaken as 10 mg if the decimal point is not seen.
12	Always use zero before a decimal when the dose is less than a whole unit "leading zero."	.5 mg	0.5 mg	Mistaken as 5 mg
13	Use the complete spelling for drug names.	<b>Abbreviated Drug Name</b>	<b>(Examples)</b>	<b>Abbreviated drug names are often misinterpreted</b>
		ARA*A	Vidarabine	Cytarabine ARA*C
		AZT	Zidovudine (RETROVIR)	Azathioprine
		CPZ	COMPAZINE (prochlorperazine)	Chlorpromazine
		DPT	DEMEROL-PHENERGAN-THORAZINE	Diphtheria-pertussis-tetanus (vaccine)
		HCL	Hydrochloric acid	Potassium chloride (The "H" is misinterpreted as "K")
		HCT	Hydrocortisone	Hydrochlorothiazide
		HCTZ	hydrochlorothiazide	Hydrocortisone (seen as HCT250 mg)
		MgSO4	Magnesium sulfate	Morphine sulfate
		MS or MSO4	Morphine sulfate	Magnesium sulfate
MTX	Methotrexate	Mitoxantrone		
TAC	Triamcinolone	Tetracaine, adrenaline, cocaine		
ZnSO4	Zinc sulfate	Morphine sulfate		

- Pediatric orders must include the dose as an amount (e.g. 200 mg) AND be expressed per kilogram (e.g. 20 mg/kg) with each medication ordered.
- Verbal orders for will not be accepted for chemotherapy.
- Enter the complete data and time to clarify which orders are most recent and supersede older orders: Include day, month, year, **and time of day** to facilitate determination of order sequence.
- Please **DO NOT** write over (or stamp FAXED over) any part of an order. Orders are scanned or faxed, so strikeovers that might be clear on the original may be illegible on subsequent copies. Clarify any orders to be corrected by writing the correction below.
- Verbal orders for medications must be written down and read back to the ordering prescriber. Documents a verbal order by writing "**VOR** or **TOR**" followed by your name and title.

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# **SCHEDULES**

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## **Orientation Schedule**

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**Insert Transition Schedule**

## **Clinic schedule**

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## Sample Inpatient Schedule

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**JULY - DECEMBER 2008 ER CALL DATES**

Tuesday	July 01	CSR Family Practice Residency Program	(210) 231-1598
Friday	July 04	CSR Family Practice Residency Program	(210) 231-1598
Monday	July 07	CSR Family Practice Residency Program	(210) 231-1598
Thursday	July 10	CSR Family Practice Residency Program	(210) 231-1598
Sunday	July 13	CSR Family Practice Residency Program	(210) 231-1598
Wednesday	July 16	CSR Family Practice Residency Program	(210) 231-1598
Saturday	July 19	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	July 22	CSR Family Practice Residency Program	(210) 231-1598
Friday	July 25	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	July 29	CSR Family Practice Residency Program	(210) 231-1598
Friday	August 01	CSR Family Practice Residency Program	(210) 231-1598
Monday	August 04	CSR Family Practice Residency Program	(210) 231-1598
Thursday	August 07	CSR Family Practice Residency Program	(210) 231-1598
Sunday	August 10	CSR Family Practice Residency Program	(210) 231-1598
Wednesday	August 13	CSR Family Practice Residency Program	(210) 231-1598
Saturday	August 16	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	August 19	CSR Family Practice Residency Program	(210) 231-1598
Friday	August 22	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	August 26	CSR Family Practice Residency Program	(210) 231-1598
Friday	August 29	CSR Family Practice Residency Program	(210) 231-1598
Monday	September 01	CSR Family Practice Residency Program	(210) 231-1598
Thursday	September 04	CSR Family Practice Residency Program	(210) 231-1598
Sunday	September 07	CSR Family Practice Residency Program	(210) 231-1598
Wednesday	September 10	CSR Family Practice Residency Program	(210) 231-1598
Saturday	September 13	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	September 16	CSR Family Practice Residency Program	(210) 231-1598
Friday	September 19	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	September 23	CSR Family Practice Residency Program	(210) 231-1598
Friday	September 26	CSR Family Practice Residency Program	(210) 231-1598
Monday	September 29	CSR Family Practice Residency Program	(210) 231-1598
Thursday	October 02	CSR Family Practice Residency Program	(210) 231-1598
Sunday	October 05	CSR Family Practice Residency Program	(210) 231-1598
Wednesday	October 08	CSR Family Practice Residency Program	(210) 231-1598
Saturday	October 11	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	October 14	CSR Family Practice Residency Program	(210) 231-1598
Friday	October 17	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	October 21	CSR Family Practice Residency Program	(210) 231-1598

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Friday	October 24	CSR Family Practice Residency Program	(210) 231-1598
Monday	October 27	CSR Family Practice Residency Program	(210) 231-1598
Thursday	October 30	CSR Family Practice Residency Program	(210) 231-1598
Sunday	November 02	CSR Family Practice Residency Program	(210) 231-1598
Wednesday	November 05	CSR Family Practice Residency Program	(210) 231-1598
Saturday	November 08	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	November 11	CSR Family Practice Residency Program	(210) 231-1598
Friday	November 14	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	November 18	CSR Family Practice Residency Program	(210) 231-1598
Friday	November 21	CSR Family Practice Residency Program	(210) 231-1598
Monday	November 24	CSR Family Practice Residency Program	(210) 231-1598
Thursday	November 27	CSR Family Practice Residency Program	(210) 231-1598
Sunday	November 30	CSR Family Practice Residency Program	(210) 231-1598
Wednesday	December 03	CSR Family Practice Residency Program	(210) 231-1598
Saturday	December 06	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	December 09	CSR Family Practice Residency Program	(210) 231-1598
Friday	December 12	CSR Family Practice Residency Program	(210) 231-1598
Tuesday	December 16	CSR Family Practice Residency Program	(210) 231-1598
Friday	December 19	CSR Family Practice Residency Program	(210) 231-1598
Monday	December 22	CSR Family Practice Residency Program	(210) 231-1598
Thursday	December 25	CSR Family Practice Residency Program	(210) 231-1598
Sunday	December 28	CSR Family Practice Residency Program	(210) 231-1598
Wednesday	December 31	CSR Family Practice Residency Program	(210) 231-1598

**OB Float Schedule 2008-2009**

**ATTACH OB Float Schedule 2008 – 2009**

**CPC, Journal Club, Resident Lecture Schedules (from Christie)**

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**2007 Pay Schedule**

**ATTACH NEW SCHEDULE**

# **PROGRAM CURRICULUM**

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## RESIDENT CURRICULUM

### **FIRST YEAR:**

Family medicine inpatient, 16 weeks  
Obstetrics, 8 weeks  
Pediatrics (inpatient), 8 weeks  
Orthopedics, four weeks  
Gynecology, four weeks  
Surgery, four weeks  
Night float, four weeks  
Neurology, two weeks  
Radiology, two weeks

### **SECOND YEAR:**

Family medicine inpatient, eight weeks  
Obstetrics, eight weeks  
Pediatric ER, four weeks  
Adult ER, four weeks  
Cardiology, four weeks  
Gynecology, four weeks  
Surgery, four weeks  
Dermatology, four weeks  
Night float, four weeks  
Research, two weeks  
Psychiatry, two weeks  
Elective, four weeks

### **THIRD YEAR:**

Family medicine inpatient chief, eight weeks  
Pediatrics outpatient, four weeks  
ICU/Pulmonary, four weeks  
Sports medicine, four weeks  
Night float, four weeks  
Urology, two weeks  
Managed care, two weeks  
Research, two weeks  
Ophthalmology, two weeks  
Public Health/Community Health, two weeks  
ENT, two weeks  
Elective, twelve weeks  
Electives, two two-week rotations (GI, Rheumatology, ID or any other in-town rotation)

\*NOTE: For curriculum goals and objectives on these rotations, go to New Innovations (NI).

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## **ELECTIVE REQUESTS**

A resident must complete an Elective Request form, available on New Innovations or in the Administrative office, **90 days prior** to the start of an elective. This form must be completed by the resident including all necessary signatures, goals and objectives, and the schedule. The resident is responsible for contacting the preceptor to arrange the elective. After signatures are obtained, submit your request to the Residency Coordinator. One copy will be given to Veronica Rosas to update the New Innovations block schedule, one will be kept in the Resident Portfolio, one will be kept in your academic file and one copy will be returned to the resident.

## **CLINICAL CURRICULUM**

### **HOME VISITS**

Residents will make a home visit to at least two of their continuity patients during their three years of training. At least one of these patients should be for an older adult (age 65 or older) continuity patient. The goal is to visit the patient and assess the home environment. For these visits, documentation should be made as a home visit note in the patient's chart. Knowledge of Spanish, at least medical Spanish, will be very useful as we are serving a large Hispanic population. Home visit will be performed by the resident accompanied by their faculty advisor. Residents should select patients from their continuity panels for whom they would like to schedule a home visit and obtain the patient's permission. Residents should then schedule a time for the visit that is convenient for the patient, faculty advisor and the resident. Residents should also contact the patient to remind them about the scheduled home visit **at least two days** prior to the visit and immediately contact and notify the patient should the visit need to be rescheduled. Residents should complete at least two of their home visits prior to December 31<sup>st</sup> of their third year of training. Upon completion of each home visit, residents should send the patient's name and date of the home visit to the Home Visit faculty coordinator (currently Dr. Ortiz).

### **NURSING HOME VISITS**

Nursing Home Visits take place at Incarnate Word Retirement Community (IWRC), located adjacent to the University of the Incarnate Word on Broadway. The facility is home to retired Sisters of Charity of the Incarnate Word (founders of Santa Rosa Hospital) and open to non-religious patients as well. It consists of four separate housing areas: Independent Living, 2 Assisted Living Units, an Alzheimer's Unit, and a skilled nursing Extended Care Unit. Dr. Simone Norris is the faculty member in charge of all the IWRC patients, and sees patients on the premises in clinic two half-days per week (Tuesday afternoon/Friday morning). Each resident is Assigned continuity patients including patients in the Alzheimer's Unit and Extended Care. Nursing Home rounds are routinely made on the third Thursday of each month. All available residents and faculty meet at IWRC to round on patients. Residents who are not able to attend nursing home rounds on that day are responsible for making arrangements (WELL IN ADVANCE!) for their Continuity patients to be seen on a different day or by another resident on their team. In addition, residents are responsible for triaging phone calls from all different sections of IWRC after hours, and will see patients from IWRC in the Santa Rosa Emergency

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Department and on the inpatient service. Medical records of all the IWRC patients are maintained in the Family Health Center. For these visits, documentation should be made in the patient's chart and in the regular progress note and a copy kept in the nursing home clinic chart. Dr. Norris requests that residents page (text page) or otherwise notify her of patient encounter after hours, whether by telephone contact from the nursing staff at IWRC, in the emergency department or hospital, to preserve continuity of care.

### **NURSING HOME VISITS**

Contact numbers are as follows (so you will know who is paging you).

IWRC switchboard: 829-7561  
Independent Living: ext. 134  
Assisted Living "A": ext. 500  
Extended Care: ext. 155  
Alzheimer's Unit (Villa 1) and  
Assisted Living "B" (Villa 2): ext. 550  
Dr. Norris pager: 553-0393  
cell: 413-7051  
home: 481-7051

## **DIDACTICS**

Didactics are held every day from 12:40- 1:25pm. Each Thursday afternoon residents and faculty have an extended didactic session from 12:40 to 5:00 pm unless otherwise noted. All are held in Conference Room F located on the 5th floor of the Center for Children and Families. The Thursday 12:40 p.m. conference is the most formal of the weekly series. This time is protected for CPC's, guest lectures, special presentations and office business meetings as well as, specific topics related to the core curriculum. Resident and faculty meetings, occur Thursday afternoon.

All faculty and residents may choose (or are assigned) an area of curriculum interest, from which they will work together to create a list of topics that will be included in the 18-month cycle of lectures. Weekly (currently scheduled on Fridays), residents will be responsible for delivering the lecture content. Faculty are also given specific times/dates, and will coordinate Thursday afternoon workshops as well.

In addition to CPC and Journal Club presentations, residents will be expected to present two 30 minute lectures per year, usually given at Friday noon lecture. A list of possible topics will be provided. The schedule varies and if changes need to be made, the resident remains responsible for the lecture and must notify the chief resident ASAP of any changes in the schedule.

All residents (and medical students) are expected to attend the noon lectures and to sign the attendance sheet. **One does not sign in and then leave without attending the lecture nor arrive extremely late and sign in. This behavior will be noted and counted as an absence.**

Please note that you will not be given credit for your excused absences and that the lectures from which you were excused will not be included in the calculation of your overall attendance, so during these times the resident must be diligent in attending all other lectures. If you are unable to attend lecture for the above reasons, call Veronica Rosas at 704-2535 prior to lecture to receive an excused absence.

Attendance is expected for all PGY-I's, PGY-II's, and PGY-III's without specific assignments, unless previous arrangements are made with your attending physician or faculty and Veronica is called.

Overall attendance of 80% or higher is expected for all lectures. **Unacceptable attendance (less than 75% per month) may result in increased call time or loss of vacation time which will be based on your quarterly attendance rate.** You will be notified monthly if you are below acceptable attendance. Monthly attendance reports will be kept in your resident portfolio and reviewed at your advisor appointments.

All of the attending physicians and preceptors are well aware of your lecture attendance requirements and have been asked to support your efforts to be at the lectures on time.

## **CLINICAL PATHOLOGY CONFERENCE (CPC)**

CSR Family Practice Residents are each required to give a CPC lecture during their 2<sup>nd</sup> and 3<sup>rd</sup> years. Residents are assigned to a date one year in advance, allowing them adequate time to choose an appropriate case for discussion. Each month, the designated resident will prepare a clinical case presentation, coordinating his or her presentation of the case with the presentation of other health professionals (i.e., the pathologist, surgeon, radiologist, infectious disease specialist, social worker, etc.), who were involved with the care of the patient. Cases for discussion may be collected from either inpatients or outpatients cared for by the presenting resident. The resident is expected to coordinate and invite the other professionals to present on their involvement in the case. As this is a CME event, the family medicine resident is to discuss the objectives with the CME coordinator (Jann Harrison) and these objectives will then be communicated to the other presenter(s) prior to the lecture. Objectives of the sessions are to review the differential diagnoses of the presenting problem, and to discuss the presentation, treatment, and prognosis of the presenting case. The resident is to explain the case, educate the audience about the disease(s), the disease process (es), explain the involvement of family medicine in the care of the patient and moderate the group discussion. The faculty will be evaluating the resident on her or his clinical judgment, knowledge of the disease(s) and complications, diagnostic skills, organization ability and presentation skills. **Attendance is required.**

## **MONTHLY CLINICAL CONFERENCE**

Once per block, residents on the Family Medicine Inpatient Team (FMIT) will prepare a clinical presentation focusing on a patient from the month's service who experienced complex or questionable management.... The resident will present the patient's demographics, symptoms, progression of the illness, differential diagnoses, and treatment options. The attending may choose to co-present or add to the presentation. A discussion will follow the presentation. The faculty will be evaluating the resident on his or her clinical judgment, knowledge of the disease and complications, diagnostic skills, organization ability, and presentation skills. **Attendance is required.** The FMIT will also present teaching points from the inpatient service at a lunch lecture during the last week of the block.

## **JOURNAL CLUB**

During monthly Journal Club meetings, a designated resident will partner with a faculty member to critically analyze and discuss a current medical journal article. The articles are expected to be read prior to the meeting in order to have active participation. Each month, the faculty and designated resident will select the article to be reviewed, distribute the article to all the residents and faculty prior to the meeting and lead the discussion. **Attendance is required.**

## SCHOLARLY ACTIVITY PROJECTS

### **RESEARCH DAY**

In order to complete all requirements for graduation, all residents are expected to present their research in an approved format, suitable for publication in May. All research presentations **must be pre-approved** by the advisor and research coordinator.

### **TEACHING RESPONSIBILITY**

Residents are encouraged to take an active role in instructing, tutoring and precepting medical students, less senior residents, and other health professionals (nurses, PharmD students, etc.) Involvement in teaching is an excellent learning tool.

The Society of Teachers of Family Medicine (STFM) offers an annual award, the STFM Resident Teacher Award, to a third year resident who demonstrates interest and excellence in teaching medical students and residents, in providing patient education, in community outreach, and in presenting at regional or national meetings.

The American Academy of Family Physicians recognizes similar resident activities with the Bristol Myers Squibb Award. Please contact the Residency Coordinator for details.

### **CONTINUING MEDICAL EDUCATION**

During the PGY-III year, up to five working days of Continuing Medical Education (CME) are allowed. If a CME conference is less than five (5) working days, only one day of travel on either side of the conference will be counted as conference time. Any CME time beyond five working days must be taken as vacation.

All CME time off must be requested with an official (blue) Paid Time-Off (CME) Request Form given to Alice at least eight (8) weeks in advance. Administrative forms can be accessed on the welcome screen of New Innovations.

All CME courses funded through the Residency Education Fund (REF) must be approved by the Residency Program Director in advance. (A conference brochure must accompany the time-off request.) Each resident will receive \$1000.00 over a course of three years (PGY I, PGY II, PGY III) for the use toward Personal Professional Development.

For approval of a 3 to 5 day conference, the conference should:

1. be germane to Family Medicine
2. Offer at least 18-20 hours of CME credit (AMA Category I or AAFP Prescribed)

**Note: Do not make any travel reservations or registration payments until you have the written approval from the residency coordinator and faculty member with the completion**

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**of the Paid Time off CME form.**

## **COMMUNITY OUTREACH PROJECTS**

Each resident is expected to complete a COP. Acceptable activities include health education programs to FHC patient population or Bexar County community service projects. All COP's must be approved in advance and in writing by the resident advisor and program director.

## **MEETINGS & COMMITTEE INVOLVMENT**

### **RESIDENT / FACULTY MEETINGS**

On a monthly basis, specific group meetings will be held for residents only, faculty only, and a combined faculty/residents meeting. During the residents' meeting, the chief resident will direct the meeting, encouraging discussion of new policy and procedures, rotation issues, call and resident concerns. The chief resident will report concerns discussed to the director, which will be passed on to the faculty at the faculty meeting. The faculty meetings are for faculty development and discussion of residency related issues. Changes in the residency program or hospital policy and general residency issues will be addressed at the faculty/residents meetings. **Attendance is required.**

### **HOSPITAL COMMITTEES**

Participation on hospital committees is a requirement for all PGY 2 & 3<sup>rd</sup> years. The list of possible committees includes:

- Adult Ethics
- Case Management Resource Review
- Infection Control
- Integrity
- Joint Commission
- Performance Improvement
- Pharmacy and Therapeutics

Indicate to the Residency Coordinator on which committee you intend to participate so information regarding the meetings will be sent to you. Following each meeting you attend, please submit a copy of the meeting agenda to the Residency Coordinator for your evaluation file.

## **RESIDENCY PROGRAM COMMITTEES**

Curriculum Committee	Committee Chair: Dr. Eliot Young
Community Project Committee	Committee Chair: Dr. Joseph Lopez
GMEC Committee	Committee Chair: Dr. James C. Martin
Recruiting Committee	Committee Chair: Dr. Todd Thames
Retreat Planning Committee	Committee Chair: Chief Residents
Residency Program Committee	Committee Chair: Dr. James C. Martin

\*Residency Program Committees include 2 residents from each PGY level

## **REQUIREMENTS FOR PROMOTION**

*As stated by ACGME Program Requirements*

PGY 1: Must see a total of at least 150 patient visits in the Family Health Center  
By the end of the third year, the PGY 3 must see a total of at least 1650 patient visits in the Family Health Center.

## **REQUIREMENTS FOR GRADUATION**

*As stated by ACGME Program Requirements*

1. Completion of all rotations with satisfactory and at the level of competency
2. Completion of list of procedures
3. Completion of community project and presentation of research project.
4. Verification that the resident has demonstrated sufficient professional ability to practice competently and independently

### PATIENT CARE

5. Provide appropriate, effective and compassionate clinical care
6. Be able to gather essential and accurate information about the patient and use it together with up-to-date scientific evidence to make decisions about diagnostic and therapeutic interventions
7. Develop and carry out patient management plans
8. Provide health care services aimed at preventing health problems or maintaining health.
9. Locate, appraise and assimilate “best practices” related to their patients’ health problems.

### MEDICAL KNOWLEDGE

10. Possess the knowledge in established and evolving psycho-social biomedical and clinical science domains and apply it to clinical care.
11. Demonstrate rigor in their thinking about clinical situations and to know and apply the basic and clinically supportive sciences which are appropriate to the discipline.
12. Know how to use the computer to manage information, access on-line medical information, and support clinical care and patient education.

### PROFESSIONALISM

13. Demonstrate the fundamental qualities of professionalism.
14. Demonstrate respect, regard, and integrity and a responsiveness to the needs of patients and society that supersedes self-interest.
15. Assume responsibility and act responsibly and demonstrate a commitment to excellence.

## PRACTICE-BASED LEARNING AND IMPROVEMENT

16. Learn to apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.

## SYSTEMS-BASED PRACTICE

17. Be aware that health care is provided in the context of a larger system and can effectively call on system resources to support the care of patients.
18. To understand how their patient-care practices and related actions impact component units of the health care delivery system.
19. Understand systems-based approaches for controlling health care cost and allocating resources
20. Must practice cost-effective health care and resource allocation that does not compromise the quality of care.
21. Be able to advocate for quality patient care and assist patients in dealing with system complexities.
22. Learn to partner with health care managers and health care providers to assess, coordinate and improve health care and know how these activities can impact system performance.

## RESIDENT PROMOTION

There is no automatic right of renewal or extension to the resident contract. Any renewal or extension requires successful advancement by the resident to the next level of training in accordance with the policies and procedures of the Residency Program and written notice from the Health Center to the resident of successful advancement. Advancement is based upon the determination of the Program Director that the resident has achieved a level of competence, both academically and clinically, commensurate with the higher level.

If advancement is to be withheld, the Health Center will endeavor to notify the resident of this decision at least four months prior to the next contract year.

## **COMPETENCY IN OBSTETRICAL CARE**

Residents are expected to have supervision of all maternity patients in labor by family medicine faculty, obstetrical adjunct faculty, or senior family medicine residents deemed to be competent by our faculty.

Qualifications for supervision of low-risk obstetrical labor by residents include the following:

1. Successful delivery of 30 patients.
2. Letter of competency signed by family medicine residency advisor and program director.

In cases where senior residents are providing supervisory care, faculty must be notified of all patients in the maternity suite, and faculty backup must be immediately available (less than 30 minutes).

## LETTER OF SUPERVISORY COMPETENCY

**Dr. Linda Alfonso** has successfully completed 30 deliveries at the CHRISTUS Santa Rosa Family Medicine Residency Program, and our faculty assessment, based on direct observation, considered to be competent to manage low risk maternity patients in labor.

**Dr. Linda Alfonso** will be provided faculty backup with no more than 30 minute availability, and faculty will be in the delivery suite for supervision of all deliveries.

Signed:

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James C. Martin, MD  
Director

# **ACADEMIC REVIEW & RESOURCES**

*Revised June 2008  
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Available online at <http://www.new-innov.com/>*

## 2008 - 2009 FACULTY ADVISORS/ ADVISEES

### Faculty Advisor

### Advisee

Dr. Diana Ballesteros

Aurelio Laing, MD (PGYIII)  
Lieu Chau, DO (PGY II)  
Andreea Livengood, DO (PGY II)

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Dr. Christie Criscuolo Higgins

Karina Wenzell Botero, DO (PGY III)  
Marco Molina, MD (PGY III)  
Sarah Bohn, MD (PGY I)

Dr. Larry Karrh

Deborah Aguilar, MD (PGY II)  
Rebekah Georges, MD (PGY II)

Dr. Joseph Lopez

Megan Williams, MD (PGY II)  
Chris Larson, DO (PGY II)

Dr. Leah Raye Mabry

Rachel McGinnis, DO (PGY III)

Dr. Simone Norris

Emily Briggs, MD (PGY III)  
Rebecca Campos, MD (PGY I)

Dr. Todd Thames

Erika Garza, MD (PGY III)  
Ben Stahl, MD (PGY III)

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Dr. Eliot Young

Ashley Summers, MD (PGY II)  
Marisa Emmons MD (PGY II)

Dr. David Ortiz

Sabrina Solomon, MD (PGY-I)  
Nicholas Hanson, MD (PGY-I)

Dr. Keith Patteson

Tyson Purdy, MD (PGY-I)  
Veronica Betancur, MD (PGY\_I)

\*NOTE: Dr. Tamara Armstrong will be a secondary advisor for all of the residents.

## **ROLE OF THE FACULTY ADVISOR**

The faculty advisor is to encourage the residents to:

- discuss adjustment to the residency program
- express ideas related to the program's improvement
- address logistics such as scheduling, leave, etc.
- discuss patient issues, medical care, etc.
- explore professional concerns and future plans

The faculty advisor will:

- encourage questions and comments in a supportive fashion
- work collaboratively with you to identify and solve problems
- discuss your residency progress
- discuss your examination results, case presentations, lecture participation, rotation evaluations, team cooperation, response to feedback, and overall patient care.
- review resident portfolio each month with resident
- discuss your research project

Faculty advisor/advisee meetings:

- To be held monthly, initiated by the resident
- Resident is to maintain portfolio to review with advisor
- Faculty advisors will meet *informally* every month, and *formally* every quarter, with online reports (New Innov) to be filled out by the end of each quarter for each advisee in July, October, January and April.

## EXAMINATIONS AND EVALUATIONS

### EXAMINATIONS

Once a month, the residents will take a short exam over the previous month's AFP journal articles. These exams are given in the style of typical Board Questions to help each resident evaluate his or her own progress, to encourage continuous learning and to learn the broad spectrum of family medicine in order to be competent family physician. These monthly tests also help the residents better prepare for the In-Service and Certification Exams. They will also be used as part of the evaluation process for the core competencies.

### IN-TRAINING EXAMINATIONS

The American Board of Family Medicine In-training Examination is administered in November of each year to all residents and is proctored by the Residency Coordinator. Your examination results are compared with other Family Medicine residents throughout the country and the national composite of the results will indicate how the residency rates as a program and the ranking of each resident. The exam results are used to determine resident strengths and weaknesses.

### NRP EXAMINATION

The Neonatal Resuscitation Program (NRP) is completed by the PGY 1 during resident's orientation. This one day course is done in conjunction with CHRISTUS Santa Rosa Hospital.

### ALSO EXAMINATION

The Advanced Life Support for Obstetrics (ALSO) course is typically taken in conjunction with the University of San Antonio Health Science Center. PGY 1 residents are expected to complete this course prior to the July 1 start date Or as early in the academic year as feasible.

### MEDICAL LICENSURE EXAMINATION

During the first year of residency, residents are expected to start the process of getting their medical license. **This process is to be completed no later than the start of the 2nd year of residency.** There will be no exceptions other than those by the Texas State Board of Medical Examiners. PGY-I residents are expected to sit for and pass the USMLE Step 3 and will have an excused absence to take the USMLE Step 3. PGY-I residents will have vacation or CME time to prepare for the licensing board examination. **All absences need to be submitted in writing and approved 90 days in advance to Alice Worthington.**

## EVALUATION OF THE RESIDENTS

Residents are encouraged to seek direct, one-on-one feedback from the assigned attending(s) on every rotation in addition to their faculty advisor.

The resident's written evaluation will occur after each rotation by the assigned attending physician or behavioral scientist on service. The written evaluations will be reviewed with the resident at least quarterly by the resident's faculty advisor. The program director will review each resident's performance on a six-month basis. All evaluations will be kept in the resident's file in the Administrative offices as well as in their Resident Portfolio.

Reviews are applied equally to all residents and are based on educational performance. If and when specific problems are identified, the faculty advisor (and other faculty, if necessary) will work with the resident to develop and implement a remediation plan. If attempt at remediation is unsuccessful, additional consultation is necessary. (See Academic or Disciplinary Difficulties)

### Professionalism

- Patient Satisfaction Survey
- 360° Global Rating
- Observation Checklist
- Journal Club Evaluation
- CPC Evaluation
- Precepting Evaluation

### System-Based Practice

- 360° Global Rating
- Resident Portfolios
- Multiple Choice Questions
- Observation Checklist
- Record Review
- Journal Club Evaluation
- Precepting Evaluation

### Patient Care

- Patient Satisfaction Survey
- 360° Global Rating
- Observation Checklist
- Resident Portfolios
- Procedure/Logbook
- Journal Club Evaluation

- CPC Evaluation
- Precepting Evaluation

### Medical Knowledge

- Multiple Choice Questions
- Journal Club Evaluation
- CPC Evaluation
- Precepting Evaluation

### Practice-Based Learning & Improvement

- Resident Portfolio
- 360° Global Rating
- Procedure/Logbook
- Journal Club Evaluation
- Precepting Evaluation

### Interpersonal & Communication Skills

- Observation Checklist
- Patient Satisfaction Survey
- Journal Club Evaluation
- CPC Evaluation
- Precepting Evaluation

**\*\*Note:** Specific examples of all of these evaluation tools are located at the end of this section.

## EVALUATION OF THE ATTENDINGS

Upon completion of each service, the residents will complete a written evaluation of the overall teaching and performance of the service attending. You are encouraged to be concise and honest about each service. All of us are interested in improving the residency program. The evaluations are to be given to the residency coordinator. The evaluations are reviewed by the program director and discussed with the attending. Residents are likewise encouraged to talk directly with the attending about service or teaching issues. Every six months, the residents will complete an anonymous faculty evaluation through New Innovations.

## ROTATION EVALUATIONS

Upon completion of each service, the residents will complete rotation evaluations on New Innovations that reviews the goals and objectives of the service and whether or not they were reached successfully. The evaluations are to be given to the residency coordinator and reviewed by the faculty. These evaluations must be completed by one week following the end of the rotation. **Failure to complete timely evaluations will result in loss of vacation days; one vacation day per week of delinquency. If all vacation days have been used, this may result in additional night call.**

## LECTURE EVALUATIONS

Periodically the residents are expected to complete an evaluation form addressing the relevance of the conference topic to family medicine, to patient care, and to continuing medical education. The honest evaluations will help us to continually improve our lecture and seminar series. Please place the evaluation forms in the evaluation box.

## PROGRAM EVALUATIONS

The program evaluation occurs in two formats. First, the Curriculum Committee (composed of 3 faculty and 2 residents from each class and the program director ex-officio) meets quarterly.

They review all rotation evaluations. They review minutes of faculty meetings, faculty / resident meetings, and chief resident reports from resident meetings. They also review, as appropriate, minutes of the Graduate Medical Education Committee (ACGME) regarding new regulations. The committee reviews curricular goals and objectives, faculty evaluations, lecture content evaluations, special needs or resources necessary for the program to comply with ACGME / ABFM requirements.

In the spring of the year, the Curriculum Committee prepares an annual program evaluation to present to the faculty committee. It is at that meeting that curricular changes are approved and the annual program evaluation is sent to the GMEC to comply with the annual program evaluation requirement of the ACGME.

In evaluating the educational effectiveness of the residency program, the committee will use resident performance and outcome assessment as well as the performance of program graduates on the certification examination.

## **RESIDENT PORTFOLIOS**

Portfolios are used to facilitate professional development and provide evidence of self-directed learning. A portfolio is held in the storage room of the Administrative office for each resident until the end of their PGY- III year. Upon graduation, the resident is given his or her portfolio CD. Prior to each appointment with your faculty advisor, be sure to review your portfolio ensuring all of the information is up-to-date. The Administrative office will put these documents in your notebook as they are submitted.

Portfolios include:

1. Resident Rotation Evaluations
2. Observation Checklist (includes 2)
3. Quarterly Evaluations (Patient satisfaction survey)
4. Journal Club Evaluations
5. Record Review
6. Conference Attendance
7. Video Shadowing
8. 360° Evaluations
9. Oral Exam Evaluations
10. Clinical Procedures
11. In-Training Exam Scores
12. Elective Requests
13. Community Outreach Project
14. Resident Self Evaluation
15. Query – Quality Improvement (Performance Improvement Plan)
16. Miscellaneous
17. CV
18. Precepting Evaluations

## **ACADEMIC REVIEW**

### **RESIDENT PROGRESS IN THE CLINICAL SETTING**

Resident progress and evaluations are discussed by the Resident Progress Committee, which consists of the residency director, faculty and coordinator.

Occasionally a resident is identified as needing help in one or more clinical care activities. The faculty is willing to help residents in this regard and usually the problem can be resolved without resorting to more formal remedial action plans.

1. The resident's assigned advisor will discuss the situation with the resident in order to understand the problem.
2. Meetings with the director, resident advisor, and other appropriate faculty will be scheduled to review the resident's progress.
3. A clinical faculty attending may be assigned to the resident to help the resident with the identified problem(s).
4. For a hospital based rotation, remediation will be devised by the rotation attending physician and the faculty advisor.

### **ACADEMIC OR DISCIPLINARY DIFFICULTIES**

Residency training is a learning process and effective evaluation and advising will frequently suggest strategies to help focus work and develop the full potential of the resident. These plans are to be devised with your faculty advisor. However, when significant deficiencies have been identified by the evaluation process, or the resident's progress has been identified as inadequate by the residency faculty, the following procedure will be used to assure fair treatment and due process for residents with disciplinary or academic problems.

Procedure:

1. The program director, faculty advisor, behavioral scientist, and other faculty deemed appropriate will meet with the resident to review concerns about the resident's performance.
2. If further information is needed, a second meeting will be held within one month to review the additional data. A written plan, indicating the resident's specific deficiencies, shall be developed for corrective action.
3. The plan for remediation, supervision, or support should be customized and may include, but is not limited to, the following:
  - a. regular weekly or semimonthly advisory meetings between the resident and appropriate faculty members to check the resident's progress;

- b. development of a focused reading program or tutorial program;
  - c. development of an ongoing supervisory and feedback program using appropriate resources such as faculty, nurses or other residents;
  - d. psychological counseling;
  - e. videotaped feedback sessions;
  - f. alteration of schedules of responsibilities;
  - g. institution of probationary status.
4. The plan of corrective action is to be signed by the resident and the program director or the member of the faculty primarily involved in the remediation process (usually the faculty advisor). A copy of the plan is given to each party.
  5. A review of the resident's performance shall take place at the end of the period defined in the plan (generally within three months). At that time, the resident may be continued on the remedial program, may be relieved of the remedial program, or may be recommended for dismissal by either non-renewal of the resident's contract or termination for cause.

If the resident is in disagreement with the findings of the faculty and the program director, he or she may appeal the decision. (See the Grievance Policy section.)

**NOTE ON PROBATIONARY STATUS:** Probationary status may be part of the remedial plan as defined above. It may also be invoked for several other problems such as:

1. failure to satisfactorily complete a rotation;
2. repeated unexcused absences from required program elements;
3. failure to obtain or maintain a current medical license;
4. failure to comply with the established rules and regulations of the residency;
5. insubordination or unethical conduct;
6. failure to provide the quality of care to patients consistent with the expected level of training and experiences of the resident;
7. other acts which compromise patient care, the resident's educational experience, or the functioning of the program.

While on probationary status, the resident must discontinue all outside medical service not involving the residency including moonlighting. The faculty member primarily involved in the remediation process (usually the faculty advisor) will be required to report monthly on the resident's progress to the director. If the resident has received acceptable reports and maintains his or her work performance at a satisfactory level, the faculty may recommend to the program director that the probationary status be removed.

## **REMEDICATION PROCESS**

Residents will be held accountable for their responsibilities on each rotation. Remediation is decided on a case by case basis at the discretion of the director.

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## **RESIDENT DISMISSAL**

Residents who fail to perform satisfactorily, who fail to respond to guidance from faculty, and are unable to improve and correct unacceptable performance will be dismissed.

## **RESIDENT COMPLAINTS**

If the resident has a significant complaint, it should first be heard by the Chief Resident then the assigned advisor. If the advisor does not respond to the resident's satisfaction, the complaint should then be heard by the Associate Director (Dr. Leah Raye Mabry) and the Director of Behavioral Sciences (Dr. Tamara Armstrong) or some other faculty member. If the resident still feels the complaint has not been given the attention it deserves, an appointment may be made with the Program Director (Dr. James Martin.)

## **GRIEVANCE POLICY**

If the resident is in disagreement with the director, faculty, and residency program and believes that he or she has been treated unsatisfactorily with regard to probationary status, remediation, or dismissal and that he or she is unable to work with the residency program to resolve this conflict, the resident is to discuss his or her concerns with Human Resources associate, Ms. Sylvia Reyes at 704-3460. She will work with that resident to address needs, help you file your grievance, and explain the steps of the grievance procedures of the hospital.

In filing a grievance, the resident will state the facts of the grievance and identify a possible solution. This information will be sent via the Human Resources Department to the resident's faculty advisor for a written reply. The solution may be accepted or rejected. If accepted, the faculty advisor, the resident and the program director will continue to discuss the solution. If rejected, the grievance will be sent to the program director, requesting a written reply. The resident may reject or accept the written reply. If further discussion is necessary, the resident may appeal to the Graduate Medical Education Committee (GMEC). The GMEC will select a panel to hear his or her case and Human Resources will choose a neutral chairperson. The panel will set a hearing and make its recommendations. The resident may accept. If accepted, the resident will work with the residency program and the panel.

## **COUNSELING AND SUPPORT SERVICES**

Counseling and support services are available for residents and their families. If you are not sure what you or your family needs, you are encouraged to talk with the behavioral scientist or your faculty advisor. The behavioral scientist has a referral list of providers and may be able to identify specific resources to fit your needs. Below are some additional resources.

1. CHRISTUS Santa Rosa Health Care Employment Assistance Program and the "CARE" Program, Sylvia Reyes (704-3460), Department of Human Resources. Ms. Reyes is willing to talk with any employee who is having difficulty performing his or her job at

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CHRISTUS Santa Rosa or who needs an outside referral. "Care" Program  
(614-2273)

Any CHRISTUS Santa Rosa employee may call the "Care Program," and set up an appointment to talk with a licensed counselor (Licensed Professional Counselor, Licensed Social Worker, or Licensed Chemical Dependency Counselor). You will be offered the earliest appointment available, usually within the week, and if it is an emergency, they will try to meet with you that day. Please check benefits with your insurance carrier. Fee for service is another option. The Care Program also provides referrals to other community agencies.

Before seeking mental health services, call your insurance carrier to confirm whether or not you need to obtain pre-authorization to see a mental health professional and to clarify the maximum number of visits.

2. Bexar County Psychological Association (736-3498)

This Association provides referrals to psychologists in the community. You can call anonymously and ask for psychologists who work with people dealing with certain situations or who work in your area. For example, "I am interested in obtaining the names of a few female psychologists who work in the downtown area and help people deal with anxiety."

3. Faculty Outpatient and Psychotherapy Clinic, Department of Psychiatry (UTHSCSA)  
7th Floor of the Medical School, 7703 Floyd Curl Drive, Suite 719L, San Antonio, 78284  
Telephone (210) 567-5440; Hours: Monday-Friday 8am-5pm

Psychologists and psychiatrists conduct individual and group adult psychotherapy. A sliding scale is available when a psychiatry or psychology resident sees you. When you call, the receptionist will conduct a brief intake over the phone and set up an appointment for you. Your first visit will be an intake and your next visit will be with your designated therapist. You will be offered the earliest appointment available, usually within six to eight weeks.

4. Jewish Family Services of San Antonio  
12500 N.W. Military Highway, Suite 250, San Antonio, TX 78231  
Telephone (210) 302-6920;  
Hours: Monday-Thursday 8am-9pm, Friday 8am-4pm, and Sunday 10-5pm

This organization serves individuals and families regardless of religious affiliation and the fee is based on a sliding scale. Licensed clinical social workers conduct the therapy. When you call they will set up an appointment for you within the week for an intake. During the intake, a collaborative decision will be made as to which social worker and what type of therapy would best suit your needs.

5. Trinity Baptist Church Counseling Services  
319 E. Mulberry Street, San Antonio, TX 78212  
Telephone: (210) 738-7780; Hours: Monday-Thursday 9am - 9pm; Friday 9-12 noon

This organization serves individuals and families regardless of religious affiliation and the fee is \$55.00 per visit and \$40.00 for a visit with an Intern. Social workers and masters level marriage and family therapists conduct the therapy. When you call they will set up an appointment for you within the week. The receptionist will ask you some general questions in order to match your needs with a therapist. You will meet the selected therapist at the first visit. They have several ongoing groups: Divorce recovery, grief support due to loss of spouse, loss of child by death, and cancer support.

6. Catholic Charities, Archdiocese of San Antonio  
2300 West Commerce Street, Suite 200, San Antonio, TX 78207  
Telephone: 377-1133; (crisis: 433-3256) Hours: Monday through Friday 8:30-5:00pm

Catholic Consultation Center, as part of Catholic Charities, serves individuals, couples, and families of all ages regardless of religious affiliation and the fee is based on a sliding scale. The minimum counseling fee is \$15.00. The director is a master's level therapist and the counselors are master's level (or lower) interns. When you call they will set up an appointment for you (if they do not have a waiting list.) The person you see at your first visit generally will be your counselor. This organization has programs addressing various issues such as adoption, teenage pregnancy, substance use and family problems. If you call the crisis number, (433-3256), they provide crisis intervention, immigration services and refugee services.

7. Center for Health Care Services  
711 Josephine, San Antonio, TX 78208  
Telephone: 225-5481. Hours: Monday through Sunday 24 hours a day

This is a walk-in clinic and crisis unit that is available for those needing mental health, mental retardation, and substance use intervention. They have counselors, caseworkers, and psychiatrists on site. No appointment is needed, just walk-in. The fee is based on a sliding scale.

8. Community Counseling at Our Lady of the Lake University  
Holy Cross Family Medicine, Suite 3  
590 N. General McMullen  
Telephone: 434-1054. Hours: Monday through Friday 10-8 (depending on availability of counselors); Saturday 9-1pm

This organization serves individuals, couples, and families regardless of religious affiliation and the fee is based on a sliding scale. The minimum fee is \$20.00. Doctoral and Master's level counselors conduct the therapy. When you call the organization, they will conduct an intake over the phone and if they do not have a waiting list, they will give you an appointment over the phone to see a counselor.

9. Community Clinic, Inc.  
210 W. Olmos, San Antonio, TX 78212  
Telephone: 821-6407. Hours: Monday through Friday 1-8pm

This organization serves individuals, couples and families, primarily 18 years and older. Master level interns provide the counseling. The fee is based on a sliding scale which is determined by your proof of income. When you call for an appointment, the person will conduct a brief intake and give you an appointment and the fee for each counseling session.

10. Group Support

Balint group is a place to obtain support, but personal and family concerns are best addressed in another setting because the emphasis of Balint group is the doctor - patient relationship.

A support group for the resident's spouse is under consideration. We will send out information to the spouses and assess overall interest, needs, best dates and times.

### **RESIDENT PHYSICIAN IMPAIRMENT**

We actively try to identify early or prevent any and all problems that impact on the physician and patient care. If you are having problems with family, work, life stresses, substances, etc., you are encouraged and supported to seek help. Choosing to talk with the behavioral scientist or your faculty advisor is an excellent first step. If you know of a resident who is having difficulty, talk to him or her and encourage the resident to seek help. Balint group is a way of addressing some of the difficulties that you have at work. Psychotherapy may be beneficial in identifying ways that you can cope more effectively. (Additional resources are listed in the counseling and support section of this handbook.) Outpatient counseling, inpatient treatment, and detoxification programs are a part of your employee benefits package.

Initial drug screens are conducted on each resident (and all CHRISTUS Santa Rosa employees) and random drug screens may be performed if deemed necessary.

If it is determined that your performance is lacking and patient care is being negatively affected due to your own impairment, the behavioral scientist or your faculty advisor will address with you your situation and report to the Residency Director. During this meeting, a plan will be devised to specifically address the problem. You will continue to meet regularly with this faculty member and your progress will be monitored.

Impairment concerns about other physicians or yourself can be discussed with Ms. Lili Thraikill, secretary for the Physician Health and Rehabilitation Committee of the Bexar County Medical Society at (210) 344-4894. Additionally, the medical professional's AA group "Caduceus" meets every Thursday evening at 7pm at the Bexar County Medical Society. For more information contact Ms. Thraikill.

# **LEAVE AND AWAY ROTATIONS**

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## LEAVE AND AWAY ROTATIONS

### RESIDENT VACATIONS

All vacations, including conference and personal leave, must be scheduled using the multi-purpose Paid Time Off (PTO) Request Forms & submitted electronically via e-mail to the clinic scheduler. The “Yellow” forms are available in the Administrative office. Submit your request by e-mail to the clinic scheduler with coverage signatures at least **90 days** before the block in which they occur, and also complete & submit the “Yellow” PTO form to Residency Coordinator. He/she will then forward this to the Department Administrative Assistant, who will track your PTO days. The form will then go to the clinic scheduler. Following his/her approval, the Clinic Coordinator will sign and return the form to the Residency Coordinator. A copy of the approved request will be given to the resident, the chief resident, the resident’s permanent file and one to the Department Administrative Assistant. Further details regarding requesting time-off can be found on the group share drive at S:\Scheduling Archive\Resident Schedule Files\Resident Time Off Policy.doc.

It is the resident’s responsibility to ensure there is coverage and that his/her clinic schedule has been blocked. Residents should check the clinic schedule prior to taking time off to ensure the dates have been closed.

All residents have 15 working days of vacation per academic year and 6 personal/sick leave days. (Academic year is July 1 through June 30). Residents may not accrue vacation from one year to the next. Exceptions will be dealt with on an individual basis. Residents are not to take leave between the last 4 weeks and the first 4 weeks of each academic year.

Vacations are not to be more than one week at a time. Exceptions will be dealt with on an individual basis.

Once approved, vacation requests are not guaranteed and may then be canceled or rescheduled due to residency & clinic staffing requirements.

No resident should schedule a vacation during a rotation in which he / she has previously taken a vacation e.g., one week of vacation in surgery during first year and a request for a week of vacation in surgery in the second year or third year.

No time off will be granted during required two-week rotations or during cross-cover months.

Personal/sick leave days are not to be used as additional vacation days and must receive approval by the program director.

Due to the sparse coverage of the call schedule, PGY-I and PGY-II residents will have vacation time scheduled during designated rotations only as follows:

### PGY-I YEAR

Vacations may only be taken during Orthopedics, Surgery and Gynecology.

### PGY-II YEAR

Vacations may be taken during Adult ER, Cardiology, Elective and Dermatology.

### PGY-III YEAR

Vacations may be taken during Pediatrics-Out Patient, ICU, Sports Medicine, and Elective.

Procedure:

1. E-mail your request to the clinic scheduler at least 90 days in advance.
2. Complete the PTO Form (/Yellow) at least 90 days in advance
2. Have the team co-managing residents who are covering for you sign this form.
3. Have the chief resident sign this form.
4. Notify your Faculty Advisor of the request for time off.
5. Give the form to the Residency Coordinator for completion of signatures.
6. If the request is denied, make changes and resubmit.
7. If the request is approved, plan for the time off. A copy will be put in your box.

### **ABSENCES**

You are required to notify the Residency Coordinator (704-2575), the clinic attending, the service department contact, the chief resident (or upper level resident), your advisor, and the receptionist on your side of the clinic as early as possible (if you are expected to be in clinic) if and when you will be absent **for any reason**. Phone numbers are listed in Section 4 of this manual. You are responsible for coverage and rescheduling of your clinic, in coordination with the clinic schedule.

NOTE: Samples of the PTO and the Elective Request forms are available at the end of this section.

### **PERSONAL / SICK LEAVE, MATERNITY AND PATERNITY LEAVE**

House Staff Policy Agreement

Sick Leave: Sick days will be deducted from Personal / Sick Leave time, but the use of sick leave must not violate ACGME & ABFM rules for time away from residency. (Disability due to pregnancy is included in definition of sick leave without pay.)

Pregnancy Leave: Up to one month prior to EDC and up to the date of delivery without pay

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unless using vacation or sick leave (authorized by your physician).

Child Care Leave: The resident (mother or father) will submit in writing, the intention to continue residency training at CHRISTUS Santa Rosa Family Practice Residency Program. The leave of absence for the mother will be granted for two months from date of delivery, without pay. One additional month without pay will be granted, if medically indicated, upon approval of the program director.

The father may take two weeks without pay if desired. An additional two weeks will be granted, if the condition of the mother or infant necessitate, with approval of program director. If the father is the primary caretaker and he submits a written request that is approved by the program director, he may take two months without pay. Options to discuss with the program director: To cancel clinic two calendar days after delivery, and (1) take two weeks without pay and pay back time; (2) use vacation time; or (3) see clinic patients and be off the rotation, if possible.

Upon approval of the program director, the resident will be allowed the additional training time needed to make up the leave without pay.

### **ABFM & ACGME Requirements:**

1. Leave longer than three months: Requires following re-entry guidelines including (a) Re-entry examination, (b) prior approval of the Board.
2. Maximum annual leave: One month, defined as thirty (30) calendar days or 21 working days is the maximum excused leave per year. This includes vacation, sick leave, maternity and paternity leave (not including CME which can not exceed 5 days per year).
3. Time off in excess of one month must be made up and added to projected date of completion of the required 36 months of training.
4. Vacation cannot be accumulated year to year or taken consecutively between years (e.g. end of June, beginning of July).
5. Only eight weeks per academic year away from the FHC are allowed. This includes time away from the FHC for community practice rotation, rural medicine rotation, vacation, leaves, illness and electives away. Periods between interruptions must be at least 4 weeks.

Additional rules concerning resident absence from residency can be found at the ABFM ([www.theabfm.org](http://www.theabfm.org)) & the ACGME ([www.acgme.org](http://www.acgme.org)) websites. Wherever the ACGME, ABFM, the CHRISTUS Santa Rosa resident contract & this handbook have differing policies concerning resident absence from the program, the most restrictive policy will apply.

## **“AWAY” ROTATIONS**

The Christus Santa Rosa Family Medicine Residency Program currently provides four, 4-week rotations to allow elective experiences by residents which may amplify or add to the residents training experiences.

1. Approval for these elective experiences must include appropriate filing and coordination with the Family Health Center scheduler, an educational description of the elective approved by the Resident Advisor and Program Director, and a letter of agreement with the off- sight clinical faculty designate.
2. Each resident is allowed one “away” rotation, defined as an elective in a location outside the city limits of San Antonio, during their 36 months of training. Approval of designation as away rotation must be in writing from the Program Director.
3. In recognition of the resident’s continuity responsibilities, “non-away” electives should be designed to allow some continuity to continue at the Family Health Center. Specifically, elective schedules in the 2<sup>nd</sup> and 3<sup>rd</sup> years should include two half days of Family Health Center continuity presence. Any modification or exception of these requirements would require substantial documentation of educational need and benefit by the resident.

## **“AWAY” ELECTIVES - PGY-III**

We have compiled a file of approved “away” elective experiences. If you would like to add an elective away rotation to the file you need to do the following:

1. Submit a completed proposal in writing to your preceptor for signature three months before starting the elective. (See Elective Month Away form.)
2. Submit the signed form to the Director of Curriculum, with a copy going to your advisor.
3. Submit form to the Program Director for his/her approval. A copy of the approved form should go to the Residency Coordinator for your file.
4. No more than two PGY-III's may be gone at any one time for an elective away rotation.
5. For scheduling purposes, a leave request form must be filled out for any away elective & follow the above approval process.

# **OUTPATIENT/INPATIENT & OBSTETRICS SERVICES**

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## HELPFUL HINTS

1. ASK QUESTIONS, especially if you are in doubt.
2. Learn from every patient.
3. Always answer your pager promptly and politely. You are expected to be available by pager from 7 a.m. - 6 p.m. Monday through Friday and during your on call times.
4. If you are absent for ANY reason, make sure someone is covering your patients. The residency coordinator, attending and upper level resident **must** be notified of ANY AND ALL absences, before or at the time of absence. (See additional information on absences.)
5. Talk to other residents about their rotation experiences. Obtain advice and suggestions on how to succeed on the rotation. Prepare personal goals in advance for your upcoming rotations. You may want to work with your faculty advisor in order to determine if the goals are obtainable and toward the direction you want for your patients and your educational goals.
6. If you have problems on a service with a resident or faculty member, talk with your faculty advisor or the behavioral scientist as soon as possible. Never burn a bridge with another individual. It may haunt you later and affect all the residents and the residency program.
7. Learn your limitations. Recognize them and work to change them.
8. A peripheral brain, be it a palm top computer or a small notebook, is recommended to facilitate access to information on medication dosage, protocols learned on various services, mental status exams, and other references.
9. Listen to the ancillary personnel. They may be able to provide insightful information about your patients in the hospital and the clinic that you may not have noticed.
10. Extreme care should be exercised before ordering medications over the telephone. Be sure to know the patient's allergies, problem list, and any medications he or she is presently taking. Note kidney and liver functioning, age, and weight. Sign verbal orders as soon as possible.
11. Treat all people with respect. You will be working with patients, families, co-workers from different cultural and educational backgrounds, so be considerate, and with respect to patients, try to understand their behavior and response to illness.

12. Work to explain medical procedures, treatments, and prognosis to your patients on their level. Be honest. Spend time talking with them and invite them to ask questions that will help them understand and follow through with the proposed treatment. If possible give them written educational materials to supplement what you have already discussed. If you do not know the answers to their questions, admit that you do not know, but that you will work to find the answers.
13. The Behavioral Scientist/Psychologist will be available for on-site inpatient and outpatient consultations, at mutually agreed upon times, as the need dictates. Residents are encouraged to be involved in the patient consult. To consult Dr. Bajorek for inpatient services, outpatient referrals, or follow-up, page Dr. Bajorek directly at 231-7167. Be prepared to give patient information, hospital location, name of referring physician, and referral question. If Dr. Bajorek does not respond within a few minutes, she will return the page after she finishes her patient's session.
14. Any problem solving or trouble shooting regarding legal situations are best discussed with Risk Management. Prevention tactics such as accurate and appropriate charting help maintain patient charts and can avoid future legal difficulties. Regarding the chart, a court of law will assume that if you did not write it down, it did not happen. Therefore, if you do not write down what you examined, found, considered, and told the patient (and family), then it was not done.

## **CHRISTUS SANTA ROSA FAMILY HEALTH CENTER**

### **FAMILY HEALTH CENTER HOURS**

Hours of the FHC are Monday through Wednesday and Friday 8:30am to 5:30pm. On Thursdays, the hours are 8:30am to 12:30 noon. Lunch closure is 12:30 noon to 1:30pm. Extended Wednesday clinic hours from 5:00 – 7:00pm offered to meet particular patient needs.

There are two clinic teams: Team A and B. Each resident will be assigned to a team and will function as a group practice, i.e., having quality assurance meetings, sharing patient coverage during absences, sharing the same ancillary staff, sharing walk-in patients, etc.

### **FAMILY ASSIGNMENT**

Each resident will be assigned clinic patients on a rotating basis. The number of families assigned each year increases as the resident increases in seniority and clinic time; PGY-I: 25 families, PGY-II: 50 families, PGY-III: 75 families. The faculty will review your caseload on a regular basis to make sure that you are experiencing an appropriate array of patient concerns, disease states and age groups. Talk with your faculty advisor about the patients that you are seeing and the types of patients with whom you would like experience. PGY-I residents are to see 150 patient visits and a total of 1650 patient visits by the PGY-III year.

### **CLINIC PATIENT ADMISSIONS**

If the patient that you have just seen in the Family Health Center is admitted to the hospital, you are responsible for initiating the admission process by contacting the in-patient team and writing a brief history, physical examination, and admission orders. Make sure to include any pertinent information about the patient in the patient's history. A comprehensive history, physical examination and admission orders will be completed by one of the residents on the Family Medicine Inpatient Service. The Family Medicine Inpatient Service is responsible for seeing the patient, writing daily notes, coordinating the care of the patient, and notifying the patient's primary care physician of the status of his or her hospitalized patient. As continuity physician for your patient, you or a designated member of your team (A or B) are expected to see your patient on a regular basis or be updated on the patient's status at an appropriate interval.

### **PHARMACEUTICAL SAMPLES**

The Family Health Center has a storage area to shelve the samples provided by the pharmaceutical representative. Here are some wise suggestions on the use of these samples.

1. Dispense a starter supply of medication with instructions to the patient to fill the prescription if no adverse side effects occur and the medication is effective.

2. Dispense starter supply of antibiotics with continuation pending culture results.
3. Give a sample of the over-the-counter medication so that the patient will know what to buy at the pharmacy.
4. Dispense complete treatment supply for those patients with financial problems.

Documentation of name, amount, lot #, and expiration date should be completed in appropriate log book. Schedule II and some Schedule III medications are not accepted at the Family Health Center. All dispensed medication should be labeled with patient's name, medication instructions, and doctor's name.

Pharmaceutical representatives will discuss their products with the faculty and residents in the Family Health Center. They also provide educational material on their medications and sponsor luncheons, in addition to numerous other functions. You are strongly encouraged to listen critically and review the information presented. Ask questions related to efficacy, effectiveness, side effects, comparison to other similar products, and the cost to the patient.

### **FAMILY MEDICINE INPATIENT SERVICE**

#### **SERVICE GOALS OF THE FAMILY MEDICINE INPATIENT SERVICE**

The resident will:

1. Have an opportunity to care for a wide variety of family medicine inpatient problems under the supervision of family medicine faculty.
2. Make decisions and care for the after-hours needs of a busy family medicine practice including phone triage, after-hours evaluation and emergency medicine.
3. Learn how to apply a multi-disciplinary approach to patient care, including nursing, other specialties, social work, behavioral medicine and pharmacy, during and after hospitalization.

#### **RESIDENT RESPONSIBILITIES**

Inpatient services include the family medicine inpatient service and obstetrics service for residents of all levels. Interns will also act as a pediatrics intern on one of the pediatric inpatient teams run by UTHSCSA pediatrics residents and attendings. Pediatric call responsibilities will therefore be determined by the UTHSCSA department of pediatrics. Family medicine and obstetrics responsibilities are outlined below.

## FAMILY MEDICINE INPATIENT SERVICE

The emphasis of this rotation is on quality, comprehensive care with continuity. Each resident will be assigned patients on the service. Patients may be adult inpatients, including ICU patients, pediatric patients and newborns. The resident is responsible for rounding on each of his/her patients prior to morning report every weekday. On weekends, the service will be covered by one intern and his/her third year back-up. The resident coming off of night call will also help round on patients on weekend mornings. Chart notes are to be written in the SOAP format with a problem-oriented assessment and plan.

Morning report is held in the administrative conference room and begins at 8:00 a.m. Residents need to have seen their patients and completed progress notes prior to morning report. Generally, during morning report, residents will present to the chief of the service. Major decisions and teaching are the responsibility of the chief of the service. The attending will be present as a consultant for more difficult patients. Variations to this format may be made with approval from the chief of the service and faculty attending.

During rounds, the resident must be prepared to discuss various aspects of their patients' medical care, including social issues in a problem oriented format. Self-directed reading is expected. In addition, each lower-level resident may be asked to provide 5-10 minute presentations to the team about the topic of his/her choice. The chief of the service will determine when and how many talks are to be given. Handouts should be provided, and a copy of each handout should be given to the Residency Coordinator.

Each resident is responsible for entering information for his/her patients into the inpatient service list that is located on the group drive. In order to ensure continuity, it is vital that this list be kept up-to-date, especially medications, important lab/study results, and to-do items. Check-out to night-call residents should be resident-to-resident and must be thorough, including explicit detailed plans and possible complications. Upon discharge, any patient who has been in the hospital for greater than 48 hours must have a discharge summary dictated.

On weekdays, residents on the service will be expected to be in-house until approximately 6:00 pm, at which point they may check-out to the resident on short-call. This resident will cover the service from 6:00-9:00 pm. First year residents will have a third-year as back-up. The third year will be in-house during the first six months of the year. Upon approval of the director, third years may take back-up call from home on non-ER call nights during the second half of the year, but must come in for all admissions or critical changes in patient condition. Second year residents will take short call alone. Night float will assume care of the service beginning at 9:00 pm. Again, first year residents will have back-up from a third year resident and second year residents will take call alone. The second year on the service will take all Friday night calls. On weekends, one intern and his/her third-year back up will cover from rounds at 8:00am (including pre-rounding) until 6:00pm, at which point night float will take over.

The team will take ER call, whereby they assume responsibility for the care of any unassigned patients that need to be admitted from the ER, usually every 3<sup>rd</sup> night. CSRFHC continuity

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patients, including pediatric patients, and nursing home patients, should be admitted at any time. Newborns will also be admitted to the service at the time of delivery. The delivering resident and/or nursing staff will notify the resident holding the pager at the time of delivery. That resident is then responsible for completing the H&P for that newborn.

Prior to the beginning of each block, the chief of the service will provide all residents with a schedule including when he/she will hold the on-call pager, when the resident will take short call and weekend call, and when talks are to be given. The schedule should be reviewed by each resident on service and any questions directed to the chief of the service as soon as possible in order to allow the chief to make appropriate adjustments as necessary.

In addition to patient care, the resident is responsible for maintaining a billing form for each of his/her patients. The chief of the service will review the daily level of service and will collect billing forms to review with the attending on a weekly basis.

At the end of the block, each resident is expected to dictate a detailed off-service note for all patients who will still be in the hospital at the beginning of the next block. It is also helpful to write a brief summary in the chart for the resident who will take over care of the patient in case the dictation is not available immediately.

All admission H & Ps and discharge summaries and any questions or concerns related to the inpatient service should be addressed to the chief of the service for that block, the Chief Resident, and attending faculty in that order of priority.

Responsibilities for each resident on the service are addressed below:

The 1<sup>st</sup>/2<sup>nd</sup> year resident will be responsible for carrying the on-call pager during several mornings and afternoons each week (according to the schedule made by the chief of the service prior to the beginning of the block). While holding the pager, the resident will answer all calls from the floor and will be responsible for working up any new admissions. After clinic hours, the resident will answer home calls from Family Health Center continuity patients.

Any questions or concerns related to the inpatient service are addressed to the senior resident, chief resident and attending faculty in that order of priority.

#### First year residents:

1. The resident will work-up, write orders and be the primary physician during the hospitalization for patients admitted to the Family Medicine Service at CHRISTUS Santa Rosa Health Care. The resident will complete appropriate record keeping tasks including daily progress notes, discharge summaries and consultation requests. (Per SRHC policy, all verbal orders must be signed within 24 hours.)
2. The first year resident will consult with their 3<sup>rd</sup> year back-up and/or chief of the service on all admissions, and on any complicated case or any case potentially beyond the level of expertise or experience of the first year resident. The attending needs to be notified of

all ICU admissions and is available for discussion of any questions the residents may have.

3. The first year resident will have 1-2 short calls/week and will cover both days of two of the four weekends/block.
4. The first year residents will discuss at the patients at Morning Report that they admitted while on call.
5. The first year resident will write a full H&P and admit orders for all Family Health Center patients that need to be admitted through the ER. Incarnate Word Nursing Home residents (including Dr. Norris' private patients) are continuity patients and should be admitted when necessary. On ER call nights, the intern will also admit patients from the ER who does not have a primary physician. All 1<sup>st</sup> year H&P's must be cosigned by a 2<sup>nd</sup> or 3<sup>rd</sup> year resident.
6. The 1<sup>st</sup> year resident will be responsible for carrying the on-call pager during several mornings and afternoons each week (according to the schedule made by the chief of the service prior to the beginning of the block). While holding the pager, the resident will answer all calls from the floor and will be responsible for working up any new admissions. After clinic hours, the resident will answer home calls from Family Health Center continuity patients.

Second year residents:

1. The second year resident will share in the work-up of patients, the writing of orders, completion of record keeping, and the primary care of patients admitted to the Family Medicine Service. The resident will complete appropriate record keeping tasks including daily progress notes, discharge summaries and consultation requests. The second year resident will work closely with the first year resident, being physically present when available, and teaching when possible. (Per SRHC policy, all verbal orders must be signed within 24 hours.) They may also cosign intern notes.
2. The second year resident will have one short call/week and will take night call (6pm-8am) and every Friday night while on service.
3. The 2<sup>nd</sup> year resident will be responsible for carrying the on-call pager during several mornings and afternoons each week (according to the schedule made by the chief of the service prior to the beginning of the block). While holding the pager, the resident will answer all calls from the floor and will be responsible for working up any new admissions. After clinic hours, the resident will answer home calls from Family Health Center continuity patients.

### Third year residents:

1. Third year residents serve as chief of the service for a total of 8 weeks and will cross-cover the service for 4 weeks during the year. The 3<sup>rd</sup> year is responsible for the team and may be called on to cover the service if the first or second year residents are unavailable, specifically during the Thursday afternoon lectures.
2. Third year residents provide supervision to the first year residents. During this time, the third year resident should be available and physically present to teach and work with the first year resident and his or her patients. All first year H&P's must be cosigned by the third year (or second year) resident.
3. The third year resident provides supervision to the first year resident any time the 1<sup>st</sup> year is on call. The third year resident is expected to be physically present for admissions and available as needed for other supervisory needs of the first year resident. During the second half of the year, and if the PGY I feels comfortable, the third year resident could possibly begin taking call from home. This decision will be made upon approval by Program Director and not at the discretion of the third year resident.
4. The third year resident conducts Morning Report (both weekday and weekend) when they are on service. The report consists of the presentation of new admissions, updates on current patients, and difficult or interesting phone medicine problems or emergency care. The 3<sup>rd</sup> year is to assign presentation times to each of the lower level residents with the goal of presenting 2 presentations per week. The third year resident should contact the resident coming off call prior to 7:00 am to assess the needs of the service and confirm that resident's availability for morning report. Copies of all Morning Report presentations must be given to the Residency Coordinator for each resident's official file.
5. The cross-cover 3<sup>rd</sup> year resident will cover 1-2 short calls/week and both days of the 1<sup>st</sup> and 3<sup>rd</sup> weekend of the block.
6. If, for any reason, the third year resident on-call must miss his or her call, it is the responsibility of that resident to find another third year resident to cover call for the assigned period.

### **NIGHT FLOAT**

Night float will assume responsibility for the service beginning at 9:00pm on weekdays and 6:00pm on weekends and holidays. The resident on short call is expected to provide the night float with a detailed check out for each patient on the team (not just his/her patients). The night float is responsible for asking any questions that may come up in order to clarify patient issues. The night float is then responsible for any pending to-do items, new issues that come up during the night as well as new admissions. Please be courteous to your night float--remember to do unto others as you would have them do unto you. It is poor form to leave multiple to-do items that could have been done during the day. It is also poor form to leave admissions for the night

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float if the call is received before 9:00pm (6:00pm weekends and holidays).

## **FAMILY MEDICINE INPATIENT SERVICE GUIDELINES FOR ALL RESIDENTS**

Each resident assigned to the service is expected to attend the following required sessions unless emergency patient care or other rotation arrangements preclude attendance:

### **1. MORNING REPORT: 8:00 a.m., Conference Room 4<sup>th</sup> floor, F Building**

Attendees: Family Medicine attending, residents on the inpatient service, night float, medical students. The Psychologist, Pharmacists & pharmacy students are also often present.

Purpose: Residents present cases and management rationale. Chief of the service and attendings teach the entire group. Night float presents the admissions from the night before. X-rays, labs, etc. that were taken overnight will be reviewed.

Night float is expected to be present in rounds each day. The attending and chief will determine when the night float may be excused. If the night float has morning clinic, he/she is expected to be present in rounds from 8:00-8:30 am to present new admissions/overnight events.

### **2. ATTENDING ROUNDS: (Immediately following Morning Report) at SRHC**

Attendees: Family Medicine attending, Family Medicine team, medical students.

Purpose: See the patients who are newly admitted to the service, who are critically ill, who are not improving with current treatment, who need changes in their therapeutic plan, and who are newborn nursery patients. Patients about whom the residents have specific questions or concerns are also seen at this time.

### **3. WORK ROUNDS: (Immediately following Attending Rounds) at SRHC**

Attendees: Family Medicine team, medical students.

Purpose: See the patients, do the patient follow-ups, order labs, continue treatment plans, etc.

### **4. CHECKOUT MORNING ROUNDS: 11:30am at SRHC**

The chief of the service will generally meet with the team before or after the noon lecture to get an update on patient progress. Residents who have clinic will check out the person carrying the pm pager at this time.

### **6. CHECKOUT AFTERNOON ROUNDS: 4:30 pm at SRHC**

Residents may check out to the short call resident at 6:00pm (or earlier with chief approval).

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Short call will check out to night float at 9:00pm.

Note 1: No one leaves until all the work is done. For example, if a resident, who is on the inpatient service, is finished with his or her afternoon clinic, and the FP team has two new admissions, the resident from the clinic, helps the FP team finish the hospital admissions.

Note 2: The chief of the in-patient Family Medicine Service team must be available each day of the weekend (Saturday and Sunday) for morning report and rounding on patients even if s/he is not on call for that weekend in order to provide continuity of care of the patients on the service. Your rotation on the Family Medicine service does not end on Friday evening, but at 6:00 am on the Monday morning of the next rotation. The night float will attend morning report for that Monday with the new team.

Note 3: Holidays will follow a weekend schedule. If that day is an ER call day, additional residents may be asked to come in for rounds and floor work. This is to be determined by the chief of the service.

#### **7. FAMILY MEDICINE DIDACTICS - Thursday afternoons in the Residency Classroom**

#### **8. FAMILY HEALTH CENTER PATIENT CARE**

In general, residents will be scheduled to see patients in the FHC according to the year of experience:

- 1-2 half days/week - 1<sup>st</sup> year residents
- 2-3 half days/week - 2<sup>nd</sup> year residents
- 3-4 half days/week - 3<sup>rd</sup> year residents

New mandates from ACGME state that residents see a certain number of patients per year. These numbers are a total of:

- At least 150 patients per year - 1<sup>st</sup> year residents
- At least 1650 patients for all 3 years - 3<sup>rd</sup> year residents

#### **HOUSE STAFF - ATTENDING COMMUNICATIONS**

The resident in charge of patient care must notify and communicate with the Family Medicine attending covering the service at the time of any of the following:

1. any admission to the service; Night time ICU patients and chest pain admissions must be reported to the attending;
2. any significant change in patient condition or major change in management including the need for invasive diagnostic and surgical procedures;
3. any death occurring on the service;

4. any significant family concerns or patient complaints;
5. any significant conflicts among nursing or other professional staff regarding patient care.

Note: The house-staff and attending should be communicating regularly about the care of each patient. This includes discussion of the need for consultations from other services or specialties.

### **WEEKEND SIGN OUT (Sat., Sun., Holidays)**

The inpatient service team will meet with the resident coming off call and the resident starting call (time determined by attending) at CSRHC. When the third year resident is on call with a first year resident, the third year resident should be present with the first year at weekend morning report.

### **IN-HOUSE CALL**

The resident is expected to take call in house when s/he is on call.

### **CHRISTUS Santa Rosa Health Care Newborn Patients - Team Responsibilities**

1. History and physical examinations must be completed in a timely fashion.
2. The delivering resident or nursing staff will notify the team when a baby is delivered.
3. All newborn patients MUST have their neonatal screens prior to discharge.

### **ADMITTING PROCEDURES (FOR DIRECT OR CLINIC ADMISSIONS)**

1. Call Admitting (704-2126) and ask for Bed Control.
2. Tell them that you have a patient to be admitted to the hospital.
3. Give them your name (resident's name) and the attending physician's name.
4. Give the patient's name, age or date of birth, and insurance coverage.
5. Tell them when the bed is needed e.g., 10pm tonight, 7am tomorrow, ASAP, etc.
6. Tell them from where the patient is being transferred e.g., at home, at a doctor's office (specify), at another hospital (specify), etc.
7. Tell them the type of bed needed e.g., ICU, telemetry, med/surg, etc.
8. Tell them the provisional diagnosis of the patient.

Admitting/Bed Control will tell you whether or not a bed is available for that patient. They will tell you one of three options:

- (1) That a bed is available and to send the patient to Hospital Admitting to register and then they will send the patient up to the designated floor. Once the patient is on the specified floor, a nurse will call the resident to get the admitting orders.
- (2) That the patient is on "call back", which means that the beds are full or that they

do not have the staff and as soon as there is a change in the bed or staffing situation they will call the patient to come to the hospital. The resident will need to provide a phone number of where the patient can be reached.

- (3) That the patient is not accepted and that you need to check with another hospital.

All of these options need to be discussed with the attending on call.

On-Call Pager Number- 210-231-1598

## FAMILY MEDICINE MATERNITY SERVICE ORIENTATION

The Maternity Service's emphasis is on family-oriented maternity care, continuity of care and teaching by family physicians and obstetrical faculty.

### Requirements for passing the rotation

- ◆ 10 vaginal deliveries
- ◆ 3 first assists at C-section
- ◆ Provide appropriate and attentive care to all patients with whom you are involved.

### Weekday Schedule

- ◆ 2 residents (usually) are assigned to the rotation.
- ◆ Your primary responsibility is to the FM patients.
- ◆ You are encouraged to be involved with all the private patients that belong to the private OBs who request your assistance.
- ◆ You will always be in Labor and Delivery, in clinic or attending your core curriculum lectures.
- ◆ CONFERENCE IS A PRIORITY—NOT PRIVATE OB PATIENTS IN OB TRIAGE!!!!

### Morning Rounds

- ◆ Before 0700h, resident going off call (if not assigned to L&D that morning) will check out to resident arriving for the day. If the transition is made midday, check out will be done then.
- ◆ 0700h: Rounds begin in the Physician Lounge on Labor and Delivery. We will proceed to the patients' rooms.
- ◆ All FM patients (ante partum and postpartum) will be formally presented, and the patients will be seen.
  - ◆ Team will discuss and formulate plans as needed.
  - ◆ Short didactic lectures will be given when time allows. These may be by faculty or residents (see separate lecture schedule).

### Evening Rounds

- ◆ 1800h: Resident(s) going off call will give report and written sign-out to resident coming on call.

### Weekends

- ◆ Resident going off duty at 1800h Friday evening will inform inpatient service resident-on-call of names and room numbers of FM patients and plans for those patients.
- ◆ Inpatient resident-on-call will evaluate FM OB patients who present to OB Triage/L&D between 1800h Friday evenings and 1800h Sunday evenings.

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- ◆ The continuity doctor for any patient seen during the above hours will be called and will manage the patient in-house if she is in labor.

### Responsibilities

- ◆ Admissions
  - ◆ Complete H&P's on all admissions (forms available in OB Triage).
  - ◆ Prenatal record, if available, must be on chart. You may need to go to the clinic to find records.
  - ◆ Inform the patient's continuity doctor of her admission. The resident providing continuity care for the patient is expected to care for her while she is in the hospital.
  - ◆ Call the inpatient service resident on-call to inform them of upcoming newborn admissions. Someone from the inpatient service will attend the delivery.
- ◆ Discharges
  - ◆ All FM discharges will be dictated. The dictation may be brief if hospital course was uncomplicated. You must include: medications, instructions, diet and follow-up plans. The attending of record will be the attending FP or OB who supervised the delivery.
  - ◆ All prescriptions will be written for any needed medications.
  - ◆ Review the discharge instructions YOURSELF with the patient and sign the discharge instruction sheet.
  - ◆ Inform PCP of patient's hospital course, especially if the patient is to be followed-up in 1-2 weeks.
  - ◆ Normal discharge follow-up is in 6 weeks for normal vaginal deliveries, 1-2 weeks for Cesarean delivery, 3<sup>rd</sup>/4<sup>th</sup> degree lacerations and fetal loss.
- ◆ Progress Notes
  - ◆ DOCUMENTATION IS VERY IMPORTANT!!!!!!!
  - ◆ All notes (and orders) will be dated and timed. Notes should be written in SOAP format.
  - ◆ Every morning, all the ante partum and postpartum patients will have notes written.
  - ◆ While in active labor, notes q 2h.
  - ◆ While in labor on Mg, Pitocin or in other high-risk situations, notes q 1-2h.
  - ◆ Postpartum patients on Mg, notes q 4h.
  - ◆ Notes for ANY management changes with justification (includes any procedures during labor).
  - ◆ All postpartum patients cared for with private OBs will be seen daily.

### Interns

- ◆ All exams to be checked and confirmed by the FP/OB attending, the R2 or labor nurse until you have gained more experience.
- ◆ All management decisions for FM patients must be discussed with the R2 or with the attending if no R2 is on duty...

- ◆ Before leaving for clinic or lecture or off call, provide a written sign out for all of your patients to the resident on Labor and Delivery for that day or evening.
- ◆ You should help in the teaching of any medical students rotating on the service.

### R2's

- ◆ Your exams only need to be checked by the attending for any significant abnormal findings, but, if you are unsure, do not hesitate to seek help or confirmation.
- ◆ You are expected to be available to assist the interns as much as possible, both in Labor and Delivery and on the wards. Additionally, you should take a leading role in teaching medical students who are on rotation.
- ◆ Before leaving for clinics or lecture or off call, provide a written sign out for all of your patients to the resident on Labor and Delivery for that day or evening.

### Consults

- ◆ Must be attending to attending

### Continuity FM Patients

- ◆ The expectation is that you will come to see your continuity patient as soon as you can after she is admitted.
- ◆ You may NOT manage by "Call me when she's ready" and expect the L&D team to do all the work/management.
- ◆ If your continuity patient is admitted in labor between 1800h Friday-1800h Sunday, you must come in to manage her labor and delivery.
- ◆ If you go on vacation/away rotations etc., you must make arrangement with your co-managing resident to care for your patient if she comes in to deliver.
- ◆ Your co-manager must see the patient antenatally at least twice.
- ◆ Keep your patient informed if you must be gone and are having your co-manager cover for you.
- ◆ After continuity patients deliver, the OB service team will make formal rounds on them in the mornings, Monday-Friday.
- ◆ You are, however, expected to see the patient daily at least for "social" rounds.

### Assignment of Newborns and NICU Babies

- ◆ Continuity patients' babies are assigned to the inpatient service.
- ◆ Occasionally, a patient will have a pediatrician. In that case, the baby is assigned to that pediatrician unless the patient wishes for the inpatient service and the continuity physician to care for the baby.
- ◆ It is the responsibility of the delivering resident to notify the inpatient service of the baby's impending birth.

- ◆ It is most appropriate for the continuity physician to do the baby's initial physical and to continue to follow the baby while still in the hospital.
- ◆ If a baby goes to NICU, it is still the responsibility of the delivering resident to notify the inpatient service—these babies do not always stay in NICU.
- ◆ The continuity and the rounding doctors must check on the baby—even when the baby is in the NICU.
- ◆ It is very bad form to ask the mom how her baby in NICU is—YOU SHOULD KNOW—you're her doctor.
- ◆ When a private OB with whom you have delivered assigns a baby to the inpatient service, it is the delivering resident's responsibility to notify the inpatient service.

### Recording Deliveries and Procedures

- ◆ All deliveries must be recorded in the Family Medicine Delivery Logbook kept in the Physician Lounge. This includes ALL deliveries in which you are involved, whether Family Medicine (continuity) patients, ER drop-in patients, private OB patients, 1<sup>st</sup> assists at C-sections, etc.
- ◆ Read and follow the instructions at the front of the log.
- ◆ Accuracy is VERY IMPORTANT, since the log is the source for determining monthly statistics and information for Morbidity and Mortality reviews.
- ◆ Keep a personal record of all procedures you perform, including deliveries, C/S's, NSTs, placement of scalp electrodes or IUPCs, ultrasounds, etc. If you do not keep track of your procedures as you perform them, it is extremely difficult to go back and locate them. Begin now.
- ◆ Two residents may not count the same delivery as a continuity patient. Designate in the log if you are the supervising resident.

### Private OB's

- ◆ A list of private OBs who work with us is posted in the Physician Lounge on L&D and in the on-call notebooks in OB Triage and the L&D nursing station.
- ◆ All management decisions are to be discussed with the private OB before implementation OR discussion with the patient and/or her family. Ask the nurse who is taking care of the patient if she has spoken with the private OB recently. If not, and it is time for an update or a decision, you may call the private OB. Ask if they wish to speak with the nurse also before hanging up.
- ◆ Santa Rosa faculty does not participate in the care of private OBs' patients except under emergent conditions or if specifically asked by the private OB.
- ◆ DO NOT perform procedures on private OB patients unless specifically asked to by the OB. They may request this through the nurse.
- ◆ If the private OB wishes to transfer care to the FM team, this arrangement must be made attending to attending.
- ◆ See any and all patients of the private OBs with whom we work unless specifically asked not to.

- ◆ If someone does not check them out to you or the nurses do not seem to be calling you, go looking for them in L&D, OB Triage and Mother-Baby. Inform your attending of any problems with not being called by the nurses.
- ◆ If you have not done any work with a private patient, do not expect to be called for the delivery.
- ◆ DO NOT see patients or perform any procedures on patients of OBs we do NOT work with. If asked to do so by the nurses or the OB, go to your attending faculty member for guidance.
- ◆ If you assist one of the "non-participating" private OBs and feel you are treated badly, DO NOT respond in kind. Be polite, excuse yourself and leave.
- ◆ If you are the only assistant in a C-section, you cannot leave at a critical point in the surgery.
- ◆ All postpartum patients cared for with the private OBs will be rounded on by the residents and notes written.

### Problem Solving

- ◆ Use the "chain of command"—the "go to" person is your R2. The R2 will discuss any problems with the faculty as appropriate. This is for resident to resident issues.
- ◆ For nursing issues, first go to the charge nurse, then to your faculty if the problem is not resolved.

### Suggested Readings

- ◆ Williams Obstetrics
- ◆ Gabbe's Obstetrics: Normal and Problem Pregnancies
- ◆ AFP Journal
- ◆ ACOG Bulletins (complete set available in Physician Lounge on L&D)
- ◆ Numerous articles on varied subjects are kept in the file cabinet in the Physician Lounge on L&D.
- ◆ Additional articles are kept in notebook in the copy room in the administrative offices of the residency program.

### Good Advice

- ◆ Be prompt.
- ◆ Be professional in your dress, mannerisms and attitude.
- ◆ Be sensitive to other people's culture, language differences, level of training/ability, etc.
- ◆ Learn to get along with your colleagues.
- ◆ Come to rounds knowing something about the conditions the patients have.
- ◆ READ!
- ◆ Do not leave undone that which is yours to do.
- ◆ Be nice to the nurses.

# **HOSPITAL SAFETY**

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## ENVIRONMENT OF CARE

In the healthcare environment, there are important safety elements that you must be aware of in order to keep you and your patients safe. These elements are called the “*Environment of Care*” and consist of seven areas, which are:

- ❖ SAFETY
- ❖ SECURITY
- ❖ HAZARDOUS MATERIALS & WASTE
- ❖ UTILITIES MANAGEMENT
- ❖ EMERGENCY PREPAREDNESS
- ❖ FIRE PREVENTION
- ❖ MEDICAL EQUIPMENT

### SAFETY

- Visually check electrical equipment before use.
- Utilize good body mechanics when lifting, moving and managing patients .
- Personal protective equipment and clothing are required for your protection from exposure and hazardous chemicals.
- Prevent trips/slips/falls, be aware of your surroundings, including objects on the floor, wet floors, spills.
- Report accidents or injuries to you patients to the nurse manager/supervisor.
- Report accidents or injuries to yourself to the Associate Health Nurse or the Nursing Supervisor.
- Complete a “Visitor and Property Incident Report”.

### SECURITY

- Secure your valuables.
- Report any suspicious circumstances (Security officer can be reached through the hospital operator, dial “0”).
- Know the “Emergency Codes” and your role:
  - **Code Red - actual or suspected smoke or fire and its location**
  - **Code Gray - disaster**
  - **Code Pink - actual or suspected infant or adolescent abduction**
  - Code Purple - workplace violence
  - Code Yellow - chemical, radiological, or biological contaminated patients
- Know the CSRHC Emergency phone numbers:
  - CSR-City Centre – x 2400
  - CSR-Medical Center Campus – x 7777

## HAZARDOUS MATERIALS & WASTE

- Information on hazardous chemicals, MSDS (Material Safety Data Sheets), for the patient care areas are available at the nursing stations.
- Notify the Housekeeping Supervisor (dial “0” for Hospital Operator) for mercury spills and small chemical spills.
- Properly dispose of biohazard waste in the appropriate labeled receptacles.
- Properly dispose of sharps in the appropriate puncture resistant containers.

## UTILITIES MANAGEMENT

- Report building, systems and equipment problems and failures to the nursing station.
- Remember that only RED outlets work in cases of lost electrical power.

## EMERGENCY PREPAREDNESS

- Code Gray is announced for Internal or External disasters or emergencies. Please report to Physician Services for assignment.
- Bomb threats are announced, “*May I have your attention. Prepare for immediate inspection*”. Look for anything suspicious in the area; Call Security (dial “0” for Hospital Operator) if you find anything that looks suspicious. Do not attempt to touch any suspicious items.

## FIRE PREVENTION

- If there is smoke or fire in the immediate area remember the **R.A.C.E.** formula (**Rescue, Alarm, Confine, Evacuate**).
- If there is smoke or fire in other areas - see the nursing staff for information on what actions you may have to take.
- The “You are Here” maps by the elevators provide fire evacuation routes.

## MEDICAL EQUIPMENT

- Preventive maintenance (P.M.) - know if P.M. is current on medical equipment (indicated by a dated sticker) before you use it on a patient.
- If there is an equipment problem or failure, please notify the nursing staff.
- Know capabilities and limitations of the medical equipment you use.
- You must be trained on any new medical equipment before using it on a patient.
- All outside medical equipment must have a safety check performed before use.

**For questions or more information on these issues call the Safety Officer at 704-2020.**

## INFECTION CONTROL ISSUES FOR MEDICAL STAFF

### ISOLATION PRECAUTIONS

**STANDARD PRECAUTIONS** extend the use of universal precautions to all body fluids (except sweat). These Standard Precautions (hand hygiene and barriers to prevent direct contact with blood/body fluids) are to be followed for all patient contact. **Hand Hygiene** practices are a primary component of Standard Precautions and are necessary before and after patient contact. Healthcare Providers must wash their hands thoroughly after any contact with blood and other body fluids and whenever visible soiling is noted. Alcohol based antiseptic hand rubs are recommended for hand hygiene before and after patient contact when hands are not visibly soiled. Hand rub dispensers are available at the entrance to patient rooms and within multi-patient wards.

**In addition to Standard Precautions, TRANSMISSION BASED PRECAUTIONS** are categorized by the route of disease transmission and include:

- A. **AIRBORNE PRECAUTIONS**—designed to reduce the risk of spread of very small infectious particles that can float in the air and cause infection in others. Airborne Infection Isolation Rooms (negative airflow rooms) are needed to prevent the risk of transmission to persons outside the room.
  - ◆ Airborne Precautions (AFB) – pulmonary or laryngeal TB--use of “*Particulate Respirators*” (N95 Masks) are recommended for **ALL** treating physicians. Fit testing is available upon request. (Consult the Cardiopulmonary Department for assistance.) Airborne Precautions including use of N95 masks is also required for suspected and confirmed cases of SARS and smallpox.
  - ◆ Airborne Precautions (Viral) – chickenpox, disseminated zoster, and measles---recommended that only immune persons enter the room.
- B. **DROPLET PRECAUTIONS** – masks are used to prevent contact of the nose and mouth to large particles (droplets which travel 3 feet or less) containing infectious organisms—e.g. *B. pertussis*, influenza, invasive *N. meningitidis* & *H. influenzae* disease.
- C. **CONTACT PRECAUTIONS** – reduces the risk of spread of organisms through direct (physical contact) and indirect contact (through a fomite), which are likely to cause infection in other:
  - ◆ Contact Precautions (Basic) – e.g. rotavirus, Shigella, RSV, *C. difficile* infection, MRSA
  - ◆ Contact Precautions (VRO) – e.g. VRE, VIRSA, VRSA

D. **STANDARD PULMONARY PRECAUTIONS** --- A new category of precautions utilized for patients with Cystic Fibrosis.

Detailed instructions are listed on the isolation signs, with common diseases identified on the back of each isolation sign as appropriate.

## **INFECTION RISKS FOR PHYSICIANS AND RECOMMENDED VACCINATIONS**

### **VACCINES**

- ◆ **HEPATITIS B** – Nosocomial transmission of HBV is a serious risk for physicians and other health care providers/personnel. The risk is greatly reduced by use of vaccine and adherence to other preventive measures (e.g. Standard Precautions). The risk of acquiring HBV infection from occupational exposure is dependent on the nature and frequency of exposure to blood or body fluids containing blood. Hepatitis B vaccination of physicians who have contact with blood and body fluids can prevent transmission of HBV and is strongly recommended. Booster doses of vaccine are not routinely recommended because persons, who respond to the initial vaccine series, remain immune even after antibody levels become low or undetectable.
- ◆ **VARICELLA** – Nosocomial transmission of varicella-zoster virus (VZV) is well recognized. All susceptible physicians and other health care providers/personnel are at risk for varicella and its complications. VZV is transmitted by contact with infected lesions, and by airborne transmission. Varicella vaccine is recommended for all susceptible health care providers, especially those who will have close contact with persons at high risk for serious complications of infection. Varicella vaccination in adolescents and adults requires two doses of vaccine to achieve high seroconversion rates.
- ◆ **INFLUENZA** – All physicians and other healthcare workers should get the “flu vaccine” annually so they do not develop influenza and pass the virus to those at high risk for influenza-related complications, such as persons 50 years of age or over and those of any age with chronic medical conditions. You should follow consistent hand hygiene and other infection control recommendations to prevent influenza transmission.
- ◆ **TD** – Booster doses every ten (10) years.
- ◆ **MMR** – Current vaccinations or serologic evidence of immunity.

### **TUBERCULOSIS**

The risk of TB transmission is increased in health care facilities in our community. Among health care providers with known exposure to an infectious patient with TB (or those involved in patient care during prolonged nosocomial outbreaks of TB) the skin-test conversion rates have

been higher. It is very important for physicians and other health care providers to receive an annual PPD test. For health care providers without a PPD test in the past twelve (12) months, two (2) injections given one to three weeks apart are needed to minimize the likelihood of confusing reactivity from an old infection (boosting) with reactivity from a recent infection (conversion). For health care providers with positive PPD-test results, preventive therapy with isoniazid is usually indicated, unless there are contraindications to such therapy.

For additional information or questions, please contact the CSRHC Infection Control Department at 704-2525.



## NATIONAL PATIENT SAFETYGOALS

### 1) **Improve the Accuracy of Patient Identification**

- ❖ Always verify correct patient, correct procedure, and correct procedure site.
- ❖ Utilize active communication.
- ❖ Use of “time-out” prior to surgical or invasive procedures.

### 2) **Improve the Effectiveness of Communication Among Caregivers**

- ❖ Write legibly.
- ❖ Utilize only approved/standardized abbreviations.
- ❖ Read-back of verbal orders.

### 3) **Improve the Safety of Using High-Alert Medications**

- ❖ Control and standardization of drug concentrations available.
- ❖ Pharmacy staff provides clinical intervention and oversight.

### 4) **Eliminate Wrong Site, Wrong Patient, and Wrong Procedure Surgery**

- ❖ Applies to operative procedures and any invasive procedure that exposes the patient to more than minimal risk.
- ❖ Pre-op verification process.
- ❖ Marking the surgical or invasive site is required for the following procedures
  - Right/Left distinction (such as left knee, right elbow)
  - Multiple structures (such as fingers and toes)
  - Multiple levels (such as the spine)
- ❖ **Use of “time-out” prior to surgical or invasive procedures.**

### 5) **Improve the Safety of Using Infusion Pumps**

- ❖ Do not allow inadvertent free flow.
- ❖ Always use administration set specified for the pump.

### 6) **Improve the Effectiveness of the Clinical Alarm Systems**

- ❖ Clinical alarms are tested as part of routine, scheduled preventive maintenance.
- ❖ Care-givers using clinical alarms must know how to activate the alarm, how to set the correct parameters, and insure the alarm is audible.

- ❖ When patient's alarm sounds:
  - Staff must physically enter the patient room
  - Observe the patient
  - Evaluate the reason for the alarm

**7) Reduce the Risk of Health Care-Acquired Infections**

- ❖ Comply with current CDC hand hygiene guidelines.
- ❖ Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-acquired infection.

**8) Reconcile Medications across the Continuum of Care**

- ❖ Complete list of patient's medications is communicated to the next provider of service

**9) Reduce the Risk of Patient Harm from Falls**

- ❖ Identify patients with a high risk for falls.
- ❖ Any patient wearing high-risk identifier ambulating without assistance should immediately be assisted to a place of rest and the nurse notified.

# **DOCUMENTATION AND COMPUTER ACCESS**

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## **MEDICAL RECORDS**

The residents are to dictate all admitting notes, history and physicals, daily notes, and discharge summaries. At the beginning of the dictation, make sure to mention your name and the attending's name and department, so that the Medical Records department knows who is responsible for signing the chart. Both the resident and the attending must sign brief hand written notes in the hospital charts.

To make sure that all chart notes have been transcribed, the residents may call (704-2286) or visit the Medical Records department (first floor, C building) and obtain a list of their incomplete charts. Remember that dictations take from one to ten days to complete, depending on the dictation. Once the note is dictated, the resident's attending is responsible for signing the dictated note. Charts will be listed as incomplete on the faculty's list if the chart has not come back from dictation. If all dictations are complete, the faculty member's list will be empty.

The Medical Records department is accessible 24 hours a day, seven days a week. The department is open from 7am - 12 am Monday through Friday and on the weekends from 7am - 3:30pm. If you need access to the hospital charts at times when the department is closed, call ahead to the department during office hours, let them know which charts you will need and when you will be coming. The department personnel will prepare what you requested and set the charts aside in the doctor's area. Call security to let you in when you are ready to review the charts.

## **DELINQUENT MEDICAL RECORDS**

Because of the consequences related to incomplete medical records and late billing, strict compliance with completion of the medical records will be enforced. CHRISTUS Santa Rosa Hospital will notify the faculty within thirty days if you have any incomplete charts. The faculty will follow up with you. The charts must be completed within two weeks from the time you were notified by the faculty. **Charts not completed after faculty notification will result in loss of one vacation day per week delinquency.**

## **ACCESS TO MEDICAL LIBRARY RESOURCES**

The Harold S. Toy, M.D. Memorial Health Science Library is located on the fifth floor of the CHRISTUS Santa Rosa Center for Children and Families. The library is managed by Jann Harrison, RN, MSN, and are open weekdays from 8:30 AM until 4 PM. The library holdings consist of a collection of 127 journals (69 of which are currently being received monthly or weekly) and a wide array of text books. For a complete list of available journals see listing below.

As a courtesy to our Medical Staff, Residents, and Professional Staff, we provide internet access for MEDLINE journal searches and the ability to obtain full text articles of journals that are not

contained in our library through Docline. You can search MEDLINE by going to the National Library of Medicine PubMed site at [www.ncbi.nlm.nih.gov/PubMed](http://www.ncbi.nlm.nih.gov/PubMed).

In addition, CSRHC provides free access via the intranet to UpToDate, the most current point-of-care clinical information available. From any in-house computer, go to the CSRHC home page at <http://intranet.christushealth.org/santarosa>. Click on Library on the upper right strip, and from there, link to UpToDate. You can search for evidence-based clinical information on Internal Medicine & Subspecialties, Obstetrics & Gynecology, Family Practice, and Pediatrics.

Please feel free to come by the library, or contact Jann Harrison with your library requests at (210)704-3785 or via e-mail, [jann.harrison@christushealth.org](mailto:jann.harrison@christushealth.org).

**CHRISTUS Santa Rosa Health Science Library**  
**Journal Holdings 2008**

<b>Journal</b>	<b>Years held</b>
1. ACP Journal Club	2000 – present
2. Advances in Nursing Science	1990 - 1998
3. American Family Physician	1981-1993, 1997-present
4. American Heart Journal	1976 - present
5. American Journal of Cardiology	1980-1985
6. American Journal of Clinical Nutrition	1994 - 2002
7. American Journal of Clinical Pathology	1976 - present
8. American Journal of Diseases of Children	1984 - 1993
9. American Journal of Human Genetics	1990 - 2002
10. American Journal of Infection Control	1992 - present
11. American Journal of Managed Care	1999 - 2001
12. American Journal of Medicine	1978 - present
13. American Journal of Nursing (OVID)	1988 - present
14. American Journal of Obstetrics and Gynecology	1977 - present
15. American Journal of Psychiatry	1983 - 2000
16. American Journal of Respiratory & Critical Care Medicine	1994 - 2007
17. American Journal of Roentgenology	1982 - 1986
18. American Journal of Surgery	1976 – present
19. American Journal of Sports Medicine	2007 - present
20. American Review of Respiratory Disease	1981 - 1993
21. Anesthesia and Analgesia	1980 - 1995
22. Anesthesiology	1980 - 1997
23. Annals of Emergency Medicine	1987 - present
24. Annals of Internal Medicine	1978 - present
25. Annals of Surgery (OVID)	1976 - 2006
26. AORN	1994 - 2004
27. Archives of Disease in Childhood	1976 - 2004

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28. Archives of Internal Medicine	1976 - present
29. Archives of Neurology	1976 - 2006
30. Archives of Pathology and Laboratory Medicine	1976 - present
31. Archives of Pediatrics and Adolescent Medicine	1994 - present
32. Archives of Physical Medicine and Rehabilitation	1990 - 2006
33. Archives of Surgery	1986 - present
34. Blood	1976 - 2005
35. Bone Marrow Transplantation	1995 - 1997
36. British Medical Journal	1977 - 2004
37. Cancer	1976 - present
38. Chest	1976 - present
39. Circulation (OVID)	1981 - 2006
40. Clinical Journal of Sports Medicine (OVID)	2002 – 2006
41. Clinical Nurse Specialist	1994 - 2001
42. Clinical Orthopaedics and Related Research (CORR) (OVID)	1953 - present
43. Clinical Pediatrics	1990 - present
44. Critical Care Medicine (OVID)	1990 - 2006
45. Critical Care Nurse	1996 - 2004
46. Current Problems in Pediatrics and Adolescent Healthcare	1991 - present
47. Diabetes	1989 - 1992
48. Diabetes Care	1992 - 2002
49. Dimensions of Critical Care Nursing	1991 - 2002
50. Ethics & Medics	1994 – present
51. Family Medicine	1997 – present
52. Gastroenterology	1982 – 1991
53. Geriatrics	1993 - 2007
54. Haemophilia	2004 – 2006
55. Harvard Business Review	1992 - present
56. Hastings Center Report	1992 - 2004
57. Health Care Management Review	1989 – 2001
58. Health Progress	1984 – present
59. Heart & Lung	1980 – 2006
60. Hospital Progress	1980 - 1984
61. Hospitals	1989 - 1992
62. Hospitals and Health Networks	1993 – 2001
63. Infectious Disease Clinics	1992 - 2007
64. Instructional Course Lectures	1970 – 1998; 2003 – present
65. Joint Commission Journal on Quality and Safety	1996 - present
66. Joint Commission Perspectives	1996 – present
67. Journal of the American Academy of Child & Adol Psychiatry	1996 - 2000

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68. Journal of the American College of Cardiology	1983 - 1995
69. Journal of the American College of Surgeons	1994 - present
70. Journal of the American Medical Association (JAMA)	1978 - present
71. Journal of Bone & Joint Surgery – AM	1945 – present
72. Journal of Bone & Joint Surgery – B	1950 – present
73. Journal of Clinical Oncology	1988 – present
74. Journal of Continuing Education in Nursing	1984 - 1995
75. Journal of Family Practice	1997 - present
76. Journal of Healthcare Management	1998 – present
77. Journal of Infectious Diseases	1993 – present
78. Journal of Neurosurgery	1976 – 2006
79. Journal of Nursing Administration (OVID)	1995 – 2006
80. Journal of Nursing Care Quality (OVID)	1995 - 2006
81. JOGNN	1989 - 2001
82. Journal of Pediatric Gastroenterology & Nutrition (OVID)	1990 - 2002
83. Journal of Pediatric Hematology Oncology (OVID)	1995 - 2006
84. Journal of Pediatric Nursing	1987 - present
85. Journal of Pediatric Orthopedics (OVID)	1990 - 2006
86. Journal of Pediatric Surgery	1980 - present
87. Journal of Pediatrics	1970 - present
88. Journal of Trauma	1992 - 1995
89. Journal of Urology	1976 - 2002
90. Lancet	1976 - present
91. Mayo Clinic Proceedings	1990 - 2004
92. MCN (OVID)	1987 - 2006
93. Medical Clinics of North America	1981 - present
94. The Medical Letter	1987 - present
95. Med-Surg Nursing	1994 - 2004
96. Modern Pathology	2007 – present
97. Morbidity & Mortality Weekly Report	1986 - 2002
98. Neonatal Network	1985 - 2002
99. Neurology	1996 - 2002
100. New England Journal of Medicine	1976 - present
101. Nursing (OVID)	1990 - present
102. Nursing Clinics of North America	1981 - present
103. Nursing Management (OVID)	1991 - 2002
104. Obstetrics & Gynecology (OVID)	1996 - present
105. Oncology Nursing Forum	1995 - 2001
106. Orthopedic Clinics of North America	1982 - 1996
107. Palliative Medicine	2000 - 2002
108. Pediatric Clinics of North America	1991 - present
109. Pediatric Infectious Disease Journal (OVID)	1982 - 2006

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110. Pediatric Nursing	1994 - 2001
111. Pediatrics	1966 - present
112. Pediatrics in Review	2003 - present
113. RN	1984 - present
114. Surgery	1976 - present
115. Surgical Clinics of North America	1981 - present
116. Urologic Clinics of North America	1981 - present
117. Urology	1990 - 1997

### **COMPUTER SERVICES AND TERMINAL ACCESS**

In each of the resident offices, the residents will have access to a computer on the CHRISTUS Santa Rosa system that provides CHRISTUS Santa Rosa Intranet with E-mail, Up-to-date, (Microsoft Outlook), Microsoft Office 97, Netscape, Medscape and OVID (UTHSCSA library). Each resident will receive an access code, a password, and a brief introduction to the CHRISTUS Santa Rosa system. It could take a week to ten days before obtaining your own access to the system. If a computer is needed prior to that time, you may use the non-system computers located in the administrative offices. You will not be able to send or receive e-mail until you have been given access to the system.

### **NEW INNOVATIONS LOGIN**

Go to [www.new-innov.com](http://www.new-innov.com) Select Client Login then enter CSRA (ALL CAPS). Then enter all in (lowercase) the first initial of your first name and your last name (i.e: jresident) for your first log in, your password and your username are the same. Please change your password after your first log in. If you forget your password, please contact the Lisa or Veronica to reset your password.

### **PACS LOGIN**

Login information is the same as used for Novell login. Username & password –initials plus last four of SSN until changed upon first log in.

## **ATHENANET LOGIN**

athenanet.athenahealth.com

## **ACCESS TO LABORATORY RESULTS**

Any CHRISTUS Santa Rosa lab results can be viewed via Meditech. Access to Meditech corresponds to access to the network system. Results from labs also are received via printer at the Family Health Center every weekday morning. Each patient's lab results are placed on the designated resident's desk. Urgent or STAT lab results can be faxed to the Family Health Center or accessed via computer and a hard copy printed.

# **RESIDENT CONTRACT & JOB DESCRIPTIONS**

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## ELIGIBILITY

### RESIDENCY APPLICANT CRITERIA AND DATES

The CHRISTUS Santa Rosa Family Medicine Residency Program accepts seven new residents per year. In order to be considered for an interview, an applicant must:

- 1) Have graduated from or will graduate from an LCME accredited medical school and be eligible to apply for medical licensure in the state of Texas
- 2) Have passed the USMLE Step 1 exam, preferably on the first attempt and provide documentation of having passed USMLE Step 2 CK and CS prior to being ranked for a position in our program.

*A passing score on USMLE Step 2 (CK and CS) or the COMLEX equivalent **IS REQUIRED** before we can rank an applicant for our program. We **HIGHLY RECOMMEND** that medical students schedule Step 2 CK and CS to be completed no later than December 31<sup>st</sup> in order to assure having scores forwarded to us by our ranking deadline of February 10<sup>th</sup>.]*

- 3) Be no more than five years out of medical school OR provide documentation of at least two years of formal clinical experience in the United States (please contact residency coordinator for details)

*Applications will be accepted starting September 2007. We will begin the interview process starting October 2007 and host interviews on Thursdays and Fridays through January 2008.*

#### **How to apply:**

We accept applications only through Electronic Residency Application Service (ERAS) and take all of our residents through the National Residency Match Program. Our ERAS program number is 130420.

Eligible applicants are assessed on criteria of academic credentials, preparedness, ability, aptitude, communication skills, and specific personal qualities (commitment to family medicine, community service, leadership, motivation, and integrity). The CSRFMRP does not discriminate with regards to sex, race, color, age religion, national origin, disability, or veteran status. The CSRFMRP participates in the NRMP.

CHRISTUS SANTA ROSA HEALTH CARE  
SANTA ROSA FAMILY HEALTH CENTER

RESIDENT GRADUATE MEDICAL EDUCATION AGREEMENT

This agreement (this "Agreement") is by and between the SANTA ROSA FAMILY HEALTH CENTER, a Texas nonprofit tax exempt 5.01(a) corporation ("Health Center") and ("Resident").

Type/Specialty of House Staff Training: Family Medicine

Education Year and term of Agreement begins on July 1, 2008 ("Effective Date") and expires on June 30, 2009 unless renewed as set forth herein.

WHEREAS, Health Center has an agreement with CHRISTUS Santa Rosa Health Care ("Hospital") to provide professional direction, staffing and coverage ("Staffing Agreement") for the Hospital's Family Medicine Residency Program ("Family Medicine Residency Program");

NOW THEREFORE, in consideration of the mutual promises in this Agreement and the payments to be made or received by each party, Health Center and Resident agree as follows:

1. Engagement.
  - (a) The Health Center hereby employs Resident on the terms and conditions set forth herein. Resident acknowledges that Resident is an employee of the Health Center. Resident shall be under the direction and supervision of the Program Director ("Program Director") and the teaching staff ("Faculty") who are responsible for the general administration of the residency program (the "Residency Program"). The Health Center acknowledges that the direction and supervision of the Resident by the Program Director and Faculty is an integral part of the engagement of the Resident and the Health Center agrees to consult with the Program Director concerning the performance of Resident's duties and obligations hereunder. The Health Center shall have overall responsibility for the administration and operation of the Residency Program. Health Center shall provide the personnel reasonably necessary for Health Center's administration of the Residency Program as determined in Health Center's sole discretion. Health Center has the sole and exclusive responsibility for determining and providing the compensation, and the hiring and/or firing of personnel in the Residency Program.
  - (b) Resident acknowledges that Resident, in accordance with the Residency Program Policy and Procedures, and Handbook, and Medical Staff Bylaws, is not a member of the Medical Staff of the Hospital and that Resident's professional duties and responsibilities will be as set forth by Resident's Program Director. Resident shall at all times during the term of this Agreement discharge Resident's responsibilities consistent with generally accepted standards of medical care in a manner consistent with the principles of medical ethics. Resident shall actively participate in training to gain experience consistent with established Residency Program standards and Health Center requirements and shall comply with the policies and procedures of the Residency Program. Resident agrees to provide professional medical services to all patients receiving care in designated Health Center sites, without regard to such patients' ability to pay status, race, creed, national origin, sex, sexual orientation, age or disability, and in accordance with all applicable federal, state and local laws, rules and regulations.
  - (c) Resident shall provide said services faithfully, industriously and to the best of Resident's professional ability to Health Center on a full-time basis, at times and places and with duties as designated by Health Center, and shall be subject to call at anytime, as patient needs, Health Center needs or exigencies may require. Resident is a salaried (as opposed to hourly) employee. Accordingly, Resident's performance of services during more than a specified minimum number of hours shall not entitle Resident to additional compensation. Notwithstanding Resident's entitlement to vacation and sick time, Resident shall coordinate with Health Center to ensure that there is adequate coverage of patients while Resident is away for whatever reason.
  - (d) In the performance of Resident's obligations and provision of services hereunder, Resident is an employee of Health Center and, as a practitioner of medicine, shall provide medical care and

treatment to patients of Health Center or Hospital and to patients at other facilities and locations as directed by Health Center.

2. Standards. All professional and administrative services provided by Resident under this Agreement will be provided in compliance with: the doctrinal and moral tradition of the Roman Catholic Church as expressed in the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops; the Hospital's ethical policies; the standards of the Joint Commission on Accreditation of Healthcare Organizations, the Department of Health and Human Services, the bylaws and policies of Health Center and Hospital, and the health care facilities designated by Health Center; and the bylaws, rules and regulations of the Medical Staff of the Hospital, as applicable to Resident, and the health care facilities designated by Health Center, all as may from time to time be amended.
3. GME Related Requirements. Resident is required to comply with the laws, rules, regulations, standards and recommendation related to the operation of a Residency Program, including without limitation, the Accreditation Council for Graduate Medical Education ("ACGME"), and the Residency Review Committee and any Residency Program specific rules, all as may from time to time be amended. The Health Center will endeavor to meet the criteria of the Residency Review Committee, and the criteria of the ACGME in coordinating the duration and sequence of assignments to clinical, laboratory, or ambulatory care facilities. The Program Director will communicate with Resident regarding assignments. Health Center guarantees that Residency Program meets specialty board eligibility.
4. Residency Orientation and Check-in. Resident will participate and meet Residency Orientation and check-in requirements, which may begin prior to the July 1<sup>st</sup> official start date of the respective academic year. Resident will be paid for the additional time required for Orientation and Check-in.
5. Outside Activities: Moonlighting. Resident is not expected to moonlight or perform activities outside the scope of this agreement. Resident may not practice medicine outside the scope of this Agreement without the prior written consent of the Health Center and Program Director, exercised in their sole discretion. Resident acknowledges that such outside services must be performed on Resident's own time and shall not interfere with Resident's rendering of services hereunder. Resident further acknowledges and agrees that Resident shall procure, at Resident's sole cost and expense, all malpractice/professional liability insurance necessary to protect and insure Resident when Resident practices medicine outside the scope of this Agreement and that the Health Center's malpractice/professional liability insurance policies and/or programs of self insurance do not cover Resident when Resident practices medicine outside the scope of this Agreement. Resident shall provide the Health Center with Certificates of Insurance verifying such coverage prior to practicing medicine outside the scope of this Agreement. In the event that such outside services interferes with Resident's rendering of services hereunder, as determined by the Resident's Program Director in his/her sole discretion, the Resident will be required to curtail or discontinue such outside services. Resident acknowledges that the institutional permit issued for medical practice during approved program rotations does not apply to outside services provided by Resident.
6. Reports and Records. Resident agrees to cause to be promptly prepared and filed reports of all examinations, procedures, and other professional services performed, and Resident agrees to maintain an accurate and complete file within the Health Center and Hospital or other locations approved by Health Center of all such reports and supporting documents, all in accordance with Health Center and Hospital's policies. The ownership and right of control of all reports, case records, case histories, x-ray and other films, and supporting documents prepared by Resident shall belong to the Health Center, Hospital, or other facility or locations approved by Health Center. Resident will be responsible to the Program Director for the prompt completion and submission of all medical records. Any failure by Resident to timely complete and submit such medical records shall result in sanctions as imposed by Resident's Program Director.
7. Use of Premises: Incurring Financial Obligation. Resident agrees not to use or permit anyone to use any part of the Health Center or Hospital for any purpose other than the performance of services under this Agreement. Without limiting the generality of the foregoing statement, Resident agrees not to use the Health Center or Hospital in any manner that may jeopardize any applicable tax exempt status, insurance, or risk management programs. Resident agrees and acknowledges that Resident has no right, power or authority to incur and will not incur any financial obligation, legal obligation or liability, or other obligation on behalf of, or binding upon, Health Center. Resident hereby agrees to fully indemnify

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and hold Health Center harmless from and against all such financial obligations, legal obligations or liabilities, or other obligations that Resident enters into or incurs without the express prior written approval of the Health Center.

8. Confidentiality and Item Ownership. (a) Resident will not, during the term of this Agreement or at any time thereafter, disclose any secrets or confidential technology, proprietary information, customer lists, or trade secrets of Health Center, strategic or operational planning information, or any matter or thing ascertained by Resident through Resident's association with Health Center, the use or disclosure of which might reasonably be construed to be contrary to the best interests of the Health Center. Resident further agrees that upon termination of this Agreement, Resident will neither take nor retain any records (e.g., patient and/or business), papers, files, computer programs and software, other documents or copies thereof, or other confidential information belonging to Health Center or Hospital. Resident may receive a portfolio approved by Health Center documenting completion of core competencies. Without limiting other remedies available to Health Center for the breach of this covenant, Resident agrees that an injunction or other equitable relief shall be available without the necessity of Health Center posting a bond.

(a) All modalities, plans, and programs, and all patents, formulae, inventions, ideas of inventions, processes, copyrights, know-how, proprietary information, trademarks, trade names, strategic and operational planning information, and other medical and patient related developments (collectively "Items"), or future improvements to such Items, developed or conceived by Resident in the course and scope of Resident's employment under this Agreement, or with the use of the facilities, property or personnel of Health Center, are the sole property of Program and shall be promptly disclosed to Health Center. At any time during the term of this Agreement and thereafter, Resident will execute an assignment of such Items to Health Center and execute such other instruments as Health Center shall request to protect Health Center's interest in such Items.

9. Representations and Warranties.

(a) Resident represents and warrants to the Health Center that, except as indicated below: (i) Resident has not been reprimanded, sanctioned, or disciplined by any licensing board or state or local medical society or specialty board or any medical school or other institution of higher learning; (ii) Resident has not had a legal action for negligence or malpractice filed against Resident nor has Resident compromised, settled, or had a final judgment entered against Resident for a negligence or malpractice claim; (iii) Resident has never been convicted of a crime related to health care fraud nor has Resident ever been excluded from participation in any federal or state health care program; or (iv) Resident has not been charged or convicted of any felony or any misdemeanor involving moral turpitude. Resident further acknowledges that Health Center is relying on these representations as essential elements to this Agreement. Resident agrees to notify Health Center within five (5) days after Resident becomes aware of: (i) any disciplinary proceedings that may be brought against Resident by any medical school, institution of higher learning, medical society or specialty board, medical organization or Hospital acting through its medical staff, directors, trustees or otherwise; (ii) any action taken against Resident by any governmental agency; or (iii) any notice or claim of pending or threatened negligence or medical malpractice action. Resident shall maintain all necessary licenses, certificates, and other authorizations to provide services as contemplated herein. Resident hereby consents to Health Center's consulting with and receiving information from third parties to verify the representations and warranties set forth in this Paragraph 8. Resident reporting of lawsuits does not bar consideration from participation in the Residency Program. Listed below are any exceptions to the representations and warranties set forth herein (if none, write "NONE"): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(b) Resident recognizes and acknowledges that Health Center may obtain information from various sources deemed reasonably necessary by Health Center regarding the professional and clinical qualifications of Resident and any other related matters (including, without limitation, criminal background checks, Hospital and clinical privileges, licensure matter, litigation matters,

disciplinary matters, etc.) By signature on this Agreement, Resident authorizes Health Center to obtain and authorize appropriate third parties to release to Health Center any and all information regarding the qualifications of Resident and any other related matter. Furthermore, Resident recognizes and authorizes Health Center to release any such information to any and all affiliates of Health Center related by ownership or control for purposes of notifying affiliates as to qualifications of Resident.

10. Professional Liability Insurance Matters. Health Center agrees to provide, at Health Center's expense, for both Health Center's and Resident's benefit during the term hereof, professional liability coverage in such amounts as determined in Health Center's sole discretion through a company or companies, or through a self-insurance program, of Health Center's choice, covering Resident's professional services undertaken within the course and scope of this Agreement. The coverage to be provided by Health Center hereunder will be consistent with Health Center's policies as amended from time to time. If the coverages obtained by Health Center are in Resident's individual name, Resident hereby gives Health Center an irrevocable power-of-attorney to negotiate, enter into, and amend the policy (policies), and in all other issues to stand in the position of the insured. Resident hereby consents to and irrevocably grants to the Health Center the power, right and authority to settle, on behalf of Resident, without further notice to or consent of Resident, any claim which is brought against or may be brought against the Health Center, Resident, both, and/or any other persons or entities, if the Health Center, in its sole discretion, determines that the settlement of such claim is appropriate. The power to settle any claim granted by Resident herein is coupled with an interest and is irrevocable. In the event Resident fails, at any time, to fully comply with any of the terms, provisions, or conditions of Health Center's self-insurance program or of the Health Center's applicable commercial insurance policies, or fails to cooperate, in any way, with the Health Center or any commercial insurer, no professional liability coverage will be accorded to Resident.
11. Compensation. In full consideration of Physician's services rendered hereunder, Employer shall pay to Resident the sum of Forty thousand five hundred dollars (\$ 40,500.00) per annum, or pro rata portion thereof, payable in accordance with Health Center's pay policies. All amounts due Resident by Health Center under this Agreement are subject to and shall be reduced by applicable employment-related taxes, including but not limited to income-tax, Medicare and Social Security.
12. Benefits. Except as set forth below with respect to appraisal, merit or compensation increases and paid time off (including without limitation, sick days, vacation, and jury duty) Resident will be entitled to benefits approved by Health Center pursuant to Health Center's policies, as amended from time to time. These benefits currently include but are not limited to health, disability and life insurance. In addition, Resident will be afforded the following:
  - (a) Lab Coats: Two (2) long sleeve coats, with name tapes, are furnished by the Health Center for use by Resident as well as laundry service for coats. These items remain the property of the Health Center at all times, and Resident shall pay for the repair or replacement of any damaged or lost items.
  - (b) Meals. Provided pursuant to Health Center or Hospital policy on resident meals, as amended from time to time.
  - (c) Quarters: On call quarters/room provided for nights when Resident is on call or assigned night duty.
  - (d) Paid time off: Twenty one (21) work days of paid time off are provided to residents, fifteen (15) days vacation and six (6) days for sick or personal business. Approved CHRISTUS holidays are also paid time off. Paid time off may only be taken at a mutually agreeable time approved by the Program Director. Vacation may not be scheduled during initial four (4) weeks or the last four (4) weeks of each contracted year hereunder. No paid time off may be carried forward from year to year. Unused vacation and sick days are forfeited each year and no compensation will be given or paid in lieu of paid time off.
  - (e) Parking. Resident will be given free parking in lots and locations designated by Health Center or Hospital.
  - (f) Personal Professional Development. Resident will receive \$1,000 over a course of three years (PGY1, PGY2 and PGY3) for use towards Personal Professional Development.
  - (g) Resident Assistance Program: A resident assistance program designed to provide counseling service to residents in need to social or psychological guidance.

Resident expressly understands and agrees that due to ACGME and specialty board requirements, Resident is not entitled to participate in performance appraisal, merit or compensation increases and paid time off as provided in the Health Center's personnel policies, rules and regulations. These matters will be governed by this Agreement and the Residency Program policies related to performance appraisal, merit or compensation increases and paid time off. Resident acknowledges that it is Resident's sole responsibility to ensure that Resident satisfies the criteria for completion of the Residency Program and specialty board requirements including without limitation the days away from program requirement set by specialty board.

13. Grievances. Resident is not entitled to the due process rights of the bylaws of the Medical Staff of the Hospital or to the grievance procedures of the Hospital's personnel policies, rules and regulations, as from time to time amended. Resident will be entitled to discuss any differences, dissatisfactions or grievances that may exist in accordance with the Program's Residency Handbook, as amended from time to time.
14. Term and Termination.
  - (a) This Agreement shall commence on the Effective Date and shall continue for a period of one (1) year unless sooner terminated as provided herein. There is no automatic right of renewal or extension of this Agreement, and any renewal or extension requires successful advancement by Resident to the next level of training in accordance with the policies and procedures of the Residency Program and written notice from Health Center to Resident of such successful advancement. Resident acknowledges that advancement to the next level of training is not automatic. Advancement is based upon the determination of the Program Director that the Resident has achieved a level of competence, both academically and clinically, commensurate with the higher level. Additionally, if advancement is to be withheld, the Health Center will endeavor to notify the Resident of this decision at least four (4) months prior to the next contract year.
  - (b) Either party may immediately terminate this Agreement for breach of any term or condition of this Agreement by the other party (the "Breaching Party") fifteen (15) days after written notice thereof is received by the Breaching Party. The party claiming the right to terminate under this subsection shall set forth in the notice the facts underlying its claim that the other party is in breach of the Agreement. Remedy of the such breach within fifteen (15) days of the receipt of such notice shall continue the Agreement in effect for the remaining term, subject to any other rights of termination contained in this Article 4 or elsewhere in this Agreement.
  - (c) Notwithstanding any other provision of this Agreement to the contrary, Health Center, in consultation with the Program Director, shall have the right, in its sole discretion, to terminate this Agreement immediately upon written notice to Resident upon occurrence of any of the following: (i) any termination, suspension, withdrawal under threat of disciplinary action, probation, limitation, or reduction in Resident's house staff privileges at Hospital or any other Hospital or health care facility; (ii) any termination, suspension, probation, limitation, revocation or lapse of Resident's (1) Physician In Training permit or Institutional Permit from the State of Texas, or (2) qualification under the Medicare or Medicaid programs; (iii) if, in the sole judgment of Health Center, Resident becomes uninsurable at standard rates under such insurance carriers or programs of self-insurance as Health Center elects to utilize to meet the insurance requirements set forth in this Agreement; (iv) in the event of the death of Resident, or the ill health or other disability of Resident which prevents or makes inadvisable Resident's continued provision of services hereunder; (v) the charging or conviction of Resident of any felony or any misdemeanor involving moral turpitude; (vi) if, in the sole judgment of Health Center or Hospital, individual health or safety is in imminent and serious danger from Resident's action or Resident does anything to harm the business reputation of Health Center or Hospital; (vii) if Resident violates any term of Health Center's policies as they exist from time to time; or (viii) if any representation, warranty or covenant of Resident hereunder is or becomes false or untrue.
  - (d) The Agreement is contingent on the insurability of Resident, at standard rates, by the professional liability insurance carrier or program of self insurance selected by Health Center, and the Resident's ability to receive and maintain a Physician In Training permit or Institutional Permit from the State of Texas. In the event that any such contingency is not satisfied as of the Effective Date, this Agreement shall at the option of Health Center be null and void and of no further force and effect.

15. Notice. Any notices contemplated under this Agreement shall be effective when personally delivered or received through certified mail posted to the noticed party at the party's last-known post office address, unless other addresses have been designated by written notice.
16. Governing Law, Construction and Venue. This Agreement shall be enforced in accordance with the laws of the State of Texas. The parties agree and intend that this Agreement comply with and be subject to all applicable federal, state, and local laws; and all rules, regulations, or policies of any federal, state, or local regulatory agency; whether now existing, or hereinafter enacted, adopted, or created; and Resident agrees to abide by all such laws, rules and regulations. In the event any law, rule, or regulation, in the opinion of Health Center's legal counsel, affects the obligations of a party or the parties to this Agreement or may or does violate any such law, rule, or regulation, Health Center shall have the option to immediately terminate this Agreement or declare that this Agreement shall, by intention of the parties, be deemed modified and amended to comply with such law, rule, or regulation. The parties agree that the state courts of Bexar County, Texas, shall be the exclusive courts of jurisdiction and venue for any legal action, special proceeding or other proceeding that may be brought, or arise out of, in connection with, or by reason of this Agreement. The parties specifically waive any rights of venue in any other courts that they might otherwise have.
17. Waiver and Severability. No delay or omission by either party to exercise any right or remedy under this Agreement shall be construed to be either acquiescence or the waiver of the ability to exercise any right or remedy in the future. In the event any part or parts of this Agreement are held to be unenforceable, the remainder of this Agreement shall continue in effect.
18. Force Majeure and Assignment. Neither party shall be liable nor be deemed in default of this Agreement for any delay or failure to perform caused by Acts of God, war, disasters, strikes, or any similar cause beyond the control of the parties. The rights and obligations of this Agreement may be assigned by Health Center to any affiliate related by ownership or control without Resident's agreement. The rights and obligations of this Agreement may not be assigned or delegated by Resident.
19. Execution, Amendments and Entire Agreement. Multiple counterparts of this Agreement shall be signed by Resident and on behalf of Health Center by its authorized representatives. Each signed copy shall be an original, but all signed copies together shall be one and the same instrument. In order to be effective, any amendments to this Agreement must be in writing and signed as required above. This Agreement and its exhibits, if any, supersede any previous understanding between the parties, oral or otherwise, and constitute the entire Agreement between the parties relating to the subject matter hereof. Both parties acknowledge that any statements or documents not specifically referenced and made a part of this Agreement shall not have any effect.
20. Policies. The terms of this Agreement shall control the terms of Physician's employment. Physician shall also be subject to the policies and procedures of Health Center and the Residency Program as they exist and are amended from time to time, including but not limited to the policies and procedures on resident complaints and grievances, professional, parental, and sick leave benefits, sexual and other forms of harassment, leave of absence, counseling services, physician impairment/substance abuse, and residency closure/reduction. A copy of the Health Center's current GME Policy and Procedure Manual ("Manual") will be provided to Resident following the execution of this Agreement and the Manual may thereafter be amended by the Health Center in accordance with the Health Center's policies. In the event of a conflict between such policies and procedures and this Agreement, this Agreement shall control.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the Effective Date.

**Resident**

**CHRISTUS Santa Rosa Family Health Center**

By: \_\_\_\_\_  
Print: \_\_\_\_\_  
Date: \_\_\_\_\_

By: \_\_\_\_\_  
Print: James Martin, MD, Program Director  
Date: \_\_\_\_\_  
By: \_\_\_\_\_  
Bill Pack, CRSRHC Regional Vice President/CFO  
Date: \_\_\_\_\_  
By: \_\_\_\_\_  
Don Beeler, CSRHC President/CEO  
Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Address: CHRISTUS Santa Rosa Family Health Center  
333 N. Santa Rosa St.  
San Antonio, Texas 78207

**CHRISTUS SANTA ROSA FAMILY MEDICINE RESIDENCY PROGRAM  
RESIDENT BENEFITS-AT-A-GLANCE**

<u>VACATION</u>	Three (3) weeks annually as PGY I, PGY II and PGY III: (15) days vacation and (6) days of sick or personal business
<u>*HEALTH</u>	CHRISTUS provides a self-insured medical plan. All physicians and providers are those listed through Texas True Choice. Associate only premium is fully paid by CSRHC. Associate + Family, Associate + Spouse, and Associate + Child requires associate contribution. Eligibility: First day of month following 30 days.
<u>*DENTAL</u>	CHRISTUS also provides a self-insured dental plan. You may see a dentist of your choice. Eligibility: First day of month following 30 days.
<u>SHORT TERM DISABILITY</u>	Income protection from the 8 <sup>th</sup> through 90 <sup>th</sup> day of a disability. Pays 60% of weekly earnings. Eligibility: First day of month following 30 days.
LTD	Income protection from the 91 <sup>st</sup> day. Pays 60% of salary to a max of \$8,000 per month.
<u>LIFE and AD&amp;D</u>	1 times your annual salary up to \$150,000. AD&D is included in Term Life Insurance- equal to 1 time.
<u>PROFESSIONAL LIABILITY</u>	\$100K/\$300K
<u>RETIREMENT</u>	Eligible for Matched Savings Plan (403b) and the Cash Balance Plan
<u>PAY CYCLE</u>	Bi-weekly
<u>PARKING</u>	Free, secure, covered parking - 24 hours a day, 7 days a week
<u>MEAL</u>	25% discount on meals in cafeteria, free meals while on-call

\* Health and Dental coverage and benefits are administered through a 3<sup>rd</sup> party provider – CBCA.

*Revised June 2008*

*Curriculum Year 2008-2009*

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## **CHRISTUS SANTA ROSA FAMILY PRACTICE RESIDENCY PROGRAM CLINICAL RESPONSIBILITIES -HOUSE STAFF**

### **Policy:**

All house-staff physicians (residents) participating in patient care activities at CHRISTUS Santa Rosa Family Medicine Residency Program are to carry out their clinical responsibilities under the supervision of a licensed practitioner with appropriate clinical privileges.

### **Purpose:**

1. To define the role, role, responsibilities and patient care activities of house-staff physicians.
2. To define the process for supervision of house-staff physicians by a licensed practitioner who is a member of the CHRISTUS Santa Rosa medical staff.

### **Procedure:**

#### **Attending (Supervising) Physician**

In most instances, the attending physician will be a member of the CSRFMRP faculty or a member of the UTHSCSA residency faculty. However, any member of CSRH medical staff with appropriate clinical privileges may act as attending physician for a member of the house-staff.

It is the responsibility of the attending physician to:

1. Maintain primary responsibility for patient care.
2. Provide education, instruction and expertise to the house-staff physician in accordance with supervision and clinical responsibility in this document.

**NOTE: The supervision and clinical responsibility guidelines contained herein are those that are minimally acceptable. It remains the responsibility of the attending physician to assess the competency level of an individual house-staff member and to require a higher level of supervision/limitation of clinical responsibilities as determined appropriate.**

#### **House-staff (Resident) Physician**

In most instances, house-staff physicians will be affiliated with the CSRFMRP or UTHSCSA Residency Program. However, house-staff physicians not affiliated with these programs, who comply with necessary requirements, are eligible for house-staff affiliation.

House-staff physicians at CSRFMRP will include the following category:

1. Family Medicine Physicians.

It is the responsibility of the house-staff physician to:

1. Complete necessary application and associated paperwork prior to beginning their house-staff affiliation.

2. Provide patient care in accordance with supervision and clinical responsibility guidelines outlines in this document.

### **General Guidelines for Supervision**

The following categorize the levels of house-staff physician supervision. These levels pertain to supervision of house-staff by an attending physician as well as those instances where an upper level house-staff physician serves as a supervisor to other house-staff physician(s).

1. **Personal:** The supervising physician is physically present and personally involved in the procedure.
2. **Direct:** The supervising physician is present in the operative suite, procedural suite, or hospital unit and available for assistance and consultation.
3. **Immediately Available:** The supervising physician immediately available in the facility for assistance and consultation.
4. **General:** The supervising physician is available for consultation and is in the proximity to meet the institution call requirements for the involved services.

### **General Guidelines Regarding Entries Made in the Medical Record**

Entries made in the medical record by residents (including written or verbal orders) do not require countersignature by the attending physician. Exceptions to this include:

- History/physical examinations performed by the resident as part of the admission process require countersignature by the attending physician.
- Discharge summaries completed by the resident require countersignature by the attending physician.
- Procedure notes completed by the resident require countersignature by the attending.

### **Specific Clinical Responsibilities**

Family Medicine house-staff include:

1. Physicians participating in an accredited Family Medicine residency program

### **Clinical Responsibilities Family Practice House-staff**

Clinical responsibilities for family practice house-staff physicians are defined based on the level of postgraduate training. The unrestricted family medicine responsibilities for family medicine house-staff physicians are shown in Table 1 (Appendix A). The responsibilities and supervision requirements in Table 1 apply to the family medicine house-staff physician only during their assigned duties in a CSRFMRP family medicine rotation. It is recognized that supervision requirements put forth by the ACGME may differ from those specified in table 1. In such a case the highest level of supervision supercedes.

Individual family practice house-staff physicians may have their clinical privileges limited at the discretion of the CSRFMRP director, Graduate Medical Education Committee or Hospital Medical Executive Committee.

### **Clinical Responsibilities- Non-Family Practice House-staff Physicians**

Clinical responsibilities for the non-family medicine house-staff physicians who are in an approved family medicine rotation are assigned by level of post graduate training irrespective of the discipline, specialty, or type of training program the house-staff physician is in. Unrestricted family medicine clinical responsibilities for the non-family medicine house-staff physicians are shown in table 2 (Appendix B). The responsibilities and supervision requirements in Table 2 apply to the house-staff physician only during their assigned duties in a CSRFMRP family practice rotation. It is recognized that supervision requirements put forth by the ACGME may differ from these specifies in table 2. In such a case, the highest level of supervision supersedes.

Individual house-staff physicians may have their clinical responsibilities limited at the discretion of the CSRFMRP director.

A family practice house-staff physician may serve as the immediate supervising physician of the non-family medicine house-staff physician at the discretion of the supervising attending physician providing that: (1) the family medicine house-staff physician does not require **Personal** supervision for the clinical responsibility he or she is supervising, (2) the required level of supervision of the family practice house-staff physician for that clinical responsibility is satisfied, and (3) non family medicine house-staff physician responsibilities assigned **General** supervision are superseded by **Immediately Available** supervision when the family medicine house-staff physician serves as the supervising physician.

### **Family Medicine House-staff**

During the course of training, residents are expected to participate in the performance of a variety of procedures. The "Procedures Performed by Family Medicine Residents" (Appendix C) delineates the most common procedures performed and outlines the necessary degree of supervision required. As the resident progresses through the program, he or she is expected to demonstrate competence at each level before proceeding to the next. All surgical procedures performed in the operating suite require the physical presence of the attending surgeon for direct supervision during the procedure. Residents may only perform those procedures that their attending has privileges in. It is the responsibility of the resident to make certain that there is the appropriate level of supervision before a procedure is initiated.

### **Other House-staff Physicians**

House-staff physicians who arrange an educational experience with a physician on the CSRFMRP medical staff in a specialty other than Family Medicine will be expected to adhere to the guidelines outlined on the "Procedures Performed by Family Medicine Residents" (Appendix C) unless other specialty specific guidelines have been developed and approved by the Residency Director or the Graduate Medical Education Committee. Should such guidelines be developed they will be included as an addendum to this policy.

**Table 1. Family Medicine House-staff Clinical responsibilities and Supervision Requirements**

<b>OBSTETRICS</b>	PGY I	PGY II	PGY III
History, Physical examination., request and interpret diagnostic tests	G	G	G
Ante partum care	G	G	G
Fetal heart rate monitor interpretation	IA	G	G
Maternal and fetal imaging using ultrasonography	IA	G	G
Fetal assessment (BPP, NST, CST)	IA	G	G
Management of labor	IA	G	G
Obstetrical delivery	D	IA	IA
Operative vaginal delivery	P	IA	IA
Vaginal breech delivery	P	IA	IA
Vaginal delivery of multiple gestations	P	IA	IA
Analgesia and anesthesia for labor and delivery	IA	G	G
Cesarean delivery (Assist)	P	IA	IA
Postpartum care	G	G	G
Dilation and curettage	D	IA	IA
Neonatal intubation	P	IA	IA
Neonatal circumcision	D	IA	IA
Other procedures not included above	P	P	P
<b>GYNECOLOGY</b>			
History, physical examination, request and interpret diagnostic tests	G	G	G
Imaging using ultrasonography	G	G	G
Colposcopy	IA	G	G
Surgical biopsy of the cervix	IA	G	G
Curettage of the cervix or uterus	IA	G	G
Surgery involving the adnexa (sterilization, ectopic pregnancy, neoplasm, infection) (Assist)	P	IA	IA
Abdominal hysterectomy (Assist)	P	IA	IA
Vaginal hysterectomy (Assist)	P	IA	IA
Corrective procedure for incontinence (Assist)	P	IA	IA
Operative laparoscopy (Assist)	P	IA	IA
Operative hysteroscopy (Assist)	P	IA	IA
Cerclage of the cervix (Assist)	P	IA	IA
Breast aspiration	IA	G	G
Repair of injury involving urogenital organs (Assist)	IA	G	G
Incision and drainage involving urogenital organs (Assist)	IA	G	G
Other procedures not included above	P	P	P

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Key: P= Personal D= Direct IA= Immediately Available G= General (Assist)= Assist at the discretion of surgeon

**APPENDIX B**  
**Procedures Performed by Family Medicine Residents**

<b>Specialty</b>	<b>PGY I</b>	<b>PGY II</b>	<b>PGY III</b>
<b>MINOR SURGERY</b>			
Suturing simple lacerations	IA	G	G
Suturing facial lacerations (simple)	P	G	G
I&D of abscess or carbuncle	IA	G	G
I&D of thrombosed external hemorrhoids	IA	G	G
Removal of foreign bodies (skin)	IA	G	G
Excision of sebaceous cysts	D	IA	G
Excision of ingrown toenail (wedge/total)	IA	G	G
Excision of superficial skin lesions (non-facial)	IA	G	G
Digital nerve blocks	IA	G	G
Surgical dressing technique	G	G	G
Flexible sigmoidoscopy	D	IA	IA
Cryotherapy of skin lesions	IA	G	G
I&D of paronychia infection	IA	G	G
I&D of finger felon	IA	G	G
Use of liquid nitrogen	IA	G	G
Other procedures not listed above	P	P	P
<b>ORTHOPEDICS</b>			
Aspiration of joints (knee)	G	G	G
Injection of joints	G	G	G
Bandaging, slings, etc.	G	G	G
Casts: wrists	D	G	G
Casts: forearms	D	G	G
Casts: walking cast	D	G	G
Reduction	D	D	D
Clavicle	D	G	G
Simple splints (wrist, finger)	G	G	G
Closed reduction of dislocations: shoulder	D	D	IA
Closed reduction of dislocations: mandible	D	D	IA
Closed reduction of dislocations: patella	D	D	IA
Closed reduction of dislocations: fingers	D	D	IA
Closed reduction of dislocations: toes	D	D	IA
Other procedures not included above	P	P	P
<b>ENT</b>			
Snellen chart	G	G	G
Confrontation for visual fields	G	G	G
Tonometry	G	G	G
Removal simple foreign body (eye)	G	G	G
Removal foreign body (ears)	G	G	G
Anterior nasal packing	G	G	G
Posterior nasal packing	IA	IA	IA
Chemical cautery nasal septum	IA	IA	IA
Removal ear cerumen (loop)	G	G	G
Removal ear cerumen (syringe)	G	G	G
Laryngoscopy (indirect)	G	G	G
Caloric testing	IA	G	G

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Myringotomy	P	D	D
Other procedures not included above	P	P	P
<b>UROLOGY</b>			
Catheterization (male)	G	G	G
Catheterization (female)	G	G	G
Circumcision (infant)	D	D	D
Other procedures not included above	P	P	P
<b>MEDICINE, PEDS, &amp; SURGERY</b>			
Lumbar puncture (under 12)	G	G	G
Lumbar puncture (over 12)	G	G	G
Thoracentesis	D	IA	IA
Sigmoidoscopy	D	IA	IA
Proctoscopy	IA	G	G
Gastric lavage	G	G	G
N.G. tube insertion	G	G	G
Bone marrow	P	D	D
E.K.G.	G	G	G
Advanced Cardiac Life Support Protocol	G	G	G
CVP line/Triple lumen catheter	P	IA	IA
Extensive skin testing (office)	IA	G	G
Immunizations	G	G	G
Scalp vein (IV infant)	D	IA	IA
Movement of spinal injuries	P	P	D
Skin biopsy	G	G	G
Paracentesis	P	IA	G
Insertion chest tube/closed drainage	P	IA	IA
Cricothyrotomy			
Transvenous pacemaker	P	IA	IA
Swan-Ganz catheter placement	P	IA	IA
Cut-down (arterial or venous)	P	IA	IA
Other procedures not included above	P	P	P
<b>LABORATORY</b>			
Cytology and culture techniques	G	G	G
Routine lab procedures	G	G	G
Interpretation of blood smears	G	G	G
Interpretation of micro urines	G	G	G
KOH and saline drop	G	G	G
Scotch tape test	G	G	G
Other procedures not included above	P	P	P
<b>PSYCHIATRY (OFFICE)</b>			
Psychiatric interviewing	G	G	G
Counseling	G	G	G
Individual therapy	G	G	G
Group therapy	D	D	IA
Family therapy	D	G	G
Marriage counseling	G	G	G
Sexual counseling	G	G	G
Complex growth/development testing	P	D	D
Comprehensive psychological testing	P	D	D
Other procedures not included above	P	P	P

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Key: P= Personal    D= Direct    IA= Immediately Available    G= General

## **CHRISTUS PHYSICIAN COMPACT**

CHRISTUS Health Strives to fulfill its Mission of extending the healing ministry of Jesus Christ, and to be recognized as a community of service based on its Core Values of Dignity, Integrity, Compassion, Excellence, and Stewardship. We seek to provide effective, compassionate care to those we serve, especially to persons who are poor and underserved, in an operationally successful manner.

Achievement of these goals depends on the development of positive relationships in the workplace and on the commitment and competence of the physicians and Associates who form CHRISTUS Health. We work together to create an environment filled with hope, dignity, and mutual respect and to be responsible, trusted partners committed to the Mission of CHRISTUS Health.

To strengthen our relationships, CHRISTUS Health has established a Compact with all CHRISTUS physicians.

Recognizing our spiritual and faith-based roots, this Compact is a set of commitments, rather than a contract, to guide these relationships. By consistent reinforcement of these commitments through organizational and personal behavior, positive recognition and rewards, CHRISTUS will attract, retain and develop the competent people needed to fulfill its Mission.

To work in a CHRISTUS facility means that the physician is a trusted partner who understands and supports the CHRISTUS Mission, Vision, and Core Values, and is willing to accept responsibility and work with others to accomplish the CHRISTUS objectives.

### **Physicians' Commitment to CHRISTUS Health**

**PROVIDE** health care in accord with the Catholic moral tradition.

**MODEL** behavior that is consistent with the Mission, Core Values, and Vision of CHRISTUS.

**ATTAIN** the knowledge and skills necessary to deliver quality health care, and improve knowledge and skills through continuous education.

**COLLABORATE** with the patient in care, be accessible to the patient, and help the patient, family, or friends to make informed decisions benefiting from the physician's knowledge and judgment.

**PARTICIPATE** in the development and implementation of evidence-based treatment protocols appropriate to the specialty, the patient, and the location. Maintain a population-based, cross-continuum view of patient care.

**HONOR AND RESPECT** the patient's privacy.

**PARTICIPATE** in monitoring and measuring physician-specific outcomes relative to the implementation of evidence-based protocols.

**TREAT CHRISTUS** Associates with respect and dignity.

**WORK COLLABORATIVELY** with CHRISTUS to develop and implement business strategies that differentiate CHRISTUS as a faith-based system that excels in clinical quality, service, and efficiency.

**ASSIST** in creating a patient-centered learning organization and health care system.

**PROMOTE** wellness and preventive medicine.

**BE RESPONSIVE** to the need for timely, accurate reporting and medical record maintenance.

**MENTOR AND MONITOR** through peer review, those who need assistance adhering to this Compact.

#### **CHRISTUS Health's Commitment to Physicians**

**COLLABORATE** with physicians to provide the high quality of care as shown in objective performance and outcome measures.

**PROVIDE** sufficient and compassionate Associates to care for patients.

**PROVIDE** quality, up-to-date facilities and medical resources.

**OPERATE** a fiscally responsible organization.

**PROVIDE** opportunities for physicians to achieve professional growth and excellence throughout their affiliation with CHRISTUS.

**ASSIST** physicians in acquiring the knowledge and skills required to treat their patients in the CHRISTUS model of a three-dimensional health delivery system.

**PROVIDE** effective medical leadership and opportunities to participate in governance and policy setting.

**PROVIDE** opportunities to design and implement practice standards relevant to the physician's specialty, patients, and location.

**COMMIT** to open, honest and timely communication with physicians.

**APPLY** this Compact fairly to all physicians.

### **CHIEF RESIDENT JOB DESCRIPTION**

Each academic year a chief resident or two co-chief residents will be selected from a slate of residents who are eligible to be elevated to the PGY III level on July 1 of the selection year. To be eligible for selection, the candidate or candidates should be in good academic standing, of good moral character, willing to fulfill the duties required of the office, and possess favorable faculty evaluations. Nominations will be made on / or before the second Thursday of February. Election by all PGY I, II, and III level family practice residents (hereafter referred to as the residents) will be conducted by the Thursday two weeks following the nomination deadline. The resident's selection by a simple majority will be forwarded to the faculty. Final selection will be by a simple majority of the active faculty of CSRFPR program and the program director.

The duties of the office will include, but may not be limited to, the following:

- To schedule the PGY I, II & III block rotations.
- To schedule and facilitate Thursday afternoon programs and conferences.
- To coordinate resident – faculty meetings.
- To be responsible for resident leadership conference in the spring of the election year.
- To coordinate resident events including the annual resident – faculty retreat.
- To function as liaison for the residents with the faculty, administration and other departments.
- To perform other appropriate duties requested by the faculty and/or the program director.
- Attend all Faculty meetings unless specifically instructed otherwise by Administration.
- Lead all resident meetings.
- Meet with Director monthly to discuss open or new discussions.
- Introduce all guest speakers and drug reps during conferences.
- Sign time-off requests for all residents (make sure they have adequate coverage).
- Keep track of what residents are off on vacation or other time off (copies provided by Alice).
- Handle/mediate all resident/faculty issues.
- Attend all GMEC Committee meetings (Chief Residents can obtain meeting dates from Coordinator).

The chief resident or co-chief residents will serve the academic year of their PGY III year.  
Circumstances for removal are:

- Failure to perform duties;
- Failure to appropriately represent the CSRFPRP;
- Upon petition for removal by a majority of the residents;
- Upon request of a majority of the faculty after a two-thirds (2/3) vote by the faculty for removal.

### **CHIEF RESIDENT DUTIES by MONTH**

#### **March**

- Give to 2<sup>nd</sup> & 3<sup>rd</sup> year to be residents block scheduling guidelines and a deadline of April 1<sup>st</sup> to have the block schedules turned in to you for revision. Check w/Dr. Brown to see which months to not schedule someone on GYN. Check w/Dr. Soulas for the same(he may not have any). Try to schedule only one resident at a time for GYN.
- Send welcome letter and block schedule information(see attachment) to newly matched interns w/deadline to return by early April. They can rank their schedule preference 1 to 7(see attachment).
- Send email to pedi chief to introduce yourself and give them your contact info. Pedi chief will email you a copy of the upcoming months schedule for our intern on the pedi service. Print and give copy to Veronica and the intern. (This process may get dropped w/transition of our chiefs and pedi chief so make sure this is getting done.)
- Send email to ER call scheduler to introduce yourself.
- Make ER call schedule through end of December and send to ER call scheduler. (Consider retreat, in-training exam, and graduation when scheduling ER call dates.)

#### **April**

- Register for chief conference for May(airline, hotel, and registration)
- Revise schedule as follows:
  - Discuss w/Dr. Karrh for his input on clinic impact
  - D/w Dr. Martin, he may or may not make changes
  - Make sure enough strong residents on each inpatient block
  - Review block schedule at faculty meeting for input
  - Give copies of revised final block schedule to Lisa, Veronica, Dr. Karrrh, Dr. Martin, Johnna, and pediatric chief
- Clinic office assignment to be coordinated w/Dr. Karrh, once completed give copy to Johnna
- Make OB float schedule, give to residents to review, and Dr. Bryant to review. Once finalized, give to Dr. Karrh.
- Finalize transition schedule for graduation weekend. Make sure Dr. Martin finds someone to cover call on Saturday night of graduation. Dr. Bryant will take care of OB

coverage. Block 1 chief usually takes over inpatient service starting Saturday am of graduation weekend.

**May**

- Help Lisa w/orientation schedule(see attached). Chiefs will welcome interns and do a tour of clinic and hospital(include more detail than you think necessary). Have first months schedules ready to distribute to new interns at orientation week.
- Go to chief resident conference.
- Start getting Intern guide book ready?

**June**

- Organize/schedule “how to be an intern” lectures (d/w Dr. Higgins).

**August/September**

- Start looking for retreat location. Clarify retreat budget w/Dr. Martin.

**November**

- Finalize retreat date, location, and schedule of activities (chiefs plan it all).
- Make sure Dr. Martin has coverage for inpatient and Dr. Bryant has coverage for OB.

# POLICIES

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## **DRESS CODE**

**Policy guidelines:** On a daily basis, each physician is to dress in a manner that supports the positive portrayal of the residency program as a professional organization. Attire for residents to wear professional dress is defined as:

**Female residents** shall wear a dress, skirt, full or ankle length slacks with blouse, or a pantsuit made of fabrics with conservative patterns, creased or tailored which are neither tight or flowing. The hemline should be no higher than two-inches above the knee when standing. For longer skirts and dresses, slits should be no higher than just above the knee. Tailored shirts, blouses, sweaters, sweater sets, blazers and jackets are appropriate but should not be tight; cleavage or a bare midriff is not appropriate. Party type dresses are not appropriate. Jewelry and accessories should be kept simple and conservative. Nails will be clean, well-groomed, and extreme length and polish colors avoided.

**Male residents** shall wear a business suit, slacks and dress shirt, slacks and polo shirt with coat, or slacks with dress shirt and tie. Either a sport coat or white coat must be worn in public areas. Nails will be clean and well-groomed.

**All residents** shall keep their hair well-groomed and away from their face. It should not come in contact with patients. Facial hair should also be well-groomed and beards should not come in contact with patients.

The residency program will provide residents with two white lab coats in the first year of their training with the option of receiving an additional coat each subsequent year as needed. Your white coat and your name tag are to be worn whenever you are seeing patients, in the hospital, or in the Family Health Center. Hospital scrubs are not to be worn in the Family Health Center while seeing your patients (except when you are on call for the maternity service, on call for the inpatient service, or actively managing continuity OB patients in labor).

## **DUTY HOURS**

The CHRISTUS Santa Rosa Family Medicine Residency Program adheres completely to the ACGME duty hour requirements:

1. 80 hour work week upper limit averaged over a four week period.
2. 30 continuous hours (with no new patients after 24 hours).
3. 12 hours off between residency commitments.
4. 24 hours or more continuous hours off duty (free from all clinical, educational, and administrative activities) averaged over a four week period.

Home call is not counted in work hours.

Delivery of continuity maternity patients is also not counted in duty hours (unless within already

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scheduled time). Special circumstances (extended patient family support, in a continuity situation) are respected but should be within the duty hour guidelines.

All residents should immediately contact the supervising senior resident and our faculty attending if the resident believes fatigue is adversely affecting patient care. Residents post call should assess themselves for physical alertness in the use of motor vehicle operations. Call rooms are available for residents requiring sleep before leaving the hospital.

## **PARKING AND SECURITY**

Residents receive free parking in the CHRISTUS Santa Rosa Hospital employee-parking garage. This parking area is patrolled and monitored. If you need assistance walking to your car or dealing with car problems, call security (230-2030 or the Operator 0). They are on call 24 hours a day, seven days a week. During orientation week, you will obtain your parking tag.

## **PAGERS**

Individual Pagers are assigned to each resident during orientation. During Family Medicine, a resident will carry an "on-call" pager as well as an individual pager. The pager number for the Medicine on-call pager is 231-1598 and the OB pager number is 230-0068. Replacement batteries are available in the administrative office, Suite 4703, on the 4th floor of Center for Children and Families.

## **CALL SCHEDULE**

ACGME guidelines regarding resident work hours are followed. Residents have at least one day out of seven without program responsibilities. In-hospital call schedule is not more often than every third night. Attention is given to cross-coverage and back-up arrangements to ensure that no resident is in a position to be overwhelmed by responsibilities.

## **CALL ROOMS**

The residents' sleeping quarters for Family Medicine Service are located on the second floor. There will be two sleeping rooms, a lounging room with television, a resource room with computer access and library, a workout room, and access to a kitchenette area. The shower room is located down the hall from the sleeping rooms. Each resident will be given a key for these call rooms. While on the OB service, the resident call rooms are on the fourth floor in the B building of the CHRISTUS Santa Rosa Hospital, near Labor and Delivery, and are accessed by a swipe of your ID badge or by code 01234. A shower, toilet, and lockers are available in the room directly across from the sleeping quarters. The OB Physician lounge code is 02326 and the ER Physician lounge code is 01234.

## **LAUNDRY SERVICE**

White coats can be laundered each week if placed in the hamper in the Side A Clinic Break

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room. Laundry is picked up Tuesday morning and returned the following Tuesday. Clean coats will be returned to the rack on Side A. (in the Break room)

### **MEAL REIMBURSEMENT**

Meal tickets will be disbursed to all residents on night and weekend call. These tickets can be obtained from Veronica Rosas in Suite 4703, 4th Floor of Center for Children and Families. As an employee of CHRISTUS Santa Rosa, the cost of your cafeteria meals will be discounted 25%. You must be wearing your name tag to receive the discount. On days where meals are not provided by the residency program and residents have resident responsibilities that require that they be present, they may eat lunch on the 12<sup>th</sup> floor, Physician dining room.

### **PAY PERIOD**

The residents will be paid every two weeks. Each resident is encouraged to authorize direct deposit of paycheck. Paychecks (or vouchers) will arrive by noon on payday in the Administrative Offices on the 4th Floor and will be placed in your inbox.

### **MAIL AND ANNOUNCEMENTS**

Your assigned mailboxes are located in the Administrative offices on the 4th floor, and bulletin boards listing conferences and other events are in the Family Health Center as well as in the Administrative offices and the 5th floor conference room. Please check those places on a regular basis, in order to stay well informed.

### **EMAIL**

Each resident is assigned a CHRISTUS email address. This account is regularly used for important administrative messages. It is expected that residents check their email at least weekly if not daily.

### **NEW INNOVATIONS**

Each resident is given a New Innovations (NI) login name and password to be accessed regularly. NI is used as a central location to communicate rotation assignments and contact information, schedules, curriculum, resident manual, rotation evaluations, procedure logging, duty hour logging as well as administrative forms for paid time off (PTO), CME time off, personal time off, elective request, moonlighting, OB Float switch, and the Santa Rosas FMRP procedure card. At the end of each rotation, NI will email you a reminder to login to NI to complete rotation evaluations. These evaluations are required and must be completed by 1 week after the rotation. Failure to complete your evaluation will result in the loss of one vacation day for each week evaluations are delinquent. If no vacation days remain, additional night call will be required

To log in to NI go to <http://www.new-innov.com/>. The institutional login is in all CAPS and is

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CSRA. The username will all be in (lowercase) and will be the first initial of your first name and your last name. Your password is the same until you change it. If you have any questions, do not hesitate to contact the Residency Coordinator or Veronica Rosas.

### **SEVERE WEATHER POLICY**

On rare occasions, San Antonio has inclement weather. Listen to the radio or weather channel to check for road closings. Your job responsibilities are of high priority so be prepared to report in at the usual time. Your attending physician will determine any changes in your work schedule during inclement weather. Many alternative routes to CHRISTUS Santa Rosa are available from all areas of the city. Please familiarize yourself with these routes in case of emergency.

### **PRACTICE OPPORTUNITIES**

The residency program and faculty frequently receive family practice opportunities and will post the most current inquiries on a bulletin board in the Administration offices or will be put in your personal mailboxes. Faculty advisors are willing to discuss your future plans and can be instrumental in identifying opportunities.

Physician recruiters will be calling for the names of our PGY-III residents. We will only release the names of those residents who notify the program coordinator that they would like their names and addresses released.

### **MOONLIGHTING**

Moonlighting is an acceptable activity in the CHRISTUS Santa Rosa Family Medicine Residency Program, as experiences in moonlighting can result in excellent educational experiences. However, moonlighting is neither expected nor required by the Program. The following rules apply to moonlighting in this residency program:

1. Resident moonlighting is a privilege.
2. Residents who moonlight must have on file in the residency a valid and clear Texas medical license, as well as evidence of their own liability insurance coverage.
3. All moonlighting activities and schedules must be documented and reported to the program director **and residency coordinator. Prior program director approval for moonlighting is required.**
4. Moonlighting activities must not interfere with any residency responsibilities. Resident abuse of these rules will result in the immediate loss of moonlighting privileges.
5. Any resident who falsely reports illness or requests for personal business or sick days in order to moonlight will lose privileges and be placed on probation for violation of professionalism in the program. A repeat violation of the moonlighting policy may result

in dismissal from the program.

## **MALPRACTICE INSURANCE**

The CHRISTUS Santa Rosa Family Practice Residency Program has obtained malpractice coverage for the residents with Preferred Professional Insurance Company. It is an individual policy within the CHRISTUS Santa Rosa group policy. It is a claims made policy with a coverage of 100K/300K. If you moonlight outside of the CHRISTUS Santa Rosa Health Care System, you will be responsible for obtaining the necessary, additional malpractice coverage.

## **DRUG ENFORCEMENT AGENCY (DEA)**

This agency regulates the prescribing and storing of controlled substances. In order to obtain a DEA number and use triplicate prescription forms, you need to request and complete an application. Call the federal DEA office at (202) 307-7255 and allow at least eight weeks to receive your DEA number. The residency program does not cover the registration fee.

## **EXPECTANT / NEW PARENT POLICY**

CHRISTUS Santa Rosa Family Medicine Residency Program recognizes that the arrival of a baby is a major event with specific issues that require attention. These include the education of the resident/new parent, the education of the other residents in the program, the health of expectant mother and baby, and the stresses in a residency engendered by the absence of any resident.

1. The resident must take responsibility to notify the Director of the pregnancy by the end of the second month of pregnancy or as soon as possible in the process of adoption. This is to allow maximum time to adjust residency schedules to meet her/his needs and those of other residents.
2. In the case of a pregnant resident, the following apply:
  - a. In general, if there are no extenuating circumstances, the pregnant resident will continue rotations as scheduled.
  - b. The chief resident will attempt to establish a call schedule during the pregnant resident's last three months to associate as often as possible call with time following to rest, i.e., Friday followed by Saturday, Saturday followed by Sunday. The pregnant resident will take no extra call or the first 3 months of post partum.
  - c. By the time of delivery the resident should have determined with the program director how maternity leave time off will be allocated (vacation, sick days, home elective, etc.). Absence from the residency, in excess of one month within the academic year, must be made up before the resident advances to the next training level, and the time must be added to the projected date of completion of the required 36 months of training. This is a policy of the American Board of Family Medicine.

3. In the case of expectant partners and those awaiting adoptive placements, the following apply:
  - a. An effort will be made to schedule elective or selective time during the month of the expected arrival.
  - b. Extenuating circumstances, i.e., obstetrical emergencies or unexpected adoptive placements will be handled on an individual basis.
4. After returning from maternity leave, the resident should make every effort to make up call covered by her colleagues in her absence.

## **POLICY ON ASSOCIATE HARRASSMENT**

### **POLICY**

To provide and maintain an environment which respects the rights and dignity of every CHRISTUS Santa Rosa Health Care Associate and reflects the Core Values of the organization.

### **PURPOSE**

It is the policy of CHRISTUS Santa Rosa Health Care (CSRHC) to maintain an environment which respects the rights and dignity of every associate and reflects the Core Values of our organization. This environment must be free from all forms of harassment, including both sexual, verbal, visual and physical harassment as well as any other actions which create a hostile, offensive or intimidating work environment. Therefore, harassment, in any form, by CSRHC associates or those associated with the Hospitals on a temporary or contract basis is expressly prohibited.

Unwelcome sexual advances, requests for sexual favors and other verbal, visual or physical conduct of a sexual nature may violate this policy when (i) submission to such conduct is made, either explicitly or implicitly, a term or condition of employment, (ii) submission to or rejection of such conduct is used as the basis for an employment decision, or (iii) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating a hostile, offensive or intimidating work environment.

Examples of conduct which may constitute sexual harassment include, but are not limited to verbal or visual harassment or abuse (for example, degrading sexual comments, unwelcome propositions and sexually offensive jokes, materials and tricks), unwelcome requests for sexual activity, inappropriate touching of a sexual or abusive nature (for example, pinching, patting or repeated brushing against another individual's body) or a threat, suggestion or action that makes the affected individual's employment, work opportunities or benefits subject to submission to sexual demands, harassment or sexually offensive conduct.

CHRISTUS Santa Rosa Health Care prohibits retaliation, harassment or intimidation against

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associates complaining of harassment.

Violation of this policy may lead to immediate termination. The decision to terminate an associate for violation of this policy will not be undertaken without a thorough review and documentation of facts related to the allegations of harassment.

## **PROCEDURES**

1. Any associate of CSRHC who believes that s/he has been harassed should immediately inform his/her supervisor, department manager or a Human Resources Management representative. If the complaint involves a direct supervisor, or if the associate is uncomfortable talking to his/her direct supervisor about the complaint, the associate should go directly to the department manager or Human Resources. Incidents of alleged harassment should be reported as soon as possible (within 72 hours) so that a prompt investigation can be undertaken by CHRISTUS Santa Rosa Health Care. If the supervisor is notified, s/he will immediately contact a Human Resources management representative who will be responsible for initiating a prompt investigation of the facts surrounding such alleged harassment.
2. Associates, supervisors, and managers should consider all allegations of harassment as a serious matter, which must be resolved discreetly and quickly in order to minimize work disruption and potential liability. All harassment complaints will be promptly investigated in a thorough and objective manner. An investigation may include private discussions with the complainant, the alleged harasser, and any witnesses. If it is determined that an associate has violated this policy, prompt and appropriate corrective action will be taken, up to and including termination if warranted.
3. All levels of management and supervision are responsible for:
  - a. Assuring CSRHC associates that harassment is prohibited by this policy and that thorough investigations of alleged incidents will take place and will, when appropriate, be followed by prompt corrective action.
  - b. Reporting, immediately upon receipt, all alleged incidents of sexual harassment to a Human Resources management representative.

## **POLICY ON RESIDENCY CLOSURE**

**POLICY: Insuring completion of training in the event of residency closure.**

CHRISTUS Santa Rosa Health Care is committed to the on-going Family Medicine Program. However, if it becomes necessary to close the program or reduce the number of residents for any unforeseen reason, this residency program and faculty will work to place each and every first and second year resident in a viable program with as little inconvenience to the resident as possible for the continuation of their post graduate training. Each third year will continue to be trained in

this institution at no loss of salary. If there are any first or second year residents that cannot be placed elsewhere, this program will continue training of these residents and will simply accept no new residents until each resident has completed his/her training. Appropriate faculty will be retained to cover the number of residents present in the program according to the constraints of the Program guidelines from ACGME and from ABFM.

# **SAMPLE FORMS**

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