# FAMILY MEDICINE RESIDENCY PROGRAM
## TABLE OF CONTENTS

### INTRODUCTION
- Mission Statement
- Principles of Family Medicine

### POLICIES AND PROCEDURES
- A. AAFP Membership
- B. ABFM Certifying Examination
- C. ABFM Continuity of Care/ Absence from the residency
- D. ACGME Core Competencies
- E. ACLS/BLS/ PALS/ NRP
- F. Advisor/ Advisee System
- G. Back up call policy
- H. Chief resident selection
- I. Chief residents job description
- J. Corrective action and discipline
- K. Dress Code
- L. Delinquent medical records
- M. Duty hours and working conditions of residents physicians
- N. Educational allowance
- O. Electives policy
- P. Employee conduct policy
- Q. Evaluations
- R. Family Care clinic policy
- S. FM didactic lectures and other conferences
- T. Family Medicine inpatient service
- U. Family Medicine inpatient continuity of care
- V. Fitness for duty policy
- W. Guidelines for residents travel expenses
- X. Grievance policy
- Y. Harassment and compliant policy
- Z. Informed Consent
- AA. In-service in training exam policy
- BB. Moonlighting policy
- CC. OSCE
INTRODUCTION

MISSION STATEMENT

The Family Medicine Residency Program strives to recruit and train physicians from diverse backgrounds who are interested in providing care to the underserved populations of Riverside County, while obtaining a high quality, broad-based education. Our goal is to train physicians who will choose to practice in the underserved areas in Riverside County and the State of California.

It is the department’s role to assist other departments in carrying out the mission of the hospital, including the education of residents, medical students and students in other health professions.

A major function of the Department of Family Medicine is the support of the Family Medicine Residency Program. The Residency Director and the faculty are all members of the Department of Family Medicine at the hospital.

PRINCIPLES OF FAMILY MEDICINE

The Family Medicine Residency Program is built upon the principles of the specialty. It emphasizes continuity of care and family-oriented, comprehensive care. Longitudinal and block rotations allow residents to apply these principles to their own patients in clinic and to follow them through the hospital, the patient’s home and in nursing homes.

4 Week Block Rotational Experiences include the following:

<table>
<thead>
<tr>
<th>Block</th>
<th>First Year</th>
<th>Second Year</th>
<th>Third Year</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Internal Medicine</td>
<td>Emergency Room</td>
<td>Family Medicine Ward</td>
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<tr>
<td>2</td>
<td>Internal Medicine</td>
<td>Orthopedics</td>
<td>Family Medicine Ward</td>
</tr>
<tr>
<td>3</td>
<td>Internal Medicine</td>
<td>Sports Medicine / FCC / Vacation</td>
<td>Pediatric Clinic</td>
</tr>
<tr>
<td>4</td>
<td>Family Medicine Ward</td>
<td>Obstetrics / Gynecology</td>
<td>Pediatric Ward</td>
</tr>
<tr>
<td>5</td>
<td>Family Medicine Ward</td>
<td>Family Medicine Clinic</td>
<td>Night Float / FCC / Vacation</td>
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<tr>
<td>6</td>
<td>Obstetrics / Gynecology</td>
<td>Family Medicine Ward</td>
<td>Night Float / FCC / Vacation</td>
</tr>
<tr>
<td>7</td>
<td>Obstetrics / Gynecology</td>
<td>Pediatric Ward</td>
<td>Ambulatory 3</td>
</tr>
<tr>
<td>8</td>
<td>Pediatric Ward</td>
<td>Urgent Care / Ortho Clinic</td>
<td>Gynecology</td>
</tr>
<tr>
<td>9</td>
<td>Newborn / NICU</td>
<td>Cardiology</td>
<td>Subspecialties</td>
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<tr>
<td>10</td>
<td>General Surgery</td>
<td>Ambulatory 2</td>
<td>Procedures</td>
</tr>
<tr>
<td>11</td>
<td>Ambulatory 1</td>
<td>Night Float / Vacation</td>
<td>Elective / Palliative Medicine</td>
</tr>
<tr>
<td>12</td>
<td>Psychiatry/Behavioral / Community Medicine</td>
<td>Surgery Clinic</td>
<td>Elective**</td>
</tr>
<tr>
<td>13</td>
<td>Vacation / Conference</td>
<td>Elective**</td>
<td>Elective**</td>
</tr>
</tbody>
</table>

**up to one elective may be done away / offsite
Longitudinal experiences:

Ambulatory Family Medicine
   1. RCRMC Family Care Clinic
   2. Rubidoux Family Clinic
   3. Perris Family Clinic
Nursing Home Care
Home Visits
Procedures
Behavioral Health
Longitudinal Obstetrics through Family Care Clinic
Systems Based Practice and Quality Improvement
Managed Care/Practice Management
Research/Scholarly Activities
Diagnostic Imaging

POLICIES AND PROCEDURES

A. AAFP MEMBERSHIP

The American Academy of Family Physicians (AAFP) is the national association of family physicians. Residents are encouraged to show their commitment to their specialty through resident membership in the Academy. An AAFP application will be given to you during the orientation period. Please complete the application and return it to the Residency Support Staff. The Residency Program pays the membership fee for each resident and our goal is to be 100% compliant with membership.

B. ABFM CERTIFYING EXAMINATION

The American Board of Family Medicine (ABFM) examination will be held in April and November of every year. The examination is computer-based and consists of multiple choice questions. The application fee is approximately $1,200 but may change from year to year. It is your responsibility to pay for your examination fee and also to apply for the examination. Please plan to apply for the ABFM examination well in advance in order to secure an appropriate examination date (website www.theabfm.org). The Program Director Certifies Each Eligible Resident To Take The Examination. If a resident obtains a score < 20% correct on the ITE, he/she may not be eligible to take the ABFM Examination in April of the PGY3 year and the decision is left to the discretion of the Program Director.

The FM Program encourages you to let the program know the results of your examination as we use this for performance improvement.
C. **ABFM REQUIREMENTS – CONTINUITY OF CARE / ABSENCE FROM RESIDENCY**

**Continuity of Care**

Residents must see patients in the FMC for a minimum of 40 weeks during each year of training. In order to graduate, a minimum of 1,650 continuity clinic patient visits needs to be met during the three (3) years of residency. The program places high regard to this requirement and assures that every resident meets it. It is at the Program Director’s discretion to substitute an elective rotation with a FCC rotation if the resident is at risk of not meeting this requirement.

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

Residents are expected to perform their duties as resident physicians for a minimum period of (11) 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 PGY-2 year and first month of the PGY-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.

**Long-Term Absence**

Absence from residency education, in excess of one month within the academic year (PGY-1, PGY-2 or PGY-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 may interrupt continuity of patient care for a maximum of three (3) months in each of the PGY-2 and PGY-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.

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.

D. ACGME CORE COMPETENCIES

Residents are evaluated and promoted based upon their performance in the six ACGME Core Competencies. Please see Appendix D for a description of the ACGME (Accreditation Council for Graduation Medical Education) Core Competencies.

E. ACLS/PALS/NRP

All PGY1 residents are required to successfully complete training in BLS (Basic Life Support), ACLS (Advanced Cardiac Life Support), PALS (Pediatric Advanced Life Support), and NRP (Neonatal Resuscitation Program) prior to starting clinical duties. Maintenance and recertification in BLS, ACLS, PALS, and NRP is required during residency.

Recertification for BLS, ACLS, PALS, and NRP will be offered once yearly during resident didactic sessions. If a resident is unable to recertify during these scheduled recertification dates, the resident may make arrangement on his / her own to recertify using continuing medical education time. Failure to maintain BLS, ACLS, PALS, and NRP certification may result in the resident being pulled off service and a delay of graduation.

ALSO (Advanced Life Support in Obstetrics) is strongly recommended for all residents, and is required for residents that plan to do Obstetrics after graduating from the program. The
program fully supports the certification of ALSO among all residents and does cover the cost of this certification as well as provide the time needed to certify.

F. ADVISOR/ADVISEE SYSTEM

Every resident will be assigned a faculty advisor for the duration of the residency training period. The advisor will meet formally with the resident at least twice a year in order to review performance and ensure that the resident is meeting residency graduation requirements in a timely manner. More meetings are up to the advisor and/or advisee.

G. BACK UP CALL POLICY

The Family Medicine Residency Program recognizes that unexpected illnesses or family emergencies can occur. Therefore, a formal system exists in which residents are assigned to provide back up call. Residents who initiate the back up call system for one night of call will return/pay back two (2) nights of call to the back up call resident. Residents who initiate the back up call system need to inform the back up call resident, chief resident, and residency coordinator. Residents assigned back up call coverage are required to respond to calls within one half hour (1/2) hour and be present for clinical duties within 2 hours.

H. CHIEF RESIDENT SELECTION

The chief residents’ responsibilities resemble many of those of the faculty. The individual in this role should not only demonstrate the leadership and management skills necessary to represent the residents, but also must have the academic capability to meet the challenges of this position. Individuals must be in good academic standing in order to run for Chief Resident. The process of Chief Resident Selection occurs as follows:

1. Chief residents are nominated by their peers.
2. Final nominated candidates need the approval of the Program Director
3. The final vote will be done by their fellow residents.

I. CHIEF RESIDENT JOB DESCRIPTION

The chief residents serve a number of roles. They are responsible for some leadership, administration, education, and supervision activities of the residency. The chief residents report directly to the Program Director. The chief residents work with the Residency Support Staff, faculty, and the Clinic Manager in the coordination of residency issues. Please see Appendix E for a description of the Chief Resident Agreement.

J. CORRECTIVE ACTION AND DISCIPLINE

1. Purpose

The purpose of this policy and procedure is to set forth the procedures to appeal corrective action or discipline, imposed on residents of the hospital’s Family Medicine Training Residency Program.
2. **Philosophy**

It is the intent of this institution that each resident successfully complete the program and become eligible to take their Board certification examination. The hospital does not anticipate the need to take corrective action or discipline against a resident. However, in the event that corrective action or discipline is deemed appropriate, it is the intent of the institution to provide the resident with the opportunity to seek informal review, and to appeal the action imposed.

3. **Informal Review of Corrective Action or Discipline**

Except when the Residency Program Director determines that a corrective action or discipline should be immediately imposed, the corrective action or discipline shall be reviewed with the resident before being implemented. The resident shall have the opportunity to seek informal review of a corrective action or discipline in accord with the following:

a. The Residency Program Director shall provide the resident, in writing, notice of the corrective action or discipline, (hereafter NOTICE LETTER), and the basis for the action (i.e., charges), along with a copy of the CORRECTIVE ACTION and DISCIPLINE POLICY PROCEDURE.

b. Within seven (7) days of receipt of the NOTICE LETTER, the resident may request, in writing, the opportunity to meet with the Residency Program Director to discuss, explain and/or refute the charges. In absence of the resident’s request for an informal review, the NOTICE LETTER shall be the Residency Program Director’s decision in the matter.

c. After the informal review with the resident, the Residency Program Director may take such further action as may be appropriate, including, but not limited to, letting the charges and corrective action or discipline stand, or modifying the corrective action or discipline and/or charges. Within seven (7) days after the review meeting with the resident, the Residency Program Director shall provide the resident with written notice of his/her further decision in the matter. Said further decision shall be the Residency Program Director’s decision in the matter.

d. Corrective action or discipline imposed shall be effective, until otherwise modified, upon the completion of the hearing process set forth below.

4. **Hearing After Imposition of Corrective Action Or Discipline**

A resident shall have the right to have a corrective action or discipline imposed against him/her reviewed in accord with the following:

a. Within ten (10) days of receipt of the Residency Program Director’s decision, the resident may request, in writing, a formal hearing. The request for a hearing shall be directed to the Director of Graduate Medical Education. If the resident fails to request a hearing as specified herein, he/she shall be deemed to have waived the right to said hearing, and acquiesce to the corrective action or discipline imposed.
b. Upon receipt of the resident’s request for a review of the corrective action or discipline taken against him/her, the Director of Graduate Medical Education shall promptly set a date for the convening of a committee to review the action; but not later than fifteen (15) days after the committee is constituted. The committee’s membership shall consist of the Director of Graduate Medical Education, Medical Director and Human Resources Director. The Director of Graduate Medical Education shall serve as Chair of the committee.

c. The Director of Graduate Medical Education shall provide the resident, committee members and other appropriate persons with written notice of the time, place and date of the hearing.

d. The resident and the Residency Program Director shall appear at the hearing. Each party may be represented by legal counsel, or other representation. However, in no case shall the Residency Program Director be represented by legal counsel if the resident is not represented by legal counsel. Failure of the resident to appear at the hearing, or to present his/her case at the hearing, shall constitute a waiver of his/her right to a review hearing and acceptance of the corrective action or discipline.

e. The hearing shall proceed and evidence taken in accord with the following:

1. Upon opening the hearing, the chair shall explain the hearing procedures and the rights of the parties as established hereunder:
2. The hearing shall be limited to matters relevant to the committee’s review of the action imposed against the resident.
3. The admission of relevant evidence will not be restricted by evidentiary rules applicable in a court of law.
4. Within reasonable limitations, both sides at the hearing may call and examine witnesses, cross-examine witnesses, and present exhibits or documents.
5. A recording of the proceeding will be effectuated by the use of a court reporter, an electronic recorder, or both, as appropriate.
6. Members of the committee may at any time ask questions of the parties or witnesses, in order to gain a full understanding of the issues and facts. At the discretion of the chair, to aide the committee in its deliberations, the chair may request the production of any evidence not presented by the parties, and seek the advisement of legal counsel to address relevant issues of law.
7. At the discretion of the chair, closing arguments may be made by the parties.
8. Unless both parties agree to an open hearing, the hearing shall be closed and its proceedings deemed confidential. Witnesses other than the parties shall be excluded from the hearing, except when providing testimony.

f. No later than 15 days after the close of the hearing, the committee shall prepare a decision and submit it to the Hospital Administrator. The decision shall contain the committee’s recommendation as to whether the action imposed should be sustained, modified, or rescinded, and the basis for the recommendation. The recommendation shall be supported by the preponderance of the evidence presented during the hearing. The parties shall promptly be provided a copy of the decision.
g. Within 15 days of receipt of the committee’s decision, the Hospital Administrator, upon consideration of the corrective action or discipline taken and the review committee’s report, shall issue a final decision as to the action taken against the resident. Upon issuance, the parties will be provided a copy of the decision.

5. Miscellaneous

a. The time requirements, with notice to the parties provided hereunder, may be extended or shortened, as may be reasonable for the fair and timely resolution of a disputed corrective action or discipline.

b. This policy and procedure applies to resident academic and training performance, corrective action and discipline within the training program. It shall not otherwise substitute for any other administrative review rights that residents may have as established by the County of Riverside or the hospital.

c. Notwithstanding a resident’s informal review or appeal of a corrective action or discipline as provided hereunder, as approved by the Hospital Administrator and Chief of Medical Staff, the resident may continue his/her clinical duties.

d. The Director of Graduate Medical Education, where he/she finds it would aid the review process, may appoint a resident who is not involved in the corrective action or discipline being reviewed, to serve as a non-voting member of the Committee, as provided under Section IV.d.

e. Upon a finding that it is necessary to ensure the fair and impartial review of a corrective action or discipline, the Hospital Administrator may, upon an individual case-by-case basis and with notice to the parties, modify any term or provision of this policy and procedure.

6. Definitions

Medical Director shall mean the President of Medical Staff of the institution or designee.

Corrective Action shall mean any action necessary to prevent academic disciplinary action, to correct and improve academic and clinical skills, and to assist a resident in completing the training program, within the standards of the program and hospital.

Day shall mean calendar day, unless otherwise provided by this policy or procedure.

Director of Graduate Medical Education shall mean the Chair of the hospital’s Graduate Medical Education Committee or designee.

Discipline shall mean any action taken against a resident to suspend, deny advancement or expel him/her from the training program based on his/her academic and training performance.

Hospital/Institution shall mean the Riverside County Regional Medical Center.
Hospital Administrator shall mean the hospital’s Chief Executive Officer or designee.

House Staff shall mean those residents, collectively enrolled in the hospital’s Family Medicine Residency Training Program.

Human Resources Director shall mean the hospital’s Human Resources Director or designee.

Medical Staff shall mean a duly appointed member of the hospital’s Medical Staff organization.

Residency Program Director shall mean the hospital’s ACGME Residency Program Director or designee.

Resident shall mean a person enrolled in the hospital’s Family Medicine Residency Training Program.

Training Program shall mean the hospital’s Family Medicine Residency Training Program.

K. **DRESS CODE**

All Medical Staff are required to present a professional appearance at all times. Male residents and attendings are required to wear a tie and dress slacks at all times, except when performing call duties that require the individual to stay overnight or procedural experience, in which case scrubs are allowed. Sandals and denim fabrics are not acceptable.

Female residents and attendings are expected to wear dress slacks or a business dress, skirt and blouse. Sandals and denim fabrics are not acceptable.

All medical staff must wear socks or other types of hosiery with shoes that cover the toes. Weekend dress may be casual, but remain professional. Tee shirts, shorts, jeans, thongs and sun dresses are not acceptable. Refer to the Riverside County Regional Medical Center (RCRMC) House Staff Manual, Dress Code.

All personnel entering the semi-restricted and restricted areas of the surgical suite, and labor and delivery suites are required to wear RCRMC scrub suits. These scrubs are provided and laundered by the hospital. **RCRMC scrub suits are not to be removed from the hospital or worn outside the hospital.** Scrubs are issued and returned as per the Auto Valet Policy. Resident physicians must follow the Operating Room Dress Code.

L. **DELINQUENT MEDICAL RECORDS**

All residents are required to complete medical records in a timely manner. Charts become delinquent two (2) weeks after the patient is discharged from the inpatient setting. Failure to complete delinquent charts may result in loss of continuing medical education time (conference leave), probation, and suspension. Delinquent charts are reflected under the name of the attending physician; and the attending physician is ultimately responsible for ensuring that residents complete their medical records and charts in a timely manner.

Also residents are expected to abide by the hospital policy that pertains to documentation in the medical record. This policy can be found in *Appendix G – Monitoring of Documentation.*
M. DUTY HOURS AND WORKING CONDITIONS OF RESIDENT PHYSICIANS

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. The residency program is committed to ensuring 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 energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

Duty Hours

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 related 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.

Duty hours are limited to 80-hours per week, averaged over a four-week period, inclusive of all in-house call activities.

Residents are provided with at least one (1) day in seven (7), free from all educational and clinical responsibilities, averaged over a four (4) week period, inclusive of call. One (1) day is defined as one (1) continuous 24-hour period free from all clinical, educational, and administrative activities. Residents should review the service call schedule at the beginning of the block rotation in order to assure they have this required time off scheduled. If this requirement is not met, they are to immediately notify the attending or senior resident so that adjustments in the schedule can be made.

Residents should have at least ten (10) hours and must have at least eight (8) hours free of duty between scheduled duty periods. Residents should monitor when they leave the hospital and adjust their return time back to the hospital to meet this requirement. Residents should notify their team (attending or senior resident) of when they will be returning the next day.

Assessment of the compliance with these requirements is done through New Innovations. Duty hour violations are discussed with each resident and service chief every 4 week block. In order to ensure that residents are not working beyond the duty hour limits, residents are required to log their duty hours on a weekly basis. However, in order to ensure accuracy, residents are encouraged to log their duty hours on a daily basis.

Riverside County Payroll Policy requires all employees to submit a time sheet of hours worked. The duty hours report from New Innovations is used by the program staff to generate resident time sheets. Hours not logged into New Innovations may result in a delay of pay. A report of the previous weeks work hours (for purposes of hour report, the work week runs Thursday – Wednesday) is due each Thursday morning in New Innovations. Hours not logged as of Thursday at 8:00 am are considered delinquent.
On-Call Activities

In-house call occurs no more frequently than every third night, averaged over a four (4) week period.

For PGY-1 residents, continuous on-site duty, including in-house call, cannot exceed sixteen (16) consecutive hours. For PGY-2 and PGY-3 residents, continuous on-site duty, including in-house call, cannot exceed twenty-four (24) hours. PGY-2 and PGY-3 residents may remain on-site for up to an additional four (4) hours in order to facilitate effective transfer of care. PGY-2 and PGY-3 residents must have at least fourteen (14) hours free of duty after twenty-four (24) hours of in-house duty.

If a PGY-1 resident notices that he / she is experiencing signs and symptoms of fatigue or sleep deprivation, the PGY1 resident must notify his / her on-call senior resident; the senior resident will then cover for the PGY-1 resident so that the PGY-1 resident can take a strategic nap. If a PGY-2 or PGY-3 resident notices that he / she is experiencing signs and symptoms of fatigue or sleep deprivation, the PGY-2 or PGY-3 resident must notify his / her on-call attending physician. If the attending physician is not already on-site, the attending physician will physically come to the hospital to cover for the PGY-2 or PGY-3 resident so that the PGY-2 or PGY-3 resident can take a strategic nap.

Residents must not be scheduled for more than six consecutive night shifts. Residents must be available for obstetrical delivery of their continuity prenatal patients throughout their three (3) years of training. Continuity deliveries, end of life care and other special continuity experiences that result in extended duty hours are not considered duty hour violations.

N. **EDUCATIONAL ALLOWANCE**

Residents are allowed to have $500.00 for educational expenses in either their PGY2 or PGY3 year. Certain criteria need to be met in order to obtain this allowance. Below you will find the criteria needed in order to be eligible for this stipend:

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<th>Criteria</th>
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<tr>
<td>PGY2 or PGY3</td>
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<td>Must have passed USMLE Step 3 Exam</td>
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<td>In “Good” academic standing, at the discretion of PD and Faculty Advisor</td>
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<td>Intraining Exam Scaled Score &gt; PGY Level average to lowest 10th number</td>
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<tr>
<td>Lecture Attendance &gt; 66%</td>
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<tr>
<td>Item is linked to an educational expense</td>
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<tr>
<td>Item has been pre-approved by Program Director</td>
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<td>Receipt must be received no later than 7 days of the purchase</td>
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O. **ELECTIVES POLICY**

During residency, a total of 4 rotations for electives are offered to all residents as follows: One 4 week rotation in the PGY2 year and three 4 week rotations in the PGY3 year. One of these
elective rotations may be an option for an away elective in the PGY 2 or PGY 3 year. However, PGY3 residents may not schedule away electives during the last 4 week rotation of residency.

Regular Elective Rotations
Definition = a “regular” elective rotation is considered a 4 week experience that requires the resident to do their continuity clinic. This experience can be obtained on the RCRMC hospital campus or “outside” at another facility (hence “outside” elective). These experiences are primarily intended to enrich the residents’ training with experiences relevant to their plans for future practice or interests as family physicians. The choice of elective by the resident may include those of remedial purposes.

The following prerequisites will be considered when granting approval for elective rotations:
1. The resident must be in good standing and must demonstrate appropriate progress in the residency program.
2. If the resident is not on track to meet the requirements for number of continuity clinic visits, elective time may not be granted.
3. All requests for elective rotations need to be submitted at least 90 days in advance to Elizabeth Greenfield, the Family Medicine residency program support staff.
4. The elective request form must have the Preceptor signature prior to submission.
5. “Outside” elective rotations may be granted, however, resident continuity clinic must still take place during this time period.
   a. The elective provides an educational experience that cannot be gained in the local community.
   b. Approval of this outside elective must also be granted by the GME committee
   c. If a resident has not obtained a medical license, he/she needs to make sure that the supervising physician for the away elective does not require medical licensure for the resident to practice.

Away Elective Rotations
Definition = an “away” elective rotation is considered a 4 week experience that excuses the resident from their continuity clinic/visits. These experiences are primarily intended to enrich the residents’ training with experiences relevant to their plans for future practice or interests as family physicians. The choice of away elective by the resident may include those of remedial purposes also.

The following prerequisites will be considered when granting approval for away electives:
1. The resident must be in good standing and must demonstrate appropriate progress in the residency program.
2. If the resident is not on track to meet the requirements for number of continuity clinic visits, elective time may not be granted.
3. The elective provides an educational experience that cannot be gained in the local community.

The following information must be provided on the application at least 120 days (4 months) prior to the start date of the away elective:
1. Educational goals and objectives of the elective.
2. Name of the sponsoring organization
3. Name and clinical qualifications of the supervising physician (including Board Certification and Curriculum Vitae).
4. Any evidence of the resident’s existing health conditions requiring active medical treatment
5. Evidence that you will not be subjected to undue harm (international electives)
6. A discussion with faculty advisor regarding goals, logistics, coordination of other obligations, etc.
7. If a resident has not obtained a medical license, he/she needs to make sure that the supervising physician for the away elective does not require medical licensure for the resident to practice.

All outside and away electives must be approved by the Residency Program Director and the Graduate Medical Education Committee.

Scheduling for Time Away from Residency Program

Schedule requests and proposed schedule changes must be submitted at least 90 days in advance. Schedule changes may require the consent of another resident whose schedule may be altered due to the proposed changes.

Research and/or Remediation Elective

Residents have the opportunity to participate in a 2-4 week research or remedial elective. The proposed research topic or remediation plan should be pertinent to Family Medicine and may consist of:

Research - a literature review, chart review, original research, etc
Remediation – a plan of action to enhance learning and skills of the residents.

These proposals must be approved by the resident’s advisor and the Program Director. All research electives require the completion of a research paper and presentation at Family Medicine conference. Additionally, if the resident requests a 4-week research elective, he/she is expected to present the research at a regional/national meeting or submit the proposal for publication. All remediation rotations require documentation of the specific plan: work performed, tests taken and results, books read, on-line resources, participation in the Educational Enhancement Program (EEP), etc.

A research/remediation elective may be done as a regular or away elective. When a regular elective is done as a research or a remediation elective, the resident is expected to maintain continuity of his/her patient panel by spending 3-4 half days per week in the Family Care Clinic.

P. EMPLOYEE CONDUCT POLICY

Please see Appendix C – Employee Conduct for the complete policy (# 400.4).

Q. EVALUATIONS

Resident Evaluation

Residents are evaluated according to the 6 ACGME core competencies. The competencies include:

1. Patient care: that is compassionate, appropriate, and effective for the treatment of health problem and the promotion of health.
2. **Medical Knowledge**: about established and evolving biomedical, clinical and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to the patients.

3. **Practice-based learning and Improvement**: that involves investigation and evaluation of their own patient care, appraisal and assimilation of science evidence, and improvement in patient care.

4. **Interpersonal and Communication Skills**: that results in effective information exchange and teaching 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 a diverse patient population.

6. **System-based Practice**: as manifested by action that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Also residents are evaluated in a variety of ways:

1. **Block Evaluations** (Formative Evaluations): At the end of each block / rotation, the faculty for that rotation will complete an evaluation of resident performance.

2. **Conference Presentation Evaluations**: Every time a resident presents during Family Medicine Conference, fellow residents and at least one faculty member will complete evaluations of the presentation.

3. **360° Evaluations**: Other evaluations of resident performance may be provided by clinic staff, patients, resident peers, and other faculty.

4. **Continuity Clinic Evaluations**: Semi-annual evaluations are performed by faculty on every resident regarding their performance at the family medicine center.

5. **Videotaping**: Each resident is required to complete at least 2 videos of clinic patient encounters each academic year. These videos are subsequently evaluated and reviewed by a faculty member in the presence of the resident.

6. **Semi-Annual Evaluations** (Summative Evaluations): Each resident is scheduled to meet with his or her faculty advisor at least twice a year to review overall progress and completion of graduation requirements. These meetings usually occur during the months of December / January and May / June. The meeting in May / June will also include a final promotion review to determine if the resident will be promoted to the next year of residency. Graduating PGY3 residents also undergo a resident exit review and exit interview.

**Faculty and Program Evaluation**

In order to improve and maintain the quality of education and training provided by the residency program, residents complete the following evaluations:

1. **Rotation Evaluations**: At the end of each rotation / block, each resident must complete an evaluation of the rotation experience and the main faculty associated with that rotation.

2. **Faculty Evaluations**: Once a year, residents complete an evaluation of all teaching faculty (Family Medicine and non-Family Medicine). Residents are also given an opportunity to evaluate support staff and nursing staff.

3. **Conference Evaluations**: Residents complete evaluations at the end of every Family Medicine Conference session. This provides feedback for the conference presenters and helps to maintain high-quality conferences.
4. **Program Evaluation:** Once a year, residents complete confidential ACGME evaluations of the Residency Program.

These evaluations are used to improve the overall program. At present, most evaluations are conducted on-line through *New Innovations*.

**R. FAMILY CARE CLINIC POLICY**

- The resident is assigned to continuity Family Care Clinic between one and five half-days each week, depending upon the PGY year level and block rotation.

- PGY2 and PGY3 residents will be assigned to one of the community based clinics located at Perris or Rubidoux as part of their continuity clinic for the second and third year of their residency training.

- The resident is expected to be present from the start until the end of the clinic half day.

- The resident is expected to complete all indirect clinic work (chart checks, medication refills, review of laboratory and diagnostic test results, return patient messages, etc.) on a daily basis. If the resident is away or on vacation, it is the responsibility of the resident to arrange for coverage by another resident.

- Any resident clinic session(s) that are cancelled due to residents absence, will need to be made up by the resident during a weekend or evening shift.

- Residents will be scheduled patients according to their year level. The following guidelines will be used to determine the number of patients each resident year level will be scheduled:
  - PGY 1 = 4 patients in the first 6 months and will increase to 6 patients each 4 hour clinic session. Increase to 6 patients will be determined when the resident has shown adequate progression in patient care competency.
  - PGY 2 = 8 patients
  - PGY 3 = 10 patients

- During each clinic session in FCC, a ratio of no less than 1:3 Attending:Resident will be used for precepting and supervision of residents. Residents will be assigned to work with a particular attending during their clinic session.

- Every resident will be assigned to one half day clinic session of procedure experience/4 week block. There will be 6 procedures scheduled during this time. It is up to the resident to ensure scheduling of their procedures for these sessions. Hence, it is encouraged for the resident to take an active role in monitoring their procedure experience.

- Every resident will be assigned to one half day clinic session of behavioral science experience/4 week block. During these sessions, the visits would be pre-determined and residents would have 70% of their scheduled patients (i.e. PGY 3 = 7 pts, PGY 2 = 5 pts and PGY 1 = 3 pts). This plan would be started with PGY-1 residents 7/1/2012 and gradually implement to the PGY 2 and 3 residents. The behaviorist will provide training.
and supervision that promotes ACGME competencies, while residents utilize a Family Medicine approach to care for ambulatory patients over time.

- If the resident is not able to be present for any clinic session due to illness or any other situation, he/she needs to notify the Clinic Assistant Nurse Manager, Family Medicine Residency Program Support Staff, and Chief Residents as soon as possible. Emailing this information is discouraged and direct contact via phone call should be used at all times with these individuals. If you are not able to contact someone, then you are required to leave a phone message. You may contact these individuals through the following contact numbers:

  A. Maryann Reilly (Clinic Assistant Nurse Manager RCRMC Family Care Center): 951 486-5219 or 30172
  B. Mayra Palacious (Rubidoux Family Care Center, Nurse Manager): 951-955-0840
  C. Courteny Vasquez (Perris Family Care Center, Nurse Manager): 951-940-6700
  D. Treva Williams (Family Medicine Support Staff): 951-486-4494
  E. Elizabeth Greenfield (Family Medicine Support Staff): 951-486-5611
  F. Sabeen Abdulsattar, M.D. (Rubidoux Family Care Center Preceptor): 951-955-5308
  G. Keyla Monterry, M.D. (Perris Family Care Center Preceptor): 951-210-1408

S. **FM DIDACTIC LECTURES AND OTHER CONFERENCES**

Family Medicine didactic lectures are scheduled every Thursday afternoon from 1-5 pm. In addition, hospital wide grand rounds are scheduled on the 3rd Wednesday of every month. All these lectures are considered a vital part of resident education and training, and residents are required to attend at least 66% of all these lectures per Quarter (3 blocks) (inclusive of vacation, away elective, sick, etc.) for educational allowance, continuing medical education time (conference leave) and ultimately promotion/graduation. A list of lectures is available on the RCRMC Family Medicine Residency website (rcrmc-fmr.org) and in the “P:drive” within our internal hospital computer system.

Residents who do not meet the lecture attendance requirement may not be eligible for promotion, away electives, educational allowance, or continuing medical education time (conference leave).

Other conferences/lectures are provided throughout the block schedules. Attendance in these conferences are encouraged but not counted toward the 66% lecture requirement mentioned above.

1. 3rd Monday/month = FCC Wellness Meeting
2. Every Tuesday = Tumor Board
3. Every Other Wednesday = Noon Case Report
4. Every Friday = Noon Lectures

Each resident is expected to give at least 1 presentation/lecture and 2 journal club presentations during residency training.
The Family Medicine Inpatient Service (FMIS) was established to provide the experience for residents to be the primary decision maker for the care of hospitalized patients. The goal of the (FMIS) is to provide the highest quality of care with emphasis on team care approach, evidence-based medicine, education and learning, as well as cost effectiveness and continuity of care.

Expectations on the Family Medicine Rotation / Call
Between four (4) to (5) residents, and one (1) to two (2) Physician assistant (PA) and one (1) to two (2) Medical students are assigned to the rotation for each block. The third year resident acts as the senior resident, provided no other third year resident is on the service. In the event that there is more than one third year or only junior residents on the service, the attending assigns a senior resident responsible for the whole team. All residents and students are to round on patients every weekday morning and on weekends; this includes on-call and post-call mornings.

On-Call Team:
1. All residents and students are required to remain in the hospital during their entire call. Call starts at 8:00am, and ends at 8:00pm, for the senior resident. First-year residents may be on-call for up to 16 hours at a time.
2. The senior resident on call will assign patients and tasks to the junior staff, with emphasis on fairness, efficiency, and continuity of care.
3. The senior resident on call must see ALL admissions and co-sign the History & Physical Exam.
4. The senior resident on call will notify the attending as per Policy.
5. The senior resident on call will write a separate “Admit Note” for all admissions. The note shall include the reason for admission, important clinical findings, including significant laboratory data, working diagnoses and management plan.
6. The senior resident on call (if certified) will supervise all procedures done by the junior resident or student.
7. The senior resident on call will ensure that the computerized patient list is updated and important information included.
8. In case of an unexpected high number of admissions, the senior resident on call will inform the FAMILY MEDICINE ward senior in a timely manner, to ensure adequate review of new patients by the FAMILY MEDICINE team. During weekends and holidays, the senior resident on call should communicate the same to the residents assigned to do FAMILY MEDICINE ward rounds, who are starting call the following day.
9. The on call and post call senior residents will decide how each service will be covered for rounds during weekends and holidays, with an emphasis on continuity of care.
10. The junior resident on call will assess and write a detailed history and physical on each admission. Efforts shall be made to involve and supervise the students on all admissions.
11. The junior resident on call shall inform the senior resident on call of any events requiring attending notification.
13. The junior resident on call shall respect and abide by the decisions of the senior resident on call, except if these decisions are equivocally against known policies and standards of care of patients and professionalism. The junior resident shall immediately report any such occurrence to the attending.

14. All residents on-call are required to admit patients from the pediatric, adult and obstetrical populations, irrespective of the service the resident is assigned on that block (Peds Ward, FM Ward, FMC with call, Newborn services).

15. During weekends, the on-call and post-call residents will round on either pediatric or adult patients. During weekdays, it is expected that the post-call residents present cases to either the pediatric or adult attendings during rounds.

Inpatient Care Team

1. Residents and students pre-round on all patients. Attending round usually begin at 8:00am. The residents and students on call will present newly admitted patients from the night before. If the admitting resident is on the Pediatric ward service, the night float resident will present the newly admitted patient instead.

2. The senior resident must pre-round with the team prior to attending rounds and come up with management plan for discussion with the attending. The senior resident may order appropriate tests or consults if deemed necessary, prior to the above discussion.

3. The team is required to inform the primary care physician of any admitted patient.

4. The ward junior resident will be responsible for coordination of all aspects of the patients’ care, including writing, and / or calling consultation requests, maintaining contact with consultants, and coordination with support services and social workers (either pediatric or adults). Any issues or problems should first be addressed with the senior resident.

5. All residents on FM Ward, Peds Ward and Nursery are not allowed to take scheduled time off from these rotations.

Check Out

1. FM Ward residents assigned to continuity clinic in the afternoon may check out after 12:00 pm to the on-call resident.

2. FM Ward residents assigned to the floor in the afternoon may check out before 5:00 pm to the on-call resident, however the FM Ward resident is responsible for patient care until 5:00 pm.

3. The junior ward resident will check out to the junior on-call resident, and the senior ward resident will check out to the senior on-call resident.

4. Routine care management, consult communication and follow-up of tests etc., should be done by the ward residents and not be checked out to the on-call team, as much as possible.

5. Hand off communication steps should be followed when shifts change. Please Refer to Appendix F – Hand Off Communication

Medical Records

1. Residents are expected to sign verbal and telephone orders within 24 hours, and complete the chart before the patient is discharged.

2. All written orders must be signed, dated, timed and stamped by the residents.

   a. Refer to Appendix G – Monitoring of Documentation

3. Progress notes should be written and completed in a timely fashion to facilitate efficient rounds and patient care. If test results are pending at the time the note is written, the note should state that. The results should be entered as an addendum later, along with any update in assessment and plan related to the new information.
4. PA / medical students may see all patients including those in the PCU. The resident assigned to the patient will review and sign all progress notes and orders written by students. It is the responsibility of both the resident and the student to ensure that all notes are reviewed and signed, prior to placing it in the chart.

NOTE: Students may write progress notes, H&P’s, and orders as scribes, but may not sign them. They may however, if required by their institution, make copies of H&P or progress notes, without patient identification, and then sign them. Such copies are not to be placed in the chart.

Hospital Discharges
1. All efforts are made to discharge patients as early as possible during the day.
2. Discharge planning is encouraged to begin at the time of admission
3. The discharge summaries must be sent to the Family Care Clinic (FAMILY CARE CLINIC) on the same day of discharge of the patient, notwithstanding weekends and holidays.
4. All attempts will be made to give patients an appointment for follow up in the FAMILY CARE CLINIC with a member of the team (resident or attending)** or the primary care physician and in the specialty clinic (if needed) upon discharge. Also, any appointments for special tests will be made upon discharge, if deemed necessary by the attending or consulting physician, prior to the follow up clinic appointment.
5. On weekends and holidays, the FAMILY MEDICINE ward senior will collect all the discharge summaries over that time from the on call senior, ensure that patients get a follow up clinic appointment(s), and that discharge summaries reach the FAMILY CARE CLINIC. The ward senior may delegate part of this task, if needed.
6. The FM Ward team is required to place post-hospital phone calls to those patients who have been discharged within 48-72 hours and document this phone visit in the medical record.
   a. The phone log computer system should be used when making these follow-up calls
7. Further instructions on the Transition of Care from Inpatient to Outpatient can be found on Appendix G = Integration and Communication between the Inpatient and Outpatient Services

Mini-Presentations
1. Ward residents are expected to give presentations to the team on topics related to the care of their patients assigned by the attending physician, if the workload permits.

Attending Notification Policy

The senior resident on call or senior ward resident shall inform the appropriate attending ASAP in the event of:

a. Admission of all obstetrical patients, patients 75 years of age or greater, and patients less than 18 years of age.
b. Transfers to PCU, ICU or NICU.
c. ER and inpatient consults and discharges.
d. Direct transfers prior to transfer.
e. Death or any significant change in hemodynamic, respiratory and neurological status.
f. Medication errors requiring clinical intervention.
g. A clinical problem requiring invasive procedure or operation not anticipated or addressed earlier by the attending.

## U. FAMILY MEDICINE INPATIENT CONTINUITY OF CARE

The Family Medicine Ward resident will notify you about your continuity patients admitted to the hospital on the Family Medicine patient service. Please coordinate care with the Family Medicine Inpatient Team ward resident. It is important that the primary care physician is involved through the hospital care of his/her patient and provides continuity post-hospitalization.

## V. FITNESS FOR DUTY POLICY

Any resident who works at the hospital is expected to report to work in a fit and safe condition. Therefore, any resident who is taking prescription medication(s), and / or who has a drug, alcohol, psychiatric or medical condition(s) that could impair his / her ability to perform in a safe manner, must report the medical status to the Program Director. The hospital’s “Referral Procedures and Disciplinary Action” will be followed for individuals who are found to be impaired at work.

## W. GUIDELINES FOR RESIDENT TRAVEL EXPENSES

Travel reimbursement may be available in certain situations (e.g., chief resident traveling to a leadership conference or any other CME related conference). In general travel expenses need to be pre-approved by the Program Director. Please refer to Appendix I - Institutional travel policy for specific guidelines.

## X. GRIEVANCE POLICY

### Purpose

The purpose of this policy and procedure is to set forth the procedures to address and resolve any grievances of residents in the hospital’s Family Medicine Residency Training Program.

### Philosophy

The hospital endeavors to provide residents with an environment conducive with assisting the resident to work and develop professionally. The hospital understands that concerns, issues or conflicts may arise during the resident’s term at the hospital. The hospital recognizes the importance of having residents’ grievances addressed and resolved in an appropriate and expeditious manner. When possible, grievances should be addressed and resolved informally.

### Procedures

**Step 1 – Informal Review:**
Every effort should be made to resolve resident grievances informally in accord with the following:

a. A resident with a grievance shall immediately consult with the Residency Program Director for assistance in resolving the grievance. Where the nature of the grievance is such that it should be brought to a person other than the Residency Program Director, the resident shall consult with the Director of Medical Education for assistance in resolving the grievance. When possible, all grievances shall be promptly addressed.

b. In consulting with the Residency Program Director regarding a grievance, the resident shall fully explain the facts and circumstances constituting the basis of the grievance, and the resident’s proposed resolution of the matter. The Residency Program Director shall endeavor to promptly address and resolve the grievance, if possible.

Step 2 – Formal Grievance Review:

In the event that a resident’s grievance has been submitted and reviewed under the provisions of Step 1 above, and remains unresolved, the resident may seek further review of the grievance in accord with the following:

a. Within thirty (30) days of the acts(s) or event(s) which are subject of the resident’s grievance, he / she shall provide the Residency Program Director with a written statement of the grievance (hereafter “Grievance Statement”). The Grievance Statement shall state the facts and circumstances constituting the grievance, and the resident’s desired resolution of the matter.

b. The Residency Program Director shall issue a written response to the resident’s Grievance Statement within ten (10) days after the receipt of the Grievance Statement. The response shall address the merits of the resident’s grievance and, as appropriate, resolution of the matter.

Step 3 – Grievance Review by Committee:

In the event that the Residency Program Director’s Step 2 response does not resolve the grievance to the satisfaction of the resident, he/she may seek further review of the matter pursuant to the following:

a. Within ten (10) days of receiving the Residency Program Director’s Step 2 response, the resident shall file a written request that the grievance be reviewed by a grievance committee with the Director of Medical Education.

b. Upon receipt of a resident’s request for review of the matter by a grievance committee, the Director of Medical Education shall promptly set a date for the convening of a committee hearing, but no later than fifteen (15) days after the committee is constituted. The committee’s membership shall consist of the Director of Medical Education, Chief of Medical Staff and the Human Resources Director. The Director of Medical Education shall serve as Chair of the Committee.

c. The Director of Medical Education shall provide the resident, committee members
and, as may be appropriate, other persons with written notice of the time, place and date of the hearing.

c. The resident and Residency Program Director shall appear at the hearing. Each party may be represented by legal counsel or other representative; however, in no case shall the Residency Program Director be represented by legal counsel if the resident is not represented by legal counsel. Failure of the resident to appear at the hearing, or to present his / her case at the hearing, shall constitute a waiver of his / her right to a committee review hearing, and acceptance of the Residency Program Director’s response.

d. The hearing shall proceed and evidence taken in accord with the following:
   a. Upon opening the hearing, the chair shall explain the hearing procedures and the rights of the parties established hereunder;
   b. The hearing shall be limited to matters to the committee’s review of the resident’s grievance statement and the Residency Program Director’s response;
   c. The admission of relevant evidence will not be restricted by evidentiary rules applicable in a court of law;
   d. Within reasonable limitations, both sides at the hearing may examine witnesses, cross-examine witnesses, and present exhibits or documents;
   e. A recording of the proceeding will be effectuated by the use of a court reporter, an electronic recorder, or both as appropriate;
   f. Members of the committee may, at any time, ask questions of the parties or witnesses, in order to gain a full understanding of the issues and facts. At the discretion of the chair, to aide the committee in its deliberations, may request the presentation of any evidence not presented by the parties and seek the advisement of legal counsel to address issues of law;
   g. At the discretion of the chair, closing statements may be made by the parties; and unless both parties agree to an open hearing, the hearing shall be closed and its proceedings deemed confidential. Witnesses other than parties shall be excluded from the hearing, except when providing testimony.
   h. No later than fifteen (15) days after the close of the hearing, the committee shall prepare and submit a written decision to the Hospital Administrator. The decision shall contain a recommendation as to whether the grievance, in any part, should be sustained or denied and, as appropriate, what remedial action should be taken. The committee’s decision shall be supported by the preponderance of the evidence presented at the hearing. The parties will be promptly provided a copy of the decision.
   i. Within fifteen (15) days of receipt of the committee’s decision, the Hospital Administrator shall accept or modify any part thereof. The committee’s decision shall become final as accepted or modified by the Hospital Administrator.

Miscellaneous

The time requirements, with notice to the parties, provided hereunder may be extended or shortened as may be reasonable for the fair and timely resolution of a grievance.

This policy and procedure applies to resident Grievances as to academic and training in the Residency Program, and shall not otherwise substitute for any other
administrative review rights that resident’s may have, as established by the County of Riverside or Hospital.

The Director of Medical Education, where he/she finds it would aid the review process, may appoint a resident who is not involved in the grievance being reviewed, to serve as a non-voting member of the committee as provided under Section III, Step 3.b.

Upon a finding that it is necessary to ensure the fair and impartial review of a grievance, the Hospital Administrator may, upon an individual case basis and with notice to the parties, modify any term of the provisions of this Policy and Procedure.

Definitions

Medical Director shall mean the hospital’s Medical Director or designee.

Day shall mean calendar day, unless otherwise provided by the policy and procedure.

Director of Medical Education shall mean the Chair of the hospital’s Medical Education committee, or designee.

Grievance shall mean any controversy, claim or concern of a resident, arising out of, or concerning his / her academic performance and / or training in the Residency Program.

Hospital shall mean the Riverside County Regional Medical Center.

Hospital Administrator shall mean the hospital’s Chief Executive Officer or designee.

House Staff shall mean those residents collectively enrolled in the hospital’s Family Medicine Residency Training Program.

Human Resources Director shall mean the hospital’s Human Resources Director or designee.

Medical Staff shall mean a duly appointed member of the hospital’s Medical Staff organization.

Residency Program Director shall mean the hospital’s ACGME Residency Director or designee.

Resident shall mean a person enrolled in the hospital’s Family Medicine Residency Training Program.

Residency Program shall mean the hospital’s Family Medicine Residency Training Program.

Y. HARASSMENT AND COMPLAINT POLICY

Please see Appendix A – Harassment and Complaint Procedure for the complete policy (#400.3).
Z. **INFORMED CONSENT**

RCRMC policy states that only a licensed practitioner can obtain informed consent. PGY1 residents are not licensed practitioners, and therefore require an attending co-signature when obtaining informed consent. PGY2 and PGY 3 residents can obtain informed consent if they are licensed.

AA. **IN-SERVICE TRAINING EXAMINATION POLICY**

a. All residents are required to take the national Family Medicine in-training examination in October. The in-training examination is predictive of future board examination success. Therefore, any resident who receives ITE Score < the rounded down score to nearest 10th of National Average (NA) for the PGY level (i.e. if the NA = 456 → then it is rounded down to 450) will be placed in remediation through the Educational Enhancement Program. Residents in this program can expect additional educational assignments.

Moonlighting is not permitted during remediation. Failure to complete remediation in a satisfactory manner may result in non-promotion, probation, or dismissal from the residency program. Please refer to *Appendix J – Educational Enhancement Policy*.

BB. **MOONLIGHTING POLICY**

All Family Medicine Residents planning to moonlight must complete a “Permission to Moonlight” form and have the Residency Director review and sign it. This must be renewed at the beginning of each academic year and when new moonlighting locations are planned. The “Permission to Moonlight” form will require the site of moonlighting and anticipated hours of moonlighting per week and block. All moonlighting hours are included in duty hour calculations.

**Prerequisites for moonlighting include:**

- Resident must be in good standing with the program.
- Resident must have an in-training exam score > the rounded down score to nearest 10th of National Average (NA) for the PGY level (i.e. if the NA = 456 → then it is rounded down to 450).
- Resident must have completed at least 12 months of post-graduate training with RCRMC Family Medicine Residency Program.(No PGY1 residents are allowed to moonlight.)
- Resident must have a current California medical license and DEA number
- Resident must complete and have signed off by the Program Director the “Permission to Moonlight” Form.
- Resident understands the RCRMC liability coverage will not be extended to cover moonlighting activities of the resident that fall outside the course and scope of the individual’s residency appointment.

**Moonlighting guidelines:**

- Moonlighting hours must conform to ACGME duty hours guidelines.
- All moonlighting duty hours must be documented in New Innovations
• Hours devoted to moonlighting are added to training program work hours and reported on all work hour surveys. At no time may a trainee exceed work hour regulations through a combination of training program plus moonlighting activities.

• Moonlighting must not conflict in any way with the resident’s obligations to his/her educational experience. (e.g. Residents cannot moonlight weekdays from 8:00 am to 6:00 pm, and residents must not schedule moonlighting if it conflicts in any way with residency responsibilities.

• Residents who are on sick leave from the program for any reason may not participate in moonlighting activities.

• Violation of any of the above rules will result in disciplinary action, which may include probation or termination from the residency.

In the event a resident is given permission to moonlight, the program director will monitor the resident’s performance for the effect of these activities upon performance in the trainee’s program. Should moonlighting interfere with the ability of the resident to achieve the goals and objectives of the residency program, the program director may withdraw permission allowing the resident to engage in professional activities outside the training program.

Violation of the above rules and guidelines may result in loss of moonlighting privileges and disciplinary action against the resident.

CC. OSCE

The OSCE (Objective Structured Clinical Examination) is administered to all residents on an annual basis. Incoming interns will receive an OSCE for baseline evaluation during the orientation period. The examination tests the following ACGME core competencies - fund of knowledge, patient care, interpersonal and communication skills, and professionalism.

DD. PHYSICIAN WELLNESS, SUPPORT, AND PREVENTION

1. Health Screening

Health screening is required for all incoming residents. Drug screening is part of this evaluation. Health screening is done annually after.

2. Employee Assistance Services (EAS)

All residents have access to the Employee Assistance Service (EAS), which provides free confidential counseling for stress management, personal problems, and substance dependency problems. The EAS telephone number is (888) 829-8999 or (951) 778-3970.

3. Family Medicine Faculty Resources

a. Behavioral Science faculty is available as a resource for confidential and personal matters that may impact a resident’s professional work performance.
b. Each resident also has an assigned Family Medicine faculty advisor whose role it is to provide mentorship, guidance, and academic counseling.

4. **Medical Staff Wellness Committee**

This committee may be utilized to provide advice, counseling or referrals, as may seem appropriate, including a referral to the California Medical Board Diversion Program.

EE. **PROCEDURES**

All procedures performed by Family Medicine Residents require on-site and in-person supervision by an attending physician. Residents are required to log all procedures in *New Innovations*. Procedures logged in *New Innovations* are electronically sent to the attending physician who then confirms the procedure. When the attending physician confirms the procedure, he/she also determines if the Family Medicine Resident performed the procedure appropriately and competently. This information is recorded in *New Innovations*. All procedures are tracked in *New Innovations*, and the total number of procedures performed are reviewed during each resident’s semi-annual evaluation. It is strongly recommended that in addition to entering procedures in *New Innovations*, residents keep a hard copy log of all continuity clinic visit patients and procedures.

In order to graduate from the residency program, all residents are required to complete a minimum number of procedures, as listed below:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central line placement</td>
<td>2</td>
</tr>
<tr>
<td>Circumcision</td>
<td>10</td>
</tr>
<tr>
<td>Colposcopy</td>
<td>10</td>
</tr>
<tr>
<td>Deliveries</td>
<td>40</td>
</tr>
<tr>
<td>Continuity Deliveries (included as part of total deliveries)</td>
<td>10</td>
</tr>
<tr>
<td>Endometrial biopsy</td>
<td>5</td>
</tr>
<tr>
<td>Excision of lumps and bumps</td>
<td>5</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy</td>
<td>15</td>
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<tr>
<td>I&amp;D</td>
<td>5</td>
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<tr>
<td>Joint aspiration and injection:</td>
<td>10</td>
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<td>Lumbar puncture</td>
<td>5</td>
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<td>Paracentesis</td>
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<td>Shave / Punch biopsy</td>
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<tr>
<td>Thoracentesis</td>
<td>2</td>
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<tr>
<td>Vasectomy</td>
<td>3</td>
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In addition to above procedures, residents must document at least 15 critically ill patients (ICU), 2 continuity nursing home visit and 2 home visits.

**FF. PROFESSIONALISM**
All residents are expected to maintain the highest level of professionalism at all times. Residents are expected to demonstrate integrity, respect, and responsibility. As professionals, residents are expected to be punctual; provide appropriate follow-up and follow-through; notify co-workers, colleagues, and attending physicians of any anticipated schedule delays; return all pages promptly; and check and respond to email on a daily basis. Please remember that as residents, you are ambassadors for the residency program, the hospital, and the profession.

If the resident is not available for service for any reason and requires absence from residency duties in any department, he/she needs to follow the following actions. He/She is required to contact the FM Dept Support Staff (by either phone, answering machine, text, email or page), and has to notify the department secretary in which he/she is assigned to and the senior resident/attending (by either phone, answering machine, text, email or page). Emailing this information is not enough and direct contact via phone call should be used at all times with these individuals. The resident needs to use these communication methods until contact has been made and/or he/she assures that the absence is accounted for. If the resident is not able to contact someone, then he/she is required to leave a phone message with each department.

GG. PROMOTION POLICY

Resident performance is reviewed for promotion on a yearly basis by the Residency Director and residency faculty. They use the evaluation tools already in place, (i.e. rotation evaluations, performance evaluation forms, procedures, clinic visits, attendance, in-training examinations, Family Care Clinic evaluations, OSCE results, conference attendance, etc), to decide on the promotion of a given resident to the next year of training. (Summative Evaluation)

The following are some of the criteria used for the general evaluation for promotion: clinical competence, professionalism, attitude / behavior, technical skills, and impairment prevention.

Promotion Specifics:

For a resident to be promoted from PGY1 to PGY2, all of the following criteria will be used in the evaluation for promotion to the next postgraduate year:

  Acceptable progress in clinical performance noted by evaluations.
  Able to supervise PGY1’s and students.
  Successfully pass the Objective Structured Clinical Examination (OSCE)
  Minimum conference attendance of 66%.
  Score > 10% of questions correct on the ITE

For a resident to be promoted from PGY2 to PGY3, all of the following criteria will be used in the evaluation for promotion to the next postgraduate year:

  Acceptable progress in clinical performance.
  Able to supervise PGY2 & PGY1 residents.
Able to act with independence for low complexity clinical problems.

For International Medical Graduate residents, apply for California medical license by the end of the PGY2 year, and for US Graduate residents, obtain a CA medical license by the end of the PGY2 year.

Minimum conference attendance of 66%.

Score > 15% of questions correct on the ITE

Must have taken the USMLE Step 3 by 12 months of training and passed it by the end of 18 months of training. (for more information on the Step 3 exam please refer to the USMLE board requirement)

For a resident to be promoted from PGY3 to Graduation, all of the following criteria will be used in the evaluation for promotion to the next postgraduate year:

Competence in clinical performance

Able to practice independently in the field of Family Medicine.

Satisfactory completion of all procedure requirements, minimum clinic visits (1650), OB vaginal deliveries (30 and 10 continuity), critically ill patients (15), Home visits (2) and Nursing Home (2) and Research Project

Completion and presentation of senior case presentation.

Minimum conference attendance of 66%

**HH. RESIDENT JOB FUNCTIONS**

After appropriate training, Family Medicine residents at RCRM must be able to perform the following:

- Perform a history and physical examination.
- Administer injections.
- Use sterile technique and universal precautions.
- Perform cardiopulmonary resuscitation.
- Wear protective clothing and respiratory equipment for care of patients with communicable diseases and / or immuno-compromised patients.
- Move throughout the clinical site and hospitals to address routine and emergent patient care needs.
• Manage obstetrical patients and perform low-risk deliveries.

• Assist at surgical operations and perform outpatient procedures, such as skin biopsies, endometrial biopsies, flexible sigmoidoscopies, and neonatal circumcisions.

• Communicate with patients and staff verbally and otherwise, in a manner that exhibits good professional judgment and good listening skills, and is appropriate for the professional setting.

• Demonstrate timely, consistent, and reliable follow up on patient care issues, such as laboratory results, patient phone calls, and other requests.

• Input and retrieve computer data through a keyboard and read a computer screen.

• Read charts and monitors.

• Perform documentation procedures, such as dictation, in a timely manner.

• Manage multiple patient care duties at the same time.

• Make judgments and decisions regarding complicated, undifferentiated disease presentations, in a timely fashion, in emergency, ambulatory, and hospital settings.

• Demonstrate organizational skills required to care for 3 to 11 outpatient cases per half day (depending upon year level of training) and 5-10 inpatient cases daily on the Inpatient Service.

• Take call for rotational services that require inpatient admissions, and work for stretches of time that are in accordance with duty hour guidelines.

• Present well-organized case presentations to other physicians or supervisors, and function as a dependable member of the health care delivery team.

• Participate in and satisfactorily complete all required rotations, including longitudinal rotations.

• Answer pages in a time sensitive manner for patient care duties.

• Participate in hospital committees as they pertain to patient safety and quality improvement (i.e. Performance Improvement Committee, Ambulatory Care Committee, Resident Committee, Graduate Medical Education Committee, Continuing Medical Education Committee, etc)

II. **RESEARCH POLICY**

All residents are expected to complete a research project by the end of PGY3 year. Guidelines of acceptable criteria for projects are available from the faculty advisors. Residents are encouraged to start their project in the PGY2 year, and present it in the PGY3 year. Residents are encouraged to submit their project for presentation, and / or publication at professional
Residents may request elective time of up to four (4) weeks, to pursue additional research projects for publication and/or presentation. All research projects have to be approved by the hospital IRB (Institutional Review Board) and all residents need to complete IRB CITTI online training before starting the project (this training is included during the orientation).

**JJ. RESIDENTS AS EDUCATORS**

1. The residents are expected to teach medical students, junior residents, and other health care professionals.
2. The residents are required to treat one another and all learners with respect and dignity.
3. The residents will be taught how to teach and evaluate learners by the program director, faculty, and chief residents during the residency training through didactic lectures, small group sessions, and role modeling.
4. The residents will be evaluated on their teaching by medical students and other learners. The data from their evaluations will be used as part of the semi-annual feedback and evaluation of the residents by their respective faculty advisor.

**KK. SELECTION AND ELIGIBILITY CRITERIA**

Eligibility for selection as a resident must conform to the guidelines of the Accreditation Council for Graduate Medical Education (ACGME) general requirements.

Residents are selected by the Residency Director from an applicant pool in the National Residency Matching Program (NRMP). All first year residents are to be matched in the NRMP.

Resident candidates must be graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME), or approved schools of osteopathy, accredited by the American Osteopathic Association (AOA), in the United States, District of Columbia, Puerto Rico, or Canada, or hold a current valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), along with a status letter from the Medical Board of California, authorizing the start of postgraduate training in the State of California.

Residents are appointed for one year, with renewal of the yearly contract by mutual consent of the Program Director and the resident. This commitment must be made prior to the promotion to the next postgraduate year, for the subsequent academic year starting July 1st.

**LL. SERVICES AND BENEFITS**

1. Educational Services
   a. The Hospital agrees to maintain the Family Medicine Program accreditation and provide a quality environment for graduate medical education and experience, which meets the standard of the appropriate specialty board.
   b. Appropriate instruction, learning and experiences will be provided on all services to which the Resident are assigned.
c. Free photocopy facilities will be provided only for professional and educational purposes. Reasonable judgment to prevent waste and unnecessary cost is expected.

d. Rotational assignments will be decided by the Department of Family Medicine after due consideration has been given to the requirements of other departments through which the Resident will rotate.

2. Professional Services

a. Residents shall be provided with a meal allowance based on their working hours at RCRMC.

b. The hospital will provide clean, pressed white coats, scrub suits and scrub dresses on a regular basis.

c. The hospital will provide name badges.

d. Residents will be provided call room facilities, with access to shower / toilet, when on “call” duty. Personal hygiene products are the responsibility of the resident. Towels will be provided.

3. Malpractice Insurance

The Hospital will provide malpractice (professional liability) insurance while resident is working on behalf of the hospital.

4. Vacation and Leave Time

a. Each Resident is entitled to 3 weeks (21 calendar days) of vacation time per year, with full pay, upon assignment of vacation by the Program Director. This time is cumulative, and alternatively may be taken as equivalent pay at the end of tenure. In addition, residents are entitled to 1 week (7 calendar days) for Continuing Medical Education (CME) annually.

b. Each Resident is entitled to all County Holidays. Residents will be entitled to compensatory time off (for holidays worked), to be taken off during non-call rotations, upon request and approval of the Program Director or Assistant Program Director.

c. Each Resident is entitled to four (4) hours per pay period of paid sick leave. Activities missed during sick leave will be made up by the resident at the discretion of the Program Director or Assistant Program Director.

d. It is the intent that Residents will not be required to make up call that would normally be encountered during vacation time. Emergency, grief, or a medical leave shall be on an individual basis and handled as a team effort.

e. Residents may take accrued time for family illness or injury, or bereavement, as stated in the County of Riverside policies, as long as the ACGME time off policies are not violated.
f. In the event of sick leave or emergency leave, notification to personnel directly affected by the Resident’s absence and the Residency Coordinator is required as spelled out under “Professionalism” policy.

g. If a resident is absent for more than 1 month during an academic year (including vacation time, continuing medical education time, sick time, etc.), the promotion / graduation date of that resident will be extended accordingly. “Absent” time does not include paid County holidays.

5. Ancillary Benefits

a. The Hospital Human Resources will inform the Residents of various medical and dental insurance plans and options at the earliest opportunity, (preferably prior to employment starting date), in order that Residents may enroll early in an appropriate insurance plan.

b. The Hospital will pay the monthly medical insurance premium for the Family Medicine Resident. The Resident will be responsible for payment of monthly premiums for family members.

c. The Hospital will accept Riverside County Regional Medical Center insurance benefits as payment in full, for all medical care and hospitalization costs at Riverside County Regional Medical Center, incurred by the insured Resident and insured immediate family members. Family members uninsured will be liable for the full amount.

d. Residents are entitled to all benefits as detailed in the Riverside County and House Staff Brochure.

e. Counseling services are available through the Employee Assistance Service (EAS).

6. Working Conditions and Remuneration

a. On services that require overnight call, it is intended that the Resident will be entitled to a minimum of four (4) days off a month. This should be worked out with the service the Resident is on, and if there is any problem, it should be conveyed to his / her director and have him / her talk to the Chief of Service, in order for the problem to be resolved.

b. Residents are entitled to select representatives with voting rights to participate on the Hospital Committees of Medical Education, Patient Care Review, Infection Control, and Ambulatory Care.

c. Residents are subject to non-academic disciplinary dismissal and review process as determined by Riverside County Regional Medical Center, at which time this agreement will immediately terminate and no longer will be valid.

Professional activities outside the educational program are allowed and delineated in the Moonlighting Policy in the Family Medicine Policy Manual.

Residents’ essential job functions are listed in the Family Medicine Policy Manual.

Residents are subject to all policies and procedures that govern RCRMC employees. This includes, but is not limited to, Sexual Harassment, Violence in the Workplace, Dress Code, and Patient Confidentiality.

Residents are also subject to all policies and procedures that govern their assigned department.

**MM. SUPERVISION REQUIREMENTS POLICY**

RCRMC assumes full responsibility for the supervision of resident physicians in the Family Medicine Residency Program. This responsibility is delegated to the individual departments and fulfilled by the Attending Physician (Medical Staff) in various clinical departments.

**Supervision in the Family Medicine Department**

Supervision of Family Medicine Residents by Family Medicine faculty occurs in the inpatient service, during longitudinal obstetrical care, and in the Family Care Clinic.

1. **Inpatient**

The Family Medicine attending physician on the service must see and examine every patient on the service daily, and supervise residents by reviewing orders and plan of care. All PGY1 residents must have on-site supervision by a senior resident or attending physician for all clinical duties including ED admissions and ward patients. The Family Medicine attending physician provides on-site and in-person supervision for all procedures.

As stated before, the following require automatic attending notification:

- All patients who are pregnant and in labor.
- All patients less than the age of 18.
- All patients age 75 and over.
- Patients admitted as direct transfers from other hospitals.
- Any patient transferred to the ICU, NICU or PICU.
- Death or any significant change in respiratory, neurological, or hemodynamic status, including cardiac arrest
- Medication errors requiring clinical intervention.
• Any significant clinical problem that will require an invasive procedure or operation that was not anticipated and previously addressed with attending physician.

2. Obstetrical Deliveries

The Family Medicine attending physician provides on-site and in-person supervision for all patients in active labor through delivery.

3. Family Care Clinic

During all three (3) years of residency, patient visits and progress notes must be reviewed and co-signed by an attending physician “live” at the time of the patient visit. All procedures performed by residents in clinic must be supervised on-site and in-person by an attending physician.

Supervision in Non-Family Medicine Departments

1. Inpatient

The level of supervision must be commensurate with the resident’s level of training and his / her individual level of clinical skills. All PGY1 residents must have on-site / in-person supervision by a senior resident or attending physician for all clinical duties, including ED admissions and ward patients. On call schedules for faculty assures that supervision and / or consultation is readily available at all times to residents on assigned clinical duties.

For inpatient and ED procedures, all residents must be supervised on-site and in-person by an attending physician.

2. Outpatient Clinics

During all three (3) years of residency, all patients visits and progress notes must be reviewed and co-signed by an attending physician “live” at the time of the visit.

All procedures performed by residents in the clinic must be supervised on-site and in-person by an attending physician.

NN. STANDARDS OF CONDUCT AND SANCTIONS

The unlawful possession, use, manufacture, distribution or dispensation of illicit drugs or alcohol on residency program property, in the workplace of any employee, or as any part of any function or activities by any employee of the institution is prohibited. Violations of the institution’s “standard of conduct” by individuals covered under this policy will result in disciplinary action. Depending upon the nature of the violation, disciplinary action can take the form of a written reprimand, suspension, demotion, reduction in pay, or termination of the individual’s association with the institution and referral for prosecution by civil authorities, in accordance with local, state, and federal law.
STATE LICENSURE

It is the policy of this residency program that all residents obtain a full California medical license to practice medicine, or in the case of Osteopaths, a license to practice osteopathic medicine, as early as possible in the second year of their training. In order to ensure that this occurs, in the case of MDs or DOs, the following steps must be taken:

a. All U.S. medical graduates must have their California medical license by the end of their 24th month of training. The DEA should be obtained no later than the 27th month of training.

b. All International Medical Graduates (IMG) must have applied for their California medical license by the end of the first month of their PGY3 year and must be licensed by the end of the 36th month of training. The DEA should be obtained no later than 3 months after the medical license is obtained.

c. In order to obtain a medical license, all residents must pass their USMLE Step III examination by the end of 24 months of training.

MDs: go to www.medbd.ca.gov for application information and the necessary forms.

DOs: go to www.ombc.ca.gov for application information and the necessary forms.

SUBSTANCE ABUSE POLICY

Please see Appendix B – Alcohol and Drug Abuse for the complete policy (# 408).

USMLE / OSTEOPATHIC BOARD REQUIREMENTS

All incoming PGY1 residents must provide evidence of having passed USMLE Step II, or Osteopathic Boards Step II, (via a letter from the testing agency or a notation on a medical school transcript). All residents must take the USMLE or Osteopathic Boards Step III by the end of 12 months of training. Passing the Step III exam or Osteopathic Boards Step III exam is required by the end of 18 months of training. Failure of passing the Step III exam by the end of 18 months of training may result in leave of absence, which will result in extension of residency, or dismissal from the program.

VACATION/ILLNESS/EXTENDED ABSENCES POLICY

Leave policies comply with ABFM and ACGME policies, and at the same time, allow flexibility to the residents. The ABFM and ACGME special requirements are available at the residency office with the Residency Director and Residency Coordinator. These requirements are distributed to all residents every June, during the residency orientation block.

Absences in excess of one (1) month during an academic year (including vacation time, continuing medical education time, sick time, etc.) will result in a delay of promotion / graduation and an extension of the resident’s training by the length of excess absent days. Paid County holidays are not included in the “absent” time.
Leaves of absence in excess of three (3) months are considered a violation of the continuity of care requirements and may delay graduation by at least one year. ABFM may require the resident to complete additional continuity of patient care time beyond what is expected to complete training requirements, in order to be eligible for ABFM certification.

In order to apply for leave:

Fill out the “Request for Time Off” form at least three (3) months prior to leave date.

Submit the leave request form to the Residency Coordinator/Support Staff

Arrange for affected call and ward coverage.

Notify the Chief Resident and / or Attending Physician on the service of your absence.

Absence from Family Medicine Clinic
a. A resident who is scheduled in Family Medicine clinic will be expected to be present at the clinic on time.

b. The only time a resident may be excused from clinic is for acute personal illness, or emergency when a patient in the hospital requires acute hands-on care that cannot be delegated to another physician. In such cases, clinics will be rescheduled for those residents during evening / weekend shifts.

Conference Leave / Educational Leave
The Family Medicine Residency Program offers 1 week (7 consecutive calendar days) as conference leave for each academic year. Conference leave is not accumulative and expires at the end of each academic year if unused. This benefit is a privilege, not a right, and must be earned by meeting the following criteria:

a. Attendance of at least 66% of the scheduled Family Medicine conferences.

b. Compliance with the Delinquent Medical Records Policy.

c. Good academic standing.

d. Conference leave and Educational leave may be used for attending conferences, studying for board examinations, or interviewing for jobs.

Use of Holiday Time Earned
a. Holiday time earned can be taken off one day at a time during non-call rotations, with permission from the Program Director or Assistant Program Director and the Attending Physician of the service involved.

b. Holiday time earned may not be combined together as time off to exceed two (2) days during a rotational block.

c. Holiday time earned must be used within the academic year in which it is
earned, or it can be cashed out at the end of residency training.

d. No more than one (1) day of earned holiday time may be taken during a two-week rotation and no more than two (2) days of earned holiday time may be taken during a four-week non-call rotation.

e. Holiday time earned may not be combined with vacation time.

Maternity / Paternity Leave Policy

RRC requirements state that a resident may not be absent from his/her continuity Family Care Clinic for more than one month at a time. Residents may take time off for maternity / paternity leave as described by the Family Medical Leave Act. However, any time taken off for maternity / paternity leave (in excess of vacation time) will result in a delay of promotion and graduation.

American Board of Family Medicine (ABFM) Policies

Resident’s absence from the program should not exceed one (1) month per year, and vacation periods may not accumulate from one (1) year to the next. Vacations may not be taken back-to-back in June and July. Continuing Medical Education (CME) and educational time away from the program does not count as time off, as long as it does not exceed 1 week (7 consecutive calendar days) per year. For a complete list of ABFM policies, residents should refer to the ABFM Policy Manual.
I. Harassment and Complaint Procedure………………………………………..Appendix A
II. Alcohol and Drug Abuse Policy………………………………………………Appendix B
III. Employee Conduct Policy…………………………………………………..Appendix C
IV. ACGME Core Competencies……………………………………………..Appendix D
V. Chief Resident Agreement…………………………………………………..Appendix E
VI. Hand off Communication…………………………………………………..Appendix F
VII. Monitoring of Documentation……………………………………………..Appendix G
VIII. Integration and Communication between Inpt and Outpt Services……Appendix H
IX. Institutional Travel Policy…………………………………………………..Appendix I
X. Educational Enhancement Program………………………………………..Appendix J
Appendix E: RCRMC FM Residency Chief Resident Agreement

Job description

The Chief Residents will function as the main administrative representatives between the residents and the Program Director (PD), faculty and support staff. The Chiefs act as a liaison for all resident suggestions and complaints with a goal of improving communication between all residency principals. The Chief Residents assist the Program Director in evaluating residency concerns, developing policies, and determining appropriate disciplinary action in accordance with due process. Essential to this relationship is confidentiality, especially when dealing with personnel issues. There is a continuing obligation, upon completion of the residency, to hold confidential any information secured during the time served as Chief. The Chief Residents, by their own example, foster the professional attitudes and image expected of Family & Community Medicine residents. The Chief Residents report directly to the Program Director.

Qualifications for Chief Residents

A resident may be selected as Chief only as a PGY-2. He or she must demonstrate leadership ability and be in good academic standing, such that the additional administrative duties required to serve as Chief Resident do not detract from the resident’s educational advancement. Residents on probation or on academic warning are not eligible for this position. Must be above reproach as a steward of the residency and have a history of exemplary professional behavior.

A. Be able to effectively interact with the PD, Departmental leadership, residency coordinator and support staff to uphold the mission of the residency program within the structure of the department and the practice.

B. Have administrative and interpersonal skills needed to handle the multiple assigned duties.

C. Be able to delegate appropriately, share assigned duties and meet deadlines

D. Have common sense and patience required in negotiating various aspects of the program

E. Have commitment to work for the good of the program, rather than any particular vested interest group or individual.

F. Understand and support the continued balance between the priorities and needs of the training program and the business of the practice.

Termination or Dismissal

Chief Resident may be dismissed from duty in one of the following ways:

A. If a call arises from the resident peers for dismissal, a petition signed by at least three-fourths of the resident class can request a dismissal. Such a petition will be submitted to the PD and a meeting of all residents will thereafter be convened at which time a three-fourths majority vote is required to sustain dismissal.
B. **PD Discretion:** If there arises an issue of such major proportion or of such a grave nature that the PD feels a Chief Resident is no longer effective in his/her role, the PD may exercise his/her authority to ask for the resignation or otherwise effectively terminate the position of the Chief Resident.

### Administrative Duties of the Chief Resident:

A. Creates the FCC schedule for all residents, which is supervised and approved by the Associate PD. Manages and updates this schedule throughout the academic year so it is always accurate and reflects changes.

B. Organizes and plans Journal club and Senior Case Presentation schedules with respective Attending Preceptors with the supervision of the PD.

C. Organizes the schedule for Sports Medicine Game coverage for the PGY-3 residents.

D. Organizes, plans and revises the Program Lecture Didactic Schedule to meet resident training and education needs.

E. Attends the annual Chief Resident Leadership Conferences; attends residency related health fairs and recruitment fairs and may participate in ERAS interviews during interview season.

F. Creates resident back-up call coverage schedule and coordinates modifications to the resident on-call coverage as the need arises. Communicates changes to the appropriate personnel and has these changes approved by the PD.

G. Acts as a resource for FMC when practice issues arise (i.e. too many residents scheduled, elective time and FMC time not requested in a timely fashion, emergency cancellation of hours) to address training and practice issues.

H. Assists the program coordinator in the planning and organization of the incoming intern orientation for the year and participates by giving a session of orientation pertaining to schedules, house rules, the “do’s and don’ts” of residency, etc.

I. Organizes and chairs the monthly resident support meetings.

J. Attends faculty and department meetings whenever possible.

K. Provides information and assists the PD with developing or revising policies and procedures for the residency program.

L. Assists the PD with managing disciplinary issues and grievances related to residency program.

M. Participates in Curriculum Development activities in concert with the PD and/or Core Faculty.

N. Helps organize and plan the annual residency retreat, the Annual Open House, the Annual Holiday and Graduation celebrations.

O. Works with residents in remediation as directed by the PD and Core Faculty.

P. Organizes the selection for Faculty Teaching Awards along side the residency support staff.

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**Term of office**

Term of office as active Chief Resident is slightly more than one academic year. The newly selected PGY2s will gradually assume the full duties of active Chief Residents from the outgoing PGY3 “former” Chief Residents during the April - May time period. The total length of term in service as both active and former Chief Residents will be approximately 14 months, unless a separate arrangement is agreed upon with Program Director.
Compensation

A. **Stipend:**
   a. At this point, there is no stipend, but once enacted, the Chiefs will receive their stipend on a quarterly basis for fulfilling their responsibilities based on their performance and completion of their tasks.

B. **Administrative Time**
   a. At the discretion of the Assistant Director, the Chief Residents may take administrative time 1 half day per block in order to carry out their duties. This may be scheduled at the discretion of the chief resident with the approval of the Assistant Program Director.

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**Characteristics of “The Ideal Chief Resident”**

A. A person who possesses an individual passion about supporting & accomplishing those things he or she perceives to be right
B. One who seeks for the facts & thoughtfully considers data from appropriate sources before deciding on a course of action.
C. One whose main priority is to consistently work for the greatest long-term good of our patients, practice & residency program within the RCRMC and specifically, FCC.
D. One who is capable of providing wise and timely counsel.
E. Able to recognize that the “needs” of patients & the residency program may at times be more important and therefore require a higher priority than the “wants & needs” of individuals.
F. Having the confidence and ability to express his or her own individual thoughts and feelings as well as those of his or her constituents in an articulate, polite, respectful and honest manner, irrespective of the audience.
G. Capable of acting as a mediator and avoiding serving as an instigator or propagator when problems arise.
H. Due to consistently good behavior, has earned the respect and trust of supervisors, peers and support staff.
I. Capable of coping with tough issues and making hard decisions even if those decisions may be unpopular with peers.
J. A person who has a sustained track record of demonstrating the following attributes: Integrity; Thoughtfulness; Fair-mindedness; Truth-seeking; Self-confidence, Solutions-oriented

By my signature below I agree to the terms of this contract

______________________________________________ Date ________________
Appendix F

Hand-Off Communication Process:
Transfer of patient information occurs among all residents and attendings involved in the care of the pt. The hand-off, which includes time, day and provider, is documented on FM Service census list. Pertinent daily pt info is updated and stored in a database and is accessible to any provider taking care of pts on the FM Service.

1.) Pt admitted to Hospital from ER: pt info is communicated by ER provider to accepting Sr resident on call, who performs an evaluation on the pt and communicates to supervising attending. Efforts are made to contact the pts PCP to enhance continuity and to help with pt care.
2.) Pt admitted to Hospital from our FMC: pt info is communicated by PCP to accepting Sr resident on call. The same communication process is performed as above in 1.).
3.) Pt in hospital: once resident shift is ending, they hand-off pt info to oncoming resident physician. This occurs 3 times per day: at 5pm, 8pm and at 8am. “Primary team/residents” end their shift at 5pm and communicate pt info with residents on “day call.” Then “day call” residents hand-off pt info to “night float team/residents” at 8pm, at which point there is indirect supervision of hand-off communication by attending physician over the phone. This process is repeated to the “primary team/residents” at 8am.
4.) Attending Physicians: once shift ends, communication and transfer of pt info occurs with the on-coming attending overtaking the FM Service via phone, email, or face to face.

Hand-Off Information:
1.) ≥ 2 patient identifiers - Name, Medical Record Number; 2.) Reason for Hospitalization and Course; 3.) List of Chronic Medical Problems; 4.) Current Reconciled Medication List with Allergies; 5.) Current Clinical Status/Condition - Code Status, Diet, IVF, Telemetry, and DVT Prophylaxis; 6.) Pertinent Test Results; 7.) Update on new events that occurred during last shift; 8.) Action Plan/To do List
RE: MONITORING OF DOCUMENTATION REQUIREMENTS

Dear Colleagues:

Our February 2012 Joint Commission Survey revealed similar deficiencies as were outlined in the March 9, 2009 memo sent to you regarding documentation in medical record. The main issues identified were the continued use of: 1) Unapproved Abbreviations, 2) Missing time and date in the medical record, and 3) Signature, time and date of verbal orders within 48-hours. If not corrected, the seriousness of these issues could place our hospital accreditation in jeopardy. I would appreciate the cooperation of all medical staff and residents in achieving 100% compliance. We will be monitoring compliance of these issues monthly. At the March 2012 MEC Meeting these issues were discussed with the group. The MEC has approved the following disciplinary actions when non-compliance is identified. The following actions that were approved by MEC on March 16, 2009 are still in effect:

Resident Physicians:

1. First Offense: Letter from the GME Office to the resident and Department Chair requesting a response.
2. Second Offense: Letter from GME Office to the resident and Residency Program Director requesting a response.
3. Third Offense: Removal of the meal card allowance for one week.

Attending Physicians:

1. First Offense: Letter from the Chief of Medical Staff to the attending and Department Chair requesting a response.
2. Second Offense: Letter from the Chief of Medical Staff to the attending and Department Chair and $25 fine paid to the medical staff.
3. Third Offense: Letter from the Chief of Medical Staff to the attending and Department Chair and $50 fine paid to the medical staff.
4. Fourth Offense: Referral from the Chief of Medical Staff to the Professional Practice Evaluation Committee for further action.

Thank you for your attention to this matter.

Arnold Tabuenca, M.D.
Chief Medical Officer

L-002

26620 Cactus Avenue, Moreno Valley, California 92555
Phone: 951-486-4464 • FAX: 951-486-4475 • TDD: 951-486-4397
Appendix H

Integration and Communication between the Inpatient and Outpatient Services

• When a patient is identified as a possible admit to the hospital from the emergency room or from one of the hospital clinics, patient information is communicated by the treating provider to an accepting physician on call, whom performs an evaluation on the patient. This evaluation is facilitated with the use of an integrated medical record.

• Patients admitted to the hospital, are taken care of in a multidisciplinary team based approach. This team includes physician(s), a medical social worker, a case manager, nursing staff and any other (ancillary) specialist that is needed for the coordination of patient care.

• Once the patient is in the hospital, a Primary Care Physician (PCP) is identified whenever possible to enhance continuity and to help with the care of the patient.

• Discharge planning for the patient may begin from the time of admission.
  o A social worker and case manager assess and coordinate all needs for the patient as they pertain to medical care, functional capacity, cognitive ability, insurance and financial arrangements, family and home support.

• When a patient is ready to be discharged, the primary team assures an appropriate follow-up appointment.
  o Whenever possible, a post-hospital follow-up appointment is made with the PCP to ensure continuity of care and best outcome for the patient.
  o The appointment along with the reason for f/u is written on the patient’s discharge summary, which is accessible at the post-hospital follow-up visit.
    ▪ Post-hospital follow-up instructions are verbally given to the patient, and spelled out clearly on the discharge summary.
    ▪ The patient receives a copy of the discharge summary along with an appointment card to serve as a reminder.
    ▪ The discharge summary is also faxed to the PCP and/or to the follow-up clinic of the primary team.
  o If the patient requires a post-hospital follow-up appointment within 2-3 weeks, an appointment is made for the patient prior to discharge.
  o If the patient is discharged during the weekend or after hours, the patient’s contact information is obtained and given to the unit clerk. On the next business day, an appointment is scheduled with the desired clinic and provider with the date and time. The patient is then contacted and notified of this appointment information.

• When a patient requires a lab or test prior to the post-hospital follow-up appointment, the primary physician team specifies this on the discharge summary and the patient’s nurse provides the appropriate paperwork and instructions for coordination of care before the patient leaves the hospital.
  o The post-hospital follow-up provider will follow through with any pending results, referrals, tests and pt needs that were ordered

• When a patient needs a post-hospital follow-up appointment with a specialist, every effort is made to book an appointment for the patient before their discharge.
  o If an appointment cannot be made, then the recommended follow-up period is written on the patient’s discharge summary so the post-hospital follow-up provider will refer the patient in a timely manner.

• (The primary team may also make a Post-Hospital Discharge phone call within 48-72 hours of hospitalization. Any patient concerns, as well as the patient’s condition are addressed during these calls in an effort to decrease re-admissions and to ensure that coordinated care took place)
Appendix I – Travel Policy

COUNTY OF RIVERSIDE, CALIFORNIA
BOARD OF SUPERVISORS POLICY

Subject: REIMBURSEMENT FOR GENERAL TRAVEL AND OTHER ACTUAL AND NECESSARY EXPENSES

Policy Number D-1 Page 2 of 10

1. Communicating with representatives of regional, state and national government on policy positions adopted by the Board of Supervisors;

2. Attending educational seminars designed to improve officials’ skill and information levels;

3. Participating in regional, state, and national organizations whose activities affect the county's interests;

4. Attending county events;

5. Implementing a county-approved strategy for attracting or retaining businesses to the county, which will typically involve at least one staff member and;

6. Attending meetings for which a meeting stipend is expressly authorized.

In accordance with Government Code Section 53232.2(f), all expenses that do not fall within this policy shall be considered for approval by the Board of Supervisors prior to incurring the expense, unless the expense involves a meeting in which a member of the Board of Supervisors is required to make a public report (see section 12). All expenses must be verified by a valid original receipt, as required by Government Code Section 53232.3(c), which includes the name of the vendor (e.g. hotel, restaurant) date of service and actual amount charged.

Members of the Board of Supervisors and elective constitutional officers, as well as their employees, shall be exempt from Sections 2 through and including 10 of this Board Policy.

2. Lodging

Actual cost for lodging, not to exceed $159 per night inclusive of all occupancy and accommodation taxes and other room related taxes and fees, is allowed provided such cost is reasonable for the location and is consistent with government and/or conference/convention rates, if available, or usual charges established for the general public. For lodging in high cost cities as defined by the Internal Revenue Service (e.g., San Francisco, New York, Washington D.C.) or by the Board of Supervisors (Sacramento) actual cost not to exceed $239 per night is allowed. Lodging costs exceeding the established limit may be reimbursed at a higher rate if a written statement explaining the reason for the expense is submitted by the department head to the designated Executive Office analyst along with a completed
Appendix J

Educational Enhancement Program (EEP)

II. Purpose: To enhance the medical knowledge and test taking skills of the participants of the program for the ultimate goal of high academic achievement and successful completion of the Board Certification Exam.

III. Policies and Requirements
   a. Mandatory participation for all residents who meet the following criteria
      i. All entering Interns
      ii. ITE Score < the rounded down score to nearest 10th of National Average (NA) for the PGY level (i.e. if the NA = 456 → then it is rounded down to 450; whoever scores less than 450 in that PGY level will be in EEP)
      iii. Discretion of the Program Director and Faculty Advisor based on evaluations and clinical performance overall.
   b. Participants must
      i. Score > 70% on average of all quizzes taken
      ii. No more than 3 quizzes will be allowed to be missed, unless excused
      iii. If either one of these criteria are not fulfilled, disciplinary action may take place, including but not limited to interruption in vacation time, regular elective and away elective rotations, or promotion denial. This will be left to the discretion of the Program Director and Faculty Advisor of the resident

IV. Procedures
   a. EEP sessions will be conducted on a weekly basis, on Thursdays from 5-5:45pm after the lecture didactic series
   b. A weekly 20 Question quiz will be given to participants to complete
   c. The 20 questions for the EEP session will be available one week prior to the residents and will contain both the questions and the source/reference from which the question was derived.
   d. It is the responsibility of the resident to do the research and find the answers to the questions prior to the session.
   e. The percentage result of this 20 question quiz will be counted toward the EEP requirement
   f. A Faculty or Chief Resident will moderate the weekly sessions
   g. After the 20 question quiz is taken, it will be collected and handed in to Program Support Staff for grading. Then the moderator will conduct another random 10 question quiz that should be completed in 10 minutes and go over these questions during the session. Emphasis will be placed on test taking techniques and knowledge gaps.

V. Duties
   a. Resident Participants
      i. Attend the EEP sessions on Thursdays so as to meet the requirements
      ii. Complete the required 20 question quiz on a weekly basis
      iii. Participants are only excused when on vacation or leave of absence (≥1 week for any reason). During these excused times, the resident will not be required to take the quiz or participate in the session.
      iv. If the participant is on night float, sick or has any other circumstance that requires < 1 week absence, and this time interferes with attendance of the Thursday session at 5pm, then the resident should take the quiz either a time before or after the assigned session.
      v. The participants are encouraged to take “make up” quizzes during the Thursday, 5-5:45pm sessions
      vi. No more than 6 weeks will be allowed for the make up of the missed quizzes. It will be counted as a “0” after the 6th week.

VI. Graduation from EEP
   a. Participants may finish/graduate from Educational Enhancement Program (EEP) if they score > the rounded down NA for their PGY level on the next ITE of that year
   b. If there is any question or concern about a resident graduating from the EEP program the Program Director and Faculty Advisor of the resident will have the ultimate decision
RESIDENT HANDBOOK ACKNOWLEDGMENT FORM

• I have read and the Family Medicine Residency Program handbook for this academic year and I understand that it is my responsibility to read and comply with the policies contained in this handbook and any revisions made to it. The handbook describes important information about the Family Medicine Residency Program, and I understand that this handbook replaces any previous understanding, practice, manual, handbook or workplace addenda, policy or representation concerning the terms and conditions of the Family Medicine Residency Program.

• I am aware of the residency program’s disciplinary policy.

• I agree to abide by the policies and procedures contained within the handbook. I understand that the policies and benefits contained in this handbook may be changed, modified, or deleted at any time.

• I understand that it is my responsibility to retain a copy of this handbook and to request a new copy if mine is lost or damaged.

• I certify that I will accurately and completely report my work hours.

_____________________________  _______________
Employee Name (please print)  

_______________________________  _____________________
Employee Signature  Date

(last revised 6/2012)