

**SOUTHERN
REGIONAL AHEC**
FAMILY MEDICINE RESIDENCY

1601 Owen Drive • Fayetteville, NC 28304
(910) 678-7259

Resident's Manual 2011-2012



*Duke/Southern Regional AHEC
NSU-COM/Southern Regional AHEC
Family Medicine Residency Program*

Learning... Teaching... Healing

Table of Contents

Contents

PURPOSE OF THIS MANUAL.....	1
WELCOME	2
HISTORY AND STRUCTURE OF THE SR-AHEC FAMILY MEDICINE RESIDENCY PROGRAM	3
VISION, MISSION AND ORGANIZATIONAL VALUES OF SOUTHERN REGIONAL AHEC	4
ORIENTATION	5
COMMUNICATIONS SYSTEMS.....	5
TELEPHONE SYSTEM.....	5
Long Distance Calls.....	5
E-MAIL SYSTEM.....	5
MAIL SYSTEM (POSTAL).....	6
SALARIES AND BENEFITS	7
2011-2012 RESIDENT ANNUAL STIPENDS.....	7
PAY PERIODS.....	8
QUESTIONS ON PAYROLL AND BENEFITS	8
PAID TIME OFF (PTO).....	8
MATERNITY/PATERNITY LEAVE/EXTENDED LEAVE.....	9
PROFESSIONAL MEETING (CME) TIME AWAY	10
USMLE/COMLEX Step III.....	10
FUNDS FOR CME AND PROFESSIONAL DEVELOPMENT	10
TRAVEL REIMBURSEMENT.....	10
LAB COATS	11
HOUSING	11
MEALS.....	11
FEES PAID.....	11
SOUTHERN REGIONAL AHEC POLICIES APPLICABLE TO RESIDENTS	12
Graduate Medical Education Trainee Duty Hours Policy.....	12
DISABILITY ACCOMMODATION & TECHNICAL STANDARDS.....	13
EQUAL EMPLOYMENT OPPORTUNITY & Resident Selection	16
FORMAL CRITERIA FOR ELIGIBILITY OF RESIDENTS	16
LEAVES OF ABSENCE.....	16
SEXUAL AND OTHER UNLAWFULL HARASSMENT	17
DRUG AND ALCOHOL USE	17
DRUG TESTING POLICY	17
HEALTHCARE OF RESIDENTS POLICY	17
RESIDENT PHYSICIAN IMPAIRMENT POLICY.....	17
GRIEVANCE PROCEDURE.....	20
RESIDENCY PROBLEM RESOLUTION PROCEDURE.....	20
ETHICS IN PATIENT CARE	21
POLICY REGARDING PROGRAM CLOSURE OR REDUCTION	21
Work Place Environment Policy.....	21
OSHA REQUIREMENTS	23
HIPAA SECURITY REVIEW	23
MOONLIGHTING POLICY.....	24
DRESS CODE	25
CAPE FEAR VALLEY HEALTH SYSTEM HOSPITAL DRESS CODE	25
Cumberland County Hospital System, Inc.....	25
POLICY	25
CARE OF CFVHS CALL ROOMS, DOCTOR’S LOUNGE & RESIDENTS LOUNGE IN THE FAMILY MEDICINE CENTER.....	28
DEPARTMENT AND RESIDENCY PROGRAM OBLIGATIONS	29
NATIONAL STANDARDS	29
ADVERSE ACCREDITATION ACTIONS.....	29
INDIVIDUAL EVALUATIONS.....	29
OBLIGATIONS OF RESIDENTS	29
EXPECTATIONS OF RESIDENTS	30
RESIDENT GRAND ROUNDS EXPECTATIONS	32
RESIDENT JOURNAL CLUB GUIDELINES.....	33
Noon Conference Attendance Policy.....	34

CLINIC SCHEDULE CHANGES.....	34
CALLING IN SICK (Not Scheduled in FM Clinic).....	35
CALL SCHEDULE CHANGES.....	35
CALL DURING SOUTHERN REGIONAL AHEC HOLIDAYS.....	36
EXTRA ER CALL.....	37
OUT OF HOSPITAL UPPER LEVEL CALL.....	37
RESIDENT EMERGENCIES.....	37
ADMITTING PATIENTS WHILE ON MEDICINE.....	44
CUMBERLAND COUNTY HEALTH DEPARTMENT CALL COVERAGE.....	44
NURSING HOME REQUIREMENTS.....	46
OSTEOPATHIC RESIDENT INPATIENT & OUTPATIENT OMM DOCUMENTATION.....	49
NIGHTLY DOCUMENTATION LOGS.....	49
ACADEMIC ADVANCEMENT CRITERIA.....	50
I. Promotion Criteria for PGY-1.....	50
II. Promotion Criteria for PGY-2.....	50
III. Promotion Criteria for PGY-3.....	51
EDUCATIONAL SCHEDULE.....	55
FIRST YEAR CURRICULUM OVERVIEW.....	58
SECOND YEAR CURRICULUM OVERVIEW.....	60
THIRD YEAR CURRICULUM OVERVIEW.....	61
REQUIREMENTS CHECKLIST:.....	62
ELECTIVE ROTATIONS.....	64
AWAY ELECTIVE ROTATIONS.....	64
INTERN DUTIES & RESPONSIBILITIES WITHIN THE FAMILY MEDICINE CENTER.....	65
TEAM LEADER’S RESPONSIBILITY.....	66
RESIDENT TEAM ASSIGNMENTS.....	66
PRECEPTING MEDICARE PATIENTS.....	67
PRECEPTING OB PATIENTS.....	67
FAMILY MEDICINE CENTER PATIENT FLOW.....	68
COLLECTIONS.....	68
INSURANCE.....	69
APPOINTMENTS IN THE FAMILY MEDICINE CENTER.....	69
NEW PATIENTS.....	70
NEW PATIENTS – PEDIATRICS.....	70
LATE PATIENTS and DOC OF THE DAY.....	70
WALK-INS.....	71
ROUTINE NURSING RESPONSIBILITIES.....	71
PATIENT EDUCATION.....	72
OB PROTOCOL FOR FAMILY MEDICINE.....	72
MEDICAL RECORDS.....	73
GJ T ..(000).....	73
THE CHART/MEDICAL RECORD.....	73
For paper charts you will need to request the chart from Medical Records.....	73
PHONE/TRIAGE NOTES.....	74
DISABILITY INSURANCE AND WELFARE FORMS.....	74
TERMINATION OF PATIENTS FROM THE PRACTICE.....	74
DEATH CERTIFICATES.....	74
Cape Fear Valley Health System:.....	75
Guidelines for Dictation at CFVHS.....	75
Dictation from Within Hospital.....	75
Dictations from Outside the Hospital.....	75
FAMILY MEDICINE CENTER X-RAY.....	76
CHIEF RESIDENT POSITION.....	78
Junior Chief Job Description.....	80
RETREAT COMMITTEE GUIDELINES.....	82
APPENDIX A...FACULTY AND KEY STAFF LISTING.....	83
FACULTY LISTING.....	83
KEY STAFF LISTING.....	84
APPENDIX C...Clinical Services Manual.....	87

PURPOSE OF THIS MANUAL

This manual has been developed for the residents of the Duke/Southern Regional AHEC Family Medicine Residency Program to provide information on policies, procedures, fringe benefits and other elements that may directly affect residents in our program. It is referenced in your resident agreement. Southern Regional AHEC may revise its policies and procedures at any time, whenever deemed necessary. You will be informed of changes by program staff. Please read the manual and keep it for future reference. Questions reference the residency manual may be addressed with Chief Resident and Residency Coordinator. For grievances, refer to grievance procedure on page 26.

WELCOME

Welcome to the Southern Regional AHEC Family Medicine Residency Program. We are delighted that you are joining us for your family medicine residency education. Family Medicine is a unique and challenging specialty that concentrates on the patient as a whole person within the social context of family and community. As a family medicine physician in training, you will be exposed to all facets of the practice of family medicine within this residency program.

The principles of family medicine mandate health care that is comprehensive, continuous, and oriented toward the individual, his/her special social support system, and the patient's community. The family physician is required to have knowledge, not only of family medicine, but also the various specialties and subspecialties. The ultimate goal of your residency education is to provide the knowledge and skills to practice and deliver excellent health care. The curriculum of this program has been developed and accredited according to the guidelines of the Accreditation Council for Graduate Medical Education and the American Osteopathic Association. It is tailored to the needs of the community and the surrounding region.

The Southern Regional AHEC Family Medicine Residency program provides comprehensive clinical and didactic education throughout the three-year curriculum. Initially, in-hospital rotations are emphasized with subsequent progressive emphasis on ambulatory experiences. We recognize that personal maturity and self-awareness are extremely important and that educational assistance and support of residents throughout the residency years greatly influences how you will practice in the future. We hope that upon graduation from this residency that you will be a physician who is competent in all areas of family medicine and one who has developed the skills to professionally and personally be successful in his/her career.

PURPOSE OF THIS MANUAL

The purpose of this handbook is to introduce you to the program, its curriculum and the policies and the procedures you will need to be familiar with to get the most out of your education. We hope you will use this manual as a reference and guide during your residency.

This resident manual was developed to outline expectations, policies, programs, and benefits available to eligible residents. It is neither a contract of employment nor a legal document. Residents are responsible for reading, understanding and following the contents of this residency manual. Residents will sign a statement attesting to such.

Southern Regional AHEC may revise its policies and procedures at any time, whenever deemed necessary. You will be informed of changes by program staff. Read the manual thoroughly and use it for future reference. Questions on the residency manual may be addressed with the Chief Resident, residency Coordinator or Program Director. For grievances, refer to grievance procedure on page 26.

HISTORY AND STRUCTURE OF THE SR-AHEC FAMILY MEDICINE RESIDENCY PROGRAM

The Southern Regional AHEC Family Medicine Residency Program is sponsored and financially supported by the Fayetteville Area Health Education Foundation, Inc. (FAHEF), a nonprofit organization governed by a Board of Trustees. FAHEF is also known as Southern Regional Area Health Education Center. The Board of Trustees are representatives of the nine county region served by Southern Regional AHEC. The Southern Regional Area Health Education Center is one of nine statewide AHECs originally developed in response to concerns regarding the supply, distribution, retention and quality of healthcare professionals. Southern Regional AHEC was chartered in 1974 and accredited by the Liaison Committee for Graduate Medical Education in 1976. The first four residents began their residency training in 1977. The residency program is affiliated with Duke University Medical Center, but also incorporates medical education programs from the University of North Carolina at Chapel Hill, Campbell University, and East Carolina University. The residency's primary hospital affiliation is Cape Fear Valley Medical Center. Educational opportunities are also available at Duke University Medical Center, Scotland Healthcare System, Southeastern Regional Medical Center, Womack Army Medical Center, and area health departments.

In 2002, the Family Medicine Residency was also accredited as an osteopathic residency. Southern Regional AHEC is responsible, along with Duke University Medical Center, for recruiting and maintaining the faculty for the residency program, providing and maintaining the educational facilities and equipment, supporting a health sciences library, and is the vehicle through which state monies are appropriated to the residency. The educational content is the responsibility of the Vice President of Clinical Education & Services, and faculty of Southern Regional AHEC and supported by the Division of Family Practice at Duke University Medical Center.

All residents are considered employees of Southern Regional AHEC and are expected to comply with policies of the organization that are not covered in the Residency Manual.

VISION, MISSION AND ORGANIZATIONAL VALUES OF SOUTHERN REGIONAL AHEC

Vision

The vision of SR-AHEC is to be a recognized leader in health care education and services.

Mission

The mission of SR-AHEC is to deliver quality healthcare education. SR-AHEC meets its mission of addressing the regions' health workforce needs by:

- Promoting state of the art healthcare education
- Continually seeking innovation in the education experience,
- Providing timely information resources, improving access to care through high quality clinical services and
- Increasing the number and diversity of practicing healthcare professionals.

Organizational Values

The core values of SR-AHEC are:

- Service to others
- Accountability
- Integrity
- Diversity

ORIENTATION

Prior to beginning the duties of the residency there will be a comprehensive orientation program. This time will be devoted to familiarizing the resident with the intricacies of the program, hospital and Family Medicine Clinic. Resident responsibilities will be addressed, including medical records, OSHA, HIPPA requirements, pharmacy issues, quality assessment, education assessments, risk management, human resource issues, etc. ALSO course and Electronic Health Records training will be offered.

COMMUNICATIONS SYSTEMS

TELEPHONE SYSTEM

The direct dial line number to the appointment desk is 910-678-0100. The telephone number for the Southern Regional AHEC switchboard is 910-323-1152. Switchboard hours are from 8:00 am to 5:00 pm Monday through Friday.

Before 8:00AM and after 5:00PM and on weekends the system is automatically connected to the Answering Service, 910-323-6512. In certain selected locations, the telephone will ring during the hours we are switched to the answering service. Outgoing calls can be made from any Southern Regional AHEC telephone after hours as usual.

To make an outgoing call, it is first necessary to dial "9" to connect the system to the city trunk lines.

Long Distance Calls

To make a long distance call from the Family Medicine Center: Dial 9 - 1 - area code - phone number. You will hear a buzz or humming sound. When you hear this sound, dial your four digit long distance access code. Failure to enter a proper code will block your call.

Personal use of the telephone for long-distance calls is not allowed. Employees should practice discretion when making local personal calls and should limit their personal calls to an absolute minimum. Reports from the phone system are examined to ensure compliance with this policy.

See SR-AHEC Personnel Manual #504 for further information.

E-MAIL SYSTEM

Each resident will be given remote access to the SR-AHEC e-mail system and network. The e-mail system is available 24 hours a day, seven days a week. To access the GroupWise E-mail program from any Internet capable computer go to the following URL: <https://www.southernregionalahec.org/groupwise>

Residents are responsible for reading and acknowledging all e-mail messages from faculty and staff in a timely manner. Failure to review your email at least daily could result in the resident missing valuable information such as schedule changes, meetings and policy announcements. The GroupWise E-mail system is the official E-mail communication channel used by SR-AHEC. Relying solely on a personal AOL or Hot Mail account to communicate with SR-AHEC staff is not acceptable. Each resident will be required to read policy 512, Internet Usage, page 66 of the Personnel Policy Manual and sign the Electronic Information Acknowledgement Form.

MAIL SYSTEM (POSTAL)

The use of the SR-AHEC postage machine for personal correspondence is not permitted. All mail received at SR-AHEC, unless identified as personal, belongs to the organization and, therefore, may be opened by authorized personnel.

COMMUNICATION POLICY PAGERS & CELL PHONES

The Residency Coordinator is the focal point for contacting residents and staff. All residents should have with them and turned on at all times their cellular phone. The residency coordinator will send a text message to you for communication. When you receive a text message or phone call it should be answered within 15 minutes unless it will interfere with patient care or duty hours. If patient care is a priority and it is beyond 15 minutes please ask a staff member to return your page.

Service Pagers should be carried and turned on at all times when on medicine and pediatrics call by the responsible resident while on duty. When you receive a page it should be answered within 15 minutes unless it will interfere with patient care or duty hours.

When paged by the Answering Service they will wait 15 minutes between pages. If you don't respond to the second page the Answering Service will page the Attending. (Answering Service has specific details on this procedure.)

REIMBURSEMENT ALLOWANCE

Resident must submit a copy of their cell phone bill to Residency Coordinator before the 10th of each month for processing of \$50.00 reimbursement towards cellular expense. Reimbursement will not be made on bills submitted late.

E-MAILS/ PHONECALLS

Each resident must answer SR-AHEC system e-mails on a daily basis. Each resident must promptly return phone calls.

SALARIES AND BENEFITS

A complete description of benefits provided by SR-AHEC is outlined in the Personnel Policy Manual. Items addressed in this section are specific to residents. The benefits outlined in this manual are offered to residents who join the Southern Regional AHEC Family Medicine Residency Program.

- 401(k) Retirement Plan(1st quarter after 90 days)
- Bereavement (Funeral) Leave
- Cape Fear Regional Theatre Tickets (taxable benefit)
- Continuing Education Leave
- Continuing Education Allowance
- Dental Insurance(after 90 days)
- Family Medical Leave
- Health & Prescription Insurance for resident and his/her immediate family(immediately)
- Healthplex membership(taxable benefit)
- Holidays
- Jury Duty Leave
- Life Insurance (after 90 days)
- Long-Term Disability(after 90 days)
- Malpractice Insurance
- Military Leave
- Moving expenses - \$500 per resident
- Paid Time Off (PTO) –See Residency Contract
- Professional License fees required for position
- Professional Membership Dues
- Short-Term Disability(after 90 days) if elected
- Uniform Allowance (labcoats)
- Use of SR-AHEC Vehicles for business purposes

2011-2012 RESIDENT ANNUAL STIPENDS

- PGY-1 - \$49,189
- PGY-2 - \$51,046
- PGY-3 - \$52,971

PAY PERIODS

Residents will be paid every two weeks for the previous two weeks of work. There are a total of 26 pay periods a year. Your stipend will be divided equally among the 26 pay periods. Direct deposit to your financial institution is highly recommended but not required. If you elect to be paid by check, your check will be available from the Residency Coordinator each payday. Paystubs will be available from the

QUESTIONS ON PAYROLL AND BENEFITS

Southern Regional AHEC payroll and benefits questions should be directed to the Human Resources Director, Linda Baez, (910) 678-7247, Email: Linda.Baez@sr-ahec.org. The Human Resources Director is available during the orientation process to explain benefit options and help residents enroll in desired programs.

PAID TIME OFF (PTO)

Each resident is entitled to twenty (20) days of PTO during the residency year. Three days plus a weekend of off-duty time in addition to scheduled holidays are provided during the Christmas/New Year season. There is also an administrative day given to allow the resident to complete RAD or Med Challenger requirements, research or other duties pertaining to the residency. This holiday time off may not apply during OB.

Each resident/intern will be given 8 hours towards a floating holiday. This floating holiday must be used during the calendar year given and can't be carried forward. The floating holiday must be taken in a whole day increment. Scheduling of the floating holiday will follow the same rules as scheduling paid time off (PTO). Please get with the Clinic Scheduler if you have questions regarding this time.

First-year residents have one-week of PTO that must be scheduled into their Community Medicine rotation. The balance of PTO should be scheduled according to policy. Other suggested times for PTO during the first year are during your ER (adhering to required hour standards), Pediatrics, Surgery and elective rotations. PTO is not allowed during the Medicine or Obstetrics rotations. PTO is not encouraged during Pediatrics rotation but may be negotiated and is limited in the number of residents who may take PTO at that time. No PTO should be taken in block 7 other than your holiday time off over the Christmas or New Years week.

All PTO must be scheduled 90 days in advance of the requested time off. PTO requests submitted less than 90 days in advance will not be routinely approved, but may be considered on an individual basis depending upon the circumstances. PTO requests for similar times will be on a first request, first-serve basis with consideration given to the particular rotation involved. PTO may not accumulate from one year to another. Annual PTO must be taken in the year of service in which they are granted. **PTO cannot be for longer than one week.**

Residents should not be away from a rotation more than 5 days. No two week PTO periods may be concurrent. For example, one week at the end of one rotation may not be added to the first week of the next rotation. No PTO may be taken during a two week rotation unless approved by Program Director. PTO will not be compensated for if not taken. The ACGME recommends that PTO be separated by at least three months.

PTO requests must be submitted to the Scheduling Service Coordinator for routing to the appropriate personnel for approval. The information will then be posted in the Scheduling Service Coordinator's office for the purpose of night call scheduling. To encourage interaction with incoming interns, PTO during orientation should be limited to Boards, Board prep, and interviews. PTO cannot be accrued to reduce the total time required for a residency. Third-year residents may take PTO during the last week of the residency if they have satisfied all training requirements and have unused PTO for that year.

Southern Regional AHEC has ten scheduled holidays when the Southern Regional AHEC Family Medicine Center is closed. There is no compensation for those on call on a holiday and residents are expected to be in the preceptor's offices if these offices are open. The only exception is if the resident is on call for the Family Medicine Center; priority is given to the Family Medicine Center/hospital coverage. It is the resident's responsibility to notify the preceptor of this FMC call on a holiday.

In the event of a snow day, comp time will not be given. Residents are expected to remain in their preceptor's office until the preceptor is finished, even if SR-AHEC closes early. The only exception to this is if staying at the preceptor's office will exceed the duty hour regulations established by the ACGME.

MATERNITY/PATERNITY LEAVE/EXTENDED LEAVE

Maternity/Paternity leave is deducted from the annual PTO allowance. A maximum of ten working days will be allowed for paternity leave. A maximum of fifteen working days will be allowed for maternity leave. It is expected that those who become pregnant and/or those who plan to take paternity leave plan their schedules so they are not on services with heavy call or responsibilities, i.e., Medicine, Obstetrics, or Pediatrics. It will be each resident's responsibility to make the appropriate schedule changes. Call coverage arrangements should be made by each resident as in the case of vacation leave. If such coverage cannot be arranged, the coverage will be assigned by the Chief Resident. The ABFM Information Manual for Program Directors specifies that time off from the residency in excess of one month within the academic year, PGY-1, PGY-2, or PGY-3, 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 thirty-six months of training. In order to have maternity/paternity leave approved, the appropriate form must be completed (as per FMLA guidelines). A resident on maternity leave must submit a doctor's release in order to return to work. In cases where a resident leaves the program and the absence exceeds one month, the Program Director must inform the Board in writing of the resident's departure and return. Absences exceeding two months violates the continuity of care requirement. The Program Director may utilize various criteria to judge the point where the resident may reenter the program provided that:

- a) The resident will not be readmitted to the program at a level beyond that which was attained at the time of departure;
- b) Approval of the Board similar to that for any admission at an advanced level is obtained prior to reentry; and,
- c) Requests for authorization for readmission provide a detailed description of the evaluation used to determine the level at which the resident is to be readmitted.

The ABFM also recommends that no two PTO periods be concurrent and there must be at least three months between any two PTO segments.

Please refer to Policy #601 & 602, Family Medical Leave Act (FMLA), in the SR-AHEC Personnel Manual for 'leave of absence without pay'.

PROFESSIONAL MEETING (CME) TIME AWAY

PGY-2 and PGY-3 residents are allowed up to five days per year of time away for approved CME activities in addition to their 20 days of paid time off (PTO). Unused CME time cannot be transferred to the next program year. First year residents are not allowed CME time away from the residency – with the exception of the NCAFP Winter Conference (Resident Award).

PGY-3 residents may take CME time during their last week of residency as long as they have completed all required training. This change was approved by the American Board of Family Medicine (ABFM) in April 2006. All CME meetings must be approved by the Program Director. Requests should be made at least forty-five days in advance and should include the conference time, attached conference brochure, and completed form. The CME request is then returned to the Residency Program Coordinator and, if approved, a travel authorization form will be completed and placed in your mailbox for signature. If traveling in state, use of a Southern Regional AHEC vehicle may be available. If, under special circumstances, residents have used their total conference time, they may, with the Program Director's approval, attend additional meetings at their own expense provided vacation days are available to cover time away.

If all funds are not used for meetings, second and third-year residents may use their remaining funds for other purposes deemed to be continuing medical education by the Program Director. Funds not used by the close of the fiscal year cannot be carried into the next year and will be forfeited.

USMLE/COMLEX Step III

Residents must successfully pass USMLE/COMLEX III prior to the beginning of their PGY2 year. Scheduling of Step 3 should be done during one of the rotations that allow time off (elective, community medicine, ED) as per the scheduling guidelines in the PTO section. The request for time off for Step 3 must be submitted 90 days in advance on a leave request form and submitted to the Scheduling Services Coordinator. Residents should not schedule or pay for the exam until their time off has been approved.

The time off for Step 3 is educational, and is not charged against your PTO. You will be granted reasonable time to travel both to and from the test, however no time will be given for studying unless you use PTO. If time away from a rotation to take STEP 3 and PTO is also requested during the same rotation and will exceed 5 days, it must be approved by the Program Director.

FUNDS FOR CME AND PROFESSIONAL DEVELOPMENT

PGY-1 = \$275 per year; PGY-2 = \$425; PGY-3 = \$525. Funds must be used during the program year and cannot be transferred to the next year. Unspent funds for professional development may be used to purchase textbooks in either electronic or print format. First year residents may use their funds for books or other purposes of continuing medical education as approved by the Program Director. Second and third-year residents may use funds not expended on meetings/conferences for other purposes deemed to be continuing medical education by the Program Director.

TRAVEL REIMBURSEMENT

Residents with prior approval may be reimbursed for travel to required off-site clinic/hospital rotations if SR-AHEC vehicles are not available and personal vehicles are used. Reimbursements will be considered on an individual basis. There is no travel reimbursement for residents or faculty going to CFVHS or the Family Medicine Center after hours. There is no reimbursement for residents doing elective or away rotations.

LAB COATS

OSHA regulations require personal protective equipment (PPD) for medical personnel. Lab coats are designated as PPD for physicians. To comply with this regulation SR-AHEC will provide lab coats in the following quantities:

- three lab coats for PGY-1 residents
- two lab coats for PGY-2 residents
- two lab coats for PGY-3 residents

Residents are authorized to have the following embroidered on their lab coats:

- Their name & professional designation (example Mary Smith, M.D.)
- Family Medicine Center
- These are the only items that are authorized for reimbursement. Anything different from this is the resident's responsibility.

Laundry service for the lab coat is provided by SR-AHEC. Lab coats should be brought to the linen closet across from the FM classroom and placed in the laundry bin for cleaning.

HOUSING

SR-AHEC does not provide housing for residents. The Residency Coordinator can help direct residents interested in finding housing to local realty agents who will assist with your housing needs.

MEALS

Lunches are provided for noon conferences, which will be listed and distributed on a monthly basis. If you wish to have a lunch, you must notify the Residency Administrative Assistant the week the month in advance that you will attend the noon conferences. **If you do not reserve a lunch, it will not be available.** Residents who schedule lunches and do not attend noon conference may lose free lunch privileges. Each resident is responsible for his/her meal on days when there is no conference scheduled. Each morning, breakfast is available to all residents in the Doctor's Lounge at CFVHS.

FEES PAID

Licensure fees, state board examination fees, and AAFP membership fees are paid by Southern Regional AHEC. Membership to the AOA is required and fees are paid by Southern Regional AHEC. For required in-state examinations, a Southern Regional AHEC vehicle may be used. No other expenses for examinations are paid.

- **Memberships and Licensing**
 - Paid medical license and board examination fees
 - Paid membership fees for the AAFP and AMA
 - Paid membership fees for state and county medical societies
 - Paid AOA membership for DO's
 - Malpractice insurance
 - Health club membership at HealthPlex Fitness Center (taxable benefit)
 - Cape Fear Regional Theatre memberships (taxable benefit)
 - Clinic and hospital free parking
 - Fees paid for PALS, ACLS, ALSO and BLS

SOUTHERN REGIONAL AHEC POLICIES APPLICABLE TO RESIDENTS

The Southern Regional AHEC Personnel Policy Manual is the source of information for this section. This highlights the major policies affecting residents in our program. During your orientation you will be given a Personnel Policy Manual that you are required to read and sign stating that you have received a copy of the manual. All personnel policies apply to residents as employees of SR-AHEC.

Graduate Medical Education Trainee Duty Hours Policy

The ACGME has outlined the following regulations for resident duty hours and on-call activities. Those listed in regular text apply to all residency programs while those in italics apply specifically to Family Medicine Programs.

A. Duty Hours

Duty hours are defined as all clinical and academic activities related to the residency program, ie, 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 and required academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and moonlighting if approved.
2. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
3. Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods. Residents must have 14 hours off after working a 24 hour shift.
4. Continuous on site duty including in house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to four additional hours to participate in transition of care activities. Residents cannot staff continuity clinic or conduct other clinical duties after a 24 hour shift.
5. Duty periods for PGY-1 residents will not exceed 16 hours in duration.

B. On-Call Activities

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

1. In-house call must occur no more frequently than every third night, averaged over a four-week period.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 4 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined by the Family Medicine RRC Requirements
 - *For family practice programs, up to four additional hours of post call duty hours may be permitted for on-site rounds of continuing patients on the inpatient service, transfer care of patients, program conferences, scheduled continuity office hours in the FPC, and/or self-directed activities. No other clinical duties are permitted. FP residents may not have continuity office hours in the afternoon or evening following an overnight call responsibility.*
 - *For programs using a night block rotation, residents may have their continuity office hours in the FPC either before or after the night block hours, as long as there are 10 hours of rest between assigned duties and all other duty rules are addressed.*

- *Residents should also be available for obstetrical delivery of their continuity prenatal patients throughout their three years of training but with the understanding that their post-delivery schedules should be adjusted, as necessary, to comply with the duty hours restrictions*
3. No new patients may be accepted after 24 hours of continuous duty.
 - *No new patients, defined as any patient for whom the resident has not previously provided care, may be accepted after 24 hours of continuous duty. Patients seen post call during a morning continuity session in the FPC are not considered new patients.*
 4. At-home call (pager call) is defined as call taken from outside the assigned institution.
 - a. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
 - b. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit. Home call, in itself does not count towards the 80 hour limit unless you go to the hospital.
 - c. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

C. Work Environment

1. First year residents must either be directly supervised (meaning a higher up is right there with them) or they must be indirectly supervised with direct supervision immediately available (meaning someone must be IN HOUSE). Indirect supervision with direct supervision immediately available is the situation we have with Precepting in the FMC with the preceptor immediately available to see the patient with the resident if needed.
2. Bottom line: An upper level (resident or attending) must be IN HOUSE at all times when a first year resident is on duty.

Because we are a dually-accredited program and the ACOFP requires that Osteopathic residents have a 10-hour duty-free period between shifts, we have decided to make this the standard for all our residents.

Each week all residents report their duty hours in E-Value confirming compliance with the above guidelines. This will allow us to adjust schedules when necessary to ensure compliance. These reports will be collected by the Residency Coordinator and forwarded to the Team Leaders for review. Duty hour requirements are a serious obligation of all residents and faculty. Accurate, timely reporting is a priority.

DISABILITY ACCOMMODATION & TECHNICAL STANDARDS

Please refer to policy 111 in the SR-AHEC Personnel Policy Manual (Page 17), shown below.

All Residents must possess the physical and mental skills and abilities necessary to successfully complete the Residency Program Curriculum. To achieve the optimal educational experience, residents are required to participate in all phases of the training program. These standards are not meant to be all inclusive nor does it constitute all measures or standards. It does not preclude the residency from temporarily restructuring resident duties as it deems appropriate for residents with acute illness, injury, or other circumstances of a temporary nature.

Residency requires a specific set of minimum physical, mental, emotional and social abilities are needed to be successful. Residents must possess all of the abilities listed in the five categories below. The use of an intermediary that would, in effect, require a resident to rely on someone else's power of observation and/or communication is not permitted.

I. Observation

- a. Visually observe materials presented in the learning environment including; audiovisual presentations, written documents, microscopic examination of microorganisms, tissues and gross organs in the normal and pathologic state and diagnostic images.
- b. Observe patients accurately and completely, both at distance and directly.
This requires functional vision, hearing and sensation.

II. Communication

- a. Effectively speak, write, hear, read and use a keyboard and/or essential electronic devices necessary for patient care.
- b. Perceive non-verbal communications, including facial expressions, body language and affect.
- c. Communicate effectively and sensitively with patients and their families via speech as well as reading and writing.
- d. Communicate in oral and written form with the healthcare team in an effective, accurate and efficient manner.

III. Motor

- a. Elicit information from patients via palpation, auscultation and percussion, as well as carry out diagnostic maneuvers.
- b. Execute movements reasonably required to provide general medical care and emergency treatment to patients. These skills require coordination of gross and fine motor movements, equilibrium and sensation. (Delivery of infants, intubations, pelvic exams, colposcopy etc)
- c. Manipulate equipment and instruments to perform basic laboratory tests and procedures as required to attain curricular goals (needles, stethoscope, ophthalmoscope, scalpel etc)

IV. Intellectual/ Conceptual, Integrative and Quantitative Abilities:

- a. Perform calculations necessary to solve quantitative problems as required by the curriculum.
- b. Collect, organize, prioritize, analyze and assimilate large amounts of technically detailed and complex information in a timely manner. This information will be presented in a variety of educational settings, including lectures, small group discussion, and individual clinical settings. The applicant should be able to analyze, integrate and apply this information appropriately for problem solving and decision-making.
- c. Apply knowledge and reasoning to solve problems as outlined by the curriculum.
- d. Comprehend the three dimensional spatial relationships of structures.
- e. Remain awake and alert.

V. Behavioral, Emotional and Social Attributes

- a. Possess the emotional health to fully apply his/her intellectual skill, exercise good judgment and to complete all responsibilities attendant to the diagnosis and care of patients.
- b. Develop a mature, sensitive and effective relationship with colleagues.
- c. Tolerate the physical, mental and emotional stress experienced during training and patient care.
- d. Possess the qualities of adaptability, flexibility and the ability to function in the face of uncertainty.
- e. Form a compassionate relationship with his/her patients while maintaining appropriate boundaries for a professional relationship
- f. Behave in an ethical and moral manner consistent with professional values and standards.
- g. Exhibit sufficient interpersonal skills, knowledge and attitudes to interact positively and sensitively with people from all parts of society, ethnic backgrounds and belief systems.
- h. Cooperate with others and work corroboratively as a team member.
- i. Being on time and complying with scheduled clinical experiences.
- j. Being able to take constructive feedback regarding performance and making behavioral changes accordingly.

The faculty is responsible for adhering to these standards during the selection of resident applicants for acceptance into the residency program.

If you have any questions about this document or whether you meet the standards described above. Please contact the Residency Coordinator and Residency Director.

“One of the most important aspects of the ADA is the requirement that employers develop explicit job descriptions and define the essential requirements or functions of a job.”

Characteristics of Essential Functions:

- Constitute the essential tasks required in the position
- Comprise a substantial portion of the resident’s time
- Would fundamentally change the nature of the resident’s job or educational experience if removed
- Would cause significant consequences if not performed
- Require some expertise to perform and can be accomplished only by a limited number of persons

The following list includes tasks that are representative of those required of a resident in family practice at Duke/Southern Regional AHEC Family Practice Residency Program. This list is not meant to be all-inclusive nor does it constitute all academic performance measures or graduation standards. It does not preclude the residency from temporarily restructuring resident duties as it deems appropriate for residents with acute illness, injury, or other circumstances of a temporary nature.

The resident, without the use of an intermediary, must be able to:

- Take a history and perform a physical exam
- Use sterile technique and universal precautions
- Perform Life Support skills
- Move throughout the clinical site and hospitals to address routine and emergent patient care needs

- Deliver a baby and learn to repair an episiotomy and perform necessary OB skills
- Assist at operations
- 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 issue, such as laboratory results, patient phone calls, or other requests
- Input and retrieve computer data through a keyboard and read a computer screen
- Read charts and monitors
- Perform documentation procedures, such as chart dictation and other paperwork, in a timely fashion
- 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 eventually care for 10 or more outpatient cases per half day
- Take call for the practice or service, which requires inpatient admissions and work stretches of up to 28 hours
- Call no more frequent than q. 3
- Present well-organized case presentations to other physicians or supervisors
- Participate in and satisfactorily complete all required rotations in the curriculum
- Participate in and satisfactorily complete all longitudinal requirements, including noon conference attendance, behavioral science, nursing home visits, and home visits

EQUAL EMPLOYMENT OPPORTUNITY & Resident Selection

Southern Regional AHEC is an equal opportunity employer. This means we will not discriminate for or against any employee or applicant because of race, color, religion, national origin, age, gender or disability (see the SRAHEC Personnel Policy Manual, 103 Equal Employment Opportunity, page 10, for further information).

SR-AHEC participates in both the NRMP and NMS national matching programs.

FORMAL CRITERIA FOR ELIGIBILITY OF RESIDENTS

Applicants to the Duke /Southern Regional AHEC Family Medicine Program are considered based upon the following criteria:

- US Citizen or Permanent Resident (visas not sponsored)from a medical school that is not disapproved according to the California and Texas list since North Carolina does not have a list to disapproved medical schools (non-LCME schools).
- Medical school graduation date no greater than two years prior to date of internship beginning (exceptions made if recent supervised clinical experience in US).
- Passing scores of COMPLEX/USMLE 1 and 2 with a total of two or less attempts for both exams combined. No more than 1 failed exam.
- Applications only accepted through ERAS.
- Must participate in NRMP/NMS.

LEAVES OF ABSENCE

For further information on Medical Leave, Family Leave, Personal Unpaid Leave, Administrative Leave, or Military Leave please refer to the Leaves of Absence section of the SRAHEC Personnel Manual.

SEXUAL AND OTHER UNLAWFULL HARASSMENT

SR-AHEC is committed to providing a work environment that is free of discrimination and unlawful harassment. Actions, words, jokes, or comments based on an individual's sex, race, ethnicity, age, religion, or any other legally protected characteristic will not be tolerated. As an example, sexual harassment (both overt and subtle) is a form of employee misconduct that is demeaning to another person, undermines the integrity of the employment relationship, and is strictly prohibited.

For further information on this policy please refer to page 80 of the FAHEF Personnel Manual, policy 703, Sexual and Other Unlawful Harassment.

DRUG AND ALCOHOL USE

SR-AHEC has a responsibility to the public and to its employees to deliver services in a conscientious and safe manner. In order to help ensure that this responsibility is met, employees must work free from the effects of alcohol and other substances that impair their performance. SR-AHEC strictly prohibits the unlawful manufacture, distribution, dispensation, possession, or use of any intoxicating alcoholic beverage, illegal drugs, or prescription drug not medically authorized, while on duty in the workplace. This also includes any substance that may impair job performance or pose a hazard to the safety and welfare of the employee or others. Failure to adhere to this policy shall constitute just cause for disciplinary action up to and including termination of employment.

SR-AHEC has established a Drug-Free Workplace Policy that is included in the Employee Personnel Manual. Please refer to the Personnel Manual provided to you during your orientation and review Policy 702, Drug and Alcohol Use, page 76-79.

DRUG TESTING POLICY

All new Southern Regional AHEC employees will complete a pre-employment drug screening at an approved and certified testing facility. In that SR-AHEC has established a Drug-Free Workplace Policy, employees including residents, may be drug tested for cause at any time (see Personnel Policy #702).

HEALTHCARE OF RESIDENTS POLICY

Residents are highly encouraged to locate a personal physician as soon as possible upon arrival at SR-AHEC. Having a personal provider allows the resident to seek healthcare in a neutral environment and ensure confidentiality in private personal matters. Residents may elect to utilize the Family Medicine Clinic as their personal healthcare provider, but must realize that their care may be provided by a faculty member or their peers. Residents will not be assigned to their faculty team leader or a midlevel that is supervised by their team leader. SR-AHEC will facilitate Residents' access to confidential counseling and psychological support services, if needed.

Rev. 01/08

RESIDENT PHYSICIAN IMPAIRMENT POLICY

Policy: It is the policy of the Southern Regional AHEC Family Practice Residency that:

- Residents perform their educational and assigned duties unimpaired by alcohol, drugs, and psychological, medical, or behavioral disorders.

- Residents will not engage in unlawful or unethical acts in relation to drugs and alcohol.
- Residents are not under the influence of, nor consume alcohol or drugs while engaged in work or educational activities.

Definitions:

- Impairment - the inability to exercise medical judgment and skill to the degree to be the community standards.
- Drugs - those substances obtained in an illegal or unethical manner for the purpose of consumption or distribution.
- Unethical - behaviors which fail to reflect the accepted principles of the profession of Medicine.
- Work - those activities and functions which reflect the provision of medical care.
- Education - those activities which contribute to the acquisition of skills, knowledge and attitudes necessary to provide medical care.

Goals:

- Identification of resident impairment.
- Intervention and treatment of the impaired physician.
- Reinstitution of the resident in the educational process.
- Monitoring and supportive aftercare of the impaired physician.

Objectives:

- Early Identification and Evaluation
 - Behavioral changes are the key to early identification of impairment in the resident physician. Impairment is indicated by changes in the areas of personality characteristics, physical condition and/or professional performance. Once these changes are noted in a resident physician's behavior and brought to the attention of the resident's team leader, the team leader will document the observations/reports and present the documentation to the identified resident physician to elicit his/her cooperation in making appropriate changes in the problem behavior(s). The resident physician will receive specific documentation to sign outlining the problematic behavior, the expected behavioral changes and the consequences for failing to make these changes. The Residency Program Director and faculty will be made aware of these identified behavioral change(s) including the resident physician's plan for making the expected change(s).
 - In the event that the problem behavior(s) continue, the Residency Program Director will determine if there is reasonable suspicion of impairment and will, in consultation with the residency faculty, determine if the case warrants referral to the North Carolina Physician Health Program (NCPHP- Appendix C) for further evaluation. There is no charge for the NCPHP evaluation. The identified resident physician will be required to comply with the NCPHP evaluation process. The resident physician will receive specific documentation to sign outlining the expectation of cooperation with the NCPHP evaluation process and the consequences for failing to comply. Failure to comply with the NCPHP evaluation process will result in the resident physician being reported to the North Carolina Board of Medical Examiners and discharged from the residency program.
 - Should the resident physician identify that they are impaired and be willing to seek voluntary professional evaluation and treatment, referral will be made to the NCPHP for evaluation and treatment planning/implementation. There is no charge for the NCPHP evaluation. Southern Regional AHEC's group health insurance plan will pay for a portion of the prescribed treatment. All charges not covered by the group health insurance will be the responsibility of the identified resident physician. During treatment the resident physician may be placed on medical leave from the residency not to exceed 90 days. The identified resident physician will be required to comply with the evaluation and treatment plan prescribed by the NCPHP. The resident physician will receive specific documentation to sign outlining the expectation of cooperation with the NCPHP evaluation

and treatment process and the consequences for failing to comply. Failure to comply with the NCPHP recommendations will result in the resident physician being reported to the North Carolina Board of Medical Examiners and discharged from the residency program.

- Cases in which impairment is not suspected will not be referred to the NCPHP. In such cases the Residency Program Director and faculty will determine appropriate responses to the continued problem behaviors. The resident physician will receive specific documentation to sign outlining the problematic behavior, the expected behavioral changes and/or medical treatment and the consequences for failing to make these changes. Failure on the part of the resident physician to cooperate in making the expected change(s) will result in the resident physician being discharged from the residency program.
- Resident physicians identified as engaging in illegal activities will be reported directly to the Residency Program Director. The Residency Program Director will notify the appropriate legal authorities of the evidence for illegal activities by the resident physician. The North Carolina Board of Medical Examiners and the NCPHP will also be notified of the reporting.

- Treatment

- If the NCPHP prescribed evaluation does not identify impairment in the resident physician, the Residency Program Director and faculty will determine appropriate responses to the identified problem behaviors. The resident physician will receive specific documentation to sign outlining the problematic behavior, the expected behavioral changes and the consequences for failing to make these changes.
- In the event that impairment is substantiated, the identified resident physician will be required to comply with the treatment plan prescribed by the NCPHP. Southern Regional AHEC's group health insurance plan will pay for a portion of the prescribed treatment. All charges not covered by the group health insurance will be the responsibility of the identified resident physician. During treatment the resident physician may be placed on medical leave from the residency not to exceed 90 days. The resident physician will receive specific documentation to sign outlining the expectation of cooperation with the NCPHP treatment plan and the consequences for failing to comply. Failure to comply with the NCPHP recommendations will result in the resident physician being reported to the North Carolina Board of Medical Examiners and discharged from the residency program.

- Aftercare

- At the successful completion of the prescribed treatment and at the recommendation of the NCPHP, the resident will return to Southern Regional AHEC to continue in the residency program. Upon return to the residency, efforts will be made within the requirements of the program to adapt the resident's schedule to reflect the resident's health status and need for aftercare. The resident physician will be required to comply with all aftercare and monitoring recommendations made by the NCPHP. These recommendations may include but are not limited to: peer-group counseling, on-site monitoring, contingency contracting, random drug testing, or pharmacological therapy. The resident physician will receive specific documentation to sign outlining the expectation of cooperation with the NCPHP aftercare plan and the consequences for failing to comply. Failure to comply with the NCPHP recommendations will result in the resident physician being reported to the North Carolina Board of Medical Examiners and discharged from the residency program.
- Relapse is often part of the impairment process and will be addressed in a manner similar to the initial identification of the impairment. In such cases the NCPHP will be notified and recommendations solicited regarding prescribed evaluation and treatment. Identified resident

physician will be required to comply with the recommendations of the NCPHP. The resident physician will receive specific documentation to sign outlining the expectation of cooperation with the NCPHP evaluation and treatment process and the consequences for failing to comply. Failure to comply with the NCPHP recommendations will result in the resident physician being reported to the North Carolina Board of Medical Examiners and discharged from the residency program. Recurrent relapses will result in the identified resident physician being reported to the North Carolina Board of Medical Examiners and discharged from the residency program

GRIEVANCE PROCEDURE

The grievance procedure for residents is reserved for those situations where a resident's future participation in the program is jeopardized. The steps to be followed in filing a grievance are outlined in the Residency Problem Resolution Procedure.

RESIDENCY PROBLEM RESOLUTION PROCEDURE

(Adapted From Personnel Policy 712)

SR-AHEC is committed to providing the best possible working conditions for its residents. Part of this commitment is encouraging an open and frank atmosphere in which any problem, complaint, or question receives a timely response from SR-AHEC faculty and/or management.

SR-AHEC strives to ensure fair and honest treatment of all residents. All residents, faculty and employees are expected to treat each other with mutual respect and contribute to a positive work environment.

If a resident disagrees with established rules of conduct, policies, or practices in the residency, she/he can express this concern through the problem resolution procedure. No resident will be penalized, formally or informally, for voicing a complaint in a reasonable, business-like manner, or for using the problem resolution procedure.

If a situation occurs when a resident believes that a condition of participation in the program such as notification of non promotion, dismissal from the program or non renewal of appointment a decision affecting their career status is unjust or inequitable, they are encouraged to make use of the problem resolution procedure. The procedure consists of the following steps. The resident may discontinue the process at any step.

1. The resident presents the problem to the faculty advisor within (7) seven calendar days after the incident occurs. The faculty advisor responds to the problem during the initial discussion or within (7) seven calendar days, after consulting with appropriate others, when necessary. The faculty advisor documents the discussion. If the faculty advisor is unavailable or the resident believes it would be inappropriate to contact that person, the resident may present the problem to the Human Resources Director.
2. If the problem is unresolved, the resident submits the problem in writing to the Residency Director within (7) seven calendar days. The Residency Director will respond with resolution in writing within (7) seven calendar days.
3. If the problem is still unresolved, the resident submits the problem in writing to the President/CEO within (7) seven calendar days. The President/CEO counsels and advises the resident, meets with the faculty advisor, and Program Director if necessary, and within (14) fourteen calendar days either resolves the problem in writing or submits the problem to an Appeals Committee for review. The President/CEO appoints the Appeals Committee. The Residency Director may not serve on the Appeals Committee.

4. The Appeals Committee reviews and considers the problem. The Appeals Committee has full authority to make a recommendation to the President/CEO. Such recommendation must be made within (5) five calendar days following the meeting of the Appeals Committee. The decision of the President/CEO is final.

Not every problem can be resolved to everyone's total satisfaction, but only through understanding and discussion of mutual problems can residents and faculty develop confidence in each other. This confidence is important to the operation of an efficient and harmonious learning environment.

ETHICS IN PATIENT CARE

Refer to Personnel Policy Manual (Policy #105)

POLICY REGARDING PROGRAM CLOSURE OR REDUCTION

Southern Regional AHEC will follow all requirements of the ACGME& AOA regarding program reduction or closure.

The process by which this will be accomplished is as follows:

Residency Reduction:

1. Residents in the affected program(s) will be notified at least four months before the first of July implementation.
3. All residents in the affected program will be allowed to complete their training.
4. All reductions will be accomplished by reducing the number of residents matched in a program.

Residency Closure:

1. Options for residents who may be displaced will be considered before any decisions about closure are made.
3. At least one year notice will be given of intent to close the residency program
4. Residents with two years or less of training left will be able to complete their program at Southern Regional AHEC.
5. Southern Regional AHEC will make every effort to assist displaced residents in finding positions so they may continue their training.

Work Place Environment Policy

The SR-AHEC FM Residency is committed to civil behavior, mutual respect and maintaining a positive workplace environment that is free from all acts or threats of violence or harassments perpetrated by or against employees, students, or members of the public.

This policy does not cover complaints or allegations of harassment based on membership in a protected group. Any complaints of harassment based on protected status are dealt with according to the policies and procedures of SR-AEHC personnel manual.

While on SR-AHEC property or while conducting SR-AHEC business at other locations, each employee, student, or individual is obligated to act civilly, respectfully and professionally towards others and is prohibited from subjecting any other employee, student, or individual to any violence, threat of violence, or harassment.

Violent action or harassment on SR-AHEC property or facilities, or while on SR-AHEC business, will not be tolerated or ignored. Individuals who engaged in violent, threatening or harassing behavior may be:

- Removed from the premises ;
- Subject to disciplinary action, up to and including dismissal or expulsion; and/or
- Subject to arrest and criminal prosecution.
- Disruptive behavior towards staff.

Nothing in this policy is intended to infringe against an employee's right to freedom of speech or expression and/or academic freedom. These rights must be balance with the need to maintain a workplace environment free from violence and harassment.

Applicability:

This policy applies to:

- All levels and areas of SR-AHEC operations and programs, including classrooms;
- Students ;
- Administrators and staff; and
- Visitors and all other persons.

Definitions**Workplace violence:**

Any direct or indirect physical or verbal assault, threat, or intimidating behavior occurring in the work place.

Workplace violence may involve, but is not limited to a violent, threatening, or intimidating act by anyone covered by this policy.

Some examples of workplace violence may include, but are not limited to:

- Verbal or non-verbal threats to inflict harm, including vague threats.
- Disorderly conduct, such as throwing or pushing objects, punching walls and slamming doors.
- Physical assaults, hitting, slapping, pulling hair or other unwanted physical contact.

Harassment:

Any direct or indirect behavior and /or bullying that is intended to interfere with the work performance of another or creates a hostile work environment.

Some examples may include, but not limited to:

- Abusive or offensive-behavior
- Emails or harassing nature
- Constant unwarranted criticism , intimidation based on the power structure, inconsistent enforcement of rules, unreasonable job demand including the assignment of meaningless tasks, etc.
- False or malicious statements.
- Withholding resources and information such that another is unable to perform the functions of their position.

Responsibilities:

All persons covered by this policy:

- Must respect the principles of freedom of speech /expression and academic freedom.
- Must refrain from workplace violence and harassment.
- Are encouraged to seek assistance to resolve individual personal issues that may lead to workplace violence / or harassment.
- Are encouraged to resolve issues informally and directly with the individual (s) involved whenever possible.
- Are encouraged to report unresolved incidents of workplace violence or harassment in accordance with the Grievance Procedure.

Unit supervisors, managers, directors, and other administrators:

- Are responsible for reporting and responding to complaints regarding workplace violence and general harassment as outlined in the Employee Procedure.

OSHA REQUIREMENTS

By Federal Law, North Carolina State Law, and Southern Regional AHEC Policy, we are mandated to follow the OSHA guidelines with regard to health care. You must use Universal Blood and Body Fluid precautions with all patients.

In order to protect yourself, you must follow the OSHA guidelines as provided to you during orientation and during annual updates. You have been provided with an exposure control plan that you must review and are the OSHA Federal Blood Borne Passage and Standards. These standards encompass not only HIV but also hepatitis and TB precautions. It is imperative that you review the OSHA guidelines.

It is imperative that Southern Regional AHEC be in compliance with the OSHA guidelines and it is up to each resident in this program to follow the guidelines to protect not only yourself but your patients. You will receive an initial orientation to OSHA during your first year orientation and annually thereafter. You will be provided with updates of the manual at both the initial orientation and at the annual updates.

We require that each resident has completed a full series of Hepatitis B vaccines. We also screen for TB on a routine basis in the Family Medicine Center. Cape Fear Valley Medical Center may have other precautions that you will be required to comply with.

HIPAA SECURITY REVIEW

As health care providers, we must comply with HIPAA regulations. These regulations are federally enforceable rules with severe criminal and civil penalties! YOU and your health care agency are responsible for your actions as a clinician. This short summary outlines basic HIPAA requirements. As health care professionals, you will receive specific training regarding the HIPAA Privacy and Security Rules during your orientation and yearly thereafter.

HIPAA was enacted in 1996. It has three parts:

1. Portability of health insurance
2. Accountability of health care providers
3. Administrative simplification.

Accountability of health care providers requires privacy of patient-identifiable health information.

1. A patient's health information must be kept private.
2. Access or share only the minimum amount of patient health information necessary to perform your job.
3. You can access or share a patient's health information without their written authorization only for purposes of payment (billing), treatment (referrals), and health care operations (chart reviews). Sharing of a patient's health care information for any other reason requires written authorization by the patient.

Administrative simplification includes rules governing:

1. Transaction of health care payment
2. Privacy and security of protected health information (PHI). PHI is any patient specific health information that is written, spoken, or electronic.

The HIPAA security rule deals with electronic PHI.

1. It must be preserved so that it is available when needed.
2. Its must be kept private.

Security of electronic PHI is made possible by computer professionals.

1. Software and hardware protection against hackers and viruses.
2. Use of encryption software on computers and personal digital assistants.
3. Access control to give workers the minimum necessary access to records.
4. Protective procedures, such as regular data backups to protect against loss.

Staff must also help protect against data loss or intrusions into our data systems.

1. Log off computers when you leave for the day.
2. Password-lock a computer that will be unattended. (Ask how.) If you don't, anyone could use manipulate information under your login. It's like leaving your debit card in the slot at the ATM!
3. Do not share your password with anyone. Your password is your digital signature that identifies your activities in the system. You are responsible for data manipulated under your ID.
4. Do not put unsecured PHI on mobile devices such as laptops, PDAs, PPCs, or cell phones. Security of mobile devices used for PHI must be approved and implemented by SR-AHEC. If lost or stolen, unencrypted PHI is subject to exposure.
5. Beware of downloading items from the Internet to your computer. Free downloads often come with hidden and harmful "passengers," executable programs that could steal any information you type or spam everyone listed in your e-mail address book.
6. Do not click on executable files (.exe files) that come to you as e-mail attachments. E-mail from someone you don't recognize may also be dangerous. If it looks like spam, don't open it. When in doubt call the Help Desk at 273 or 276.
7. If your computer starts running slowly or seems peculiar in any way, this could be an indication of "infection" by a virus or by "spyware" or "adware." Call the Help Desk at 273 or 276 for a remedy.
8. Ask unauthorized persons in your area where they need to go and escort them there. Alternatively, advise a supervisor of the problem immediately.

For in-depth information concerning HIPAA visit web site: <http://www.hhs.gov/ocr/hipaa/>

MOONLIGHTING POLICY

Limited moonlighting is allowed but not required. If a resident plans to moonlight, he/she must first request approval from the Program Director. If at any time the faculty perceives that moonlighting activities are interfering with the resident's quality of care or educational responsibilities, he/she must discontinue moonlighting. Failure to obtain prior approval for moonlighting activities will result in termination of moonlighting privileges. The resident is responsible to inform the Program Director of their moonlighting activities, the location, anticipated number of hours per month, and predicted duration of moonlighting activities at that location. Moonlighting and Family Medicine Center call coverage or patient care center responsibilities cannot be done concurrently.

Internal Moonlighting

Any hours a resident works for compensation at Cape Fear Valley Health System or any of the CFVHS's primary care clinical sites must be considered part of the 80 hour weekly limit on duty hours as defined by the ACGME. Therefore, any hours of planned moonlighting must be approved before any actual moonlighting occurs.

Our program does not permit internal moonlighting at this time

External Moonlighting

Each resident must complete a Moonlighting Review form prior to agreeing to any moonlighting. On this form is information regarding the opportunity (please see attached form). This form must be submitted prior to the moonlighting event and must be reviewed and signed off by Program Director. A copy will be returned to you and a copy will be kept for your files.

Residents must report their moonlight hours weekly in their duty hour report, and will be monitored for fatigue, and/or impairment. If this is noted then permission to participate in moonlighting will be withdrawn.

Residents must show proof of their own malpractice insurance to cover any moonlighting opportunities. SR-AHEC does not provide coverage for moonlighting.

DRESS CODE

It is the expectation of the Family Medicine Center (FMC) that, while in the FMC appropriate and professional attire be worn. It is required that nametags be worn to identify yourselves to patients or outside visitors. Open-toe shoes may not be worn in the FMC; this is an OSHA guideline. ***Scrub suits or “greens” are not to be worn in the FMC at any time!***

CAPE FEAR VALLEY HEALTH SYSTEM HOSPITAL DRESS CODE

Cumberland County Hospital System, Inc.

Human Resources Policy

TITLE:	POLICY NUMBER	APPROVED BY	EFFECTIVE DATE	PAGE
PERSONAL APPEARANCE OF EMPLOYEES	703	B.E.H.	10/25/84	<u>1</u> OF <u>3</u> PGS.

POLICY

Employees, as representatives of the Health System are expected to maintain a high standard of personal appearance. Employees in certain job classifications are required, while on duty, to wear uniforms of a color, type, and design specified and/or approved by the appropriate department manager and vice president. Employees not required to wear uniforms are expected to dress in a manner that is professional and normally acceptable in business establishments. In the following, the word "uniform" refers to the personal appearance of employees. Individual departments may, for purposes of infection control and safety, etc., develop standards, which are even more stringent than these general guidelines.

If you are a non-direct patient care employee, scrubs are not permitted unless approved by appropriate vice president and the Vice President for Human Resources. For specialized areas, such as the Healthplex, attire will be specified at the discretion of the department director and vice president.

II. DRESS STANDARDS

A. Attire

1. Uniforms and/or dress clothes are to fit properly according to body frame, weight, and height and are to be neat, clean and in good repair.
2. Professional/Business Dress Crop Pants, Gauchos and Split-skirts are acceptable. (length is to be below mid calf to ankle length).
3. A professional appearance is to be projected at all times. The following are not considered to be professional attire and; therefore, are not permitted.
 - A. Shorts, thin-strap tank tops, T-shirts, halters, knickers, capris, mini-skirts (considered more than 2 inches above the top of the knee), casual pants with drawstrings and etc. and sundresses are prohibited.
 - B. All T-Shirts or Shirts that display slogans, team names or insignias, or other inappropriate markings, i.e., beer advertisements are not accepted.
 - C. Clothing that reveals bare chest (cleavage) or midriff, or shoulders are not permitted.
 - D. Sweatpants, stretch pants, warm up pants and pants made of jean material (regardless of color) are not permitted unless the Department Manager specifically approves their wear for specially assigned tasks, i.e., cleaning or moving projects. Denim shirts and jumpers are not permitted. Dress Down or Casual Fridays: Jean pants, are not permitted.
 - E. Hats, caps and sunglasses are not permitted unless department uniform dictates.
 - F. Shirts and blouses designed with shirttails must be tucked in unless the apparel is designed to be worn on the outside.
4. Hose or socks: They are optional with pants, crop pants, gauchos, mid-calf to ankle-length dresses and skirts unless department requires.
5. Medical Center ID badges are to be worn above the waist on duty according to Personnel Policy #704.
6. Buttons and pins, that are not given by the Health System for ID badges and service award pins, may not be worn while on duty. The only exception will be jewelry earned through graduation.
7. Neck Ties are optional for non-management staff, unless Department requires. Collared (example: Golf Shirts) shirts are acceptable Monday – Friday. Collared shirts, as golf shirts, are acceptable for management staff on business casual Friday.

B. Jewelry

1. Patient Areas - Large rings, bracelets, loop earrings, etc. are not to be worn, as they may be a safety hazard and cause serious injury. Wedding bands and watches are permitted. No more than two (2) earrings may be worn in each ear at a time and earrings or other types of ornaments are not to be worn in the nose, tongue, and eyebrows or in other visible areas of the body. (Regardless if covered or not)
2. Non-Patient Areas - Excessive jewelry is to be avoided. Earrings are to be small in size, and no more than two (2) earrings may be worn in each ear at a time. Earrings or other types of ornaments are not to be worn in the nose, eyebrows, tongue, or in other visible areas of the body. (Regardless if covered or not)

C. Cosmetics and Footwear

1. Cosmetics - Moderation is to be used. Perfumes, colognes, or other scented substances are not to be worn in clinical areas or by anyone with regular patient contact, as they are often offensive to other staff members.
2. Shoes - Shoes are to be worn. Closed toed shoes are required in clinical areas. Open toed shoes are permitted in non-clinical areas, unless designated by internal department policy for safety. Toenails are to be kept clean and neat. Flip-flops are prohibited.

D. Tattoos

Excessive, visible tattoos are not permitted. When possible, tattoos must be covered. Tattoos displaying obscenities or obscene images are prohibited.

III. HYGIENE STANDARDS

- A. Personal Hygiene - Personnel are to be neat, clean, and free from offensive body odors. Daily use of antiperspirants,

deodorants, and other hygienic products are necessary due to close personal contact. Regular oral hygiene is necessary.

B. Hair

1. General - Hair is to be clean, neatly styled and of a length so as not to interfere with the normal workday activities. Hair cannot be of unnatural colors (examples: rainbow colors, blue, pink, green etc). Excessive ornaments are not allowed. Male employees are to be clean-shaven or with neatly trimmed beards or mustaches. Facial hair that interferes with the wearing of a protective mask is not permitted.
2. Patient Areas - Long hair is to be worn pulled back so that it does not come in contact with the patient, sterile, or visual fields.

C. Fingernails - Fingernails are to be clean and short enough for patient safety, general safety and hygiene and to enable quality performance of treatment procedures, typing, etc.

Employees who have physical contact with patients' skin/environment (Nursing, Laboratory, Radiology, etc.) or items that have contact with patients' skin/environment (Central Sterile Supply, Pharmacy, Food and Nutrition, etc.) the following applies:

1. Artificial nails or extenders are prohibited.
2. Natural nails are to be kept at less than ¼ inch beyond the fingertips.
3. Polish may be used, but if used, is to be free of chips.

D. Hand washing - Hands are to be kept clean. Hand washing is required prior to leaving the restroom, and after patient contact.

IV. MAINTENANCE OF UNIFORMS

- A. Employee's Responsibility - It is the employee's responsibility to purchase, wear, and maintain in an acceptable manner uniforms as prescribed by the Health System. While on duty the employee is required to wear a clean, neat uniform and maintain a standard of neatness prescribed by the Health System.
- B. Department Manager Responsibility - It is the responsibility of the Department Managers and/or their designated representative to verify that employees within their jurisdiction be attired in a manner that brings credit upon the employee, the department, and the Health System. Any change in the design, style or color of specified uniforms is to be approved by the appropriate Service Line Director.

V. DISCIPLINARY ACTION

Employees who fail to comply with this policy are subject to disciplinary action up to and including termination. Individuals not dressed appropriately for work may be sent home to change clothes. If this occurs, the time away from work is unpaid for hourly staff.

CARE OF CFVHS CALL ROOMS, DOCTOR'S LOUNGE & RESIDENTS LOUNGE IN THE FAMILY MEDICINE CENTER

1. Resident's working/on-call may use the call rooms.
2. **SMOKING, DRUGS, ALCOHOL CONSUMPTION AND OTHER UNPROFESSIONAL ACTIVITIES ARE STRICTLY PROHIBITED!**
3. All residents are responsible for putting used towels, etc. in the restroom. Housekeeping staff will pick up dirty laundry and change linens on a daily basis.
4. All residents are responsible for removing personal laundry from the premises within a reasonable time period.
5. The refrigerator should contain only food that is not spoiled. Any non-community items should be labeled as such. If they are not labeled, you should expect that your thirsty or hungry colleagues may feel free to help themselves. Note: Bagged lunches or food in individualized containers is of course an exception and need not be labeled to prevent predators.
6. Guests, spouses and children are welcome to visit the call room but only residents may stay overnight.
7. In the event of television/video viewing, please leave the remote control at bedside – if one is available.
8. Community items such as video equipment, etc., should not be removed from the call rooms/lounge.
9. Respect the lounge and call rooms as community property.
10. Please log off the computer after use.
11. Please clean up after yourselves and use available resources properly.

If residents have concerns about the call rooms or doctor's lounge, please see the Program Director.

DEPARTMENT AND RESIDENCY PROGRAM OBLIGATIONS

NATIONAL STANDARDS

The residency program is committed to providing an educational program that meets the standards of the ACGME Programs for Family Practice and the certification requirements of the American Board of Family Practice and the American Osteopathic Board of Family Physicians. The educational program will be adapted to the unique goals, objectives and career plans of the resident insofar as the requirements of certification and the residency will permit. The resident should be familiar with the accreditation and other requirements that apply to residents in training. Residency program requirements may change once they have been implemented due to changes required by ACGME, AOA or RRC guidelines.

ADVERSE ACCREDITATION ACTIONS

Residents in a program will be informed of any ACGME Residency Review Committee adverse accreditation actions regarding the residency program.

INDIVIDUAL EVALUATIONS

The residency director shall assure that each resident receives a comprehensive, at least twice yearly evaluation of the resident's educational progress and clinical performance as they relate to the residency's curriculum objectives. Quarterly 360 degree and monthly rotation evaluations are also required. These evaluations shall be shared with the resident. Quarterly and annual evaluations should be signed by the resident and a designated faculty member.

EXPECTATIONS AND OBLIGATIONS OF RESIDENTS

OBLIGATIONS OF RESIDENTS

At the time of entry into the program, the Family Practice resident is asked to read and acknowledge in writing that he or she has read the following: (1) the Accreditation Council for Graduate Medical Education (ACGME) "Institutional Requirements"; (2) the "Program Requirements for Residency Education in Family Practice"; (3) the "Requirements for Certification by the American Board of Family Practice"; (4) the "Requirements for Certification by the American Osteopathic Board of Family Physicians"; (5) the SR-AHEC Residents Manual; and, (6) any additional requirements of the particular program into which the resident enters.

The resident will fulfill the educational requirements of the residency and observe the rules and regulations of the hospital(s) and other institutions where assigned. The resident understands that

the curriculum description and requirements noted in the residency brochure may change during the resident's tenure.

Residents are required to comply with institutional policies and American Board of Family Medicine (ABFM) regulations and the American Osteopathic Board of Family Physicians (AOBFP), and be aware of Accreditation Council on Graduate Medical Education (ACGME) requirements for the specialty of family practice in addition to program regulations.

It is also required that residents, in the performance of their clinical work, comply with policies and procedures that govern the operations of the Family Medicine Center. This includes compliance with the coding and documentation necessary to meet requirements for billing of medical services provided by residents under the supervision of faculty.

The ABFM authorizes the board certification process. The requirements for certification, board eligibility, applying for the exam, satisfactory completion of residency, part-time residency, absence from residency, etc., are all in the American Board of Family Practice Information Manual for Family Practice Residency Programs which is available at www.abfp.org.

The ACGME's requirements for family practice cover duration and scope of training, size of program, the principles of family practice, and curriculum requirements. The requirements are available on-line at the following internet address: www.acgme.org/. Programs must be in compliance with these requirements to maintain accreditation. Osteopathic Program Requirements are available [online at www.do-online.org/pdf/sir_postdoctrain](http://www.do-online.org/pdf/sir_postdoctrain)

Residencies have three types of program reviews to assure compliance with accreditation requirements. All residents are expected to participate in program reviews as requested and assist the programs in making changes needed to maintain accreditation.

The RRC does a site review of each program to confirm that the information provided to the RRC in the residency's Program Information Form (PIF) is a true and accurate report of how the program is meeting requirements. Residents are expected to meet with the RRC reviewer and answer questions honestly and accurately. The PIF and the site review report are used by the RRC to decide on the number of years of accreditation they will grant to the program.

EXPECTATIONS OF RESIDENTS

FAMILY MEDICINE CENTER

Interns and residents are expected to be on time for clinic. They are to follow the dress code and dictation guidelines as outlined later in this manual. Osteopathic interns shall complete 36 structural exams, osteopathic assessments and use manipulative techniques (when indicated) on all new patients and annual physical exams. Precepting will be available for osteopathic principles and practices either at the time of the patient encounter or upon return visit to the FM when an osteopathic preceptor is available, as well as during chart reviews by the DME.

Professional Duties Expectations Policy/Contract

The resident physician will meet the following professional duties expectations according the advancement criteria checklist:

Professionalism

1. Complete inpatient and outpatient charts in a timely manner, no more than ten (10) outstanding outpatient items per report
2. Comply with communication standards including
 - Responding to various communications via text, phone or page from faculty staff, hospital and attending; within 15 minutes
 - Daily attention to e-mail, resident must check and respond each day.
 - Patient care messages are to be addressed within the following guidelines:
 - Rx Refills completed within 48 hours
 - Phone Notes completed within 48 hours
 - Lab Reports (non-critical) within 7 days to include letter to patient or patient phone call addressing lab results.
 - Misc Forms (FL-2, insurance forms, sports physicals, handicap placards, and similar including authorization on non-preferred medications (Levitra for Viagra) etc.) within 7 days.
 - Daily and appropriate coverage arranged and properly communicated if resident is away.
3. Arrange to take USMLE or COMLEX 3 by December of PGY1 year.
4. Be at assignments and rotations on time.
5. Satisfactory and timely completion of clinical assignments including community medicine projects and practice management projects
6. Satisfactory and timely completion of administrative assignments including duty hours, procedure logs and evaluations 37
7. Display appropriate integrity, compassion, and respect for patients, colleagues and staff.
8. All rotation scores for this competency at least 3 out of 5
9. Satisfactory compliance with attendance policy for noon conference and support group as stated in noon conference policy.

RESIDENT GRAND ROUNDS EXPECTATIONS

Grand Rounds is a third year requirement. 90 days prior to your assigned date, notify your team leader of your selected topic for faculty approval. 60 days prior, submit a list of references for faculty review. 30 days prior, present slides and abstract presentation to faculty for review and approval.

1. The schedule is finalized prior to the academic year. Please look at the schedule now and find your time slot.
2. Changes will only be allowed if they are made prior to the month scheduled. Changes must be made by a reciprocal change among the residents. Any change must be communicated with the team leader and approved. Only then will Residency Administrative Assistant and Dr. Mergy change the schedule.
3. Changes will only be allowed for significant rotation conflicts, such as away elective, or other major events, such as maternity leave. "This was a busy month" is not an acceptable reason.
4. Conferences must show some evidence of scholarship, absorption and understanding of the subject matter. The presentation should be at least 40-45 minutes long.

5. Cancellations due to any acute event, such as illness, must be approved and the conference will be rescheduled as soon as possible.
6. Failure to meet these expectations will result in the scheduling of a makeup grand rounds prior to promotion to the next level. The resident may expand upon the original presentation or do another topic.

RESIDENT JOURNAL CLUB GUIDELINES

(NOTE: the following is an excerpt of the Journal Club Guidelines. You will be provided a separate in-depth briefing on these guidelines and other requirements.)

Each resident is required to complete two formal journal article review presentations during the SR-AHEC Family Medicine Residency. These presentations will occur in the second and third year of the residency. The following information is to assist the resident during the preparation and completion of this requirement.

Major Objectives of the Journal Article Review:

- Improve critical appraisal skills
- Improve clinical practice
- Promote evidence based medicine practices
- Teach lifelong learning skills
- Develop presentation skills
- Build database of reviewed material

General Information for the Resident:

1. Throughout rotations and clinic, residents are to complete Educational Prescriptions for patient care issues that they would like to explore in more depth. Educational Prescriptions can be found at each nurses' stations in the clinic, on the W Drive (Forms/CEAS/Journal Club/Educational Prescription), and from preceptors and faculty. Faculty are to promote the use of the Educational Prescription as the opportunity arises when precepting residents (inpatient and clinic). Completed Educational Prescriptions serve as the initial step in identifying which article to present for the Journal Article Review Presentation.

2. Under the guidance of the faculty, the resident will select an article to critically analyze at least 4 weeks prior to your scheduled presentation date. If necessary, the resident will work with librarians of the IAC to conduct a search of databases and identify most relevant article. The faculty, along with the presenter, will determine if the problem identified and the article selected is appropriate.

3. Have your article distributed at least two weeks prior to your presentation to all Residents and Faculty. A copy of your article must be submitted to the Residency Coordinator to be placed in your permanent file.

4. Meet with your Team Leader, or make a request to them to meet with another faculty, to discuss salient features of your particular article after you have reviewed it. This

should be completed no later than one week before your presentation.

5. The schedule for presentations is finalized prior to the academic year. Please look at the schedule now and find your time slot. ANY CHANGES MUST FOLLOW THE SAME PROCEDURE AS “THE GRAND ROUNDS EXPECTATIONS 2006-2007 DOCUMENT”. *(Please note that Dr. Miller and the Residency Administrative Assistant are responsible for coordinating the changes to the schedule once approved by the Team Leader.)*

6. You are required to do two formal journal article review presentations during your residency. The penalty for failing to present an assigned journal club presentation is the requirement to do an additional journal article review presentation.

7. You need to utilize PowerPoint slides as part of your presentation. A copy of your presentation must be electronically submitted to the Residency Coordinator when complete to be kept in your permanent record.

Noon Conference Attendance Policy

- Noon conferences are Tuesday-Thursday 12:15-1:00 pm in the Family Medicine Conference Room. AAFP Jeopardy Sessions will be held alternating Fridays from 12:15-1:00
- Each resident must attend 70 percent of all noon conferences.
- Each resident must sign in by 12:30pm to be counted as present.
- Late attendees will not be credited with attendance but should still attend the conference.
- The resident is responsible for signing in to document their presence.
- Residents are excused when on AWAY rotations, ICU, OB, Urology at Womack and Surgery in Laurinburg, The medicine team is only excused when the attending physician contacts the residency coordinator directly.
- Attendance at noon conference is expected post call as long as duty hours are not violated.
- When a resident does not meet the 70% requirement s/he must present a noon conference. The didactic topic will be assigned by their team leader.

CLINIC SCHEDULE CHANGES

Clinic or office hours will not be cancelled unless a Clinic Change Request or a Vacation Request is properly filled out and submitted to the Scheduling Service Coordinator with proper approval. See the Scheduling Service Coordinator for a copy of the three ply form. Rescheduling of patients should be kept to an absolute minimum and reserved for rare urgent/emergent situations.

Late, Delayed or Out Sick and Scheduled for FM Clinic

In the event you are unable to report to the FM clinic at your scheduled time it is imperative that you contact the Family Medicine Clinic Front Desk, Clinical Practice Manager or the Clinic Scheduler so that appropriate actions can be started to either reschedule your patients or have another provider see them. The Clinical Practice Manager is normally available in the clinic by 7:30AM.

In the event no one listed above is available please contact the Message Center and request to speak to the Nurse Manager or Business Office Manager. If you can't contact any of these individuals, ask the Message Center to take a message and ensure that it is delivered to the Clinic Director or Preceptor on duty. This will ensure that someone in a management/leadership capacity is aware that you will be late and can take appropriate action.

Key clinic numbers you should have programmed into your phone:

FM Clinic Front Desk: 910-678-0135
Clinical Practice Manager: 910-678-7251
Clinical Scheduler: 910-678-7308
Message Center: 910-678-0100
Residency Coordinator: 910-678-7259

Please remember to talk with a live person, do not leave a voicemail message and think that it will be acted on. Get with your team leader if you have any questions concerning these instructions.

CALLING IN SICK (Not Scheduled in FM Clinic)

Residents must call the Residency Coordinator if they are going to be out sick. The Residency Coordinator will inform the Chief Resident(s), Clinic Supervisor, Message Center and Scheduling Service Coordinator. Calls should be placed to the Residency Coordinator's cell phone prior to 8 a.m. After 8 a.m., residents should call Residency Coordinator's office.

If the resident is scheduled to work any place other than the Family Medicine Center that day it is his/ her responsibility to notify the appropriate supervisor. On weekends or holidays, it is his/her responsibility to notify the appropriate supervisor, on call attending and Chief Resident(s). Do not leave a voice mail message and think that it will be acted on.

CALL SCHEDULE CHANGES

Call schedule changes may occur after the call schedule is posted. However, the resident

changing call is required to find a call coverage replacement. The resident is also required to complete a Call Schedule Change Form to be signed by the residents involved and the appropriate attending physicians. This form must be completed and returned to the Scheduling Services Coordinator.

After the call schedule has been approved and distributed, individual residents should not place the responsibility of changing the call schedule or finding call coverage for themselves or anyone else upon the chief resident(s), unless there has been an obvious error or emergency (i.e. back to back call, placing a resident on call during an approved vacation, medical illness, death in the family, etc.)

CALL COVERAGE POLICY

Residents are responsible for their assigned calls once the yearly call schedule is published. If a resident, for whatever reason, is unable to take an assigned call, it is their responsibility to find a suitable resident replacement and to notify the appropriate individuals of this call switch, which include the scheduler, Residency Coordinator, Practice Manager, and the Chief resident.

If a resident fails to comply with this policy and the Chief resident has to step in and find coverage, the aforementioned resident will owe 2 calls not 1. The resident will owe the covering resident a Saturday call regardless of the day covered. They will also owe the Chief resident a Saturday call for finding coverage. If the covering resident ends up being the Chief, then the aforementioned resident will owe the Chief resident 2 Saturday calls. In the instance a Saturday call is unavailable to be taken, a Sunday call will be substituted. If this day is not available, then a Friday will be substituted.

Extenuating circumstances will be reviewed on a case by case basis by the Program Director and the Chief resident. If deemed appropriate, the additional call requirement may be altered.

CALL DURING SOUTHERN REGIONAL AHEC HOLIDAYS

1. If SR-AHEC is closed for a full day, this is treated like a weekend day for call coverage purposes. The resident on call for the Medicine service will report to the hospital at 7 am. Rounds will be at 8:30 A.M. or as designated by the Attending. The residents who were on call the previous night will leave after rounds and after their work is completed in accordance with ACGME duty hours.
2. If SR-AHEC is closed and your preceptor's office is open and you are not on Medicine call, you are expected to be in your preceptor's office working.
3. If SR-AHEC is closed for a partial day (e.g. starting at noon), the Medicine Team will continue to cover the hospital as if it were a normal working day (that is, until after sign out rounds which begins at 5:00 P.M.).

4. Residents are expected to remain in their preceptor's office until the preceptor is finished despite SR-AHEC's early closing. In the event SR-AHEC closes early but the preceptor's office remains open, residents are expected to continue duty unless otherwise limited by ACGME duty hour regulations.

EXTRA ER CALL

In the event that the Family Medicine Service has a low patient census, it may be determined by the FM attending that extra emergency room call be done in an effort to increase patient numbers. This decision must be made in regard to hospital coverage and proximity to the next ER call, but is ultimately the decision of the attending and the team service.

OUT OF HOSPITAL UPPER LEVEL CALL

After March 31st of each year, the upper level may take call from home only if the following conditions are met:

- Attending approval on the day/evening of call.
- The condition of patients on service allows it. Any ICU patient or rapidly changing patient condition would void this privilege.
- The intern must be comfortable with the responsibility and may request that the upper level stay in-house or come in at any time.
- The upper level and the intern must have satisfactory academic and clinical performance and be cleared by the Program Director to participate in this privilege.
- The attending on-call may deny this privilege for any concern or reason and the decision of the attending is not negotiable.
- All calls from the answering service must be responded to in less than 15 minutes. All patients needing to be seen by the ED will be seen by the ED for disposition. The upper level will need to see and discuss the patient with an attending prior to discharge from the ED or other hospital treatment area.

RESIDENT EMERGENCIES

Faculty members are aware that certain life emergencies or life events may occur and those residents may need to be away or request to be away. Approval must be obtained from the attending and adequate coverage arranged. Residents should never assume that a request would have been granted or it "probably would have been ok".

INTERN DUTIES & RESPONSIBILITIES WITHIN THE HOSPITAL:

Residents are expected to be on time for morning and afternoon sign out. They will write and dictate all History and Physicals on all patients admitted to the hospital, at the time of admission. Cape Fear Valley requires H and Ps and OP notes to be completed within 24 hours of admission.

Osteopathic residents will include structural exams and manipulative treatments on all admissions of the osteopathic attending. The resident will write all admission orders with the assistance of the upper level residents and will present them to the attending. They will complete a dictated discharge summary upon patient's discharge from the hospital. Discharge summaries should be completed as soon as possible, at the time of discharge. If patients they have been following on service remain in the hospital past the end of their rotation, they are to write or dictate a concise and complete off-service note. Medical Records (Health Information Systems) at Cape Fear encourages providers to come often to keep records up to date

The residents will make rounds daily prior to meeting with the attending and will be responsible for daily progress notes, orders and all other management details pertinent to their patients. The resident can review their notes and orders with the upper level residents prior to rounding with the attending.

On call, the resident is to answer all questions/calls regarding the Family Medicine Service. They are to be present for all code blues involving any patient currently on the Family Medicine Service in the hospital; however, codes are led by the rapid response/code team.

For other rotations, the resident will receive instruction as to what is expected from them upon entering each service.

RESIDENT RESPONSIBILITIES ON MEDICINE

1. Check out rounds occurs every morning at 7 A.M. in the 6th floor conference room. The resident on call the preceding night is responsible for printing patient lists and reporting on the night's events that occurred.
2. The patients assigned to you by your senior resident are YOUR responsibility. This means that YOU need to write the orders discussed, follow up on labs, speak with consultants if needed, and arrange family meetings. If you have questions or problems with the above, speak with your senior resident. They are there to assist you if needed.
3. All patients must have a note written in their record by you EVERY day. If the service is busy and you have difficulty in seeing all of your patients prior to rounds, you may need to adjust your schedule and start earlier in accordance with ACGME duty hour requirements.
4. When seeing patients in the morning, you MUST:
 - a. Check on all labs, radiology studies and EKG's, consult and report, nurses and ancillary notes, etc.
 - b. Follow up on any Accu-checks if these were ordered. In the units the sheet will generally be outside of the patient's room. On the floors these values

will be found on the Cape Fear Valley's computer system or by asking the nursing assistant.

- a. Review any orders written overnight.
 - b. See the patient and examine them: note if they are on O₂ or IVF's.
 - c. Write your note.
5. Patient notes should be written in the SOAP format (Subjective, Objective, Assessment and Plan)
- d. S = Subjective: what the patient tells you.
 - e. O = Objective: it includes patient's vitals (BP, pulse, respirations, temperature, pulse oximetry and vent settings, etc.).
 - f. A = Assessment: essentially the patient's problem list including the main differential diagnosis.
 - g. P = Plan: what is the next step in the patient care.
6. It is very helpful to include in your SOAP note any a.m. labs, the patient's current list of medicines what fluids they are on, and their code status.
7. If you are called upon to admit a patient, you must write and dictate an H&P. You must also, with the senior resident's assistance, write the appropriate admissions order.
8. All residents are out of the hospital two afternoons a week. On these days prior to leaving for lunch, you **MUST** sign out any labs to be checked on as well as patient issues to the resident remaining in the hospital. You may arrange with them to write any afternoon notes on your intensive care unit patients. They are not required to do this. However, if they do not, you will need to do so before leaving after the 5:30 P.M. rounds. You **MUST** also update the computer patient list. This includes adding on any new admits from the a.m. that have been assigned to you. The patient list will be filled in completely with meds, HPI, what needs to be checked etc., **BEFORE** going over to the clinic.
9. If your afternoon clinic is running late, please call 609-7102 (the rounding room) or page the medicine team and let someone know.
10. Miscellaneous issues:
- a. Weekend notes: Prior to check out rounds on Friday afternoon, all patients must have a weekend plan written out. This tells the people who are on call over the weekend what needs to be done with your patients and tentatively what their D/C plan is.
 - b. Off service notes: At the end of the rotation you must generate a Note to be written or dictated which tells when the patient came in, pertinent parts of their

presentation/labs, and then summarizes their course. At the end, their problems, plans and current medication list needs to be listed. This is required if the patient is expected to remain on the service for greater than 3 days after you leave the service.

- c. Presentations: When presenting a patient it is often best to refer to written information. DO NOT try to wing it. Present in an organized fashion. Do not swing back and forth between the patient's HPI, labs, and plan. Start with their age, sex, presentation, pertinent physical findings, labs, problems and plan.
 1. Begin by presenting what you believe is going on with the patient based upon the data you gathered. In other words, "What do you think is going on with this patient?"
 - a. You can list/tell the attending what are the major problems regarding the patient. What are the major issues we need to address? With each issue, you should give the attending supporting evidence.
 - b. You may give the attending a differential diagnosis. Be able to support what you working diagnoses are. That is, what is on the top of your list and why? What is your hypothesis?
 - c. Based upon your hypothesis, I want you to propose the management plan.
 - d. If you do not have a definitive diagnosis or management plan, you need to tell the attending what other types of information is needed for this patient. Are there additional diagnostic studies you want to perform to clarify the situation?
 - e. Is placing a consultation appropriate? Who do you want to consult?
 - f. Is there a reason for the patient to be non-compliant?
 2. What is your supporting evidence? What evidence do you have to support your opinion?
 - a. What were the major findings that led you to your conclusion? Labs and/ or signs and symptoms in your history and physical exams
 - b. What other choices/diagnoses were considered? What evidence do you have to support or refute your alternative diagnoses/hypotheses?
 - c. What questions are arising in your mind?

d. What is your thought process?

Example:

70 y/o female admitted with dyspnea on exertion and chest pain with chest x-ray showing no fluid or infiltrate. She developed acute respiratory distress and had to be moved to ICU. In the last 24 hours, she is doing a little better....

--my concern includes fluid overload and CHF. She has 2 liters of IVF and dyspnea worsens. She complains of orthopnea. Exam showed JVD and bilateral crackles. CXR showed increased cephalization. ABG showed hypoxemia without CO2 retention. I want to give her 1six trial and stop her IV fluids. Her other labs also showed normal electrolytes and elevate BUN with creatinine of 0.8. Her CBC was....

I want to also check an echocardiogram. Her last echo was over 2 years ago

--Another concern includes exacerbation of Asthma. She had hx of asthma with similar presentation in the past. She had some response to IV steroids. Now she is also wheezing on examination. CXR showed some hyperinflation.

I am also concerned about PE with her chest pain, but this is lower on my list because I ordered a D-Dimer and it was negative. However, I want to check a lower extremity Doppler.

--Her other concerns that need addressed during this admit includes her uncontrolled DM. Her accu-checks the last 24 hr include..... Her current DM regimen includes.....Her home regimen was....I wasn't to check HbA1c. I want to increase her lantus because her sliding scale demand in the last 24 hours was 26 units. I suspect that DM is uncontrolled because her steroids and possible infection.

--She also has anemia, but this is stable and can be worked up as outpatient.

d. When patients are admitted, find out the name of their primary physician. The primary will need to be contacted so that they can be made aware that the patient is hospitalized. You should utilize the Electronic Health System to accomplish this so that it is properly documented in the patient's chart. Also, a doctor to doctor conversation with the primary is collegial.

e. Whether you are on service or not: If one of your clinic patients is in the hospital, you must see them daily until their discharge. This is continuity of care.

11. Pediatric Back-up: When the Family Medicine Service is led by a physician who does not have Pediatric privileges; please refer to the night call schedule for the Family Medicine Physician who is on call for the night. This physician will be the Peds Attending for the day. For example, if a pediatric patient is admitted on Tuesday morning; the pediatric attending is the family medicine attending on call Tuesday night. Refer to the FM call schedule.

12. ED Call Cap: The medicine service is a teaching service and Residents are required to see a certain number of patients in the hospital to have a proper educational experience. In an

effort to foster the teaching environment and provide an appropriate volume of patients, the SR-AHEC Medicine Service admits its own patients and may take unassigned patients between noon and 8 PM. It is the attending physician's designation as to the total number of unassigned patients the team will take. The arrangement with Cape Fear Health System is that the resident service may take up to 2 patients per ER call, Monday, Tuesday Wednesday, Thursday and Friday. If the service is of a size that is large enough for teaching, the attending may opt to not take additional unassigned patients onto the service. The SR-AHEC Medicine Service will always admit established SR-AHEC patients to the service as well as Dr. David Parker's patients regardless of the census on the Family Medicine Service.

PGY-I Resident Responsibilities on Medicine Service

1. Complete initial inpatient workup (H&P) and record orders to be reviewed by a senior resident and attending physician.
2. Contact attending physician after completing orders for review and discussion of case.
3. See assigned patients daily before teaching rounds, record progress note addressing the status and management plan for each problem. The note should be complete, legible, and on the chart prior to teaching rounds.
4. Present assigned patients during morning teaching rounds according to guidelines provided.
5. Make note during teaching rounds according to guidelines provided.
6. Following teaching rounds, complete the follow-up care items discussed during rounds for assigned patients (orders, communication with consultants, family, etc) or give appropriate sign out to fellow residents for completing those items.
7. Attend morning report, post teaching rounds report, and afternoon sign-out (unless in assigned clinic) to provide appropriate transfer of patient information and care needs.
8. Read literature about assigned patient (textbook, on-line, journals, etc) and when appropriate, share information with team.
9. Adhere to principles of professionalism at all times (see professional duties expectation policy).
10. Demonstrate teamwork in patient care and educational activities.
11. Attend all noon-time conferences unless formally excused by attending physician for urgent patient care activities.
12. Review lab results, EKG's, Radiology studies, and other tests on assigned patients prior to teaching rounds. Resident should review the radiology studies, not just the reports.
13. Provide teaching to medical students, pharmacy students, and other trainees on service.
14. Notify the attending physician immediately of any new admission to service and of any acute changes in status of assigned patients.

PGY-II Resident Responsibilities on Medicine Service

1. Complete patient work-up (H&P) after 1st year resident has completed evaluation of patient.
2. First year residents should present new patients to the supervising 2nd and 3rd year resident who should then review the orders written by the 1st year resident, provide teaching and correct or amend the orders.

3. When the service is very busy or the 1st year residents have other assigned duties (clinics, behavioral science, EBM) the 2nd year resident will assume primary responsibility for care of assigned patients and may do the initial work-up of new patients.
4. See assigned patients daily, review 1st year progress note, and write a brief note addressing the major problems.
5. Provide appropriate input during teaching rounds when patients are presented by the 1st year residents and be prepared to present assigned patients in case of absence of the 1st year resident.
6. Read about assigned patients (textbook, on-line, journals, etc) and add teaching points during teaching rounds.
7. See consults requested of the SRAHEC service, discuss with attending, write appropriate orders, and record the consult in the chart.
8. Promote teamwork and communication among the medicine team.
9. Select patient for M&M conference and lead the planning of the conference (if no 3rd year resident on service).
10. Promote professionalism by example (see professional duties expectation policy).
11. Attend morning report, post teaching rounds report, and afternoon sign-out (unless assigned to clinic) and assure appropriate transfer of patient information and needs.
12. Provide teaching to medical students, pharmacy students, junior residents, and other trainees assigned to the service.
13. Attend all noon time conferences unless formally excused by attending physician for urgent patient care activities.

PGY-III Resident Responsibilities on Medicine Service

1. Oversee 1st and 2nd year residents.
2. Complete new patient work-up (H&P) after 1st or 2nd year resident has completed evaluation of patient.
3. Junior resident should present patient to senior resident after which senior resident must review orders, correct or amend orders as appropriate, and provide teaching to the junior resident.
4. Provide patient care assignments to junior residents on team.
5. Provide team leadership and promote teamwork and communication among the team.
6. Promote professionalism by example (see professional duties expectation policy).
7. See assigned patients daily, review junior resident progress note, and write a brief progress note addressing the major problems.
8. Provide appropriate input during teaching rounds when patients are presented by junior residents.
9. Provide teaching materials from literature or web sites for team members regarding interesting or complex patients.
10. See consults requested of the SRAHEC service, discuss with attending physician, write appropriate orders, and record consult in chart.
11. When the medicine service is large or the junior residents have other assigned duties (clinic, mandatory conferences), the 3rd year resident will assume primary responsibility for patient care.
12. Attend sign outs and assure appropriate transfer of patient information and needs.
13. Select patient for M&M conference and lead the planning of the conference.

14. Attend noon time conference unless excused by attending physician for urgent patient care activities

Night Float Duties and Responsibilities

The Night Float Rotation will consist of a two person team who are an extension of the medicine team. Each resident will work a fourteen hour 5 day a week shift Mon- Friday. This will not include weekends.

Each week the Night Float team will consist of residents working from 6pm until 8 am the following day (1800-0800) for a total of 56 hours. Every Monday afternoon, both residents will have continuity clinic and then report to the hospital @ 1800 hrs. On Friday mornings, both residents will round with the team at the end of each week.

Residents on Night Float will remain responsible for answering their own messages. At sometime during their shift, each resident will be responsible for answering these messages in a timely manner. The new EMR in the rounding room will offer residents the opportunity to do this depending of course on the amount of floor work. Each resident while on Night Float must also complete 13 hours of Med Challenger. If the night float resident needs help with messages that need to be handled during day time business hours, the NF may contact the clinical nurse manager or practice clinical manager for support

ADMITTING PATIENTS WHILE ON MEDICINE

When a SR-AHEC patient is admitted to the hospital, the attending on service or designee should ensure that the patient's Primary Care Physician is notified. The medicine team should do the notification by personal contact within 24 hours of admission. The patient should have seen their primary physician (resident/faculty) either for health maintenance or management of their chronic medical problems, in order for them to be identified as that physician's established patient. When the patient is either unsure/unable to identify their Primary Physician or cannot be identified as an established patient of a particular physician (resident/faculty), the medicine team will assume care for that patient.

CUMBERLAND COUNTY HEALTH DEPARTMENT CALL COVERAGE

Upper level residents provide after hours coverage on weekdays from 5pm to 8am, weekends and holidays for the Health Department's Carolina Access patients. This call includes telephone, medical triaging, medical advice and consultation. Beyond this, we are not to admit for the Health Department.

The Health Department patients that we take call for in the evening are not established SR-AHEC patients. Should hospital admission be required, they are to be admitted by their covering physicians or designees. The decision and any other advice should be recorded on the form on the next page and then be faxed to the Cumberland County Health Department at 910-433-3659, a copy to be placed in the patient's chart.

By following protocol, the Health Department will be aware of any patients who may have been seen in hospital ED and also limit the number of patients who are just showing up at the Health Department to be seen.

We have a contractual agreement with the Health Department to provide appropriate telephone services. We are able to use these monies to help provide services for you. By following the steps below, we can ensure that the patient, Health Department and SRAHEC are in compliance.

When we received a call from the Health Department patient your job is then to:

1. Triage the calls.
2. Decide if the patient needs to be seen and if decided so if they need to go to the ED, have a next day appointment with the Health Department or to Health Department same day if after midnight.
3. Document all calls and your response (see attached paperwork).
4. Turn the paperwork into SRAHEC box in mailroom in Physician's lounge at the end of your shift. It is required that it be faxed to the Health Department daily at (910) 433-3659.
5. **SRAHEC Business office personnel (Carol Oxendine) will retrieve and fax directly to the Medical Director at the CCHD.**
6. It is expected that you answer all calls professionally and courteously.

Carolina Access Call Reporting Form Cumberland County Health Department

PCP on recipient Medicaid Card: _____

Date and Time of Call: _____

Name of person who visit is requested for: _____

Carolina Access Number: _____

Reason for request to be seen: _____

Place client requests to be seen: _____

Reason stated that client did not go to PCP: _____

Name of physician contacted at SR-AHEC: _____

Client seen and treated by SR-AHEC Physician: _____ Yes _____ No

Treatment Authorized: _____ Yes _____ No

If No, instructions given to client for care and follow-up: _____

FAYETTEVILLE STATE UNIVERSITY

As part of our coverage of student health services, the Director of Student Health may call the answering service to speak with the Upper Level Resident for advice in URGENT situations. No student is to call the service. Only the student health nurse may call after assessing the student and determining that she needs additional advice on how to deal with a student health issue. After hours and weekend care is not part of the contract to these calls should rarely occur.

Please document any call that occurs and the advice provided on the nightly documentation log.

NURSING HOME REQUIREMENTS

Nursing home Residents are required to follow at least two (2) nursing home patients.

Nursing home experience must consist of at least two patients as a continuity experience over a minimum of 24 consecutive months, in addition to that which residents might experience as a part of a rotation.

If you have any questions, please contact **Deana Lilley** Scheduling Services Coordinator at (910) 678-7308.

PROCEDURE POLICY

Residents are required to keep a procedure log for patients cared for in the clinic and in the hospital. A list of the procedures and required numbers are listed on the procedure log. See copy on the next page.

Prior to the procedure, the resident should review the procedure, practice on a model if possible and discuss the procedure with their preceptor. The resident should know the indications and contraindications, equipment, how to consent and educate the patient prior to the procedure, how to prepare the patient for the procedure, the procedure technique, post-procedure care and education, proper documentation, coding and billing.

As the resident matriculates through the program, the supervising physicians will determine if the resident is competent to perform the procedure independently and without supervision.

These logs will be helpful for credentialing purposes upon graduation.

A copy of each month's procedures must be submitted to the residency coordinator by the Friday after the completion of each rotation. The resident will be responsible for keeping their own original logs updated for review by the supervision physicians and their team leader.

Helpful Resources

[Procedures for Primary Care Physicians](#) , Pfenninger and Fowler
[www. Procedure Consult.com](http://www.ProcedureConsult.com)

There are also models in the information access center

OSTEOPATHIC RESIDENT INPATIENT & OUTPATIENT OMM DOCUMENTATION

Osteopathic residents will be required to complete OMM logs for each rotation. They should be maintained daily. They must be signed by the resident and rotation coordinator to verify accuracy of numbers presented. Logs are submitted to the DME on request and shall be reviewed on a monthly basis. Logs will be available for review and chart audit during resident program inspections. Logs are not only a requirement of the training institution and the AOA, but should be accurately maintained for requesting future privileges as well as potential requirements of hospitals or liability insurance carriers to verify areas and levels of training. While DMEs are to maintain logs for three years, it is recommended that residents maintain copies of logs for their personal records. (Copies are not kept by the AOA). Logs will consist of name of service and dates, case participation, special procedures. The DME will provide each resident with the required forms. Please see the FMC curriculum manual for further information on documentation of experiences.

OMT Lectures for Osteopathic Residents

All osteopathic residents are required to attend the OMT lectures given on the third Tuesday of every month from 8:00-11:00 AM. You are excused from your rotation obligations to attend these mandatory OMT lectures are expected to return to your required rotation/responsibility as soon as lecture concludes. Please remind your preceptor that you are required to attend these sessions.

In an effort to ensure collegiality and fairness, if you are on the Medicine Service and you need to attend the OMT lecture, please be sure to see at least 2-3 of your patients on the service **PRIOR** to attending the OMT session at 8:00 am. In order to accomplish this you may need to come in at 6:30 AM, which should not infringe on your duty hours. Before you leave the service to attend the OMT session, please be sure to discuss your patients with the Upper Level. Additionally, if the OMT session ends by 10:30, you should have ample time to return to Medicine Rounds.

NIGHTLY DOCUMENTATION LOGS

Residents will fill out a Nightly Documentation Log. Documentation of ER visits, CCHD calls, Minor Treatment Center visits and authorizations will occur on a nightly log that the residents will have responsibility for completing and turning in nightly. Faculty will review and the on-call faculty supervising the residents will sign off.

- On-call resident completes nightly log documenting all visits not admitted, procedures, patient authorizations by phone
- Face sheets should be copied, if available and turned in the next day
- Faculty member on call must sign off prior to posting charges.

ACADEMIC ADVANCEMENT CRITERIA

I. Promotion Criteria for PGY-I

a. Science of Medicine Criteria

1. Satisfactory completion – defined as an overall grade of 3 or higher – of each first year rotation evaluation and faculty quarterly reviews
2. Passing grade on USMLE STEP 3 or equivalent exam(COMLEX), if not previously passed.
3. Meet all criteria to apply for a medical license as defined by the State of North Carolina (if applicable)
4. Satisfactory completion of Med Challenger requirement.

b. Art of Medicine Criteria

1. Demonstrate ethical/professional behavior
2. Medical Records, both inpatient and outpatient, must be completed in a timely fashion
3. Demonstrate the ability to work with all members of the healthcare team and present good interpersonal skills with patients and staff
4. Demonstrate the ability to supervise and teach other healthcare members
5. Ability to independently evaluate patients, make differential diagnosis and formulate a treatment plan with attending consultation
6. Supervise a panel of patients with appropriate care as determined by the faculty
7. Participate by receiving constructive feedback
8. Comply with policies in the Policy and Procedure Manual

II. Promotion Criteria for PGY-2

a. Science of Medicine Criteria

1. Satisfactory completion, is defined as an overall grade of 3 or higher, on each second year rotation evaluation and faculty quarterly reviews
2. Successfully complete Rad-Challenger: Acute Care Radiology Series
3. Satisfactory completion of Med Challenger requirement

b. Art Medicine Criteria

1. Demonstrate ethical/professional behavior
2. Medical Records, both inpatient and outpatient, must be completed in a timely fashion (refer to the specific guidelines/expectations for further information)
3. Demonstrate the ability to work with all members of the healthcare team and present good interpersonal skills with patients and staff
4. Supervision of junior residents and other learners in inpatient teams, in FMC, and teaching on rounds as evidenced by feedback from faculty and peers.
5. Ability to independently evaluate a patient, make a diagnosis and formulate a treatment plan
6. Continue to maintain and supervise a panel of family practice patients with appropriate care as determined by faculty

7. Participate by receiving constructive feedback
8. Comply with policies in the Policy and Procedure Manual

III. Promotion Criteria for PGY-3

a. Science of Medicine Criteria

1. Satisfactory completion defined as an overall grade of 3 or higher – on each third year rotation as evidenced by rotation evaluations and faculty quarterly reviews
2. Obtain permanent license in State of North Carolina, if applicable.
3. 5 home visits must be completed prior to the completion of your residency; one must be a geriatric patient and one must be from your continuity panel.
4. You must see at least two nursing home patients over the last 24 months of residency following a longitudinal fashion.
5. Satisfactory completion of Med Challenger requirement

b. Art of Medicine Criteria

1. Demonstrate ethical/professional behavior
2. Medical Records, both inpatient and outpatient, must be completed in a timely fashion (refer to the specific guidelines/expectations of CFVHS and SR-AHEC for further information)
3. Demonstrate the ability to work with all members of the healthcare team and present good interpersonal skills with patients and staff
4. Supervision of junior residents and other learners in inpatient teams, in FMC, and teaching on rounds as evidenced by feedback from faculty and peers
5. Ability to independently evaluate patients, make appropriate diagnoses and formulate an appropriate treatment plan
6. Participate in assigning panel of family practice patients to a new resident at the end of the year
7. Participate by receiving constructive feedback
8. Comply with policies in Policy and Procedure Manual
9. Check out per policy at the end of the year

The criteria listed above have been adapted from Academic Advancement Criteria for Mercy/Mayo Family Practice Residency Program, Des Moines Iowa, written by Charles Korte M.D.

Rev 4/15/10

Advancement Criteria Checklist

Criteria	Measurement Tool	PGY-1	PGY-2	PGY-3
Professionalism				
1 Complete inpatient and outpatient charts in a timely manner	Clinic administrator report: Pam Frost report			
2 Arrange to take USMLE or COMLEX 3 by December of PGY1 year	Coordinator report			
3 Be at assignments on time.	Rotation evaluations			
4 Satisfactory and timely completion of clinical assignments including community medicine projects and practice management projects	Rotation evaluations			
5 Satisfactory and timely completion of administrative assignments including duty hours, procedure logs and evaluations	Coordinator report			
6 Display appropriate integrity, compassion, and respect for patients, colleagues and staff.	Periodic evaluation			
7 Support Group attendance at least ten per year	report of attendance			
8 All rotation scores for this competency at least 3 out of 5	Rotation evaluation			
P Individualized written action plan and completed assignment for each item not completed.				
Medical Knowledge				
1 In training exam Score				
PGY-1 Minimum overall score higher than the 20% ile compared with PGY-1 scores	ABFM In training Exam			
PGY-2 Minimum overall score higher than the 20% ile compared with PGY-2 scores	ABFM In training Exam			
PGY-3 Minimum overall score 390 or higher (> 20%ile, at least 50% chance of passing boards)	ABFM In training Exam			
M Complete and document remediation plan for a score of less than 20th percentile overall.	AAFP Monograph Questions			
2 Conference attendance				
PGY-1 above 70% and 100% Journal Club attendance	Conference attendance			
PGY-2 above 70% and 100% Journal Club attendance	Conference attendance			
PGY-3 above 70% and 100% Journal Club attendance	Conference attendance			
3 Complete forty hours of Rad Challenger				
4 Complete thirteen hours of Med Challenger per year				

5	Attain a score \geq 80% on Exam Master Exam given during rotations	Rotation evaluation			
6	Pass USMLE or COMLEX Step 3.	Step 3 score			
7	All rotation scores for this competency at least 3 of 5.	Rotation evaluation			
M	Individualized written action plan and completed assignment for each item not completed. CME credit hours may be added to conference attendance hours.				
Patient Care					
1	Continuity Family Practice Numbers > or = 150 patient visits > or = 500 patient visits this academic year and > or = 650 total > or = to 1650 patient visits in FMC all three years combined	Resident productivity report Resident productivity report Resident productivity report			
PC	Additional patient care sessions scheduled until goal is met. Elective rotations will require FMC clinic time if not at or above goals.				
2	Family Practice Efficiency See 6 patient in a half day (3 and 1/2 hour) session not being behind by more than 30 minutes at least 50% of the time. See 8 patient in a half day (3 and 1/2 hour) session not being behind by more than 30 minutes at least 50% of the time. See 10 patient in a half day (3 and 1/2 hour) session not being behind by more than 30 minutes at least 50% of the time.	Nurse report/ Preceptor Observation Nurse report/ Preceptor Observation Nurse report/ Preceptor Observation			
PC	Individualized written action plan and goal met during at least two consecutive clinic half day sessions.				
3	Emergency Review Course Completion and recertification Advance Cardiac Life Support Pediatric Advanced Life Support Advanced Life Support in Obstetrics	Copy of completion certificate Copy of completion certificate Copy of completion certificate			
4	Inpatient abilities Competent to take night float call independently Competent to manage inpatient service with the assistance of the team. Competent to manage and direct the family medicine service team independently.	Periodic evaluation Periodic evaluation Periodic evaluation			
5	Ability to perform required procedures.	Procedural competencies			
6	All rotation scores for this competency at least 3 of 5.	Rotation evaluation			
PC	Individualized written action plan and completed assignment for each item not completed.				

Interpersonal Skills and Communication

1	Work effectively with others as a member of a health care team.	Rotation evaluation Periodic evaluation			
2	Display appropriate interpersonal skills with attendings, colleagues and staff.	Rotation evaluation Periodic evaluation			
3	Create and sustain a therapeutic and ethically sound relationship with patients.	Patient satisfaction surveys Periodic evaluations Rotation evaluations			
4	Handle conflict effectively and demonstrate conflict resolution skills.	Rotation evaluation Periodic evaluation			
5	Work effectively with others as leader of a health care team.	Clinic administrator report Rotation evaluations Periodic evaluations			
6	All rotation scores for this competency at least 3 of 5.	Rotation evaluation			
1	Individualized written action plan and completed assignment for each item not completed.				

Practice Based Learning and Improvement

1	Chart reviews	Coordinated with Case Manager			
	One Adult health maintenance	Chart review form			
	One Child health maintenance	Chart review form			
	One Female Adult health maintenance over 65	Chart review form			
	One Male Adult health maintenance over 65	Chart review form			
	One Diabetic	Chart review form			
	One Other Chronic Disease	Chart review form			
	OB Audit (at least one each year)				
2	Practice Based Learning assignments with presentations.				
	M&M presentation	Conference evaluation			
	Grand Rounds presentation	Conference evaluation			
	Journal Club presentation	Conference evaluation			
	Journal Club participation	Conference evaluation			
3	Active participate in practice quality improvement projects.	Clinic administrator report			
4	Research and Scholarly activities (see number 2 above AND)				
	Complete EBM course	Completion certificate			
	Complete Research Project	Evaluation			
		Optional (for outstanding)			
5	All rotation scores for this competency at least 3 of 5.	Rotation evaluation			
PI	Individualized written action plan and completed assignment for each item not completed.				

Systems Based Practice

- 1 Participate in community medicine activities.
- 2 Provide and document two home visits per year. Resident productivity report
- 3 Care for at least 2 nursing home patients per year. Resident productivity report
- 9 All rotation scores for this competency at least 3 of 5. Rotation evaluation
- S Individualized written action plan and completed assignment for each item not completed.

Osteopathic

- 1 Take and pass Osteopathic ITE ITE scores
- 2 Document OMT procedures done in FMC Log
- 3
- 4

EDUCATIONAL SCHEDULE

During the term of the residency, the resident’s professional responsibilities, specific hours of duty and educational schedule will be determined by the residency director and/or the residency director’s designee after consultation with the resident. The programs will make every effort to provide reasonable call schedules and off-duty hours.

S R - A H E C C u r r i c u l u m

F i r s t Y e a r (13 x 4 week blocks)		S e c o n d Y e a r (13 x 4 week blocks)		T h i r d Y e a r (13 x 4 week blocks)	
Family Medicine Inpatient Service (4 x 4 weeks) ½ DAY CLINIC PER WEEK	1-2 Half-Days of Family Medicine Continuity Clinic per week	Family Medicine Inpatient Service (2 x 4 weeks) ½ DAY TWICE A WEEK PM	3-4 Half-Days of Family Medicine Continuity Clinic per week	Elective (3 x 4 weeks) 2 FULL DAYS OR 4 - ½ DAYS PER WEEK	4-5 Half-Days of Family Medicine Continuity Clinic per week
Obstetrics (2 x 4 weeks) ½ DAY CLINIC PER WEEK		Elective (2 x 4 weeks) 2 FULL DAYS PER WEEK		FMC SUB SEP (1x4 weeks) 4 FULL DAYS PER WEEK	
Night Float (1 x 4 weeks) 1 FULL DAY ON MONDAY		Pediatrics (2 x 4 weeks) ½ DAY TWICE A WEEK		Family Medicine Inpatient Service (2 x 4 weeks) ½ DAY TWICE A WEEK	
Surgery (1 x 4 weeks) ½ DAY CLINIC PER WEEK		Intensive Care Unit (1 x 4 weeks) 2 FULL DAYS PER WEEK		Night Float (1 x 4 weeks) 1 FULL DAY ON MONDAY	
Elective (1 x 4 weeks) 1 FULL DAY PER WEEK		Emergency Medicine (1 x 4 weeks) 2 FULL DAYS PER WEEK		Gynecology (1 x 4 weeks) 2 FULL DAYS -THUR & FRI PM ONLY	
Emergency Medicine (1 x 4 weeks) 2 FULL DAYS PER WEEK		Sports Medicine/ Behavioral Science (1 x 4 weeks) ½ DAY FOUR TIMES A WEEK		Orthopedics (1 x 4 weeks) 2 FULL DAYS PER WEEK	
Community Medicine (1 x 4 weeks) 2 FULL DAYS PER WEEK		Practice Management/ Behavioral Science (1 x 4 weeks) ½ DAY FIVE TIMES A WEEK		Pediatrics (1 x 4 weeks) 5 HALF DAYS WEEK PM ONLY	
Inpatient Pediatrics (2 x 4 weeks) ½ DAY CLINIC PER WEEK		Obstetrics/Gynecology (1 x 4 weeks) 1 FULL DAY FRIDAY		Urology (1 x 4 weeks) 2 FULL DAYS PER WEEK	
		Night Float (1 x 4 weeks) 1 FULL DAY ON MONDAY		Pediatric Emergency Medicine (1 x 4 weeks) 5 HALF DAYS PER WEEK OR 2 ½ FULL DAYS PER WEEK	
	Surgery (1 x 4 weeks) 2 FULL DAYS PER WEEK	ENT/Ophthalmology (1 x 4 weeks) 3 HALF DAYS PER WEEK			

The following are taught in a longitudinal fashion over the entire three years:

- (1) Evidence-Based Medicine/Performance Improvement,
- (2) Behavioral Science (including: Resident Well-Being & The Impaired Physician),
- (3) Pharmacotherapeutics,
- (4) Osteopathic Principles & Practice, and
- (5) Geriatrics

To meet the program objectives outlined in the section above and to comply with AOA/ACOFP/ACGME guidelines for optimal residency training the following curriculum was developed.

FIRST YEAR CURRICULUM OVERVIEW

ROTATIONS 4-WEEK BLOCKS	EXPECTATIONS
Family Medicine 4 – 4 week blocks	Inpatient training on Southern Regional AHEC Family Medicine Teaching Ward. Admit patients of Southern Regional AHEC Family Medicine Center & of selected Internists, Family Physicians. Daily Teaching Rounds. Supervision by senior family medicine residents. Southern Regional AHEC faculty and community private physicians. Internal Medicine run by Southern Regional AHEC with interns, two upper level residents and Southern Regional AHEC attending faculty. Maximum two rotations consecutively. DO's to have Internal Medicine Staff
Pediatrics <i>2-4 week blocks</i>	Inpatient experience associated with private pediatric practices. General and intensive care nursery experience. Admit private pediatrician's patients to hospital.
OB/GYN <i>2-4 week blocks</i>	Deliveries will include both private and clinic patients. Daily Obstetrics & Gynecology clinics. Management of OB/GYN emergency admissions.
Surgery 1-4 week block	Work with private surgeon. Assist with admitting surgeon's patients to hospital. First assist in surgery. Attend office for outpatient surgery, follow-ups, and pre-hospital evaluation.
Emergency Medicine 1-4 week block	Combine all phases of ER work. Supervision by full-time ER physician on a one-to-one basis.
Night Float 1-4 week block	
Community Medicine/ Computers <i>1-4 week block</i>	Introduction to community resources, occupational medicine and social health topics. Home visit curriculum begins during PGY-1 and continues throughout the remaining two years. One week of one on one computer education. Suggested time for vacation.
Elective <i>1-4 week block</i>	
Emergency Medicine 1-4 week block	Combine all phases of ER work. Supervision by full-time ER physician on a one-to-one basis.

Family Medicine Center – 1-2 half days per week*

NOTES:

One half day per week will concentrate on issues related to an integrated approach to Family Medicine. Particular attention is paid to the physician-patient relationship, interviewing skills and resident personal development. Close multi-specialty perception, videotape review and discussions are provided for first year residents as a group.

At least 24 hours per year will be set aside for concentrated hands-on Didactic training in OMM/Osteopathic Philosophy throughout the Residency.

In addition, Community Medicine is emphasized and includes visits with various agencies and health care related institutions.

First year residents are required to do 1-2 half-days of Family Medicine Continuity Clinic per week. The day of the week should be the same for continuity purposes.

Patient load should be at least 6 patients per half-day.

****You must have 5 home visits completed prior to the completion of your residency; one must be a geriatric patient and one must be from your continuity panel. These visits can be done at any point in your three years with the program. These visits are coordinated through the Clinic Scheduling Services Coordinator.****

****You must have 40 Obstetric deliveries, 10 of which must be continuity patient prior to completion of your residency. Two of your continuity patients must be in house(SR-AHEC)**

SECOND YEAR CURRICULUM OVERVIEW

	ROTATION	EXPECTATIONS
Family Medicine Center – 3 - 4 half days per week*	Family Medicine <i>2-4 week blocks</i>	INTERNAL MEDICINE (8 weeks) Work as supervisory resident on Family Medicine Teaching Ward.
	Sports Medicine/OMM <i>1-4 week block</i>	SPORTS MEDICINE /OMM and Osteopathic Philosophy(4 weeks) Outpatient clinical experience in the Family Medicine Center with in-depth instruction in Sports Medicine. Instruction on OMM and Osteopathic Philosophy (see OMM Goal and Objectives)
	Pediatrics <i>2-4 week blocks</i>	Inpatient PEDs for 4 weeks as in first year. Ambulatory experience at local Health Department or Pediatric subspecialty clinic and Neonatal ICU experience.
	OB/GYN <i>1-4 week block</i>	Same as first year requirements.
	Behavioral Science/Practice Management /OMM <i>1-4 week block</i>	BEHAVIORAL SCIENCE/Practice Mgmt and OMM (4 weeks longitudinal) Instruction on OMM and Osteopathic Philosophy (see OMM Goal and Objectives) PRACTICE MANAGEMENT/COMPUTERS (4 weeks) Hands on computer experience and practical practice management training. Staff Behavioral Science consultation service with faculty supervision. Supervised in-depth involvement with selected patients. Interview skills development. Interaction with community services and resources.
	Surgery 1 month <i>1-4 week block</i>	Spent with local surgeon in office and hospital.
	Emergency Room (ED) <i>1-4 week block</i>	Taking direct call in the ED and at Cape Fear Valley Medical Center. Hospital and emergency room coverage.
	Electives <i>2-4 week blocks</i>	ELECTIVES
ICU <i>1-4 week block</i> ----- <i>Night Float</i> <i>1-4 week block</i>	Must document at least 15 patients while on ICU.	

NOTES:

Second and third year residents are required to have at least 312 half-day sessions in clinic over the last 24 months of their residency.

Second year resident will average 3-4 half-days of Family Medicine Continuity Clinic each week.

Second year residents are required to see a minimum of at least 8 patients per half-day in clinic.

Second year residents are required to complete RAD-Challenger on-line radiology course.

****You must have 5 home visits completed prior to the completion of your residency; one must be a geriatric patient and one must be from your continuity panel. These visits can be done at any point in your three years with the program. These visits are coordinated through the Clinic Scheduling Services Coordinator.****

THIRD YEAR CURRICULUM OVERVIEW

ROTATION	EXPECTATIONS
Family Medicine <i>2-4 week blocks</i>	Work as supervisory resident on Inpatient Teaching Ward.
Pediatrics <i>1-4 week block</i>	Inpatient as described in 1st year.
Orthopedics <i>1-4 week block</i>	Spent with local orthopedic physicians in their office, hospital, and emergency department.
Urology <i>1-4 week block</i>	Work with local Urologist in office and hospital
ENT and Ophthalmology <i>1-4 week block</i>	ENT (<i>2 weeks</i>)/ OPHTHALMOLOGY (<i>2 weeks</i>) Time with local Otolaryngologists and ophthalmologists in office, hospital and emergency room
GYN/GYN Surgery <i>1-4 week block</i>	Time concentration on GYN and outpatient procedures. May work closely with the new fellowship in Women's Health starting JUL06.
Peds ER <i>1-4 week block</i>	Emergency Medicine: Combines all phases of ER work concentrate PEDS ER. Supervision by full-time ER physician on a one-to-one basis
Medicine Selective/FMC <i>1-4 week block</i>	Residents will do a month of medicine sub-speciality in the Family Medicine Clinic.
Electives <i>3- 4 week blocks</i>	In addition to further rotations in any of the above specialties rotations may be selected from the specialties listed below or of the residents choosing: Gastroenterology, Geriatrics, Allergy, Nephrology, Rehabilitative Medicine, Anesthesiology, Neurosurgery, Elective Obstetrics, Pulmonology, Computer Skills, Self-designed electives.
----- <i>Night Float</i> <i>1-4 week block</i>	

Family Medicine Center – 3 - 4 half days per week*

NOTES:

Second and third year residents are required to have at least 312 half-day sessions in clinic over the last 24 months of their residency.

Third year resident will average 4-5 half-days of Family Medicine Continuity Clinic per week.

Third year residents are required to see a minimum of at least 10 patients per half-day in clinic.

****You must have 5 home visits completed prior to the completion of your residency; one must be a geriatric patient and one must be from your continuity panel. These visits can be done at any point in your three years with the program. These visits are coordinated through the Clinic Scheduling Services Coordinator.****

REQUIREMENTS CHECKLIST:

FIRST YEAR	SECOND YEAR	THIRD YEAR
Family Medicine (<i>4-4 week blocks</i>) <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Family Medicine (<i>2 -4 week blocks</i>) <input type="checkbox"/> _____ <input type="checkbox"/> _____	Family Medicine (<i>2-4week blocks</i>) <input type="checkbox"/> _____ <input type="checkbox"/> _____
Pediatrics (<i>2-4 week blocks</i>) <input type="checkbox"/> _____ <input type="checkbox"/> _____	Pediatrics (<i>2-4 week blocks</i>) <input type="checkbox"/> _____ <input type="checkbox"/> _____	Pediatrics (<i>1-4 week blocks</i>) <input type="checkbox"/> _____
OB/GYN (<i>2-4 week blocks</i>) <input type="checkbox"/> _____ <input type="checkbox"/> _____	OB Gynecology (<i>1-4 week blocks</i>) <input type="checkbox"/> _____ <input type="checkbox"/> _____	GYN / GYN Surgery (<i>1- 4 week block</i>) <input type="checkbox"/> _____
Surgery (<i>1-4 week block</i>)	Surgery (<i>1-4 week block</i>) <input type="checkbox"/> _____	Orthopedics (<i>1-4 week</i>) <input type="checkbox"/> _____
ER (<i>1-4 week block</i>) <input type="checkbox"/> _____	ER (<i>1 Month</i>) <input type="checkbox"/> _____	Pediatric ER (<i>1 block</i>) <input type="checkbox"/> _____
Elective (<i>1-4 week block</i>) <input type="checkbox"/> _____	Electives (<i>2-4 week block</i>) <input type="checkbox"/> _____ <input type="checkbox"/> _____	Electives (<i>3-4 week block</i>) <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
Community Med / Vacation (<i>1-4 week block</i>) <input type="checkbox"/> _____	ICU (<i>1- 4 week block</i>) <input type="checkbox"/> _____	ENT/Ophthalmology (<i>1 -4 week block</i>) <input type="checkbox"/> _____
Night Float (<i>1-4 week block</i>) <input type="checkbox"/> _____	Sports Medicine(<i>1-4 week block</i>) <input type="checkbox"/> _____	Urology (<i>1-4 week block</i>) <input type="checkbox"/> _____
	Behavioral Science & Practice Management (<i>1-4 week block</i>) <input type="checkbox"/> _____	Medicine Selective/FMC (<i>1-4 week block</i>) <input type="checkbox"/> _____
	Night Float (<i>1-4 week block</i>) <input type="checkbox"/> _____	Night Float (<i>1-4 week block</i>) <input type="checkbox"/> _____

- LONGITUDIAL: Behavioral Science
 - Sports Medicine/Family Medicine; Practice Management
- DO's will have three rotations over the three years in the Emergency Department (PEDs ED, and ED)
- You must have a minimum of 10hours off between duty periods for rest.
- Research project is required by the end of the 3rd year.

- Geriatrics: longitudinal instruction
- ****You must have 5 home visits completed prior to the completion of your residency; one must be a geriatric patient and one must be from your continuity panel. These visits can be done at any point in your three years with the program. These visits are coordinated through the Clinic Scheduling Services Manager.****
- NOTE: Second year residents are required to complete the Rad Challenger on-line radiology course.

ELECTIVE ROTATIONS

Residents are to notify the Residency Coordinator and submit their elective request forms at least 90 days prior to the elective rotation indicating where they have elected to work. If no arrangements have been made 90 days prior to the rotation, the coordinator will inform the Program Director, who will then assign the resident to pediatrics, medicine or OB/GYN.

AWAY ELECTIVE ROTATIONS

Second and third year residents may choose to do away electives. The number of away electives is limited to two rotations. These rotations may occur one (1) in the second year and one (1) in the third year. Each away elective must be approved by the Director and the FMGMEC, and must include clear Goals and Objectives and an appropriate, identified supervisor who is willing to complete an evaluation of the rotation and the resident. The supervisor must be Board Certified and provide curriculum vitae to SR-AHEC. The resident must show proof of malpractice coverage during away rotations. The resident must be able to clearly defend their reason to pursue such an elective rotation. An away elective rotation must meet the same academic standards as any other program elective rotation. If a resident does an away rotation, they are required to use one of their remaining electives as a clinic month in order to maintain their patient volume.

The two away rotations cannot be contiguous and there must be at least two months between each time away from the residency in order to provide continuity of care to the resident's patients. Due to staffing issues, no away electives will be approved during the month of December. Each resident's request for time away for an elective rotation will be considered on an individual basis. Only one resident may take an away elective at a time.

Residents going on international rotations are required to present grand rounds on a topic pertinent to the resident's experience while away. This is in addition to the resident standard grand rounds requirement. Please note that the trainee must provide proof of malpractice coverage during the away rotation if it is outside of the state of North Carolina.

INTERN DUTIES & RESPONSIBILITIES WITHIN THE FAMILY MEDICINE CENTER

The Family Medicine Center has been especially designed to approximate a typical group practice as much as possible, both in appearance and function. The resident is deliberately exposed to a variety of patients, conditions and ages. A team system is designed to make a small group practice out of a large one.

The Family Medicine Center is geared toward both resident education and patient care at the same time. Faculty preceptors are available for resident support and supervision.

Every staff member of the Family Medicine Center is responsible for the various functions necessary to maintain any medical practice but each in his own way is involved in the teaching of the residents. All residents are expected to become acquainted with the staff of the center and of the residency program and to come to understand their functions within the system.

Teaching of patient care techniques within the Family Medicine Center is primarily accomplished by the resident attending his own patient panel with a full or part time faculty member available at all time within the building for a consultation and discussion. It is expected that all patients seen by first year residents will be discussed with the faculty member precepting whereas second year residents will discuss all new and problem patients. Third year residents will discuss all problem patients. The charts for residents will be reviewed regularly by the faculty members. **All Medicare patients must be precepted.** Any resident scoring less than 20th percentile on the in-training exam must precept all patients. Residents must precept all referrals (including specialists, x-ray procedures, physical therapy, etc.) and all procedures. If you are required to precept and you do not do so, this can put the program at medico-legal risk. Failure to precept when required can lead to probation, suspension, or even termination.

On occasion the resident's examination of a patient will be monitored with the video tape equipment available in one of the examination consultation areas of the Family Medicine Center. These recordings can be taped to play back and critiqued by fellow residents and/or faculty members.

Outpatient clinical skills are not the exclusive subject matter within the curriculum. Equally important to the resident if he plans to open an outside practice is a group of skills that is only partly medical. The effective use of the telephone, prescription writing, patient compliance education, use of consultations and referrals utilization of community resources for patient benefit, sensitivity to social medical care issues; these are only a few of the considerations that a good family physician must deal with on a daily basis. The education of a good family physician cannot be considered complete if these aspects are neglected.

Practice Management is another area for learning. All residents will be thoroughly grounded in the business aspects of family practice through direct experience in the Family Medicine Center supplemented by lectures and workshops.

The experience in the Family Medicine Center is also intended to supplement the lectures and workshops designed to teach practice management. A residency cannot exactly simulate a private practice but attention to billing, practice cost, and insurance concerns are practice management issues experienced in the FMC.

TEAM LEADER’S RESPONSIBILITY

The Team Leader is a Family Practice faculty member who is assigned to each resident for their entire residency.

The Team Leader meets these broad objectives:

1. Enables residents to attain their professional goals through a series of regularly scheduled one-on-one faculty-resident meeting which involves monitoring and supporting the professional growth and development of the residents.
2. Monitors the residents’ growth within the residency and addresses areas of strengths and areas needing improvement. It is the team leader’s responsibility to provide feedback to the residents regarding their educational progress.
3. Furnishes the faculty with needed information to further support the residents’ growth and development in the program and to obtain faculty feedback regarding the residents’ performance to guide the educational process.
4. Supports individual education or remediation interests of residents.
5. Be a source of reference and contact regarding residency policy, procedure, or other needed information to the residents.

RESIDENT TEAM ASSIGNMENTS

Dr. Lenny Salzberg	Team Leader		
Cresencio Duran, D.O.	PGY-3		
Jedyln Pierrilus, M.D.	PGY-3		
Shervon Pierre, M.D.	PGY-2		
Cecilia Nashatizadeh, M.D.	PGY-2		
Ekkarat “Eddie” Akragorn, M.D.	PGY-1		
Mitul Butala, M.D.	PGY-1		
Stepahnie Reese, D.O.	PGY-1		
Charanjit “Raja” Virk, M.D.	PGY-1		

Green Section Faculty Advisors and Residents			
Dr. James Mergy	Team Leader	Dr. Sushma Kapoor	Team Leader
Robert Alcott, M.D. (Chief Resident)	PGY-3	Edwin Houng, M.D.	PGY-3
Jason Gosnell, D.O.	PGY-2	Harkiran Grewal, M.D.	PGY-2
Reem Alkadhi, M.D. (Junior Chief Resident)	PGY-2	Rebekah Hughey, M.D.	PGY-2
Donald Grant Duild, M.D.	PGY-2	Leann Rettell, D.O.	PGY-2
Rebekah Sprouse, M.D.	PGY-2	Nella Gasteazoro-McCraw, M.D.	PGY-1
Philippe Bulaitan, M.D.	PGY-1	Rishita Patel, M.D.	PGY-1
Jonathan McCraw, M.D.	PGY-1	Syed Asad Shah, M.D.	PGY-1
Ashany Sriskandarajah, M.D.	PGY-1		

PRECEPTING MEDICARE PATIENTS

All Medicare patients must be precepted prior to their leaving FMC. The preceptor must document the visit in the medical record. The Medicare preceptor would be selected as the authorizing physician for all charge orders for the precepted Medicare patient. During the first six months of the academic year, all Medicare patients seen by PGY-1 residents must be precepted with the preceptor physically in the exam room during the entire visit. Documentation that this happened must occur. Failure to comply with this is a violation of Federal Regulations and can cause financial penalties to the FMC and or cause us to no longer be able care for this group of patients. There are no exceptions to this.

When there are two preceptors, residents will be assigned to one preceptor and must precept all Medicare patients with their assigned preceptor.

PRECEPTING OB PATIENTS

Residents are required to precept all OB patient visits and follow Cape Fear Valley OB affiliation guidelines (see policy).

FAMILY MEDICINE CENTER PATIENT FLOW

When the patient arrives at the Family Medicine Center (FMC) for their appointment they report to the receptionist desk and will be asked to make their co-payment and any outstanding balances. Please note: We have contracts with insurance companies that require these payments upfront. The patient will be checked in on the schedule and then sent to the FMC hallway.

As the patient progresses through the FMC, information is added to the charge order screen by the physician, such as diagnosis, procedures and charges. A list of procedure codes and diagnosis codes can be found at each nurse's station. The authorizing physician for all charge orders will be the medical team leader except when you have a Medicare patient. In this care, the authorizing provider will be the Medicare preceptor.

When patient's visit is completed, all charge orders must be signed for the receptionist to complete the final processing. If the patient did not pay upon arrival the patient is expected to pay at this time. The receptionist will enter all information regarding charge (CPT) codes, diagnosis codes and payment amounts into the computer.

The charge orders must be properly completed by physician. This information is used for billing purposes and will be available in the computer for completing monthly reports which will give the patient profiles for each physician. This information is stored for future research and documentation.

COLLECTIONS

It is SR-AHEC's intention to establish and maintain a high percentage of collections. Our patients initiate an unwritten contract when he/she calls on us for professional service. They expect us to give our full attention to his/her problem and provide proper diagnosis and treatment. They expect us to be competent and trained, and expect us to have the proper equipment and supplies. They also expect to pay for these professional services.

We expect of the patients the same courtesy and awareness of responsibility. They realize there will be a fee for professional services and expect an opportunity to pay these fees in an efficient and dignified manner. It is important that patients understand the charges and particularly which charges will or will not be taken care of by insurance. It is much more convenient and less costly to Southern Regional AHEC if the patient pays the bill at the time of service. It is very time-consuming and costly for the business office and particularly collections to follow-up on unpaid visits. As a general rule, we do not accept self-pay patients unless an immediate family member is already an established patient. However, faculty may make exceptions at their discretion for educational purposes.

Patients are entitled to know what to expect and should be forewarned when they are sent for X-ray or laboratory tests. They are buying medical care and should be told what will be expected of them. Each physician has ready access to a fee schedule and should use same. Frequently problems can be avoided in this way and the patient can discuss ability (or lack of ability) to pay.

If the physician feels the patient should be seen here as a "teaching case" or some other particular reason, the provider should discuss with team leader and patient should be advised to talk with our Clinical Business Office Manager, who will evaluate patients ability to pay. He/She will then discuss this with the CEAS Vice President and together the decision will be made as to the discount the patient will be given.

It is much better for the physician to be aware of the patient's status before the patient is overburdened financially by fees for medical care. If the patient does not qualify for a "discount" and doesn't make arrangements to pay the fees within a reasonable time, the bill will be turned over to an outside collection agency. This can ruin a patient's credit rating. All of this can be avoided if the proper information is obtained from a patient.

INSURANCE

We participate in a large number of insurance plans as preferred providers or as primary care providers. In addition, we accept most commercial insurances. Many patients will tell the receptionist, "My insurance company will take care of my entire bill". It is important that you, the physician, be able to explain your role and that of the patient and his/her insurance company. The unwritten contract for medical care is between the physician and the patient. It is the responsibility of the patient to see that the bill is paid. Many people take for granted that insurance is payment of medical expenses. As a courtesy to our patients, we do file insurance for them. However, patients are responsible for co-payments, deductibles and non-covered services.

Prior approval must be obtained for Medicaid patients before payment can be received for dental work, cosmetic surgery or the third visit to a psychologist or medical social worker.

APPOINTMENTS IN THE FAMILY MEDICINE CENTER

Patients in the Family Medicine Center are scheduled to from 8:00AM to 11:30AM and from 1:30PM to 4:30PM.

There is a recommended limit of two new patients per resident in any half-day session but it may be exceeded on an infrequent emergency basis. Effective Residency Year 2011/2012 all faculty and residents will have 20 minute templates

Resident's time intervals will be:

- PGY-1
 - New patient: 20 minutes appt w/20 minutes buffer
 - Follow-up visit: 20 minutes appt w/20 minutes buffer
 - Sick visit: 20 minutes appt w/20 minutes buffer

- PGY-2
 - New OB patient: 40 minutes appt

- Subsequent OB visit: 20 minutes
 - New patient: 20 minutes appt w/15 minute buffer
 - Pediatric physical (not new)20 minutes
 - Follow-up visit: 20 minutes
 - Sick visit: 20 minutes
- PGY-3
 - New OB patient: 40 minutes appt
 - Subsequent OB visit: 20 minutes
 - New patient: 20 minutes appt w/10 minute buffer
 - Pediatric physical (not new)20 minutes
 - Follow-up visit: 20 minutes
 - Sick visit: 20 minutes

Residents may request additional time with specific patients.

NEW PATIENTS

New patients are instructed to arrive twenty minutes prior to their scheduled appointment time to fill out their necessary paperwork (demographic, financial, HIPPA & prescriptions). All new patients are sent in the mail a copy of the Family Medicine Center packet.

Any new patient who is a "no show x 3" cannot make a new appointment at a later date. All members of a family may be assigned to the same resident for continuity of care. Any new patient calling to be seen for a severe acute problem will be referred to the triage nurse for disposition.

NEW PATIENTS – PEDIATRICS

Parents of new pediatric patients should be encouraged to bring the child's immunization records.

LATE PATIENTS and DOC OF THE DAY

Ideally patients will arrive on time. Providers will make every effort to see every patient scheduled. There is no golden rule or grace period on what "late" is. If a patient shows up late for their appointment and it will further delay the provider's clinic the preceptor/DOD or Clinical Practice Manager will assist with getting the patient seen. The following options will be offered to the patient:

- Patient can wait and see scheduled provider as a work-in
- Patient can schedule a later appointment time that day if the provider has one available

- Patient can accept a new appointment with another provider that same day if one is available
- Patient can reschedule appointment for a later date

At this time if there is no other option for the person to be seen, the DOD may elect to see the patient. This is totally under the control of the DOD. Under no circumstances will the preceptor see the patient, due to ACGME rules.

WALK-INS

Patients who walk into the clinic with an acute problem, or request to be seen as a same day patient, will be scheduled by the front desk for the earliest available appointment. If patient is having severe acute problems, example: shortness of breath, chest pain, etc. the triage nurse will be notified so the patient can be handled appropriately. Every effort will be made for the patient to see their provider, but if their provider is not available, the patient will be seen by another available provider or referred to urgent care or emergency room.

ROUTINE NURSING RESPONSIBILITIES

Nursing staff are responsible for monitoring of the patient schedule each clinic half-day. When the patient arrives at the FMC, front desk staff changes the patient's status to "Checked-in" (Patient Slot Turns Blue). When the patient is "Roomed" by the nursing staff the status bar in the EHR is turned "Green". If the patient has their vital signs taken and are asked to wait in the hallway, the patient's status is changed to "Vitals Taken" which is Light Blue. Knowing these statuses will allow the resident's clinic to run more smoothly.

Prior to the start of each clinic half-day, nursing staff will start an office visit in the EHR for each patient. This office visit contains the templates the resident needs to successfully document the office visit. When the patient arrives and is "Checked-in" by the front desk, nursing staff will bring the patient back to an exam room and check their vital signs and enter them on the appropriate template of the EHR. Vital signs include height, weight, temperature, blood pressure, pulse, respirations, pain level and BMI. Nursing staff will also update the allergies and medications templates. If the patient is here for a well-child check nursing staff will also record head circumference and review immunizations.

Nursing staff will obtain urine specimens on all patients with chief complaints of urgency, dysuria and/or frequency. Likewise, if the patient presents with sore throat, the nurse will swab for strep test.

If a patient presents in clinic, and is experiencing chest pain at that time, an EKG will be done by the nurse.

Nurses will have all patients prepared for necessary examination - gowns for women, etc. Nursing staff are there to assist the provider. Please don't hesitate to ask for their assistance.

PATIENT EDUCATION

Patient education is important part of care. Education provided should be documented in the medical record as part of the office visit. Please review the Patient Handout section of the EHR and familiarize yourself with what education materials are available.

OB PROTOCOL FOR FAMILY MEDICINE

First year residents may be assigned new OB patients after they have satisfactorily completed their first month of OB training.

Second year residents may be assigned new OB patients at any time.

Third year residents may be assigned new OB patients whose EDC is prior to mid June.

Residents must have at least 2 continuity OB patients in the FMC

All assignments will be recorded and tracked by the SRAHEC OB Coordinator or Clinical Nurse Supervisor. All primary providers will be assigned a “buddy” in order to have back-up care. Residents are on call for their own OB patients in the last month of pregnancy. However, residents can arrange among themselves an on-call schedule for deliveries. This will not preclude the primary care resident from doing the delivery. This schedule will be given to the OB Coordinator, the answering service, the delivery room and posted in each section.

A copy of prenatal records will be forwarded to Labor & Delivery at CFVMC three times during OB care (or as needed). Copies will be brought to the floor at approximately 20 weeks, 24-26 weeks and again after GBS lab is completed. These records will be held in the triage area of the Labor & Delivery floor. A copy of the prenatal record will be given to the OB patient at 37 weeks. She will be instructed to keep it in her hospital bag.

The OB Coordinator will maintain a master calendar of OB patients. A master OB list will be kept on the ‘F’ drive for easy access. This list will include patient name, EDC, next appointment, primary provider and ‘buddy’. All OB patients should be directed to the OB Coordinator **after each clinic visit** to schedule procedures and future appointments in order to keep an accurate record.

It is prudent that each resident maintain his/her own list of OB patients and their EDC. (You may want to enter this in your Procedures Log.)

Once an OB patient has confirmed their pregnancy in our clinic (approx 5-6 weeks gestation) a

nurse visit will be set up for the patient at 8-10 weeks gestation. This nurse visit will be used to complete a thorough family history and OB/GYN history. It will also be used to assist in determining if there is significant patient/family history of DM making early GTT labs a requirement. Vitals will also be checked. This nurse visit note will then be forwarded to the primary OB provider for signature. This will give the resident an opportunity to review the history prior to the patient's first OB appointment at 12 weeks.

The first OB appointment will be scheduled for an extended office visit (approx 40 minutes). Using the OB List (CFV Duke OB) drop down menu list in orders, all procedures/labs will be ordered for this visit. A Cystic fibrosis screen should be offered to EVERY OB patient and added when agreed to using the 'extras' field at the top of the OB ordering list.

OB patients will be seen in FMC at 12, 16, 20, 24 and 28 weeks. At that time, appointments will be booked every 2 weeks for 30, 32, 34 and 36 weeks. Thereafter, the patient will be seen weekly until delivery.

MEDICAL RECORDS

INTRO:

In 2007 SR-AHEC implemented an electronic medical record (EMR). The Health Information Manager oversees the proper handling of paper and electronic health records.

The Health Information Manager (HIM) has the following responsibilities:

1. Complete supervision and monitoring of all medical records (electronic and paper) at Southern Regional AHEC organization.
2. Maintain security of the medical records and raise awareness of the confidentiality of patient health information. This includes compliance with HIPPA.
3. Authority to make copies of medical records upon receipt of an appropriate written release.
4. To check each record for completion, the following points are of particular interest:
 - a. Problem list and chronic medication lists must be current and complete
 - b. Progress notes must be complete, signed and dated in a timely manner.
5. To make suggestions for the improvement of the quality of medical records.

THE CHART/MEDICAL RECORD

For paper charts you will need to request the chart from Medical Records. Paper charts are not to be removed from the SRAHEC facility. If a paper document is required for patient admission to the hospital it must be copied and the primary document retained at SRAHEC advance notice to retrieve them.

Patient's paper charts are to be in the following places only:

1. In clinic section where patient is being seen

2. In the residents box in the preceptor room
3. In the bucket to be returned to Medical records
4. IN the medical records file room

SRAHEC currently utilizes GE Centricity Practice Solutions Practice Management and Electronic Health Record tasks. The EHR patient encounter starts with the selection of the proper encounter forms to document the visit. Training will be provided to all residents on the use of the EHR.

No one should discuss information contained in the patient's record with anyone who is not directly involved in the care of the patient. Any discussion about a patient by authorized personnel should not be in an area where another patient may overhear.

PHONE/TRIAGE NOTES

A record of all after business hour telephone calls needs to be entered into the patient chart.

DISABILITY INSURANCE AND WELFARE FORMS

Disability insurance and welfare forms addressed directly to the physician should be delivered to medical records after the physician completes required information. First year residents and others without a permanent NC medical license need to have the form co-signed by their team leader. Medical Records staff will place a copy of the form in the medical record.

TERMINATION OF PATIENTS FROM THE PRACTICE

Following a review by faculty and the Vice President/CEAS chief, patients may be denied further care at the Family Medicine Center. Formal notification is made by certified letter. Emergency care must be provided for thirty (30) days after the notification. Business Office personnel will update the practice management system to reflect the change in the patient's status.

DEATH CERTIFICATES

Routinely death certificates are received by residents. Once received the death certificates will be forwarded to Medical Records for completion and processing. Residents **may** fill out the certificate, but under **NO** circumstances will a resident sign a death certificate. The only person authorized to sign the death certificate is the Faculty Preceptor. See the Health Information Manager if you have any questions regarding these instructions.

Cape Fear Valley Health System:

For charts completed at Cape Fear Valley Medical Center, the history and physical must be dictated within 24 hours. A written history and physical must be on the chart at the time of admission. Discharge summaries must also be completed in a timely manner. Policies of Cape Fear Valley Medical Center must be followed with regard to timely completion of their medical records. Chronic offenders in the completion of medical records will receive progressive disciplinary action.

Guidelines for Dictation at CFVHS

Dictation from Within Hospital

1. Lift handset & listen for system instructions
2. Bypass instructions by entering required digits:
 - a. 4-digit physician number
 - b. 2-digit work-type
 - c. 7-digit patient admission number
 - Pre-admit, use 6's
 - To correct, press "*" & re-enter digits
3. Functions
 - a. **Dictate:** Press and hold "D" on handset. Release to stop.
 - b. **Rewind:** Press and hold "R" button. Release to stop. A tone will sound when the beginning of report is reached.
 - c. **Listen:** Press and hold "L" button.
 - d. **Fast Forward:** Press and hold "7" button.
 - e. **Dictate Several Reports:** Press the "next Report" button when the end of each report is reached. Go to step 2b.
 - f. **Disconnect:** Hang up

Dictations from Outside the Hospital

1. Dial dictation system – 609-5672
2. Listen for system instructions. Bypass instructions by entering required digits:
 - a. 4-digit physician number
 - b. 2-digit work-type
 - c. 7-digit patient admission number
 - Pre-admit, use 6's
 - To correct, press "*" & re-enter digits
3. Functions:
 - a. Listen for verbal prompt before beginning.

- b. **Short Review:** Press “3” to review last phrase dictated.
- c. **Continuous Review/Rewind:** Press “8” to review beginning of report.
- d. **Listen:** Press “1” anytime during review.
- e. **Fast Forward:** Press “7” to advance to end.
- f. **Pause of Dictation:** Press “4”. To resume press “2”.
- g. **Dictate Several Reports:** Press “5” when the end of each report is reached. Go to Step 2b.
- h. **Disconnect:** Always press “9”.

For any questions concerning the proper handling of patient medical records your first call should be to Medical Records (910) 678-7244.

FAMILY MEDICINE CENTER X-RAY

Procedures:

When an order is entered into the Electronic Health Record the patient should be directed to X-ray. Patients are treated on a first come first serve basis unless a stat order is sent. Once the X-ray has been taken the digital image can then be viewed on the X-ray viewing station in the Central Nursing area. For Specialty Clinic patients the image can be burned to a CD-ROM and sent to the provider. If the patient requires a copy of the X-ray a CD-ROM can be made for them. The patient may be asked to wait for results in waiting room or may be free to leave. The ordering physician should provide the reason for the X-ray in their order. The digital image along with a transcription log will be sent to a local radiologist who will return their findings daily.

Routine results are electronically sent to medical records for indexing into the patient’s chart. If results are called in by the radiologist, the call will be routed to the provider or the X-ray tech.

ROUTINE X-RAYS SHOULD BE SCHEDULED BETWEEN 8:30AM - NOON and 1:30PM - 4:30PM.

The following x-rays are routinely available at the Family Medicine Center:

Abdomen	Elbow
Ankle	Femur
Bilateral Hands	Finger
Cervical Spine	Foot
Chest	Forearm

Hand
Heel
Hip
Humerus
Knee
Lumbar Spine

Pelvis
Ribs
Shoulder
Tibia-Fibula
Toe
Wrist

NOTE: Other views may be available if the technician is able and qualified to do them. If you have questions on a specific type of X-ray it is important that you discuss the type of X-ray with the tech before ordering. Due to equipment or staffing limitations an X-ray may have to be referred out to either CFVHS or another vendor.

Please call extension 254 with any questions.

CHIEF RESIDENT POSITION

The Chief Resident & Junior Chief Resident position at Southern Regional AHEC is usually filled by one third year and one second year in good standing in the program. Interested residents are nominated and elected by all residents with final approval by the faculty. Each resident can only cast one vote per candidate. The term is for one year and begins approximately April 1 to facilitate overlap with the previous Chief Resident. Listed below are the role, duties and benefits associated with this position.

1. **RESIDENT VOICE:** The Chief Resident represents the residents. This role includes being the spokesman for the residents at faculty meetings and in situations where resident opinion is requested. The Chief should communicate resident concerns and issues. Views of all residents, including minority opinions, should be represented. The Chief should attempt to lead the residents to consensus when possible and present this unified voice to the faculty. The Chief should also be prepared to voice their own opinions at faculty meeting and as requested when appropriate.
2. **LIAISON:** The Chief Resident is the liaisons between faculty, residency coordinator and residents. They are responsible to accurately report back to the residents decisions made at faculty meetings. The Chief should be able to convey that the residents' voice was heard, regardless of outcomes. The Chief Resident should be available to the director, residency coordinator, and other faculty regarding resident concerns as requested.
3. **NEGOTIATIONS:** The Chief Resident is responsible for monitoring the general "feel" of the group, identify individual problems, negotiate solutions between residents and intervene or refer when appropriate. They are also responsible to the Program Director to keep the Director aware of ongoing problems or issues that affect the program. The Chief Resident is also required to "fill-in" in unexpected emergencies or help negotiate solutions. Every effort should be made to maintain "harmony".
4. **COMMUNICATIONS:** The Chief Resident is responsible to be open to communications with faculty, residency coordinator, hospital representatives, and outside agencies (e.g. recruiters, pharmaceutical representatives).
5. **ROLE MODEL:** The Chief Resident is to serve as role models to other residents.
6. **BUSINESS REQUIREMENTS:**
 - a. Conducts monthly Chief Resident meetings and facilitates communication between residents and addresses concerns.
 - b. Attends Faculty meeting and provides a Resident Report.
 - c. Schedules: Chief Resident is responsible for the schedules listed below. They will coordinate these schedules with the Program Director and Residency Coordinator:
 - i. Master Rotation Schedule
 - ii. Monthly Medicine Call Schedule
 - iii. Coordination of OB and PEDs call schedule with Medicine

- iv. Coordinate Jeopardy Call Schedule
 - d. Handle scheduling emergencies and 'trouble shoot' conflicts
 - e. Management of PTO leave requests as it relates to the call system
 - f. Maintain and assure equal resident distribution of medicine call, which includes keeping track of #weekend and #ER calls per resident
 - g. Distributes information to residents in a timely manner. Such information may include AAFP/NCFP meetings, announcements, grant applications, moonlighting/job opportunities, etc.
 - h. Represents residents at Practice Meetings.
 - i. Assists residency coordinator with graduation planning and organization.
 - j. Manuals. Monitor and update the survival manual.
 - k. Participates in new resident orientation.
7. SOUTHERN REGIONAL AHEC COMMITTEE INVOLVEMENT: The Chief Resident is required to participate in Southern Regional AHEC Committees as well as promote the participation of all residents in committees. The Chief Resident is a member of the Family Medicine Graduate Education Committee (FMGMEC).
8. RECRUITMENT: The Chief Resident is required to participate in recruiting activities of the residency including the recruitment committee, fairs, meetings and the actual recruitment process of residents, and faculty when appropriate.
9. COMMUNITY INVOLVEMENT: Chief Resident is responsible for:
- a. Representing the residents/residency at meetings outside of Southern Regional AHEC
 - b. Participating in career days, health fairs, etc.
 - c. Promoting the involvement of all residents in appropriate community issues and the representation of the residency outside of Southern Regional AHEC.
10. SUPERVISION: Direct supervision of the Chief Resident's performance is by the Family Medicine Program Director.
11. BENEFITS
- a. Chief Residents will each receive an additional \$100 of CME funds
 - b. An increase in annual salary of \$1500.
 - c. The Chief Resident will attend a Chief Resident Leadership Conference
12. TERMINATION: If a Chief resident is grossly negligent of their duties or fail to meet the requirements of the position or the residency program, they may be terminated from the position. The request for removal may originate from residents or faculty, will be given due process but will ultimately be the decision of the faculty after careful consideration of the concerns.
13. CHIEF RESIDENT SELECTION PROCESS: Residents who are interested in the position of Chief Resident should write a one page "position paper", stating why they would like to be Chief and why they are qualified for the job. It would be beneficial for the residents who are voting to have the opportunity to read this before the day of elections. On the day of

elections, the candidates should answer any questions residents may have.

Junior Chief Job Description

QUALIFICATIONS

A rising second year in good standing with the program without a history of probation

RESPONSIBILITIES

The term is for one year and begins approximately April 1 to facilitate overlap with the previous Junior Chief Resident. Listed below are the roles and duties associated with this position.

The main role of the Junior Chief will be as an aide to the 3rd Year Chief in their administrative responsibilities.

1. **RESIDENT VOICE:** The Junior Chief represents the residents. This role includes being the spokesman for the residents at faculty meetings and in situations where resident opinion is requested. The Chief should communicate resident concerns and issues. Views of all residents, including minority opinions, should be represented. The Chiefs should attempt to lead the residents to consensus when possible and present this unified voice to the faculty. The Chiefs should also be prepared to voice their own opinions at faculty meeting and as requested when appropriate.
2. **NEGOTIATIONS:** The Junior Chief, along with the Chief Resident, is responsible for monitoring the general "feel" of the group, identify individual problems, negotiate solutions between residents and intervene or refer when appropriate. They are also responsible to the Program Director to keep the Director aware of ongoing problems or issues that affect the program. The Junior Chief Resident may be required to "fill-in" in unexpected emergencies or help negotiate solutions.
3. **COMMUNICATIONS:** The Junior Chief Resident is responsible for open communications with faculty, residency coordinator, hospital representatives, and outside agencies (e.g. recruiters, pharmaceutical representatives).
4. **ROLE MODEL:** The Junior Chief Resident is to serve as a role model to other residents.
5. **BUSINESS REQUIREMENTS:**
 - a. Helps conduct monthly Chief Resident meetings and facilitate communication between residents and addresses concerns.
 - b. Will not attend Faculty meetings, as this is a Chief Resident responsibility.
 - c. Schedules: Will assist the Chief Resident in creating and maintaining the following schedules. They will coordinate these schedules with the Assistant Program Director, Program Director and Residency Coordinator:

- i. Master Rotation Schedule
 - ii. Monthly Medicine Call Schedule
 - iii. Coordination of OB and PEDs call schedule
 - iv. Jeopardy Schedule, if applicable
 - v. Following Senior Schedule, if applicable
 - d. Handle scheduling emergencies and 'trouble shoot' conflicts
 - e. Management of PTO leave requests, as it relates to the call system
 - f. Maintain and assure equal resident distribution of medicine call.
 - g. Distributes information to residents in a timely manner. Such information may include AAFP/NCFP meetings, announcements, grant applications, moonlighting/job opportunities, etc.
 - h. Represents residents at Practice Meetings.
 - i. Assists residency coordinator with graduation planning and organization.
 - j. Participates in new resident orientation.
6. SOUTHERN REGIONAL AHEC COMMITTEE INVOLVEMENT: The Junior Chief Resident may be required to participate in Southern Regional AHEC Committees as well as promote the participation of all residents in committees. The Junior Chief Resident is a member of the Family Medicine Graduate Education Committee (FMGMEC).
7. RECRUITMENT: The Junior Chief Resident is required to participate in recruiting activities of the residency including the recruitment committee, fairs, meetings and the actual recruitment process of residents, and faculty when appropriate.
8. COMMUNITY INVOLVEMENT: The Junior Chief Resident may be responsible for:
 - a. Representing the residents/residency at meetings outside of Southern Regional AHEC
 - b. Participating in career days, health fairs, etc.
 - c. Promoting the involvement of all residents in appropriate community issues and the representation of the residency outside of Southern Regional AHEC.
9. SUPERVISION: Direct supervision of the Junior Chief Resident performance is by the Chief Resident and the Family Medicine Program Director.
10. TERMINATION: If a Junior Chief is grossly negligent of their duties or fail to meet the requirements of the position or the residency program, they may be terminated from the position. The request for removal may originate from residents or faculty, will be given due process but will ultimately be the decision of the faculty after careful consideration of the concerns.
11. JUNIOR CHIEF RESIDENT SELECTION PROCESS: Residents who are interested in the position of Junior Chief Resident, and with the approval of their faculty team leader, should write a one page "position paper", stating why they would like to be Junior Chief and why they are qualified for the job. All residents will vote for the Junior Chief Resident.

RETREAT COMMITTEE GUIDELINES

The Residency program holds an annual Resident/ Faculty Retreat. The retreat committee will always have the following representatives: Two residency faculty members (including the most recently hired faculty member), the residency coordinator, and two residents.

The committee will report to the faculty at faculty meetings at several fixed intervals: At conception of the committee (about three months prior to the retreat), when plans are being finalized (one month prior to the retreat), two weeks prior to the retreat (to finalize memos to residents, faculty, community preceptors, and to check last minute details), and two to four weeks after the retreat to present a wrap-up or summation of lessons learned both about process and content, including a report of a satisfaction/utility survey. Retreats must adhere to the budget and to all SR-AHEC travel policies.

The committee will be responsible for distributing an agenda and directions to everyone prior to the day of the retreat.

There are several purposes and goals of a resident-faculty retreat. One goal is to have a day where residents, faculty, and staff can interact in a less formal, less structured setting. Another goal is to tackle an issue or problem (e.g. medical malpractice, team building exercises) that cannot otherwise be addressed in normal settings (e.g. faculty meetings, curriculum committee meetings, noon conference, etc.). Another goal is to have fun.

Who needs to go to the retreat? This is up to the committee to recommend to the faculty well prior to the retreat. For example, if the retreat were to cover coding, obviously the staff would need to be there. If the retreat were to cover computer issues, REIS faculty may need to be there.

The committee should make a recommendation at the conclusion of the follow up report as to when the next retreat should be (the following year, in six months, or other).

APPENDIX A...FACULTY AND KEY STAFF LISTING

FACULTY LISTING

Eron Manusov, M.D.	Director, Family Medicine Interim Director, Osteopathic Medical Education
Ada Ventura-Braswell, M.D.	Director, Obstetrics & Gynecol
John Hall, D.O.	Asst. Director of Osteopathic Medicine, Faculty Advisor
Niveen Iskander, M.D.	Director, Pediatric Education
Sushma Kapoor, M.D.	Associate Director, Faculty Advisor
Kimberly Lewis, Pharm.D.	Asst. Director, Pharmacotherapy Education
Howard H. Loughlin, M.D.	Director, Specialty Clinic, Pediatric Education
Donald Maharty, D.O.	Director, Osteopathic Student Medical Education
Dan Marlowe, PhD	Director, Behavioral Science Education
James A. Mergy, M.D.	Director, FM Clinic; Associate Director, Faculty Advisor
Susan Miller, Pharm.D.	Director of Pharmacotherapy Education and Director of Pharmacy Residency
Lenard D. Salzberg, M.D.	Associate Director, Faculty Advisor
David Tat, M.D.	Director, Internal Medicine & Infectious Disease

KEY STAFF LISTING

Deborah Teasley, ext. 230	President/CEO/Designated Institutional Officer
Eron Manusov, ext 203	Program Director, Family Medicine Residency; Vice-President, Clinical Education and Services
Lynn Greene, ext. 232	Vice-President, Administration & Finance
Russet Hambrick, ext. 249	Vice-President, Regional Information & Education Services
Phil Anderson, ext 113	Clinical Information Manager
Linda Baez, ext. 247	Human Resources Director
Drew Hales, ext. 218	EMR Support Technician
Carl Keiper, ext 251	Clinical Service Manager
Lori Rameriz, ext. 308	Scheduling Services Coordinator
Wendy Morgan, ext. 260	Residency Administrative Assistant
Deana Lilley, ext. 259	Family Medicine Residency Coordinator
Jennifer Powell, ext. 117	Practice Business Manager
Michael Spexarth, ext 114	System Administrator (Computer Services)
Saundra Stanley, ext 316	Admin. Student Services/Community Based Practices
Claire Vogeley, ext. 230	Administrative Assistant/ Credentialing Specialist
David Webb, ext. 211	Corporate Controller

NURSING

Joshua Oxendine, RN, Nursing Supervisor, ext. 202
Jamie Anderson, RN, Specialty Clinic Nurse Coordinator, ext. 221

Green Section

Sandra Stokes, RMA, ext. 292
Roshanda Bronson, LPN ext. 291

Yellow Section

Ingrid Rodriguez, RMA, ext. 237
Lynda Sabalboro, CMA 278

Blue Section

Val Locke, RMA ext. 285
Michelle Vida, RMA ext. 288

OB Coordinator

Lanna Jacobs-Harris, RMA, ext. 243

ACC

Christy Spears, RMA, 219

MESSAGE CENTER ext 440

Pat Sherman, Message Center Patient Representative, ext. 229
Sara Flowers, Message Center Patient Representative, ext. 215
Kristen McMillan, Message Center Patient Representative, ext.294

REFERRALS

Erica Vandiford, Referrals Coordinator, ext. 131
Chevelle Carter, Referrals Coordinator, ext. 307

LABORATORY/X-RAY

Ashley Posey, Medical Lab Manager, ext. 037
Judith Farrior, Medical Lab Technician, ext. 254
Cassandra Hopkins, X-Ray Technician/Lab Technician, ext. 303 or 254
Kenyana Thompson, X-Ray Technician/Lab Technician, ext. 120 or 254
Jo Ann Brady/Lab Corp Phlebotomist, ext. 122 or 254
Shawn Carver/ Lab Corp Phlebotomist, ext. 122 or 254

FAMILY MEDICINE RECEPTION DESK

Brittany Nogueros, ext 256
Nick Ammons, ext 135
Bertha Stackhouse ext 023

ACC RECEPTION DESK

Ginger Akins, ext. 105

MEDICAL RECORDS/TRANSCRIPTION

Pam Frost, Health Information Manager, ext. 245
Danielle Andrews, Clerk, ext. 244
Lisa Anderson, Clerk, ext.213

APPENDIX B...SR-AHEC Personnel Manual

Policies in the SR-AHEC Personnel Manual that pertain to your employment at Southern Regional AHEC are listed below. Please consult your Personnel Manual for additional information. The Personnel Manual can be found on the W drive:
W:\References\Personnel Manual.

Policy#	Policy Title	Policy#	Policy Title
050	Employee Acknowledgement Form	501	Safety/OSHA
103	Equal Employment Opportunity	504	Use of Phone and Mail Systems
104	Diversity	505	Smoking
105	Business and Patient Care Ethics and Conduct	508	Use of Equipment and Vehicles
106	Hiring of Relatives	509	Emergency Closings
107	Immigration Law Compliance	510	Visitors in the Workplace
108	Conflicts of Interest	510A	Children in the Workplace
109	Outside Employment	511	Computer and E-mail Usage
110	Confidentiality/Non-Disclosure	512	Internet Usage
111	Disability Accommodation	513	Workplace Monitoring
114	Re-employment	514	Workplace Violence Prevention
201	Employment Categories	515	Ergonomics
202	Access to Personnel Files	601	Medical Leave
205	Personnel Data Changes	602	Family Leave
301	Employee Benefits	603	Personal Unpaid Leave
303	Workers' Compensation Insurance	604	Military Leave ⁷⁴
304	Bereavement Leave	701	Employee conduct and Work Rules
305	Jury Duty	702	Drug and Alcohol Use
306	Benefits Continuation (COBRA)	703	Sexual and Other Unlawful Harassment
309	Health Insurance	706	Name Badges
310	Life Insurance	707	Return of Property
311	Short-Term Disability	709	Security Inspections
312	Long-Term Disability	710	Solicitation
313	401(k) Savings Plan	800	Life-Threatening Illnesses in the Workplace
316	Parking	801	Compliance Program
402	Paydays	802	Communications Policy
404	Administrative Pay Correction		
405	Pay Deductions		

APPENDIX C...Clinical Services Manual

Listing of policies in the Clinical Services Manual that pertain to processes within Clinical Education and Services (CEAS) Division.

Policy #	Policy Title
CEAS-1	Scope of Services
CEAS-2	Patient Care Assignments
CEAS-3	Bioethics Committee Consultation
CEAS-4	Patients Rights and Responsibilities
CEAS-5	Chart Audits
CEAS-6	Care of the Terminally Ill Patient
CEAS-7	Informed Consent
CEAS-8	Consents
CEAS-9	HIV Consent
CEAS-10	Consent for Photograph/Video Monitoring or Taping
CEAS-11	Patient Confidentiality
CEAS-12	Surrogate Decision Makers
CEAS-13	Resolving Conflicts of Care
CEAS-15	Power of Attorney for Healthcare
CEAS-17	Code of Ethics
CEAS-18	Conflict of Interest
CEAS-14	Do Not Resuscitate Orders
CEAS-16	Hearing Impaired or Non-English Speaking Patients
CEAS-24	Termination of Patient Care
CEAS-25	Plan for the Provision of Patient Care
CEAS-26	Radiology
CEAS-27	Laboratory
CEAS-28	Medical Records
CEAS-29	Pharmacy
CEAS-30	Mental Health
CEAS-31	Referrals
CEAS-32	Provision for Nursing Care
CEAS-33	Business Office
CEAS-34	Appointments
CEAS-35	Patient Check-in
CEAS-37	No-Shows/Missed/Late Appointments
CEAS-38	Referrals for Services
CEAS-39	After Hours Care
CEAS-40	Transferring for Medical Services
CEAS-41	Investigational Treatment Trials
CEAS-42	Informed Decision Making
CEAS-43	Drug Samples
CEAS-44	Patient Directives
CEAS-45	Patient Appointments
CEAS-46	Staff Recruitment and Retention, Development and Education
Pt Care	Patient Education and Educational Assessment

APPENDIX D -- North Carolina Medical Board Disciplinary Guidelines

Among the things that bring physicians to the Board's attention and result in disciplinary actions, the following ten are particularly common. They are not presented here in order of importance – the Board considers all violations of the Medical Practice Act to be important.

So be aware, the Board's attention will focus on you if it has reason to believe you may have...

- abused alcohol or controlled substances, or used illegal drugs;
- prescribed inappropriately;
- violated the boundary between patient and physician by sexual exploitation or other means;
- practiced incompetently or provided care below acceptable standards;
- behaved disruptively or unprofessionally;
- exploited patients for financial gain;
- abused patient rights (which are well described in the section of the American Medical Association's *Code of Medical Ethics* reprinted on the back of this sheet);
- improperly supervised physician assistants or nurse practitioners;
- practiced or behaved in a manner that brought about a restriction or revocation of your privileges by a hospital, HMO, or other medical institution or organization; or
- failed to respond in a timely manner to a request from the North Carolina Medical Board for information or for an appearance before the Board.

For more detailed information or questions, please contact the Assistant Program Director.